

How do therapists experience working with interpreters,
particularly in regard to issues relating to power and the
therapeutic alliance?

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Abstract

This study aimed to explore therapists' experience of working with language interpreters in therapy, particularly in relation to issues of power and the therapeutic alliance.

Semi-structured interviews were conducted with ten qualified therapists working within an IAPT or secondary care psychology service from one London NHS Trust. The interviews were supplemented with a diagrammatic elicitation task. The verbal data were analysed using IPA from a critical realist epistemological position, to support a contextual understanding of the experiences.

The analysis resulted in the development of three super-ordinate themes: "The system is the most powerful thing", the knotty question of power, and dyadic and triadic alliances. Each was supported by several sub-ordinate themes, with the first super-ordinate theme considered as an overarching theme as it related to most aspects of participants' experiences.

One of the key findings of the study related to an understanding of the context of the therapy setting as a driver of therapists' experience of working with interpreters. Whether the therapist experienced the 'system' as pressured and demanding or supportive, appeared to link to how they perceived and related to the interpreter, particularly in terms of issues of power and alliances. A Kleinian psychoanalytic theoretical framework was drawn upon to contextualise the analysis and offer a way of understanding the impact of organisational factors on the therapists' experience.

The findings of the study suggest that an understanding of how therapists experience power dynamics and the therapeutic alliance when working with an interpreter is enhanced by contextualisation of the experiences. The new insights into how contextual factors may drive therapists' experiences of working with interpreters offer a contribution to current research focusing on the interaction between organisational systems and the experiences of NHS and IAPT psychological therapists.

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Abbreviations

A&E: Accident and Emergency

BAME: Black Asian and Minority Ethnic

BPS: British Psychological Society

CAMHS: Child and Adolescent Mental Health Service

CAT: Cognitive Analytic Therapy

CBT: Cognitive Behavioural Therapy

EMDR: Eye Movement and Desensitisation Reprocessing

IAPT: Improving Access to Psychological Therapy

IPA: Interpretative Phenomenological Analysis

LEP: Limited English Proficiency

NHS: National Health Service

NICE: National Institute of Clinical Excellence

PTSD: Post Traumatic Stress Disorder

TA: Therapeutic Alliance

UEL: University of East London

UK: United Kingdom

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Introduction

1.1 Chapter Overview

This section begins by providing the context to my interest in understanding therapists' experiences of working with language interpreters, followed by the background to, and rationale for, investigation of this topic. The research aims and relevance to Counselling Psychology are then offered.

1.2 My Personal Interest in the Topic

Counselling Psychologists often become aware of a need for research through their own direct experience, by sensing a gap in their own ability or knowledge, or observing a gap in that of others (Kasket, 2012). In my own case, I had been working with interpreters in therapy regularly in my role as a High Intensity Cognitive Behavioural Therapist (CBT) in an Improving Access to Psychological Therapies (IAPT) service, with a wide variety of experiences of doing so, and not much reflection on how I related to the interpreter. Having begun my Counselling Psychology training, I began to develop my humanistic values, and to broaden my clinical experience to include working in other models of therapy, and to a secondary care psychology setting. This resulted in me viewing the experience of working with interpreters through a new lens. Through my own reflective process, I became aware of my previous lack of focus on the therapeutic alliance and power dynamics. My curiosity to learn more about how other therapists experience working with interpreters, particularly in relation to these elements of the work, was sparked.

1.3 Background to the Research Topic

The need for, and benefits of, the provision of language interpreters for therapy have been established, and are supported through guidelines, research and legislation. However, there may be factors which impact on therapists' and organisations' experience of meeting the requirements.

1.3.1 Prevalence of need. Over the last 2 decades England and Wales have become more ethnically diverse, and a recent UK National Census (Office for National Statistics, 2012) showed that among the population there were 726,000 individuals who could speak English, but not well, and 138,000 who

could not speak English at all. This equates to around 1% of the population, though in areas of London this figure rises to between 8 and 9%. This same census found having Limited English Proficiency (LEP) to be linked to a worse health status, which the authors suggest may be due to lower proficiency in English making it difficult to access suitable health care. The Department of Health (2005) has highlighted the low uptake of psychological therapy by Black and Asian Minority Ethnic (BAME) communities, and has identified not being able to speak the common language as a key barrier to accessing therapy. For clients with LEP, a language interpreter may be required in order to be able to access psychological therapy.

1.3.2 Provision of therapy. In England and Wales, people who access psychological therapy through the NHS may do so through their local IAPT service or (for more complex or chronic difficulties) secondary care psychology service.

IAPT is an NHS programme designed to increase access to psychological therapies for the general population, offering NICE approved psychological treatment for depression and anxiety disorders, using a stepped care model. Its original inception was based on the economic argument that funding an increase in access to psychological therapies would become cost-neutral as anxiety and depression-related public costs, such as welfare benefits and medical costs, would be reduced, and revenue from people returning to work through taxes and productivity would increase (Clark, 2011). The IAPT programme set initial targets relating to the number of patients to be seen, and for 'recovery rates' for patients. Additionally, it was expected that within three years 25,000 fewer people would be on sick pay or receiving state benefits. By 2017, IAPT had reached a rate of access of 960,000 per year and a recovery rate of 51%. Continued expansion of the programme is supported by the current UK government with a target of a 1.5 million access rate by 2021 (Clark, 2018).

Ensuring that people's access to psychological therapies is not hindered by their ethnicity, culture or language, forms a key aim of the IAPT programme (Department of Health, 2009) and is protected by the Equality Act 2010. This Act imposes a duty on organisations to ensure they can demonstrate how they are advancing equality of opportunity for different groups in the uptake of health care services, including people with LEP. It is acknowledged that not to provide

a service on the grounds of language would contravene this Act (South London and Maudsley NHS Foundation Trust, 2016, p.4). NICE guidance relating to providing psychological treatment for people with depression and anxiety explicitly stipulates that services must provide, and therapists must work proficiently with an independent interpreter if one is needed (NICE, 2009; NICE, 2011). The British Psychological Society (BPS) offer good practice guidelines recommending that all psychologists should receive training in working with interpreters so as to ensure that certain groups are not being denied access to psychological services on grounds of language (BPS, 2017). In 2017, the London Mental Health Trust, from where the participants for this study were recruited, undertook 6,945 face-to-face sessions, in 65 different languages, using interpreters (South London and Maudsley NHS Foundation Trust, 2017).

A recent survey has shown that psychological professionals in the UK are feeling increasingly stressed in their jobs (NHS, 2015). The authors describe an overall picture of burn-out, low morale and increasing stress and depression for NHS psychology staff. The findings of the study suggest that the target driven environment, particularly in IAPT, is experienced by therapists as pressured and demanding. IAPT was described by survey respondents as being politically driven and fixated on targets. Pressure to meet these targets, extra administrative demands, an increase in having to work unpaid hours, and staff being prevented from providing adequate therapy due to resource cuts, were frequent themes in contributing to stress and low morale (NHS, 2015).

1.3.3 Literature relating to working with interpreters in therapy.

Existing literature generally supports the value of working with interpreters in therapy.

Undertaking therapy in a person's first language has been shown to be of benefit. Studies have shown that recall in the original language increases emotional intensity (Marian & Kaushanskaya, 2014), and that memories are more numerous, detailed and emotionally marked when expressed in the language in which they were experienced (Schrauf, 2000). It has been observed that the process of translation from a first to a subsequent language can serve to distance the client's emotional connection to the material, allowing experiences expressed in a second language to be kept as unreal (Buxbaum, 1949). It is widely acknowledged that some words or expressions have a very

culturally specific meaning, which may feel untranslatable to the client, resulting in the meaning of that experience being altered or missed in its communication to the therapist (Marian & Kaushanskaya, 2014).

Therapy using interpreters has been found in quantitative research to be as effective as psychotherapy with direct communication (D'Ardenne, Ruaro, Cestari, Fakhoury, & Priebe, 2007), and to be associated with improved clinical outcomes for patients (Brune, Eiroa-Orosa, Fischer-Ortman, Delijaj, & Haasen, 2011). However, qualitative research has reported mixed findings relating to how well therapy can work through an interpreter, particularly when working psychodynamically (Darling, 2004; Foster, 1998).

1.3.4 Alliances and power relations in therapy. Research suggests there may be an impact on the Therapeutic Alliance (TA) when an interpreter is used in therapy (Tribe & Thompson, 2009b), and that issues relating to power may be particularly relevant when working with clients from BAME and refugee populations (Patel, 2003).

Most current conceptualisations of the TA are based on Bordin's (1979) definition of an agreement on goals, tasks and the development of bonds between the therapist and client (Becher & Wieling, 2015). A robust positive relationship between the TA and therapy outcome has been shown (Horvath, Del Re, Fluckigers, & Symonds, 2011) and qualitative studies exploring client experience have highlighted the value of the TA in enabling change and recovery (McManus, Peerbhoy, Larkin & Clark, 2010).

Power is exercised in the social, economic, and political relations between individuals and groups, and is perpetuated through social divisions, including gender and ethnicity, and through institutions and organisations (Patel, 2003). In therapy, it may be considered that the practitioner is in a position of power, and the dynamics within the therapy relationship may also reflect wider societal imbalances (Cooper, 2009).

1.4 Rationale for the Study

The need for provision of language interpreters to enable people with LEP to access psychological therapy is clearly established, and the requirement for therapists to work with interpreters in therapy is supported through legislation and guidelines. However, there are a number of factors that may

impact on the therapist's experience of doing so. There may be an impact on the therapeutic alliance, and dynamics relating to power may be affected when working with an interpreter. Recent research relating to stress experienced by NHS psychology staff suggests there may also be factors relating to the environment in which therapy is offered that impact on the therapists' experience. Little previous research has considered the experiences of therapists within the context of the therapy setting. Research exploring therapists' experiences of power and alliances when working with interpreters, within the contexts of the services provided, could offer a timely and valuable contribution to the literature relating to therapists' experience of working with interpreters.

1.5 Aim of this Research

The aim of this study was to explore therapists' lived experiences and perceptions of the power dynamics and therapeutic alliances when working with an interpreter, with a secondary focus on gaining an understanding of the impact of the context of the therapy setting on these experiences. The methodology used to achieve this aim was Interpretative Phenomenological Analysis (IPA), a qualitative research approach concerned with exploring in detail how people make sense of their lived experiences (Smith, Flowers & Larkin, 2009).

1.6 Relevance to Counselling Psychology

An exploration of therapists' lived experiences and perceptions of alliances and power dynamics when working with interpreters is highly relevant to Counselling Psychology (as well as to mental health generally) with its emphasis on the client's subjective experience, an orientation towards empowering clients, and commitment to non-hierarchical client-therapist relationships (Cooper, 2009). This study aimed to illuminate and complement existing research into the ways therapists experience and conceptualise alliances and power dynamics when working with an interpreter in therapy, as well as offering new insights into how the context of the therapy impacts on these experiences. It is hoped these insights could be used to support understanding of how organisational systems, at a national and local service level, interact with therapists' experiences, as well as inform the training of

Counselling Psychologists and other psychological therapists relating to working with interpreters in therapy.

1.7 Summary

This section provided an overview of the origins of this study and a background to the topic. The rationale for this research, based on the importance of studying this topic and meeting gaps in existing literature, was provided. The relevance and potential contribution to Counselling Psychology theory and practice of the study were stated.

The next section will provide a critical review of existing literature and empirical findings relevant to the topic of the research. This will provide a fuller illustration of the rationale for this study, presenting a more detailed discussion of the gap in the existing literature that led to the development of the research aims.

Literature Review

2.1 Introduction

In this section I critically review the available literature relating to the experiences of therapists working with language interpreters, organising the findings of the review into conceptual areas. The chapter concludes by highlighting the key findings of the review, and offering a proposal for a research study to meet the identified need.

2.2 Literature Review Findings

2.2.1 Effect of interpreters on therapy outcomes. The use of professional interpreters is associated with improved clinical care and outcomes in health care generally (Karliner, Jacobs, Hm Chen & Mutha, 2007). However, there is little research that investigates the use of interpreters and their effect on psychotherapy outcomes, although that which does exist suggests similar findings.

D'Ardenne et al. (2007) compared routine clinical outcomes of three groups of clients with Post-traumatic Stress Disorder (PTSD) receiving CBT: refugees who required interpreters, refugees who did not, and English speaking non refugees. They found that refugees with interpreters showed proportionally more improvement than refugees without interpreters, though this did not reach statistical significance. The authors conclude that use of interpreters in CBT is feasible and is associated with improved clinical outcomes. This study was conducted under routine clinical conditions, improving the generalisability of the results to similar 'real-world' services. However, the cultural appropriateness of PTSD measures may be questioned, affecting the validity of the study, and there was no exploration of factors which might have contributed to the improvement shown where an interpreter was present.

Brune et al. (2011) compared the outcomes of 190 individual psychotherapies with refugees with a diagnosis of PTSD: half of the therapy was conducted with interpreters, and half without. The clients in this study received therapy that contained elements of psychodynamic, cognitive and supportive psychotherapy, and measures of depression and global distress (rather than PTSD) were used to measure the severity of symptoms. The authors concluded that the outcome of therapy using an interpreter is as

effective as psychotherapy with direct communication, and propose that psychotherapy with the help of an interpreter should not be considered a poor alternative.

2.2.2 Using different therapy models. The existent research relates to therapists working with a variety of different therapy models. Regardless of the model used, there seems to be agreement that simplifying interventions is helpful when working with an interpreter. For example, Mofrad and Webster (2012) suggest that behavioural interventions, such as exposure and behavioural activation, are useful as they rely on basic human learning rather than detailed language, and, when working psychodynamically, Darling (2004) suggests that comments and reflections should be kept concise.

Some research documents concern about the interpreter not understanding specific techniques of therapy, such as the use of reflecting (repeating) or silences (Kuay, Chopra, Kaplan & Szwarc, 2015), or of specific interventions such as Eye Movement Desensitisation and Reprocessing (EMDR) (Miller, Martell, Pazdirek, Caruth & Lopez, 2005). The view has been expressed that ongoing psychotherapy, especially psychodynamic therapy, cannot work with an interpreter (Foster, 1998). The ability of a client to express transference through an interpreter has been questioned (Schweitzer, Rosbrook & Kaiplinger, 2013) and, in relation to similar concerns, the phrase 'complex emotional reactions' has been adopted by some authors to explain the dynamics that arise in an interpreter triad (Tribe & Thompson, 2009b).

There is, however, research that supports the viability of working psychodynamically in therapy with an interpreter (Schweitzer et al., 2013). Darling (2004) concludes that it does seem possible and hopeful to carry out this type of work. Darling (2004) suggests maintaining an awareness of the likelihood of tentative comments being translated more literally which may change their meaning, giving the example of her tentative 'I wonder' being translated to 'she thinks'. In relation to Cognitive Analytic Therapy (CAT), Emilion (2011) found that working through an interpreter works well if the therapist is able to have a dialogue, both in relation to self and with the interpreter, constantly exploring the explicit and implicit meanings in what is being discussed, and if there is reflection on the feelings evoked in the therapist

and the interpreter, and these are conceptualised in the form of reciprocal roles (patterns in relationships).

2.2.3 Role of interpreter. The role and tasks of the interpreter in a therapy setting are much debated (Tribe & Thompson, 2009a). Traditionally, interpreters acted as a 'black box' providing a strict word for word translation between the therapist and client (Miller et al., 2005). However, it has been suggested they actually fulfil a wider role, including cultural brokerage, cultural consultancy, advocacy and conciliation (BPS, 2017), with the task of translation involving translating at the literal, metaphorical, cultural and non-verbal levels of communication, and making sense of the world-view of each party (Schweitzer et al., 2013).

Within the studies reviewed, the majority of therapists viewed interpreters as being more than a simple language translator. For example, one participant stated "Interpreters are not a mouthpiece but are central to all aspects of our work." (Yakushko, 2010, p.452). Participants in a number of studies highlighted the advantages of working with an interpreter in terms of their role as a cultural broker (Quinn, 2011; Mofrad & Webster, 2012; Emillion, 2011), particularly as a 'cultural bridge', and in enhancing the therapist's overall understanding of their clients (Engstrom, Roth, & Hollis, 2010).

However, there were examples where it was clear that the therapist did not value the role of the interpreter, even viewing the presence of the interpreter as an intrusion or an unfortunate necessity (Miller et al., 2005). The most extreme position was from one clinician who stated that they did not wish the interpreter to offer any cultural information "Don't interpret. Just translate verbatim whatever they say. And even if you don't understand what they are saying, it doesn't matter." (Becher & Wieling, 2015, p.454). The literature also highlights mixed views relating to the interpreter's role in relation to the therapist. In Kuay et al. (2015), one participant talked of "conjoint work" with the interpreter, whereas for others in the study clear boundaries between the roles were seen as important; "I don't see them as a co-therapist, I'm the therapist." (p.285).

2.2.4 Interchangeability of the interpreter. The research contains a mix of views relating to the importance, or not, of having a consistent interpreter

during the therapy. Brune et al. (2011) suggest that the triad should always be made up of the same persons, believing that the therapeutic process would be interfered with should the interpreter change. Darling (2004) agrees, viewing continuity of the interpreter as an essential part of maintaining the psychoanalytic frame. Baker, Izzo and Trenton (2015) hold a different view; whilst commenting on the therapeutic frame and the importance of its maintenance, they suggest that a client preference for a particular interpreter may be dysfunctional and wonder if it may be evidence of splitting or the client defending against their own displacement by creating a situation where they are no longer the outsider. They suggest that a tolerance for interchangeability of interpreter from all parties is a positive sign of a strong therapeutic alliance between the therapist and client, and that rotating interpreters over the course of therapy is preferable.

2.2.5 Positive and negative experiences. The literature suggests that many practitioners view working with interpreters in a negative light, at least initially. One study, which interviewed both trainee and qualified counsellors working in a variety of settings within the UK, found the participants reported a sense of unease and curiosity about working with an interpreter (Quinn, 2011). Other studies have mentioned therapists' anxieties about being observed in their practice (Mofrad & Webster, 2012; Schweitzer et al., 2013). Other concerns cited by therapists have been related to inaccuracies in translation, and a sense that interpreters are taking over the therapy (Raval & Smith, 2003). Specific examples relating to inaccuracies in translation include concerns that the interpreter had filtered the meaning (Quinn, 2011) or omitted information (Engstrom et al., 2010). Concerns about difficulty in communicating empathy were cited, with one participant commenting "Often I think they might experience the interpreter as being empathic towards them rather than me." (Pugh & Vetere, 2009, p.310).

Although positive experiences of working with interpreters are cited, the general flavour seems to be one of caution and complexity. Recently, however, authors have encouraged researchers and therapists to focus on the positive aspects of working with an interpreter. Tribe & Thompson (2009a) suggest that the presence of an interpreter can help normalise the experience of therapy for the client, help the therapist manage traumatic material, help clinicians reflect

on their use of language and increase their alertness to non-verbal communication, as well as increasing the clinician's understanding of different cultural perspectives. In the literature reviewed, a number of the positive experiences identified by the participants related to the process of the interpreted therapy, including allowing headspace for the clinician to process and observe countertransference (Quinn, 2011), or the value of their cultural perspective (Engstrom et al., 2010). Others related to the participants' appreciation of the presence of the interpreter as a supporter and someone to share the experience with, particularly when traumatic material was discussed (Miller et al., 2005).

2.2.6 Therapeutic alliance. In traditional psychotherapy the alliance is dyadic: between the client and therapist. When an interpreter is introduced, then this becomes a triad, with subsequent challenges to traditional notions of the therapeutic alliance (Tribe & Thompson, 2009b).

Although a number of the studies reviewed include therapists' views relating to the effects on the TA of working with an interpreter, there is only one existent study that uses a quantitative methodology to investigate the TA within an interpreter triad. In this study (Boss-Prieto, De Roten, Elghezouani, Madera, & Despland, 2010), the participants (9 clients, 5 interpreters, 7 therapists) were given six dimensions of the TA (help, understanding, collaboration, trust, agreement on tasks, agreement on goals), and asked to explain what each dimension meant by word association, and then evaluate each dimension for each dyad within the triad on a scale. Some overlap in the meanings expressed between the clients and interpreters, and between therapist and interpreter, were found, but little overlap between therapists' and clients' meanings. There was no significant difference between any of the dyads' rated alliance levels, although the therapists always rated the alliance between themselves and the interpreters as lower than did the interpreters. The authors suggest this may be because therapists may have theoretical ideals about what constitutes a good therapeutic alliance. They conclude that the results imply that there exists a TA between the therapist and client when working with an interpreter. This conclusion suggests that the authors prioritise the traditional dyad between client and therapist, and is further limited by the fact the participants were asked only to rate the TA between the dyads, rather than between the triad as a

whole. Other limitations relate to the small sample, all of which were of Albanian heritage, and the use of a non-validated measurement tool, affecting the validity and generalisability of the findings.

The finding that clients and therapists have divergent perceptions relating to the TA, particularly within a transcultural setting, has been confirmed within qualitative research. Mirdal, Ryding, and Sondej (2011) interviewed traumatised refugees, their therapists and their interpreters. Within triads with successful clinical outcomes (as rated by the therapist), the relationship was described by both therapist and client as being characterised by solicitude, compassion, strong liking and tenderness. These findings suggest that dimensions other than those defined by Boss-Prieto and colleagues are important in defining the effective TA within an interpreter triad.

Different ways of conceptualising the TA between the interpreter, client and therapist have been offered. Tribe & Thompson (2009b) suggest that the most helpful approach to therapeutic work with an interpreter is to view this as 3-way relationship, with the interpreter fully involved in the therapeutic relationship. They offer an alternative view to viewing the relationship as an equilateral triangle, where the distance between each is the same, and unhelpful alliances may develop. They suggest that in practice the distance between participants is in motion and alliances change throughout therapy, with potential alliances developing between client and interpreter, particularly. This pattern was observed in Miller et al., (2005), where several participants described the client initially forming a stronger bond with the interpreter, then more gradually with the therapist. Therapists experienced this, initially at least, as threatening. Changes in distances between participants were also experienced as problematic in research by Hsieh & Hong (2010). Tribe & Thompson (2009b) suggest there could be something beneficial about building a fixed alliance between clinician and interpreter so they can support each other and function as a co-working couple, to manage the changing shape of the triangular relationship between the two parties.

Robertson (2014) suggests that adopting a more systemic focus may help therapists decentralise their position in the triadic relationship and lessen their anxiety about the closeness of the interpreter and client relationship. Examples of this anxiety were evident throughout the literature reviewed. Numerous participants gave examples of feeling excluded from the relationship.

For example, one therapist reported coming into the waiting room to collect the client and interpreter, finding them speaking together in an animated way, but then encountering silence when they entered the therapy room (Schweitzer et al., 2013). Reported ways of managing this feeling of exclusion included humour, with one therapist asking, “Excuse me, can I be part of this...?” (Kuay et al., 2015, p.285), and making an effort to becoming familiar with the shared topic (Mofrad & Webster, 2012)

2.2.7 Boundaries. Most research contained the view that it is important to attend to the boundaries of the relationship between the client and interpreter. One participant in the Baker et al. (2015) study expressed a dilemma over the appropriateness of interactions between the client and interpreter outside of the session. Whilst the therapist could see that the client was benefiting from the interpreter’s support and the modelling of the successful transition into life in the US, the interaction between the two left the therapist feeling more and more disempowered, and less and less like a therapist. For another participant in this study, outside interactions were definitely crossing a boundary. The authors of this study suggest therapists should be vigilant for interactions outside of the established frame that might contaminate or complicate the holding environment of the therapeutic relationship. Darling (2004) also refers to the danger of leaving the therapy setting open to contamination in relaying her experience of having worked with an interpreter where she came into the waiting room to find the client and interpreter chatting. She describes feeling as though the session had started and she had been left behind.

2.2.8 Power. Literature on therapy carried out with the help of an interpreter has tended to focus on clients from a refugee background, and on therapy related to symptoms of PTSD relating to negative pre-migration experiences, such as political violence, war and torture. However, in the UK, people with LEP may come from a variety of backgrounds, and may experience a wide range of psychological difficulties.

It has been suggested that good three-way therapy work is characterised by egalitarian relationships (Tribe & Thompson, 2009b). However, issues of control and power have been identified as being where most difficulties arise

within the relational dynamics within the interpreter triad (Brisset, Leanza & Laforest, 2013). The researchers suggest these difficulties are the expression of power struggles in wider society, which impact on languages and minorities.

Tribe and Thompson agree that dynamics tend to reflect the way the power relations are working within the 3-way relationship, but also in the wider world. "It is (therefore) important to view what is taking place within therapy with a wide lens, and explore which structures of power may be being reflected within the dynamics of the three way relationship" (Tribe & Thompson, 2009b p.8). Numerous differences may exist between the interpreter, client and therapist including differences in language, ethnicity, class, age, gender, and political and religious beliefs (Patel, 2003). Tribe and Thompson (2009b) identify questions of power as being of acute relevance when working with those who have experienced persecution, including refugee populations. However, issues related to power are mentioned explicitly in only a small number of studies.

Using critical theory and an ethno-cultural framework, Becher and Wieling (2015) sought to test their hypotheses that the likely differences between the therapist and interpreter would give greater authority to the clinician's social construction of mental health, and that both therapist and interpreter would report better clinical experiences if power dynamics allowed for a collaborative relationship. Interviewing 10 interpreters and 7 clinicians, the researchers provided definitions of power and privilege at the start of interviews to ensure shared understanding. Key findings were that negotiation of power was connected to the quality of the TA, and that interpreters and therapists talked about power in different ways. They found the majority of interpreters did not recognise the power they had, whereas therapists were explicit about both their own power and the power of the interpreter, suggesting that although both therapist and interpreter hold power, the power of the therapist is more frequently acknowledged across the groups.

The specific ways in which power was perceived to be held by interpreters and clinicians reflect comments and findings by other authors, including Raval and Smith (2003). These include the clinician's power as mental health expert and the gatekeeper to treatment, with higher pay and more respect, with interpreters viewed as ancillary and interchangeable. The clinician may hold the power to perpetuate Western-based truths, while the interpreter

may hold a different truth yet have no voice. However, therapists may perceive that interpreters hold power in terms of the way they choose to translate the material presented to them by the client, and hold cultural insights and a shared language with the client.

Emilion (2011) writes about power dynamics and reciprocation when working with an interpreter using the CAT model. She talks in her research about powerful feelings being evoked in the interpreters, including feelings of helplessness and at times feeling out of control. These were understood in terms of the reciprocal role (relationship pattern) of 'powerfully controlling to powerless' operating between therapists and interpreters, and, at times, between clients and therapists. The interpreters talked about feeling 'blindly led' in the sessions, which 'pushed' them into the powerless role, in which they felt vulnerable and helpless. Whilst they wanted to move out of this role into the controlling position, they did not feel their professional role allowed this to be expressed or explored.

2.2.9 Context. The majority of the existent research is based in specialist refugee or trauma therapy centres outside of the UK, and the impact of the setting of the therapy in relation to the participants' reported experiences is not generally commented on in the studies. In the UK, people with LEP requiring the services of an interpreter to access therapy may be seen in an IAPT service or a secondary care psychology service.

A recent survey has shown that NHS psychological professionals in the UK are feeling increasingly stressed in their jobs (NHS, 2015). IAPT was described by survey respondents as 'a politically driven monster', which is fixated on targets. Pressure to meet these targets, extra administrative demands, an increase in having to work unpaid hours and staff being prevented from providing adequate therapy due to resource cuts, were frequent themes contributing to stress and low morale.

These findings fit with those of a study by Erbil (2015) who explored the experiences of IAPT practitioners of working with language interpreters. Erbil found that participants talked about the demands of the service as creating a time pressure in working with interpreters. Participants talked specifically about how the extra time needed to work with interpreters was not acknowledged by service management, and 'clashed' with performance indicators around protocol

driven treatment, resulting in feelings of anxiety and frustration. Similarly, Raval and Smith (2003), in their study of practitioners working in a UK Child and Adolescent Mental Health Service (CAMHS), found that experience of time pressures affected the ability of therapists to develop a co-working relationship with the interpreter.

Another UK-based piece of research comments upon the impact of the context of the therapy on the experience of working with translators, this time drawing upon a psychodynamic theoretical framework. Darling (2004) draws on work which postulates that organisations institutionalise their defence systems in response to stress. She reflects that the CAMHS service, within which she worked, was under pressure, not just through financial constraints, but also because of the disturbed presentation of clients. She suggests that her organisation's institutional defence to this situation may have been to adopt an approach characterised by an emphasis on dealing with anxiety by speedy action, rather than providing a space for thoughtful consideration of emotional realities, which might then lead to accepting uncertainty and the capacity to bear not knowing. Darling suspects that her anxiety around needing to relate to her clients, many of whom had complex needs, had prompted her to organise matters in a way which actually served to obstruct and attenuate her capacity to work with her interpreter colleagues in a meaningful and thoughtful way.

2.3 Epistemological and Methodological Critique

The research reviewed includes a range of methodologies used to investigate this topic from a number of epistemological positions, although only a limited number of the studies included information relating to the paradigmatic underpinnings of the research. Much of the literature comprises case studies (Schweitzer et al., 2013; Mofrad & Webster, 2012) or authors' clinical observations (Darling, 2004; Tribe & Thompson 2009a). Amongst the studies, Grounded Theory was used with the aim of developing categories from the analysis, which could then become the basis for a model relating to therapist experiences by Erbil (2015) and Hseih and Hong (2009). Narrative Analysis was used by Miller et al. (2005), and Becher and Weiling (2015) employed Spradley's (1980) ethnographic Developmental Research Sequence (DRS) from a critical position to examine how elements of power and privilege impact upon relational dynamics between therapists and interpreters. A

phenomenological approach was used in a number of the studies, both descriptive (Mirdal et al., 2012; Yakushko, 2010) and interpretative (Pugh & Vetere, 2009; Raval & Smith, 2003). However, even where IPA was used explicitly with the aim of providing a contextual understanding of the therapists' experiences (as in Raval & Smith, 2003), this seemed to focus on wider societal structures rather than the specific context of the therapy setting.

2.4 Implications of the Review for the Proposed Study

The aim of this study is to produce detailed accounts of therapists' lived experiences of working with interpreters in clinical practice in order to gain a rich understanding of the phenomenon. Whilst this topic has been investigated using different methodologies, underpinned by different epistemological positions, the process of reviewing the current literature has highlighted to me a gap in exploring therapists' experiences from a critical realist perspective, using a contextual interpretative phenomenological methodology. My aim is not to develop a model or theory of the phenomenon, but to develop an understanding of therapists' experiences. Adopting a critical realist position supports acknowledgement of the reality of power and oppression, and analysing the data using IPA allows for developing an understanding of the experiences within the context of the therapists' work setting. Although IPA has been used to explore this topic previously, the contextualisation offered in relation to the therapy setting of the participants' accounts is limited.

The studies reviewed suggest therapists experience and conceptualise the roles and dynamics between the client, therapist and interpreter in different ways, and that sometimes they may use concepts from psychotherapeutic models in doing so. Few studies have explored or commented on this in detail, or related it to the contextualisation of the therapists' account of their experience.

Most studies relate to therapists' experiences in individual psychotherapy. People with LEP may be seen for therapy in a variety of settings including couples, family, group or individual therapy.

Only one study (Erbil, 2015) includes Counselling Psychologists as participants. Counselling Psychologists have a unique position in holding values related to empowerment and the prioritisation of the TA. This makes very relevant the issue of working with clients in a way that is consistent with these

values. Therefore, research that explores their experiences of working with interpreters, from their unique perspective, is important.

All the research that collected therapists' experiences used either a descriptive case study or semi-structured interview data collection method. Even though some participants chose to describe their experiences in visual terms (such as likening the distance and diffusion they felt to being like a goldfish bowl with therapist looking in at the interpreter-client relationship in Quinn, 2011), no studies used any type of pictorial or visual representations of therapists' views. It seems possible that a data collection method that facilitates exploration of the therapists' perceptions and conceptualisations of the TA and power dynamics in a visual way would be a valuable addition to verbal descriptions of experiences.

Most of the research settings were specialist services for victims of torture. In England, clients requiring an interpreter for psychological therapy may be seen in an IAPT or secondary care psychology service, and may be experiencing a range of psychological difficulties. Research suggests that there may be contextual factors within these settings that may have particular relevance for therapists' experiences of working with interpreters (Erbil, 2015; Raval & Smith, 2003; NHS, 2015), making research that explores experiences within context particularly relevant.

Overall, the literature review has identified a number of gaps in the literature, but, most importantly, has highlighted issues relating to the context of therapists' experience, including the pressured nature of NHS therapy services and the resulting stress and low morale reported by psychological therapists, which seem likely to inevitably impact on their experiences of working with interpreters. This, coupled with the documented prevalence of need for interpreters and the requirement for therapists to work proficiently with interpreters, support the benefits of a study which looks at the experiences of NHS therapists of working with interpreters.

2.5 The Proposed Study

The process of undertaking a review of the available literature has highlighted a number of gaps relating to a contextual and detailed understanding of therapists' experiences of working with interpreters, particularly in relation to experiences relating to alliances and power dynamics.

A qualitative study from a critical realist ontological and epistemological position, using IPA to analyse data collected through the methods of semi-structured interviews and diagrammatic elicitation, is proposed. The research will aim to explore the experiences of therapists of alliances and power dynamics when working with interpreters, within the context of the therapy setting.

Methodology

3.1 Chapter Overview

This chapter begins with a statement of the research aims and questions. This is followed by the ontological and epistemological positioning of this study and a brief presentation of issues concerned with ethics and reflexivity. Next is offered an overview of the chosen methodology and methods. Following consideration of quality appraisal in qualitative research, a chronological account of the process of analysis is provided. This chapter is written in the first person to help the reader engage with the process of analysis as it happened, and to allow direct expression of both methodological and personal reflexivity.

3.2 Research Gap

A review of the literature suggests that this topic has generally been explored using the methods of case studies and semi-structured interviews, gathering data from therapists working in specialist services with clients experiencing symptoms relating to trauma. Few studies have explicitly explored therapists' experiences of therapeutic alliances or dynamics relating to power, or how therapists' experiences might reflect contextual factors, including the setting of the therapy and the psychotherapeutic model used.

3.3 Research Questions

How do therapists experience working with language interpreters in therapy?

How do they experience and conceptualise the alliances and dynamics relating to power within the triad?

How are contextual factors relating to the therapy reflected in the way therapists talk about their experiences of working with interpreters?

3.4 Research Aims

To create knowledge which will provide new insights into therapists' experience of working with interpreters, within the context of the therapy setting.

To use data collection methods which facilitate exploration of therapists' lived experience, from an ontological and epistemological position that acknowledges the reality of power and oppression, using a methodology which supports the contextualisation of therapists' experiences, and embraces the intersubjective relationship between researcher and participant.

3.5 Ontological and epistemological positioning of this study

Active adoption of a theory of knowledge and an epistemological stance that determines, and is made visible through, the methodology and method, is essential for the Counselling Psychology researcher (Willig, 2013). In considering my own epistemological position, I thought carefully about the type of knowledge I was aiming to produce, and my own views on the nature of reality and subjectivity. Of particular importance to me were the implications of the different stances relating to the role of language, context and intersubjectivity.

Choosing a paradigm and methodology that are closely related to practice is important to Counselling Psychologists (Morrow, 2007). In aiming to gain an understanding of how therapists experience working with interpreters, I was clear that I wanted to elicit a detailed account of each individual's lived experience to gain a richer understanding of the phenomenon. I subscribe to the critical realist ontological and epistemological position that there is an objective reality which exists independent of how people think or talk about it, and that language may be used to express the way we structure the world. This position argues that data can tell us about reality, but it is not a direct mirroring of it. Although meanings, intentions, attributes, are not directly observable, they are part of the real world. However, they are not accessible except by the researcher going beyond (or interpreting) the text to further understanding of them. (Willig, 2013). The researcher has the job of detective as they seek to uncover patterns that govern behaviour and drive experience (Willig, 2012a). These mechanisms or forces are taken to be real and may be social or psychological in nature (Willig, 2013). Holding this position in relation to this research felt important as a Counselling Psychologist, as to view power and oppression as socially constructed felt as though I might be denying the reality of their existence in society.

My view of the relationship between the researcher and participant is one of collaboration and co-creation of knowledge. I therefore subscribe to the importance of reflexivity in reflecting on my role as the researcher in the meaning-making of the data and in relation to the power and privilege I may hold over the participant, including in shaping what is known about the participants' experiences.

3.6 Reflexivity

Qualitative approaches acknowledge that the researcher influences the research. Reflexivity encourages researchers to reflect upon and make explicit the ways in which their own values, experiences, interests, beliefs, thoughts and feelings are implicated in the research (Willig, 2013). I am aware that my experiences, knowledge, beliefs and understanding of this topic inevitably influenced the whole research process, including its focus, philosophical underpinnings, and the analysis and discussion of the study's findings. I particularly acknowledge the effect of the tensions within the dual role I hold as a researcher and therapist, and my insider/outsider position in relation to the participants.

There are a number of ways in which the Counselling Psychology researcher may engage in reflective practice. Following the suggestions of Kasket (2012), I began with a reflective exercise to identify my thoughts, feelings and beliefs about the topic. This helped me to understand what some of my hopes or expectations were about what I might find in the data. I also participated in a reflexive research group at University, and regularly wrote in a reflexive journal.

Ensuring that reflexivity is attended to at all stages or parts of research, and that the reader can assess how the researcher's perspective and position shaped and impacted all parts of the research, is essential in meeting a commitment to rigour in qualitative research (Willig, 2013). In order to facilitate this, I include reflexive notes relating to epistemological, methodological and ethical issues throughout this thesis. This process concludes in the discussion chapter with a reflection on how the topic could have been investigated differently, and how this might have given rise to a different understanding of the participants' experiences.

3.7 Overview of IPA and Rationale for Choice of Methodology

Interpretative Phenomenological Analysis (IPA), a qualitative research approach founded by Smith (1996), was chosen as the methodology for this study. This section will offer an overview of IPA, followed by the rationale for this choice of methodology in relation to the aims and questions of the research, and the ontological, epistemological and axiological position of the researcher. Reasons for discounting other methodologies will be briefly discussed.

3.7.1 Theoretical foundations of IPA. IPA aims to provide detailed examinations of the lived experiences of participants, and is informed by concepts and debates from two key areas of the philosophy of knowledge: phenomenology and hermeneutics. It requires a combination of phenomenological and hermeneutic insights in its attempt to get as close as possible to the personal experience of the participant, while recognising that this inevitably becomes an interpretative endeavour for the researcher and participant (Smith et al., 2009).

3.7.1.1 Phenomenology. Husserl (1970, 1982) proposed that phenomenology is interested in the world as it is experienced by people, so it is our perception of objects that is of interest, rather than how they may first appear in everyday experience. It is the meaning that people attribute to subjects and objects that constitutes their reality; they cannot be separated from people's experience of them (Husserl, 1970, 1982). He suggests that our tendency to try and fit 'things' into a system of categorisation gets in the way of this 'phenomenological attitude' of reflecting inwards to our perceptions. Similarly, IPA avoids attempting to fix experience in predefined categories, being concerned instead with the detailed exploration of human lived experience in its own terms (Smith et al., 2009). Husserl (1970, 1982) invoked the term 'intentionality' to describe the relationship between what is going on in the consciousness of the individual and the actual object. He asserts that the experiential content of consciousness (which may be considered as people's lived experiences) should be explored in its own terms, as the same object or subject could be perceived and experienced very differently by different people. Similarly, IPA is also concerned with the subjective meaning of a participant's

experience, which is understood to represent the experience itself (Smith et al., 2009).

3.7.1.2 Hermeneutics. Hermeneutics (the theory of interpretation) is a major theoretical underpinning of phenomenology (Heidegger, 1962/1927; Smith et al., 2009). Hermeneutics posits that it is not possible to obtain knowledge that is outside of an interpretative stance, and views phenomenology as an explicitly interpretative activity (Heidegger, 1962/1927). Both hermeneutics and phenomenology aim to examine phenomena as they are perceived by people (Heidegger, 1962/1927). In the same way, IPA is concerned with how participants attempt to make sense of their experience (Smith et al., 2009). Language and culture are viewed by both phenomenology and hermeneutics as shaping, limiting and enabling people's interpretations of phenomena (Heidegger, 1962/1927). Additionally, they view people's sense-making and meanings to occur in, and as a result of, varied relationships and social interactions with others (persons-in-context), which may be refined through self-reflection. This is referred to as symbolic interactionism (Mead, 1934).

Hermeneutic thinking suggests that the researcher (or interpreter) brings their own prior experiences, values, beliefs, and preconceptions to the encounter, and that these will inevitably influence the interpretation that is made (Heidegger, 1962/1927). These 'fore-conceptions' are held, but it is argued that priority should be given to new phenomena (Heidegger, 1962/1927; Smith et al., 2009). Similarly, in IPA, experiences may be understood through the interpretation of the researcher of the participant's account of the experience (Smith et al., 2009). Consequently, IPA involves a 'double hermeneutic', where the researcher is making sense of the participant, who is making sense of their world (Smith & Osborn, 2003). The iterative process of interpretation in IPA (of moving back and forth to the data) relates to the 'hermeneutic circle' idea which posits that the whole can only be understood in relation to its parts, which, in turn, can only be understood in relation to the whole (Smith et al., 2009). In keeping with hermeneutic phenomenological thinking, IPA acknowledges that interpretations are inevitably founded on the fore-conceptions of the researcher, and suggests a researcher may not necessarily be aware of all of the pre-conceptions that might influence their analysis, and so posits that reflective

practices are required in order for the researcher to be able to better know what their preconceptions are in order to understand what happens in an interpretation (Smith et al., 2009).

3.7.2 Characteristics of IPA. IPA has the characteristics of being idiographic, inductive and interrogative. It is idiographic in that it is concerned with the particular: in a commitment to a detailed, deep analysis, and in understanding how a phenomenon is experienced by particular people in a particular context. While it does not seek general laws, it does not reject generalisations, believing that it is by going deeper to the particular that we see what it is that we share more universally (Smith, 2004). It is inductive in that it focuses on perception and experience rather than pre-defined categories, and flexible techniques are employed to allow for unanticipated themes to emerge during analysis. Broad research questions that allow for the collection of expansive data are used, rather than hypotheses based on existent literature being tested or examined (Smith et al., 2009). Lastly, IPA is interrogative as it aims to make a contribution to psychology by illuminating existing literature. The results of the analysis do not stand in isolation, but rather are subsequently discussed in relation to the extant psychological literature (Smith et al., 2009).

3.7.2.1 Focus on context. IPA is described as a broadly contextualist approach because of its focus on persons-in-context, supported by the assumption that you cannot meaningfully take a person out of context (Braun & Clarke, 2013). Inferences and interpretations are made cautiously by the researcher, with an awareness of the contextual and cultural ground within which data are generated. Interpretations tend to emphasise the psychological rather than the critical socio-cultural aspects, possibly to avoid overwriting the subjectivities of participants with the analyst's theoretical commitments and/or their political frameworks, (Braun & Clarke, 2013).

3.7.2.2 The role of language. IPA is based on the assumption that language provides participants with the necessary tools to capture their experiences and describe them to the researcher (Willig, 2012b). Husserl's phenomenological view of language suggests that experience precedes language, and that language is a medium for encapsulating and transmitting

meaning. The participant's choice of words and phrases is of great interest to the researcher who will pay attention to the particular meanings invoked by them. Metaphors are seen to come closer to the richness of experience; doing more than simply reflecting an experience but actually adding to or amplifying it. Understanding underlying meaning may be related to the focus on context of IPA as the researcher steps outside of the account and reflects on its status in a wider social cultural and theoretical context, reflecting on prevailing social and economic structures and on the meaning of accounts within the context (Willig, 2012b). This is the view of language as expressive rather than constructive or performative.

3.7.2.3 Intersubjectivity and IPA. IPA posits that the meanings an individual ascribes to an event are of central concern, but are only accessible through an interpretative process. The role of the researcher is recognised as central in interpreting the experiences of individuals, and the intersubjective relationship between the researcher and individual is embraced (Willig, 2013). Meanings are considered to be negotiated between a researcher and participant and the research is seen as a joint product of the researcher, the participant and their relationship. It is not considered to be possible or desirable to bracket the researcher's subjectivity. Instead, the presuppositions and assumptions of the researcher are placed in the foreground and used to advance the researcher's understanding of the phenomenon (Willig, 2013). Not only are the fore-conceptions of the researcher, and how these are held, relevant to the interpretative process, but intersubjectivity can enter interpretations through the researcher's contributions to the conversation, particularly the interviews, as these provide the context within which the participants produce the accounts of their experience.

3.7.2.4 Epistemological basis. IPA holds a critical realist ontology in a way that other qualitative approaches do not, which reflects its phenomenological and hermeneutic roots (Reid, Flowers & Larkin, 2005). IPA seeks to capture as closely as possible the way in which a phenomenon is subjectively understood and experienced by individuals (Finlay, 2005), and is underpinned by hermeneutic thinking, which is critical of the view that it is possible to obtain knowledge outside of an interpretative stance (Heidegger,

1962/1927). In line with the critical realist position, IPA accepts the impossibility of gaining direct access to reality through data without interpretation, as data is not a direct reflection of what is going on in the world, and needs to be interpreted in order to understand the underlying structures that generate the phenomenon (Willig, 2013).

3.7.3 Rationale for choice of method. It is important that a researcher's methodology is consistent with the researcher's ontological and epistemological position, and supports the aims of the research (Willig, 2013). The methodology of analysis used for this study was Interpretative Phenomenological Analysis (IPA). This was chosen because of its focus on lived subjective experiences and of language as the mediator of these, its acknowledgement of co-construction of reality by researcher and participant, and its understanding of persons-in-context (Braun & Clarke, 2013). The contextual nature of the approach supports my research question around exploring how the context is reflected in participants' experiences, and the focus on intersubjectivity fits well with my values as a Counselling Psychologist.

Other methodologies were considered but discounted due to a lack of fit with my epistemological position and research question. Grounded Theory's aim to produce theoretical accounts did not fit with my concern with micro-analysis of individual experience. Discourse Analysis was rejected due to its focus on the role of language in a person describing their experience, whereas my interest lies with exploring how people ascribe meaning to their experiences in their interactions with their environment. The more descriptive phenomenological methodology of Giorgi (1985) was considered unsuitable due to its aim to reveal essential general structures of a phenomenon rather than focus on the personal experience of the individuals. Most types of Discourse Analysis explore the function of language within specific contexts, with the focus limited to the observable (Reid et al., 2005). This means that links between discourse and real world actions are difficult to make because the real world can only be understood as a construction. In contrast, IPA offers researchers the opportunity to integrate research and practice (Reid et al., 2005), important to my role as a scientist-practitioner.

3.8 Quality Appraisal and Qualitative Research

In response to growing dissatisfaction with qualitative research being evaluated according to the criteria for validity and reliability that are applied to quantitative research, a number of guidelines for assessing quality in qualitative research have been produced. In order to be able to evaluate the quality of a piece of qualitative research in a meaningful way, it is important to know the objectives of the research and its paradigmatic underpinnings (Willig, 2013). Research using phenomenological methods may be evaluated by assessing the extent to which they ground their observations within the context that generated them, and to which reflexivity issues are addressed in acknowledging and demonstrating how the researcher's perspective and position have shaped the research. IPA involves interpretations by the researcher of the meaning of the data, and so, in order to be able to understand and assess the researcher's interpretations, the reader must have detailed information about the process of how they were generated (Willig, 2013).

These recommendations relate to the four broad principles for assessing the quality of qualitative research offered by Yardley (2008). These include ensuring sensitivity to context is shown through an awareness of the literature relating to the topic and an appreciation of the interactional nature of data collection within interview. Also, that commitment and rigour are shown through attentiveness given to the participant during the research process and the care taken in analysing the data. It is also important that transparency and coherence are demonstrated by reporting a clear description of all stages of the process of the research and by reflecting on the aims of the research and the theoretical assumptions of the approach. Finally, that impact and importance (whether the research reports something interesting, valuable or useful) are commented upon.

These guidelines were held in mind during the process of planning, carrying out and evaluating this study, and will be commented on in detail in the discussion chapter, as well as being reflected upon within the reflexive notes throughout.

3.9 Ethics

There are a number of ethics codes that were adhered to in planning and carrying out this research, including those from the British Psychological Society

(BPS, 2014) and the University of East London (UEL, 2015). However, it felt important to go beyond simply adhering to these guidelines. Instead, I aimed to critically engage with the wider consequence of my work and the challenges and ethical dilemmas within my study including around privacy, responsibility for shaping what is known about the participants' experiences, imposition of theoretical frameworks, and my dual roles and related issues of power. These tensions and dilemmas are engaged with within the reflexive notes throughout the thesis.

Approval for the research was obtained from the Research Ethics Committee of the University of East London (appendices A and B), from the NHS Health Research Authority (appendix C) and the Research and Development office of the Trust within which the research took place (appendix D).

Each participant was verbally informed about the study and provided with a Participant Information Sheet (appendix E) which detailed the aims and purpose of the study, what participation would involve and how the data would be used. Participants were informed that their participation was voluntary and that they could choose to withdraw their data up to four weeks after the interview. Each participant signed a consent form (appendix F). No participant refused to answer a question or requested to withdraw from the study.

Participants were informed that the data provided would be reported anonymously and would be safely and securely stored in accordance with the University of East London's code of good practice in research and the Data Protection Act 2018. Audio recordings and transcripts were password protected and stored on the researcher's personal computer, which remained at the researcher's house. Participants were assigned and referred to by a number from one to ten and any identifying details were removed from transcripts. At the end of the interviews, participants were asked to reconfirm their consent.

3.10 Conducting IPA

This section of the chapter outlines the process of conducting IPA undertaken in this study.

3.10.1 Sampling and inclusion criteria. In IPA, participants are selected purposively because they are able to offer insight into or a perspective of a

particular experience. It is important that the sample is relatively homogeneous in order for it to be possible to examine in detail any variability arising. For rich data to be generated, participants should have sufficient experience of the phenomena under study and it must be meaningful enough for the individual (Smith et al., 2009). To meet these conditions, the inclusion criteria were set that participants should be qualified counselling or clinical psychologists or psychotherapists, with at least one year's experience of working with interpreters, including at least two different clients.

3.10.2 Sample size. Because of the idiographic focus of IPA, IPA studies are conducted with relatively small sample sizes. Smith et al. (2009) suggest that, for a professional doctorate, 4-10 interviews should be undertaken. Ten participants were recruited for this study, each of whom was interviewed once. This sample size will be reflected on in the participant section.

3.10.3 Recruitment. Using opportunities as a result of one's own contacts is acknowledged to be a practical source of participants (Thompson & Chambers, 2012), and is a frequent method of recruitment in IPA studies (Smith et al., 2009). As an employee of the Trust I was able to use internal contacts to promote the study and access potential participants.

Details of the study were emailed to Team Leaders within primary and secondary care psychology teams within the Trust, with a request made to disseminate the details to their respective teams. Interested participants were asked to email me for further details, confirming that they met the criteria for the study. I then made contact with the participant to check if they had any questions or concerns and to arrange a venue and time for the interviews. Participants were asked to sign an informed consent form before commencing the interview. Audio recording equipment was used during the interviews. The interviews lasted between 35 minutes and 1 hour and 10 minutes.

As an employee of the Trust, I was aware of the potential for participants to feel obliged or coerced into participating if they had prior knowledge or had previous contact with me. In an attempt to minimise this, I did not directly approach any potential participants, but instead asked a third party to disseminate details of the research, and I did not follow up on non-responders.

3.10.4 The participants. There were 10 participants in this study. In order to protect the anonymity of the participants, the potential for their identities to be pieced together alongside information from the participants' accounts is minimised by not revealing exact work settings, referring to the participants by numbers, and ensuring demographic details reported and collected were deliberately minimal. This was considered to be particularly important because of the fact that all the participants were recruited from one London Mental Health Trust.

All participants identified themselves as qualified clinical or counselling psychologists, CBT therapists or psychotherapists. The years post qualification of the participants ranged from 3 years to 25 years. Reported psychological models used in practice included CBT, CAT, EMDR and psychodynamically informed therapy. Participants reported working mainly with individuals, but also with couples, families and groups. Participants worked either in an IAPT service or secondary care psychology service within the Trust. The reported length of experience of working with interpreters ranged from 1 year to 20 years. The sample included four male and six female therapists.

I recruited 10 participants for the study. As a novice IPA researcher, I was driven by anxiety that a smaller sample would not provide enough variability or a sufficiently detailed and rich understanding of the phenomenon. Having identified from the literature review that the context of the therapy seemed important, I actively tried to recruit therapists from a range of psychotherapeutic models and therapy settings. I also hoped to recruit Counselling Psychologists, as I had noted that this group had been included in only one previous study and I had felt it important to reflect the views of this group in a study whose aim was to contribute to knowledge and practice in the Counselling Psychology field. On reflection, I realised I had misunderstood the concept of variability within IPA and found that the relatively large sample posed a challenge for me in terms of my capacity to analyse each case in great detail, and remain true to IPA's commitments to idiography and depth. Smith et al. (2009) acknowledge that with a larger sample size there is a shift to a more group level analysis and, with hindsight, I can see that I fell into the trap of viewing higher numbers of participants as being indicative of 'better' work.

I also became aware that I had inadvertently made it harder to protect the anonymity of my participants because of the variance in roles, settings and

therapy models I had sought, necessitating the inclusion of minimal information only on each participant.

3.10.5 Data collection. IPA is used to analyse verbal data which may be collected by methods including interviews and diaries and through discussion of diagrams (Willig, 2013). Data collection methods in IPA studies should be flexible enough to allow topics to emerge and the semi-structured interview method has been identified as the method that best provides this flexibility, and the elicitation of detailed stories, thoughts and feelings from participants (Smith et al., 2009). It is this data collection method that was principally used in this study. However, from my examination of previous literature relating to this topic, I identified a gap in that, despite participants having used visual representations and metaphors in talking about their experiences, no study had used any visual data collection methods to facilitate elicitation of therapists' experiences. In reviewing possible data collection methods that might support this, I began to consider visual methods of data collection.

3.10.5.1 Visual methods in psychology. Visual methods include the use of film, photographs, objects or drawings to explore the experiences of research participants (Willig, 2013). The materials may either be introduced by the researcher as a stimulant for discussion, or produced by the participant prior to or during the interview. The visual produced may be analysed in its own right, or be used as a way of eliciting verbal data, which may then be analysed using a research methodology such as IPA (Willig, 2013). Elicitation methods have been used in Counselling Psychology research, alongside interviews, to explore participants' experiences of Body Dysmorphic Disorder (Silver & Farrants, 2015), living with advanced cancer (Willig, 2016), and with psychologists to map their conception of the scientist-practitioner construct (Goodyear, Terence, Lichtenbery, & Wampold, 2005), with the verbal data being analysed using a range of methodologies including IPA. These methods have been shown to be a useful way of supporting data collection where the aim for the research is to facilitate communication about aspects of participants' experience that may be difficult to tap into through conversation alone (Willig, 2016).

3.10.5.1.1 *Diagrammatic elicitation*. The use of diagrammatic elicitation (where participants create original diagrams – also referred to in the literature as participatory diagramming and graphic elicitation) is an elicitation method that has emerged over the past ten years as a powerful instrument to supplement those interviews which seek to gather knowledge about experiences that are not fully understood (Rodriguez & Kerrigan, 2016). Common elements of the method are for the participant to create (with variable amounts of guidance by the researcher) a visual interpretation of the topic of interest, depicting the relevant components and inter-relationships (Umoquit, Tso, Varga-Atkins, O'Brien, & Wheeldon, 2013). The use of diagrams alongside interviews have been shown to increase participants' recall and self-reflectiveness, help participants reflect upon complex thoughts and behaviour more deeply than in interview alone, and to elicit participants' emotional experiences (Copeland & Agosto, 2012). The method has been found to help elicit rich data and to be particularly valuable where participants are required to explain complex processes or relationships (Crilly, Blackwell, & Clarkson, 2006), or to represent personal understandings of relationships, experiences and concepts (Copeland & Agosto, 2012).

It is essential that research methods are consistent with the epistemological position of the researcher and the method of analysis, and that these are consistent with the status that the visual text is given by the researcher (Willig, 2013). Data produced by diagrammatic elicitation are acknowledged as being co-created between the researcher and participant (Umoquit et al., 2013), and diagrams have been suggested to be a way of modelling reality as it is understood by the participant (Crilly et al., 2006), rather than providing an objective 'reality' of the topic (Willig, 2013): a good fit with the critical realist position. The focus on inter-subjectivity and the aims of exploring experiences, facilitating reflection and eliciting emotional experiences, are consistent with the methodology of IPA and the research aims of the study. In alignment with the reflexivity required in IPA, Willig (2013) suggests that when carrying out an IPA study that uses visual methods, the researcher should reflect on their own biases and ways of viewing the world as these will inevitably influence the way they view both the visual material and the verbal data produced as a result of the visual medium.

Diagrammatic elicitation has not previously been used in exploring the experiences of therapists of working with interpreters. My review of the literature suggested that, given the aims of the research and its focus on exploring experiences of dynamics and alliances, diagrammatic elicitation seemed a potentially valuable data collection method to use in conjunction with interviews, and that it aligned well with the aims of the research and my epistemological position and methodology.

3.10.5.2 The interview schedule. When developing a schedule for a semi-structured interview the researcher should aim to facilitate a comfortable interaction with the participant, which will enable them to provide a detailed account of the experience under exploration (Smith et al., 2009). It is suggested that questions that are open and expansive should be used, avoiding questions which are leading, over-empathic or manipulative. Smith et al. (2009) recommend a schedule of around 6-10 open questions, which facilitate description as well as more analytical or evaluative responses, to be appropriate for a 45 minute interview.

The interview schedule (see appendix G) was developed in advance of the interviews. The questions asked were based on the topic under investigation, the gaps in extant literature and the research aims of the study, and were designed to meet the conditions suggested by Smith et al. (2009), as described above.

Following the gathering of participants' relevant details, the first main question was to ask the participants about their initial reactions to learning that they would be working with an interpreter. This question was designed to try to capture a more embodied and uncensored response and to set the tone for an in-depth discussion, including emotional and physical feelings as well as thoughts and cognitions.

The second question related to participants' experience of working with interpreters. Contrast, narrative and evaluative questions were used to encourage a detailed and personal response. To try and draw out a variety of experiences, participants were asked to think about best and worst experiences and to reflect on what made them so. Participants were then asked to reflect on their perceptions of what constituted the role of the interpreter and how this may differ from their own role as therapist.

The next two questions related specifically to the participants' experience of the therapeutic alliances and power dynamics when working with interpreters. A very basic definition of each was provided, and participants were asked to reflect on their experiences. Contrast questions were asked to prompt a reflection on any differences in experiences in working in a dyad rather than a triad. Structural questions were asked to encourage reflection on development of any alliance or dynamics over time.

Having asked participants to reflect on their perceptions of the alliances and dynamics, the diagrammatic task was introduced. Previous literature has highlighted the importance of researchers providing clear instructions in creating diagrams to reduce participant anxiety and uncertainty about the task (Umoquit et al, 2013). In terms of creating the visual, it is suggested relationships may be expressed through topological connections or adjacency (Crilly et al., 2006), and solid or dotted lines used to indicate strength of relationship (Umoquit et al, 2013). Following this guidance, the participants were invited to create a diagram to express their experiences of power dynamics and alliances within the therapy triad, using different sized circles for perceived power, and adjacency of circles and thickness of lines to depict strength of alliances. Prompts and questions were used to clarify the meaning of the participant's diagram and in some cases, where appropriate, to contrast the depiction with the previous reflections given in the interview.

The interviews concluded by asking if there were any other thoughts, feelings or reflections that the participant would like to share.

As a novice IPA researcher, this was the first time I had developed an interview schedule under this methodology. This task was completed very early on in the research process, as it was required for the Ethics submission. Reflecting on its content now that I have become clearer on my epistemological position and more familiar with the aims of IPA, there are adjustments I would make in support of a more open and exploratory approach to the participants' experiences. For example, providing (even minimal) definitions of the therapeutic alliance and power may have led the participants' responses. I am aware that my personal experiences and knowledge relating to the phenomenon under investigation inevitably impacted on the development of the interview schedule and the process of the interviews, and I have held this awareness in reflecting on the subsequent analysis.

3.10.5.3 Pilot interview. Having initially developed the schedule, I firstly asked a colleague to interview me using the schedule, with the purpose of using the exercise to identify any presuppositions about the topic and expectations of participants' answers I may have held. These reflections were noted. I then undertook a pilot interview with a personally known therapist who met the inclusion criteria for the study. These two processes highlighted the need for inclusion of contrast prompts to help expand reflections, a clearer set of instructions relating to the diagram, and clarity on how the data relating to the diagram would be analysed. The schedule was then revised accordingly.

3.10.5.4 Conducting the interviews. Interviews were carried out between May and July 2017 in offices at the London Mental Health Trust from where the participants were recruited, at a time within office hours convenient to the participant. Interviews began with a reminder of the aims of the research and plans for the dissemination of the findings and a re-iteration of the confidentiality and data withdrawal policy. Participants were invited to ask questions and then, if happy to do so, to sign the consent form. The audio recorded interview then began.

During the interview, I tried to phrase questions as openly as possible to give time for the participants to answer fully, using prompts and probes to encourage elaboration. However, in conducting the interviews, I realised that my lack of experience and anxiety meant that there were times that I missed following up on important threads, and that instead of probing spontaneously to open up interesting areas, I relied on the schedule to provide a structure. With hindsight, I can reflect this may have limited participants' expression of accounts. I was alert for any potential for my participants feeling discomfort. From the literature, I was aware that research had shown that some participants had felt uncomfortable about being asked to draw a diagram. On reflection, I realised that in my initial interviews this anxiety resulted in my introduction of the diagrammatic task with a lack of confidence, possibly impacting on the participants' experience of the task.

The conducting of the interviews highlighted to me the dual role I held as a researcher and clinician. A number of participants said, "you know" after sharing a view or experience, indicating that they were responding to me as a clinician.

This prompted my reflection on my position as an insider/outsider and how this would impact on the data collection and analysis. This position is reflected on in more detail in the discussion section.

3.10.6 Preparation of data. The data for this study was prepared in accordance with the transcription guidelines offered by Smith et al., (2009). The audio recorded interviews were transcribed verbatim by a professional transcription agency. I then checked these transcriptions against the recordings for accuracy and anonymised any identifying information. Each transcript was page and line numbered to facilitate easy access to excerpts.

Detailed transcriptions of the prosodic aspects of language are not required for IPA analysis because of its primary focus on interpreting meaning of the content of accounts (Smith et al., 2009). Notes of significant non-verbal utterances such as laughter or pauses were made, as these were considered relevant for interpretation of meaning.

Transcripts of all 10 interviews can be found on the memory stick accompanying this thesis.

3.10.7 Process of analysis. This section will provide an overview of the process of analysis of the data collected from the participants. This is offered in detail to with the aim of supporting transparency of process.

3.10.7.1 Reflexive exercise. My process of analysis began with a reflexive exercise. Kasket (2013) suggests that researchers engage in an exercise to reflect on their relationship to the research topic in order to identify any presuppositions or personal agenda. The researcher may then consider how all this might affect the research process and how they might manage this. Undertaking this exercise (see appendix H) helped me to reflect on my history and experience of working with interpreters, and my hopes and expectations for the findings of my study. I identified that I had a range of experiences of working with interpreters, including a very positive experience with one who had developed a strong, and supportive relationship with the client and myself, and another where I had experienced the interpreter as trying to align themselves with me as a fellow professional, which I had experienced as disrespectful to the client. My expectations of my findings included that therapists who worked

from more relational models of therapy would perhaps attend more to relational dynamics and be more open to triadic working. The hopes for my findings I identified as being a greater understanding of the impact of context on participants' experiences and that my participants would talk about more positive aspects of their experiences. The results of this exercise supported my reflexive process during data analysis; by identifying my presuppositions I was able to place them in the foreground and use them to advance my understanding of the phenomenon.

3.10.7.2 Step 1: Reading and re-reading. I began the process of immersing myself in the data by reading and re-reading the transcripts, whilst listening to the audio recording. This felt particularly important to do because I had used a professional agency to transcribe the interviews. Smith et al. (2009) suggest that being able to imagine the participant's voice during subsequent readings of the data helps with a more complete analysis. This was certainly my experience; tuning into the intonations and emphases of the participants gave me a much richer insight into the written data, and, in some cases, supported the interpretations that I later made. An example of this was the laughter of one participant, which seemed rueful; an important distinction in my meaning-making of their experience.

At this point I recorded my first reactions to the data. Smith et al. (2009) suggest that researchers may find themselves feeling overwhelmed by ideas and possible connections at this stage. Some of the initial reactions to the data were that whilst I felt incredibly excited that after all the planning I finally now had my data, I was also overwhelmed by the sheer volume of data. My early impression was that there seemed to be a theme of struggle and feeling threatened in the participants' experiences. This was associated with some concern and disappointment on my part, which I realised was related to my hopes for an account of more positive experiences than had been found in most other studies.

3.10.7.3 Step 2: Initial Noting: Providing detailed notes and comments on the text. The next stage of the analysis involved working line by line through the transcript, making exploratory comments in the adjacent column. At this stage there is a merging of the researcher's pre-understandings, with a newly

emerging understanding of each participant's world (Smith et al., 2009). The comments focused on three areas: descriptive, linguistic and conceptual. Descriptive comments reflected my phenomenological focus, in staying close to the participants' explicit meaning. Linguistic comments focused on exploring the specific language used by the participant, while the conceptual comments moved away from direct representation of the text towards a more interpretative tone, with a move away from explicit claims of the participant and towards their overarching understanding of the experiences they were discussing.

At this stage of the analysis I was particularly struck by the participants' use of metaphor. For example, one participant described the experience of anticipating working with an interpreter as like a headache, and another likened the experience of the communication between the interpreter and client to watching a tennis match. These metaphors seem to offer access to a more embodied experience of the participant, and provided a link in my analysis between descriptive and conceptual comments.

I was aware of tensions at this stage, specifically of staying true to the interpretative aim of IPA by adding depth and sophistication to the analysis by moving it beyond the superficial, whilst ensuring that my interpretations were closely tied to the text, and of using myself to make sense of the participant's experience but yet not getting too caught up in my own ideas and experiences.

3.10.7.4 Step 3: *Developing emergent themes.* These exploratory notes then form a larger data set, with the analysis now shifting to working with these notes rather than the transcript, from which emergent themes are identified. This involves capturing and reflecting an understanding of the notes, and the psychological essence of the piece. It is a process of description and interpretation as the original words and thoughts of the participant as well as the analyst's interpretation are reflected (Smith et al., 2009). Appendix I offers an example of the analysis of one participant's transcript, showing exploratory comments and emergent themes alongside the transcript.

This stage presented a number of challenges to me. Moving away from the participants' direct accounts and to my own analysis caused me to doubt my confidence in my interpretations. In developing and naming the emergent themes I remained reflexive, continuously questioning whether they were

grounded in the data and the extent to which my meaning-making reflected my own experiences and values.

3.10.7.5 Step 4: Searching for connections across the emergent themes within one participant's account. Smith et al. (2009) suggest that at this stage the analyst has some creativity in finding a way of drawing together the emergent themes and suggest that not all the emerging themes need be included; some may be discarded depending on the research question and its scope.

I created a typed list of all the emergent themes that had been identified in the participant's account. I then spent time moving them around, by cutting and pasting on a Word document, to form clusters of related themes. In this process, I used abstraction (where like is put with like and a new name given), subsumption (where an emergent theme helps bring together a series of related themes), and polarization (where there are oppositional relationships between emergent themes), to form the clusters. Appendix J shows an example of the clustered themes for participant 7. The theme of 'a cautionary tale' was clustered using abstraction, and the theme of 'therapist or translator?' through polarization.

During this process my experience was that, even where it became clear that an emergent theme was outside of the scope of the research question, I found it difficult to discard it; concerned about losing something important about the participant's experience.

The creation of a table which brings together the clustered themes with their related excerpts is an important part of this step of the analysis (Smith et al., 2009). This table unites the emergent themes directly with the transcript. Viewing these together without the exploratory notes was a significant step in the analysis for me. There were examples where I felt that my interpretative leap was too far from the participant's experience. I wondered if my analysis had been impacted by my presuppositions and expectations, in that I seemed to be looking for matching examples in the data. At this point, following further reflection, a small number of themes were renamed.

3.10.7.6 Step 5: Moving to the next case. Once analysis is completed for the first participant, the researcher moves to the next participant's transcript or

account and repeats the process. Smith et al. (2009) suggest that each case must be considered on its own terms in order to do justice to its individuality, which necessitates the researcher attempting to bracket the ideas that emerged from the analysis of the first case, whilst working on subsequent cases.

Although I deliberately closed down each file of analysis on my computer when I moved onto the next participant's, beginning the analysis with fresh eyes was a challenging experience for me.

3.10.7.7 Step 6: Looking for patterns across the cases. This stage involves looking for patterns across the cases. This is a creative process, which includes considering connections across cases and the potency of themes. The final result of this process is usually a table of themes for the group which shows how themes are nested within superordinate themes and illustrates the themes for each participant (Smith et al., 2009). It was at this stage of the analysis that the challenges of my large body of data became clear. It is suggested that with a large corpus of data the analysis of each case cannot be so detailed, with a shift of emphasis to a more group-level analysis. However, even where the analysis is primarily at the group level, the fact that the group level themes are still illustrated with particular examples taken from individuals retains the IPA idiographic commitment.

Smith et al. (2009) posit that, for larger studies, measuring recurrence across cases is important, and can be a way of enhancing the rigour of the findings. How recurrence is defined is left to the researcher to decide. I made the decision that themes would only be included if they appeared in at least half of the participants' accounts. This decision was based on striving to hold a balance between convergence and divergence, commonality and individuality. I held some concern that the richness of the understanding of the phenomenon may be lost by setting a higher target for recurrence, and that a lower target would render the analysis unmanageable. The table in Appendix K shows the recurrence of each super-ordinate and sub-ordinate theme and in which participants' accounts they are reflected.

In order to look for patterns across the cases, I printed out each participant's themes. Since the number of major themes per participant ranged between 10 and 16, I had around 120 major themes spread out on the floor to organise into super-ordinate clusters. Having set the recurrence criteria for a

theme, this meant engaging in the lengthy and challenging process of linking the major themes whilst tracking how many of the participants were linked to each one. Although my recurrence criteria provided containment for my analysis, I was left with having to discard some themes which had seemed interesting. An example of this was the theme of 'therapist as police', which occurred in only two participants' accounts. However, use of the processes of polarization, subsumption and abstraction during this stage helped me to incorporate individuals' experiences into a group level analysis, and to retain an idiographic focus on the individual voice while making claims for the larger group. I experienced this stage of the process as a powerful example of the hermeneutic circle of IPA; of the whole being understood as its parts which are then understood in relation to the whole.

I eventually identified three super-ordinate themes, which contained a number of sub-ordinate themes, themselves derived from the major themes comprising them. The sub-ordinate themes reflect distinct, significant aspects of their overarching labels, whilst retaining a link to the individual's experience. For example, a number of the participants' narratives reflected a polarization between perceiving and experiencing the interpreter as purely a translator and as a human with skills and expertise to bring. To illustrate this, Table 1 shows one each of P4 and P7 major themes (respectively) with corresponding emergent themes. Both their major themes were then incorporated into the super-ordinate theme of Dyadic and Triadic Alliances under its sub-ordinate theme of 'Human co-worker or translating robot? Or both?'

Table 1

Example of major emergent theme and sub-themes from participants 4 and 7

P4	P7
Interpreter as a function vs human A good interpreter is a mouthpiece Interpreter self defining as mouthpiece Interpreter as human rather than a function Interpreter as a person – more than a function Interpreter as faceless – it shouldn't matter who they are Conflict between view of interpreter role as mouthpiece and positive experience of triadic relationship Client preferences should be met (gender) Religious differences important Client reluctance - concerns about it being someone from their community	Translator or therapist? Will they be who I need them to be? The 'ideal' interpreter Interpreters should have therapist skills Interpreter as pure translator Interpreter must be 'right' for therapy to be effective The struggle to find the right interpreter There is a right way of interpreters being Therapist needs of interpreter may differ from clients Accurate direct translation is not enough Learning about working with interpreters through experience Cultural context valuable Interpreter as not understanding aims of therapy Not all interpreters have these skills

To support this stage of analysis I created a table of the super-ordinate themes, sub-ordinate themes and all participant quotes linked to each. This document enabled me to remain aware of all relevant quotes for each theme during the selection process for writing up my findings, the last part of the analytic process.

3.11 Summary

This chapter offered an overview of the chosen methodology and methods and a chronological account of the process of analysis. Methodological and personal reflexivity were included throughout. The ontological and epistemological underpinnings of the research were stated, and a consideration of issues relating to reflexivity and ethics in qualitative research were offered.

The key themes and written accounts of the participants' narratives are offered in the next chapter.

Analysis

4.1 Chapter Overview

This chapter aims to offer a rich and nuanced analysis of the experiences of the participants of power dynamics and therapeutic alliances when working with an interpreter. The analysis is organised into three super-ordinate themes, each of which contains sub-ordinate themes highlighting different dimensions of the theme. The first super-ordinate theme permeates most aspects of the analysis, and is considered as an overarching theme.

When reporting on a large number of participants it is important to offer a sense of the whole picture (Smith et al., 2009). Therefore, each super-ordinate theme offers both a summary of the analysis, written at the level of many participants, and a more idiographic focus as extracts from individual participants' experiences are offered. The hermeneutic circle of IPA is present in the constant shift between providing an overall description of the shared experiences, and relating the findings to the group as a whole, and in the way that these narratives offer a re-linking of themes and their relation to the overall analysis. A balance between providing my account of the analysis and enough excerpts for the reader to be able to assess the transparency and transferability of the analysis is strived for.

Two data collection methods were used to collect the verbal data that has been analysed: semi-structured interviews and diagrammatic elicitation. It has been suggested when using the diagrammatic elicitation method that including original diagrams in the presentation of findings helps to orientate the reader to the type of diagram that was used (Umoquit, Tso, Burchett, & Dobrow, 2011) and supports transparency. Photographs of the diagrams drawn by the participants, with the accompanying verbal data, are included where they are considered to offer a richness or contextual depth to the analysis.

4.2 The Themes

The three super-ordinate and corresponding sub-ordinate themes are contained in Table 2.

Table 2

Super-ordinate and sub-ordinate themes

Super-ordinate themes	Sub-ordinate themes
The most powerful thing is the system	1. Time pressure
The knotty question of power	1. Attending to power 2. Power – wanted and unwanted 3. Language as power 4. Reluctant reliance 5. Status as power 6. Can we share power?
Dyadic and triadic alliances	1. Human co-worker or translating robot? Or both? 2. The prized dyad 3. The tennis match 4. A cautionary tale 5. I am not like them, I am like you 6. Models and psychological concepts used to conceptualise alliances 7. A three legged stool

4.2.1 Super-ordinate theme one: “The most powerful thing is the system”.

This theme’s name was taken directly from a participant quote, and was identified as an overarching super-ordinate theme in that it related to many aspects of the other themes. Whilst an overview of how this theme captures a common link overarching the other themes is offered here, a detailed exploration of how it relates to aspects of participants’ experiences will be provided throughout the following analysis.

From the participants’ narratives, the ‘system’ could be understood as the specific local service within which they worked, the national NHS programme within which their service was situated, or a wider political or socio-economic context. ‘The power of the system’ was present throughout participants’ accounts, closely related to the way they talked about many aspects of their experiences of working with interpreters, particularly how they

experienced issues relating to power and alliances within the client-therapist-interpreter triad.

Broadly, this theme captures the experience of the participants of the organisational context, whether demanding and pressured, or supportive, as a driver of their own perceptions and experiences when working with interpreters. It seemed that when the participants themselves experienced being under threat by the power and demands of the system, this was reflected in the way they experienced the interpreter, and themselves in relation to the interpreter. Where an experience of feeling supported by the system was described, the narrative contained experiences of feeling comfortable to share power and to tackle power disparities in the room, together with a view of the interpreter as a valued co-worker. In contrast, where participants talked about an experience of feeling pressured by the system, they seemed to experience working with an interpreter as anxiety provoking, and to express a preference for an interpreter's role to be one of a translator. These participants preferred to hold onto the dyadic relationship with the client, and talked about a feeling of powerlessness in relation to the work with interpreters.

A key element of this experience of the powerful system seemed to relate to 'time', and the sub-ordinate theme of 'time pressure' captures the experience for many of the participants of the driver of the service demands. Many participants described a pressure of time exerted by the service onto them, which appeared to underpin a sense of threat and anxiety in the participants relating to meeting the demands of the system relating to their work with clients, and, in turn, of their professional sense of self. This was often talked about as exacerbated by organisational structures such as the room booking system.

4.2.1.1 Sub-ordinate theme one: Time pressure. Almost all the participants talked about feeling under time pressure in their work and the experience of this being heightened when working with an interpreter. Participants talked about there not being *enough* time and not being able to get what needed to be done 'in time'. This seemed related to a generally held view that working with an interpreter took longer and so having to fulfil service demands such as working through assessment and treatment protocols within a rigid timeframe became an amplified pressure.

“First of all, it’s gonna be slow....the way that we assess within our service, particularly with CBT, is fairly sort of protocol driven. We’re expected to complete a lot of...to get a lot of information within that assessment and because of the process of using an interpreter, it’s a lot slower and often I find that you don’t get enough information during that initial assessment. Also, I’m very worried. I often feel a little bit anxious because part of role involves assessment management of risk and one of the most simple aspects is providing people with means of accessing services and then you’re feeling unsafe and if they don’t have...if they’re unable to speak English or even read written information, that adds a component of anxiety.” (P1, line 44)

This feeling of ‘unsafety’ points to an experience of threat to the participant’s sense of self as a competent clinician as what they consider to be one of the basic aims of an assessment (of managing risk) is compromised by the time-consuming process of working with an interpreter. A conflict between viewing the assessment protocol as a pressure but, yet, when it cannot be followed, a wanted object of containment, is alluded to by the participant.

Almost all the participants made some reference to the system of booking therapy rooms, which seemed to be generally ‘on the hour’. This process was experienced as part of a rigid system which was beyond negotiation; with ‘time’ controlled and allocated by an all-powerful system.

“..the most powerful thing is the system. It’s the system saying this is how many appointments you can have and this is how much time you have for your appointments.” (P10, line 335)

This participant’s narrative gives a sense of the absolute power that the system was perceived to have by many participants, and offers an insight into therapists’ experience of the rigid ways of working available within it. Tension and conflict in ‘battling against time’ seemed to be a common experience for participants, and appeared to permeate almost all aspects of their therapy work when using an interpreter. This next excerpt, which relates to the issue of briefing interpreters at the beginning of sessions, illustrates the conflict

experienced by many participants between what they considered to be good working practice and what was considered possible within the context of the system.

“So if I’m coming out of a session going straight into an interpreted session probably not but then that’s just good practice for me to then make sure that I have got a little bit of time beforehand. Not always easy here ‘cause we’ve got the rooms on the hour.” (P4, line 234)

For this participant, the ability to work in a way that is congruent with their beliefs and values around good working practices is challenged by the rigid structures and systems. It seems that such conflicts are experienced as a source of great stress, anxiety and, potentially, guilt, for therapists.

“Perhaps a bit stressed we don’t have masses of free time so when you know that you... Particularly as I guess we are likely to be sending that person to [another service]. That’s another referral and anything that you know where you’re going to make another referral when you’ve got approximately five minutes of spare time for the whole week it’s just a bit harder but that’s, that’s not the client’s fault and those are my own feelings. We should be trying to make our service accessible, we should be offering these appointments so I guess it’s a bit of a balance of, sort of, almost selfish feelings of frustration a bit of stress balanced with trying to think “Well actually this person’s in distress they need some support and they do need an assessment or treatment - just deal with it.” (P4, line 66)

The participant states “we *should*...”, suggesting an experience of an internal battle between what the therapist believes they are expected to do (or possibly what they believe professionally or morally they should do), and the resentment they feel at being made to do it, when time is limited. It is possible that this resentment is experienced by the participant in relation to both the service, the interpreters and the clients requiring an interpreter. Repeated reference to ‘another referral’ suggests evidence of an experience of burden. The punitive way the participant tells themselves to ‘just deal with it’ indicates

that these resentful feelings are unacceptable to the therapist. The passage may be considered to contain evidence of a journey for the participant from starting by being caught up in their own feelings when thinking about the pressures of time, to then making an effort to bring their focus back to the client's position and needs.

Resentment is felt in relation to another time-related conflict for this next participant.

"The issue is that the complications have meant that we've had to deal with that particularly this week we had to use quite a bit of the therapy session to deal with that. And we were at an important stage in the EMDR, so it took up a chunk of the time. We did then still, we did some processing, but we didn't have enough time." (P7, line 302)

Whilst earlier in their narrative the participant acknowledges the supportive nature of a close relationship which had developed outside the therapy room between interpreter and client, feelings of frustration that, within a limited time, having to manage this 'issue' in session had taken away from the 'real' work of the EMDR processing therapy that needed to be done, are present. This participant's experience illustrates a seemingly common response by the participants to the rigid system, of shifting to a more closed and rigid position as anything that takes up time is experienced as a threat to the ability of the therapist to meet the demands of the system. An impression of an ominous ticking clock, held in the hands of an omnipotent system, looming over the participants and counting down the hour until the end of the room booking or the end of the allocated number of appointments, is formed.

The use of the metaphor 'like wading through treacle' by one participant to describe an assessment using an interpreter seems to capture and convey the embodied collective experience of many participants of the slow and exhausting struggle in battling against the unyielding force of the system. The treacle may be understood to relate to the resistance created by the demands, restrictions and limitations of the system, and by participants' own conflicted feelings about working with interpreters, within this restricted and pressured system.

In summary, this superordinate theme contains different ways which the

participants talked about the system as being ultimately powerful, and these appear to underpin important aspects of the participants' experiences of working with interpreters within particular contexts, and to link to many of the other themes in this analysis. Importantly, an experience of the system as a threat or as supportive appears to closely link to participants' experiences of the role of the interpreter and of working with them in therapy. The pressure of time seems to amplify and drive experiences of pressure and demand, to create painful conflicts, and to link to an experience of threat to the therapists' sense of self as a competent clinician, and to their power and agency as a therapist.

4.2.2 Super-ordinate theme two: The knotty question of power. This super-ordinate theme contains different ways that participants talked about power. The name of this theme was inspired by the use of the word 'knotty' by one participant, which seemed to capture the discomfort and complexity with which participants experienced issues relating to power. The way participants talked about experiences of their own power often seemed to be related to their experience of the powerful system. Participants talked about feeling deskilled, incompetent and powerless without a shared language, which seemed to link to an experience of threat to their role as professional, driven by a pressure to meet the demands of the service. Where participants felt supported by the system they seemed to experience feeling empowered to tackle issues relating to power. Overall, power seemed to be identified as a 'knotty' issue, one which some participants seemed reluctant to acknowledge: some did not want it, some wanted to hold on to it, some felt that they didn't have it, and some wanted to share it. For some, power was unspoken, forgotten and painful; for others it was not an important issue. For a number of participants, the process of the interviews had helped to facilitate reflection on issues of power.

4.2.2.1 Sub-ordinate theme one: *Attending to power.* This sub-theme addresses whether and how participants connected with issues of power in the therapy room. A number of participants acknowledged that they had not previously attended explicitly to power issues when working with an interpreter, although were clear in their view that they are always present. This contrasted with the views of two participants who felt that power issues were not of relevance or importance in this setting. For one participant, their experience of

connecting with power disparities was experienced as painful to do and as requiring courage.

“Because I would drop her at her house in the car and fetch her, she became subject to envy and resentment from some of the young people we were working with. But at the time I think I was braver. We just went straight in with, “Let’s talk about envy. Let’s talk about power. Let’s talk about race.” I think because in [a particular country] in the left there was a discipline of us not running away from those questions.” (P6, line 399)

“Certainly in the organisation I worked for there was a culture of it being more explicit. Nevertheless, painful” (P6, line 709)

The participant reflects back on a time where they felt empowered to explicitly tackle issues relating to power disparities, implying a contrast with the present. Power is linked to resentment and envy, which was directed towards the interpreter by clients as a result of being associated with the therapist. For this participant, both the organisational culture and political agenda had created a context which validated and provided a language for the expression of their values, whereby they felt brave enough to connect with and attend to issues of power through dialogue, despite painful feelings being invoked by doing so.

4.2.2.2 Sub-ordinate theme two: Power – wanted and unwanted.

Participants generally acknowledged power imbalances within the triad, and there seemed a general discomfort with acknowledging the power that they held as therapists. Often this power was talked about as unwanted and was associated with feelings of discomfort and even guilt and shame, particularly when related to the perceived position of privilege they felt they had in relation to the client and/or the interpreter. Power was, for some, talked about as pain.

“And I think in a certain situation the social imbalance and historical inequity between [the interpreter] and myself was painful. It was terrible but we had to talk about it. You can’t resolve that kind of thing completely” (P6, line 710)

For this participant, the painful experience of power imbalance between themselves and the interpreter and the client was unwanted and unresolvable, experienced as a kind of monster, which must be faced, however terrible the encounter.

The narratives of many participants seemed to contain evidence of an internal battle or conflict for the therapist. For some, this was in wrestling with some of the discomfort and even pain of acknowledging the disparities in power between members of the triad. Other participants talked about an experience of discomfort with holding power as therapist, to manage the session and decide how many sessions would be offered. In this instance, being able to deflect responsibility onto the system was welcomed.

“Sure, yeah, and sometimes that’s quite helpful in a way, to not have to take that responsibility on yourself and be as me, who is saying you can’t have any more therapy.” (P10, line 368)

For this participant, there seems an experience of relief as the powerful system can be held responsible for limiting the therapy, rather than facing the unease that owning their power creates. Blaming the system appeared to be a strategy used by a number of therapists to deflect power and reduce discomfort.

However, there seemed to be a complexity to the participants’ experience of power within the triad, as some narratives suggested that participants tried to maintain or assert power and control, despite their discomfort. Ways of doing so included using clear instruction to the interpreter and communicating rigid expectations of the interpreter’s role. A number of participants talked about strategies they used in therapy which seemed to have the purpose of increasing their own power by reducing the power of the interpreter, such as by using translated materials. Many narratives contained a sense that this need to maintain power and control was driven by an anxiety relating to delivering service expectations.

4.2.2.3 Sub-ordinate theme three: Language as power. The interpreter’s unique position of knowledge of both languages was talked about

as being a position of power, and perhaps even the most powerful position in the triad.

“It would be difficult to say because of the interpreter or is it because of the language? Certainly, the interpreter is the most powerful in there, there’s this person there that we both need” (P8, line 412)

For this participant, knowledge of both languages was viewed as a position of power over both client and therapist; the interpreter is needed in order for the therapy to happen: client and therapist are unable to communicate directly without the interpreter present. With communication as the foundation of therapy, being unable to communicate directly verbally speaks to a fundamental threat to the therapist’s identity and sense of efficacy.

Participants experienced the interpreter as having the power to shape the meaning of the communication. Some participants were sceptical of the accuracy of the translation received, wondering if some ‘polishing’ or ‘spin’ had been put on the communication, or if the meaning had been manipulated.

“... I think there are a few times where the interpreter actually said things that kind of were a bit protective of the patient and wasn’t always directly translating what was being said, it felt like sometimes she was kind of putting her own spin on what was being said and...” (P9, line 188)

For this participant, the manipulation of meaning was understood to be motivated by a desire to protect. It is not clear whether it is understood to be aimed to protect the client from the questions or interventions of the therapist, or the therapist from the content of the client’s material. Whichever way, there is a sense from the participant that their power is being diminished as the interpreter exercises their power to choose what is communicated, which is not welcomed by the therapist.

Some participants talked about an experience of the interpreter as a barrier to communication, and a feeling that the meaning of what they were trying to communicate to the patient, or the empathy behind the communication, may be lost. Psychological concepts and the rationale of therapy models were identified as being difficult for the interpreter to translate, and the therapeutic

alliance and change methods within therapy models as being compromised by challenges in communicating through an interpreter.

“But actually doing CBT with people, work through an interpreter sometimes I get a little bit of a pang of learned hopelessness [laughter] because it’s the actual process when we’re very much....within our course, we’re very much kind of taught in terms of CBT primacy and cognition and in order to...you need to have fast access to key negative thoughts and such like. Doing that through an interpreter is very, very difficult and at times I find it impossible. So I often feel a little hopeless really.” (P1, line 72)

For this participant trying to work using their model of CBT with an interpreter invokes feelings of helplessness and hopelessness. The passage suggests that the experience of working through an interpreter has stripped the participant of their ability to use their framework of knowledge and skills that is held to be familiar and containing, leaving them feeling incompetent and demoralised. The feelings of hopelessness allude to a sense of futility and of complete powerlessness in the therapy room.

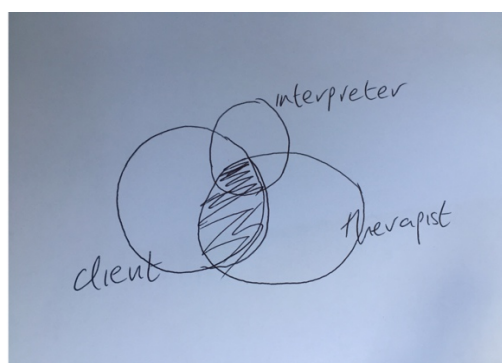
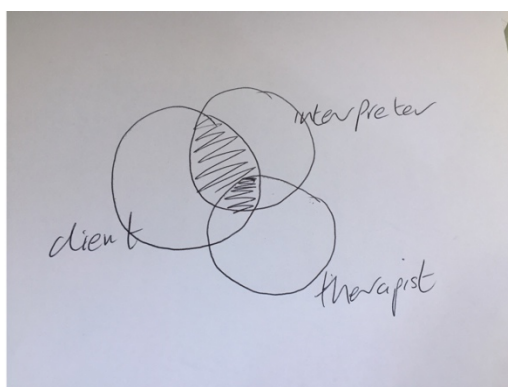
4.2.2.4 Sub-ordinate theme four: Reluctant reliance. Feelings of incompetence and powerlessness without shared language seemed to link to participants’ apparent experience of reluctant reliance on the interpreter. For some, this reluctance was associated with an experience of resentment. The interpreter’s power to impact on therapy was at times experienced as being disproportionate to their skill and value, which left participants feeling powerless and frustrated. This theme seemed to link to the experience of ‘wanted’ power, as some participants talked about strategies they used in therapy which seemed to have the purpose of reducing reliance on, or by-passing the need for, the interpreter entirely, such as using diagrams or translated materials.

“So thinking about working with somebody who had panic, and trying to illustrate the panic cycle just using pictures...But I suppose that’s more about short-cutting. That’s more about not having to use the interpreter rather than finding a way to use the interpreter well, if you like. That’s

about how to try and not have to use them, and communicate in a more direct way.” (P2, line 252)

Here, the participant begins by reflecting on ways in which they make adjustments in therapy when working with an interpreter. However, this process reveals to them what seems previously unknown; that in fact their strategy of using diagrams is motivated by a desire to avoid having to communicate through the interpreter. This example speaks to the reluctance many participants alluded to at having to rely on interpreters, and points to an understanding of the use of diagrams as being one way of the therapists trying to regain some control over the therapy process.

Some participants talked about being concerned that the interpreter would not share the same commitment to the client as the therapist, and therefore could not be relied upon to attend therapy consistently. To minimise their potential to disrupt therapy through non-attendance, participants talked about the need to minimise interpreters’ power by reducing reliance on them. During the diagrammatic task, one participant depicted their experience of the interpreter as having significant power (depicted in Figure 1 by similar size circles to the therapist and client), in their choice to attend sessions (a choice the therapist did not have) which they reflected that they would ideally reduce (as depicted in Figure 2) in order to reduce reliance on their attendance.



Figures 1 & 2. Photographs of diagrams produced by participant 7

“But that person could just disappear, I mean ultimately we don’t remain in their lives either but you know that could work really brilliantly for one session and then they never see them again.” (P7, line 804)

This excerpt illustrates the participant's experience of uncertainty in relation to trusting the commitment of the interpreter. Although the threat of abandonment is described in relation to the experience of the client, there is a suggestion that the abandonment could be in relation to them both. A contrast is made between their own commitment and that of the interpreter, highlighting the reluctance to rely on the interpreter and possible resentment at the interpreter's power to disappear without consequence.

4.2.2.5 Sub-ordinate theme five: Status as power. A number of participants talked about status as power. Status was attributed by the participants to a number of factors including professional status, which was viewed as being reinforced by the medical setting of therapy. Without exception, the client was viewed as being perceived as having 'lower' status and therefore power, generally by virtue of being displaced from their own country.

"I guess the main power that I was aware of there was my professional status but obviously everything else that goes along with that, advantages of being educated, and in my country of origin." (P10, line 317)

This excerpt suggests an awareness held by the participant in the therapy room of the power disparities between themselves and, in this case, the client. Being an educated professional is experienced as one of a multitude of factors which elevate their status above that of the client. A sensitivity in how this power is held is implied. An 'othering' occurs as the participant contrasts being in 'my' country to the client being displaced from 'their' country.

Race, ethnicity, sexuality and mental health status were also identified as relating to status, with the assumption that the patient, as seeking help for psychological difficulty, was vulnerable and of lower status. As someone who did not speak the language of their host country, multiple struggles for the client were acknowledged. The status of the interpreter was talked about as being somebody who had more resources than the client did, somebody who had 'made it' in this country.

Being the employer of the interpreter was acknowledged as a position of power. The interpreter was viewed as being employed by the Trust to work on

behalf of both the client and therapist, and there were questions over whether the interpreter would view themselves as needing to ingratiate themselves to the therapist in order to secure continued employment. The position of therapist was also associated with power over the client's treatment as this status afforded the therapist the power to diagnose and offer treatment (or not).

For one participant, the diagrammatic task (Figure 3) seemed to facilitate reflection on the clients' power. The participant initially drew the circles the same size (depicting equal power) and then revised this by drawing a smaller circle for the patient (indicating less power).

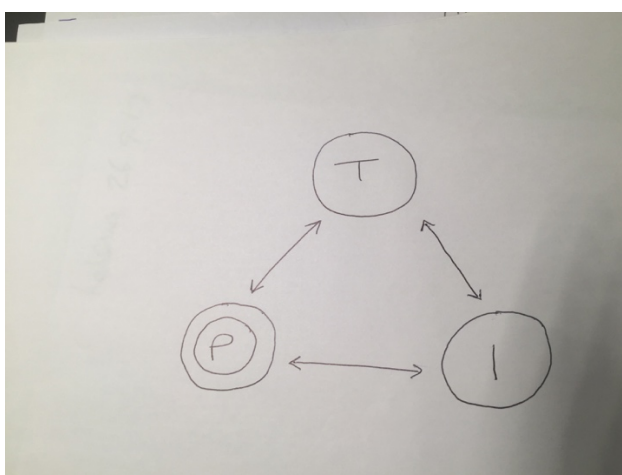


Figure 3. Photograph of diagram produced by participant 9

"Lots of different things that can come into play but I guess particularly in this context it would usually be about cultural, ethnic, language and kind of mental health status being slightly more vulnerable than both the therapist and the interpreter who we would probably normally assume have certain kind of privileges and then we would probably assume that they're both not accessing mental health services and that they both have access to things like... they're both able to communicate within their culture and the society that we live in whereas the patient probably isn't able to do that so easily. So, probably actually there maybe... it would be slightly smaller." (P9, line 624)

The process of thinking and talking about power seems to have resulted in a shift for this participant from perceiving all members of the triad to have equal power to viewing the client as having less. As the participant engages

with this internal dialogue, the extent of the client's struggles are revealed and acknowledged.

4.2.2.6 Sub-ordinate theme six: Can we share power? This sub-theme captures the participants' conflicts and processes around the sharing of power among the triad. For some this was an active, deliberate process. For others, power dynamics were viewed as inevitably shifting and redistributing over time within therapy. The latter was mainly related by participants to the empowering effects of therapy for the client. Participants particularly talked about the aim of CBT being to empower the client, leading to a redistribution of the power imbalance during therapy, although this aim was viewed as potentially challenging to achieve when working with an interpreter.

"In CBT, you often want the client to be leading and taking more responsibility in the sessions later on, maybe not so much in the earlier sessions. That might be quite difficult if there is an interpreter there as well." (P5, line 303)

For this participant, the natural process of empowerment of the client within CBT is viewed as at risk of being curtailed by the presence of the interpreter. Having the interpreter there "as well" suggests an experience of the interpreter as outside of, and a hindrance to, the work of therapy, with the client's empowerment by the therapist (via the CBT) being impacted as a result.

In actively seeking to share power, one participant described a journey from being a novice therapist, where their insecurity had led them to hold on to their power in quite a defensive way, to being able to share it as they became more confident and competent. This experience of confidence and competence in an identity as therapist also seemed to underpin another participant's choice to position themselves as the non-expert within the triad, and to work from a position of 'not knowing'. Acknowledging the client's expertise in their own experiences, and the interpreter's language and cultural expertise, was experienced as a way of sharing power, helping them to relinquish their position as 'expert'. These experiences suggest that an openness and willingness to sharing power is supported by a lack of threat to and a non-defensive confidence in a therapist's own identity.

In summary, this superordinate theme contains different ways in which participants talked about power. For many participants power disparities were something that felt uncomfortable to acknowledge or address and were therefore avoided in the room. Not being able to use language to communicate seemed to be experienced as diminishing the power of the therapist whilst elevating that of the interpreter. The frustration and possible resentment some participants expressed about this seemed to link to a positioning of the interpreter as purely a translator rather than co-worker. Where participants felt supported in addressing power disparities, an experience of being able to connect with difficult feelings about power was apparent, alongside an openness to sharing power by accepting a position of not knowing.

4.2.3 Super-ordinate theme three: Dyadic and triadic alliances. This superordinate theme captures the ways participants talked about the alliances and dynamics between the client, therapist and interpreter, which seemed closely linked to and underpinned by participants' experience of the context of the therapy. Seven subordinate themes were related to this superordinate theme. Participants talked in different, and often inconsistent, ways about how they viewed their own role and the role of the interpreter, and of their experiences and perceptions of alliances, both of dyads within the triad, and of the triad as a whole. The perception of the role of the interpreter seemed closely linked to whether the participants positioned the interpreter as an extra or intruder, distracting from or diluting the important dyad of the therapist-client relationship, or of a co-worker to be incorporated into the triadic alliance. Where participants seemed threatened or intruded upon by the presence of the interpreter, this drove a rigidity in attempting to control any potential for the development of a close relationship between the interpreter and the client, and a sensitivity to feelings of exclusion in the therapy room. In talking about their experience of the alliances, many participants used concepts and language from specific psychological models. Almost all participants talked about an experience of three-way working being important for effective therapy, though this was often viewed as idealistic.

4.2.3.1 Sub-ordinate theme one: Human co-worker or translating robot? Or both? Participants talked in dichotomous and inconsistent ways

about how they experienced working with interpreters – either as a co-worker / co-therapist and human with their own needs and areas of value and expertise, or a faceless instrument of translation. Overall, there were real inconsistencies and conflicts in what the participants seemed to want and expect from their interpreter; on one hand talking about a faceless interpreter and experiencing the interpreter being more than a pure translator as detrimental or even threatening, and on the other, the interpreter as human and a co-therapist with valuable skills and vulnerabilities. These two excerpts from the same participant clearly illustrate the complexity and inconsistency present in the narratives of many participants regarding the role and function of the interpreter.

“Again I had a very good interpreter coming in for an assessment she sat...she said to me before she started she would sit with her eyes down on her lap she wouldn’t make eye contact with either myself or the patient because she said “I’m just here to be a mouth piece, I’m not part of your therapeutic relationship, I’m just literally translating, facilitating conversation.” Which was helpful.” (P4, line 94)

“It probably is quite unsettling for the client to have a different person each week providing the interpreting and I guess as much as I need to trust that the communication I’m getting is accurate and good representation of what the client’s saying they will want that from me as well. So actually the interpreter has got a more significant role in that relationship than perhaps it seems on paper. So whilst they are technically just a mouthpiece I guess they’re not.” (P4, line 199)

The participant’s initial narrative offers a clear view of a preferred experience of the interpreter purely as a translation device, as they label this functional role as ‘good’ and ‘helpful’. By explicitly removing herself from the triad and de-humanising her role to that of a ‘mouth-piece’, the interpreter relieves the therapist from having to think about engaging with any relational issues within the triad, and the client-therapist dyad is preserved. However, the second narrative suggests that, following some reflection prompted through the interview process, the participant considers the perspective and needs of the client and the interpreter. As soon as this is done, the therapist can no longer

maintain an anonymous, face-less view of the interpreter. As the participant refers to a 'person' rather than 'interpreter', they become human and their value and significance within the triadic relationship is acknowledged.

The dilemma over how to relate to the interpreter (as human or function) was present for many participants. For one participant, an experience of difficulties experienced in the therapy when a close relationship had developed between the interpreter and client had triggered a shift from a previous position of welcoming the humanness of the interpreter, to the more rigid 'safe' position of relating to them instrumentally as a translator.

'oh gosh actually it probably is quite important that the interpreter is just seen as a sort of vehicle for translation'. (P7, line 368)

This theme of 'safety' also occurred in the experiences of participants as interpreters were acknowledged as humans with unique, and possibly difficult, experiences of their own which might make them vulnerable to being affected by traumatic material discussed, particularly where a traumatic experience may be shared with the client.

"Er..It was a mother who was heavily pregnant and she had had a previous traumatic birth, and she had been referred late to our service. So I undertook a face to face assessment with an interpreter who turned up and was also heavily pregnant. That was probably the most challenging for me as a therapist...I think it raised a lot of anxiety for me about how to protect the interpreter." (P5, line 130)

Here, to be human is connected with the potential for vulnerability, which then presents the therapist with a burden of responsibility for protecting the interpreter. Having been confronted unexpectedly by an interpreter who is obviously pregnant, the therapist is presented with immediate concerns about how the client's trauma might be experienced by the interpreter. There are many unknowns relating to the interpreter's history, raising the therapist's anxiety in how to meet the needs of both client and interpreter, and bringing sharply into focus the humanness of the interpreter before them.

Most participants talked about an experience of valuing consistency in having the same interpreter each week, and of considering ‘matching’ characteristics of interpreters to clients to be important, supporting an experience of the interpreter as a unique human.

“In the trauma project there was one staff member who I worked with all the time. So we then developed a way of working together where she became a bit like a systemic... she became a co-therapist or therapist somehow.” (P6, line 108)

For this participant, viewing the interpreter as a co-therapist was related to having developed a working alliance over time. Having access to a regular staff member within the project had provided the space for a relationship to develop between the interpreter and therapist. Talking about developing ‘ways of working together’ suggests a mutually respectful process of learning from each other, with a description of ‘co-therapists’ suggesting a non-hierarchical partnership with a shared role and purpose between therapist and interpreter.

4.2.3.2 Sub-ordinate theme two: The prized dyad. This sub-theme captures the seeming wish of participants to protect and prioritise the relationship between the therapist and client. The need to safeguard this alliance appeared to relate to the experience of many, although not all, participants, of the interpreter as an intrusion onto, a potential disruption to, or dilution of, this important dynamic.

“Okay, I see the role of interpreter, hopefully, as I was saying earlier, ideally should be a mere instrument of translation really. Someone who brings into the session as little as possible in order to minimise any interference in terms of the relationship that is meant to be established with the therapist.” (P8, line 238)

For this participant, limiting the interpreter role to one of pure translation is experienced as a way of defending the prized dyad. Anything beyond this role seems to be viewed as a potential threat to the client-therapist relationship. The

use of the phrase 'meant to be' suggests this is viewed by the participant as a legitimate and common position to hold.

From participants' accounts it seems that therapists' experiences of interpreters as an intrusion or threat may be understood, in part, as relating to the models of therapy in which they work, which were talked about as being based on a dyad rather than triad.

"Because you know we were trained and we were kind of brought up thinking this is like two people in the room and the therapeutic alliance is like very special and it's between the two, the patient and the therapist in what happens." (P3, line 68)

It seems that for this participant, the focus on the alliance between the client and therapist has been ingrained in their psyche by their training, and is viewed as the fundamental cornerstone of therapy and as a necessarily exclusive relationship. The narrative offers an insight into how challenging the therapist may have found it to move away from this viewpoint to a more open and inclusive position.

4.2.3.3 Sub-ordinate theme three: The tennis match. The metaphor of watching a tennis match offered by one participant to describe their experience of feeling excluded from the communication between the interpreter and client seemed to capture a common experience for the participants. For most participants, the experience of exclusion was talked about in a negative way, though for one participant the exclusion was accepted as part of the inevitable shifting alliances between the triad. Some participants talked about feeling distant or separate from the interpreter-client interaction, wishing to be included.

"So you'll say something, and then they will relay whatever they'll relay to the client, and then that might go on for some time, and they'll have a back and forth, and I don't really know what's going on. Then I just feel like I'm no longer part of the process, and I might have to sort of interject, or ask, look, can you tell me what they're saying?" (P2, line 203)

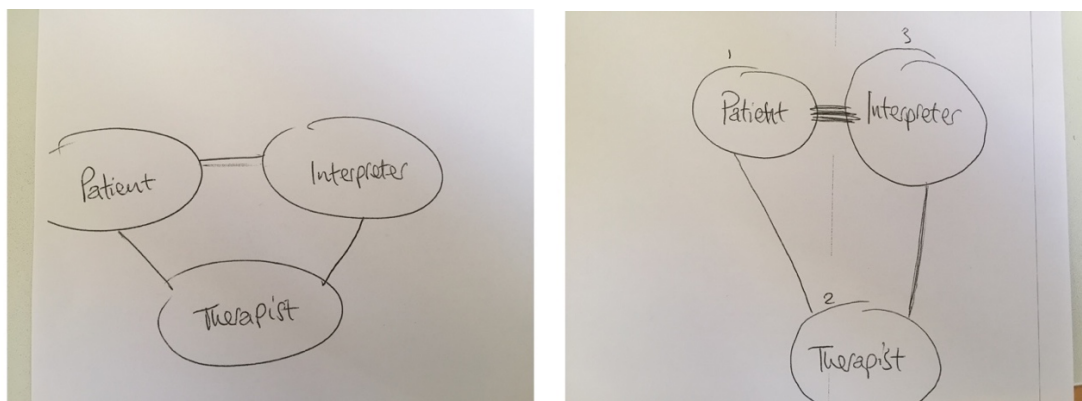
This participant's account alludes to a lack of confidence that what they say is being accurately communicated to the client. This is reinforced by the experience of the 'back and forth' conversation between the client and interpreter. The expected communication rhythm of the interpreter triad of the therapist speaking, then the interpreter, then the client, and then the reverse, is interrupted. The power of the interpreter as the only one with knowledge of both languages is brought into sharp focus, as the therapist is left powerless and excluded from the therapy session. The therapist's interjection of "look" appears to be an urgent command to be viewed, and acts to disrupt the 'tennis match' and attempts to reinstate the rhythm and their position as a part of the triad.

However, not all participants responded to an experience of exclusion by trying to fight it. One participant talked about feeling like giving up and just leaving them to get on with it, offering an insight into an alternative way in which therapists may respond to the experience of powerlessness and exclusion. For another participant, the process of exclusion was experienced as a deliberate action by the interpreter, in response to the way the therapist had positioned themselves.

*"They gang up together sometimes don't they? They gang up together because the more you undermine the interpreter the more they become a pair with the patient and you're left alone and that's why I think it's really important to address that and to know that if you're feeling insecure then you're more likely to be, to position yourself in a particular way."
(P3, line 559)*

The participant describes a process which unfolds in response to the therapist's insecurity prompting them to claim a position of power in the triad. Paradoxically, the therapist then becomes powerless as the interpreter pairs with the patient. As a 'gang' they are experienced by the therapist as powerful, bonded and exclusive. Earlier in their narrative the participant relates the camaraderie between the client and interpreter to the trust which develops between them as a result of being from the same community. The participant seemed to experience being in a position of the untrusted outsider, amplifying their experience of exclusion.

For one participant the process of the diagrammatic elicitation task facilitated reflection on their experience of exclusion.



Figures 4 & 5. Photographs of diagrams produced by participant 4

“So, in terms of how I’d ideally like it I’ve got maybe so where the circles are roughly equal and the lines would be roughly equal. I think that’s probably unrealistic in many ways. So it probably.....ah! That’s interesting! Because to me it probably feels a bit more like having the patient and interpreter quite close and it feels like I’m further away sometimes” (P4, line 468)

The participant initially draws a representation of their ‘ideal’ alliances (depicted by equally spaced circles and width of lines in Figure 4). Having done so, they are struck that their actual experience is one of a close bond between the interpreter and client. Their description of feeling far away (and depiction in Figure 5 of positioning the circles representing the patient and interpreter closely together, joined by a thick line representing a strong alliance) alludes to an embodied experience of exclusion.

4.2.3.4 Sub-ordinate theme four: A cautionary tale. This sub-theme captures the dilemma experienced by a number of participants relating to the boundaries of the interpreter/client relationship. In particular, participants seemed to experience conflict as to whether contact between the interpreter and client outside of the session was ‘good’ or ‘bad’. The development of a relationship outside of the therapy context between the client and interpreter was talked about as a blurring of boundaries and potentially problematic, and

the responsibility of the therapist to manage. However, this was not the experience of all participants. There was a stark contrast between the experience of one participant who described having been 'burnt' by an experience where what they had perceived initially as friendly chat had become a close relationship which then caused problems for therapy, and another, who described an alliance forged over the shared experience of motherhood, as being helpful for therapy.

For this first participant, an initial perception of communication and relationship building outside the session as positive changed following an experience where a client had asked a favour of the interpreter, which the interpreter had agreed to, because of her resonance with his story and experiences. The participant felt that this had really overstepped the professional boundaries that should exist between interpreter and client and had negatively impacted on the therapy.

"But I'm learning more as I go along about; I suppose it's about the importance of dealing with those sorts of alliances and boundary issues. Nipping it in the bud, being aware of it quite early on, whereas if I'm honest probably previously I might have thought 'oh that's fine you know that's kind of nice' if the interpreter is quite friendly and chatty with the client. And with this experience I think 'oh gosh actually it probably is quite important that the interpreter is just seen as a sort of vehicle for translation'." (P7, line 368)

This participant's account suggests a sense of pessimism as they reflect back on having not realised what the repercussions of the developed relationship would be for the therapy. This experience appears to have shifted the participant from a position of openness to one of caution and suspicion, with a corresponding shift to a preference for limiting the role of the interpreter to one of pure translation. This experience fits with that of number of participants of the development of a relationship between the client and interpreter being perceived as threatening in some way and of negative experiences appearing to activate a shift in the therapist's position to a more rigid and restricted view of the role of the interpreter in therapy. For another participant, communication

linked to previous contact between the interpreter and client related to an experience of powerlessness for them.

"I also had another interpreter once a number of years ago who had seen this patient previously in an inpatient or a hospital setting. Halfway through our assessment she grabbed the woman's hand and pointed at what looked like a recent self-harm mark and clearly had a conversation about that and then turned to me and said, "I've just told her off because she said she self-harmed last week and she's not taking her medication so I've told her she must do those things." And again, you just think "Well that's a boundary that you should not be crossing as an interpreter, even though I appreciate you're doing that from your best intentions." But again there's a powerlessness, lack of control." (P4, line 146)

The participant experiences the interpreter's intervention as being outside of her role and as a direct challenge to the therapist's position of power. There is a conflict for the therapist as they acknowledge that the interpreter's communication may be driven by the client's best interest, but the overriding experience seems to be one of threat to their position.

A number of participants talked about deliberately trying to minimise the contact between the client and interpreter with the apparent aim of reducing the opportunities for a relationship to develop.

"Not always easy here 'cause we've got the rooms on the hour and you can't always necessarily separate them in the waiting room but it's not impossible. But then one thing that is quite easy to do is prevent them leaving together 'cause obviously you don't want them to develop a relationship outside of the sessions per se. So I will often say that I'm going to show the patient out and that I will be coming back to sign...they usually have a time form to sign, so I can manage the exit quite easily so there's that at least." (P4, line 255)

For this participant, clear and deliberate strategies are used to keep the interpreter and client apart in order to manage the threat that their close relationship might present. The use of the word 'obviously' suggests an

expectation that other therapists would hold a similar view and support their behaviour.

However, for one participant, the relationship between the client and interpreter, although separate, was experienced as helpful and as facilitating a positive shift in therapy. The participant talked about a situation where the interpreter and client were in similar situations regarding their ex-partners, the interpreter had shared her experience in the session and then the client and interpreter had carried on the discussion outside of the session.

“The next week when they came back they said they’d spoken a lot about it again in the waiting room waiting for me for the second week. They sort of almost both reported that it had been a very deep discussion and they carried on chewing it over after the event, the two mothers, and then they were able to get back on track. Again, it was an odd thing I felt ‘cause it’s not in the text books at all but nevertheless it felt helpful to let the interpreter not just say I’d like you to translate, but actually to become part of it. Certainly, the mother’s therapy shifted..there was something about the interpreter’s role in that which I felt like it enhanced rather than interfered.” (P6, line 254)

This account contains an apparent experience of welcoming the development of the interpreter-client relationship, and of positively valuing the contribution of the interpreter’s intervention to the outcome of therapy. Although the description of the interpreter-client dyad as ‘the two mothers’ might be thought to imply a feeling of exclusion, this separateness does not seem to be experienced as a threat to the therapist. The therapist does not experience their role in therapy to be diminished by the therapeutic role of the interpreter. The interpreter’s role is recognised as being broader and of more value than simply translation and is welcomed as such.

4.2.3.5 Sub-ordinate theme five: I am not like them, I am like you.

This sub-theme captures the experience of participants relating to a simultaneous process of deliberate alignment with one member of the triad, and dealignment from the other. Some participants talked about experiencing the

interpreter as trying to distance themselves from the client and their experience, instead aligning themselves with the therapist, as two professionals together.

“At times like that sometimes the interpreter herself wants to position it as a professional with us. So sometimes I’ve had interpreters say, “But my story is very different to hers, my story is not the same as hers”. So that wanting to distance themselves in a way, so you hear that quite a bit sometimes.” (P3, line 603)

This account alludes to a process of negotiation of power dynamics between the therapist and interpreter. As the interpreter experiences themselves through the eyes of the therapist, it appears that a threat to their professional status is experienced as they assume that the therapist positions them as sharing a similar (lower) status with the client. The interpreter’s attempt to communicate that their experiences are very different to that of the client seems to be understood by the participant as part of the interpreter’s need to achieve validation as a professional in the eyes of the therapist.

For other participants, the process of alignment and dealignment was experienced as being between the interpreter and client, with the client aligning themselves with the interpreter as someone who understands their experience, because of their shared culture, when the therapist, who does not, cannot.

“Sometimes a patient will talk to the interpreter, sometimes talk to me like “Sister”, or, “Auntie, you tell her ‘cause she doesn’t understand.” That’s not straightforward but it is something that can be picked up on and so the assumption I don’t understand, feeling a pressure to prove that I understand something. Sometimes I actually do understand and it’s being assumed that I don’t. Other times I don’t.” (P6, line 478)

The familial terms used by the client to the interpreter speak to the close bond created by a shared cultural experience. The client calls upon the interpreter to communicate their experience to the ‘outsider’. As someone outside of the shared cultural experience it is assumed the therapist does not adequately understand the client experience. The participant experiences a complex response to this assumption; they feel a strong pressure to prove that

they do understand even though they may not. This response speaks to a pull to be viewed as an 'insider' rather than 'outsider'.

4.2.3.6 Sub-ordinate theme six: Models and psychological concepts used to conceptualise alliances. This sub-theme captures participants' experiences of using therapy models and concepts to conceptualise alliances. Most of the participants' narratives contained psychological concepts as a way to communicate their experience of the alliances, suggesting a common experience of therapists' models being used as a framework and lens through which to view work with an interpreter. Many participants drew mostly from psychodynamic theory. Examples included talking about the interpreter and therapist as parents, with the client in the child position, of 'othering' in how members of the triad positioned each other, and the development of separate dyads within the triad through processes of rivalry and splitting. Where therapists worked predominantly with CBT they seemed less likely to use their model as a framework for conceptualising the alliances. However, a couple of participants talked about their uncertainty at how the CBT model's aim of client empowerment might be affected by the presence of the interpreter. One participant conceptualised the alliances using the CAT model, and, during the diagrammatic task, talked about explicitly using the model with the interpreter to make sense together of their shifting roles in relation to the content and process of the sessions. This was represented (in Figure 6) by a number of different sized circles for each triad member.

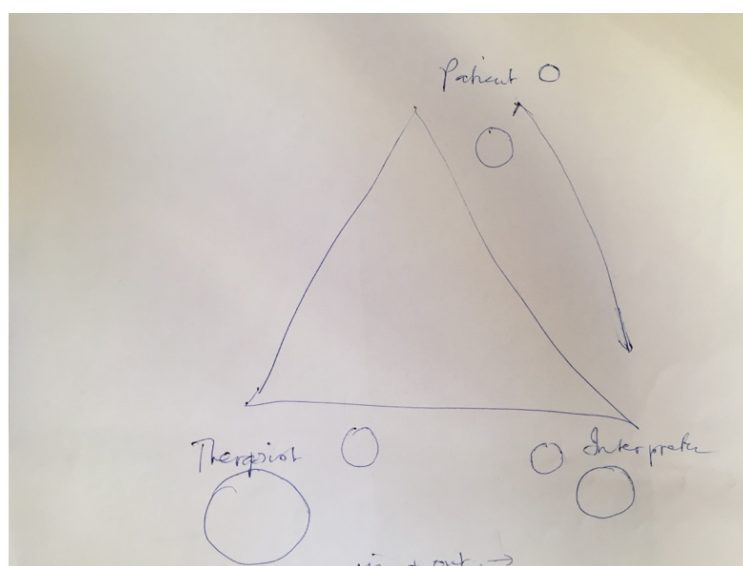


Figure 6. Photograph of diagram produced by participant 3

“We had maps because I’m CAT, so we had maps and sometimes we would look at the roles on the map and I’d kind of say “God I’ve become a bit critical now haven’t I of the patient and you’ve become a bit rescuing and kind of doing that.” (P3, line 202)

For this participant, the CAT model provides concepts and a language with which to understand and communicate roles in therapy. The account speaks to an experience of containment of having such a framework to do so. The participant alludes to welcoming a shared understanding of the CAT model and of the interpreter as an integral part of the therapy triad. There is evidence of a dynamic view of alliances, with interchangeable roles for the interpreter and therapist.

A view of a containing function of the therapy model framework is supported by another participant’s narrative. For this participant, it felt so important to have a psychological model as a framework to conceptualise the interpreter position, that, without one, they didn’t feel confident enough to work with an interpreter in their current work setting.

“But with individual long-term therapy, I just know...the triad, I’ve never been willing to try it. Systemic I’d feel fine. Any kind of therapy where it’s actually within the frame to have a co-therapist, I would then treat the interpreter as my co-therapist or co-worker. So: consultations, short time work. Long-term work I think that reading the transference would become really, really complex. I’d have to genuinely be working with someone who was also psychodynamically trained as opposed to just an empathic experienced interpreter and so I’ve never tried it.” (P6, line 603)

As a psychodynamically trained therapist, the participant seems lost and uncertain about how to conceptualise and relate to an interpreter without the containment of a therapy model framework which offers a clear way to do so. This experience suggests that their model is an integral part of their identity as a therapist and forms the lens through which view and relate to others in the therapy situation. The narrative suggests a wish to work with an interpreter as a co-therapist rather than as a pure translator, but also a firmly held belief that

specific training in the model would be required for the interpreter to be able to fulfil this role.

However, this viewpoint was not shared by one participant who felt strongly that all therapists should work with interpreters, regardless of their model of therapy, suggesting a belief that work with interpreters may be conceptualised separately to the model or that flexibility in the application of the therapy model is possible.

“I mean there are some schools where they still don’t work with interpreters which I think is in breach of equal opps really.” (P3, line 301)

4.2.3.7 Sub-ordinate theme seven: A three legged stool. This final sub-theme captures the experience of the importance of three-way working for the participants. Although a range of views and experiences relating to how the alliances between the therapist, client and interpreter do, or should ideally, operate were described, almost all the narratives contained an acknowledgement that an element of three-way working was important. Participants talked about collaboration underpinning triadic working, of shared working, of sense-making together, with ‘everyone on board’. Triadic working was associated by participants with good therapy outcomes for the client, and therapy triads were experienced as developing over time, in the same way as therapy dyads. For some participants, a journey of having shifted from positioning the interpreter as an intruder to an integral member of the triad was talked about. One participant likened the ideal of evenly spread alliances between the therapist, client and interpreter to a three-legged stool.

“Well, I think over time, especially as relationships build, I would want the relationships to be pretty evenly spread, so I think if, over time, you became very pally and buddy with the interpreter, that might not be great for the client’s experience. They might start to feel a bit like they had two therapists, or again, that more parental dynamic... So I think, as time goes on, I think it’s probably about balance, sort of a three... Like, a bit like a stool. I guess you want them to all be the same sort of length to keep it on an even keel, and feel like it’s a team environment where you’re all working on the same project together.” (P2, line 825)

The metaphor of the stool offers a clear representation of the three members of the triad as the stool's legs; necessarily evenly spaced and of even length in order that the seat of the stool maintains a state of balance. The legs work together to ensure that the stool fulfils a shared purpose or function, namely one of support. For this participant, having separate alliances between different dyads was experienced as unhelpful. This could be thought of as having one shorter or longer leg, potentially destabilising or unbalancing the stool, disrupting its function and purpose.

For another participant, although a triadic relationship was important, this did not exclude the value of separate relationships with the interpreter and client.

"I certainly think that kind of with some of the cases where I've worked with an interpreter for a whole course of therapy it has felt like there have been times when a good alliance or relationship has developed between all three of us and between me and the interpreter and me and the patient separately as well" (P9, line 373)

This account offers a more fluid and flexible view of alliances within the triad. The development of alliances within dyads are not perceived to be at the expense of the triadic relationship.

In summary, this super-ordinate theme relates to the way participants talked about their experiences of alliances, relationships and dynamics between the client, therapist and interpreter. The participants' accounts suggest that they generally experienced a close alliance between the interpreter and client as threatening and excluding. Participants felt protective of their interpreters, although this was experienced as an additional pressure. Having their model of therapy as a framework for working with an interpreter seemed to be containing for the participants. Split alliances were not generally welcomed and triadic working was valued, although not always viewed as realistic.

4.3 Analytic Summary

This analysis has sought to explore the experience of ten therapists of working with interpreters, particularly in relation to therapeutic alliances and

power dynamics. Three super-ordinate themes identified from their narratives help to provide an overall picture of what it is like for these therapists to work with an interpreter in their IAPT or secondary care psychology service setting. In summary, participants' experiences seem closely linked to their experience of the setting in which they work, and the psychological model with which they work. This suggests that an understanding of how therapists' experience power dynamics and the therapeutic alliance when working with an interpreter is enhanced by consideration of the experience within the context it occurs. Detailed consideration of the findings in relation to existing literature will be offered in the next chapter.

Discussion

5.1 Chapter Overview

This chapter outlines the main findings of the study and considers these in the context of existent theoretical ideas, literature, and in terms of their wider significance to the practice of Counselling Psychology. A section relating to personal and methodological reflexivity is offered, followed by considerations relating to directions for future research in this area. The chapter closes with a summary of the study, and final conclusions are drawn.

5.2 Summary of Analysis

The main finding of this study was that, for most participants, and particularly those working in an IAPT setting, the experience of working with an interpreter was associated with some anxiety, uncertainty and frustration. Participants talked in dichotomous, and often contradictory, ways about how they viewed and related to the interpreter, and seemed to experience internal conflict and tension in how they would prefer to, and how they felt they realistically could, work with interpreters. Issues relating to power were generally experienced as uncomfortable, and although most participants talked about valuing three-way working, many narratives contained an experience of dyadic alliances and of holding a position of responsibility and expertise as therapist. Although some participants talked specifically about a feeling of frustration at the slower pace of therapy involving an interpreter, generally the frustration was related by participants to the demands and limitations of the system within which they were required to operate. It therefore seems that it is the pressure exerted by the system that drives the experience of the frustration and anxiety associated with working with interpreters for these participants.

5.3 The Context

The participants' narratives contained some distinctive differences between the experiences of participants who talked about feeling pressured by the system within which they were working, and those who felt supported. Where therapists felt supported by the system, they appeared to experience the interpreter in a non-threatening way; welcoming them as a co-worker, talking positively about triadic working, welcoming the development of a separate

relationship between client and interpreter, feeling better able to sit with uncertainty and 'not knowing' and more comfortable in explicitly attending to power disparities in the room. In contrast, where participants talked about an experience of feeling pressured by the system, they seemed to experience working with an interpreter as anxiety provoking, were more likely to express a preference for an interpreter's role to be one of a translator (or to oscillate between a view of a co-worker/translator) and to talk about a feeling of powerlessness in relation to the interpreter and of exclusion from the interpreter and client's relationship. These participants often talked about a felt need to control or direct the session and protect their role as professional, and seemed more likely to want to hold on to the dyadic model of therapy.

Contextualising participants' experiences within the systems within which they worked offers a richer and deeper understanding of how these participants experience working with interpreters. Where participants experienced feeling pressured (or under threat), working with an interpreter was experienced as somehow threatening. The threat to the participant seemed to be experienced on a number of levels, though always underpinned by the threat experienced by the perceived need to meet service demands. Participants' narratives contained ways in which they had attempted to manage the threat, and some experiences of conflict that had arisen from these.

Whilst this chapter provides an overview of how the themes relate to the existing literature, it is the contextual aspect of the findings that will be the focus of discussion, both in relation to current research and pertinent theoretical frameworks.

5.4 Discussion of Themes in Relation to Existing Literature

In this section, the three super-ordinate themes are considered in the context of existent literature.

5.4.1 Super-ordinate theme one: "The most powerful thing is the system". This super-ordinate theme was identified as underpinning and connecting multiple aspects of the participants' experiences. The participants' narratives appeared to contain two different experiences of the system: a source of pressure, demands and limitations, which worked against the therapists' openness to three-way working with interpreters, and, on the other

hand, a source of support, which supported three-way working and the sharing of power.

Concerns about 'time' were central to many participants' experiences. A time pressure associated with working with interpreters in an already pressured and demanding system related to participants' experiences of uncertainty, anxiety and frustration. Trying to gather sufficient information to competently assess risk and assess for diagnosis, and to work through protocol-driven treatment with an interpreter were all experienced as sources of pressure and stress.

The power of the system was talked about in a number of ways, but particularly related to the experience of demands of the service in terms of therapists' clinical activity, which were exacerbated by a pressure of time and restrictive and rigid organisational structures. Whilst participants in previous studies have talked about the slower pace of therapy through an interpreter (Pugh & Vetere, 2009; Miller et al., 2005), only in one other study where participants were working in the setting of an IAPT service, have the demands of the service (or system) been talked about as creating a time pressure in working with interpreters. Erbil (2015) explored the experiences of IAPT practitioners of working with language interpreters, finding that participants talked specifically about how the extra time needed to work with interpreters was not acknowledged by service management and 'clashed' with performance indicators around protocol-driven treatment, resulting in feelings of anxiety and frustration for the therapists. These findings fit with those of the current study where a time pressure associated with working with interpreters in a pressured and demanding system related to participants' experiences of uncertainty, anxiety and frustration. For the current participants, trying to gather sufficient information to competently assess risk and assess for diagnosis, and to work through protocol-driven treatment with an interpreter, while restricted to room bookings on the hour and limited numbers of sessions, were all experienced as a source of pressure and stress. The findings appear to support an understanding of the nature of IAPT services as creating a specific context to therapists' work in those services, which drives a common experience of working with interpreters which is characterised by stress, anxiety and frustration.

Whilst for most participants the system related to the actual service within which they worked, some participants talked about the interpreter agency as an element of the powerful system. Participants' narratives contained an experience of anxiety associated with the uncertainty as to who the interpreter would be. Agencies were generally experienced as unreliable, regularly not fulfilling the specific requests of the therapists. Other studies have recommended that it is preferable for interpreters to be 'in-house' (Becher & Wieling, 2015), in order that there is an opportunity to build familiarity and a relationship between the interpreter and therapist as they work more regularly together and the interpreter becomes more familiar with the service and client group.

The power of the system was also talked about (notably by a participant not working in IAPT) as a positive support in terms of having a culture of explicitly attending to issues of power. Whilst Mirdal et al. (2011) aimed to highlight organisational factors within a transcultural clinical setting, which are experienced as helpful when working with interpreters, the findings of the study do not comment on this particular aspect in detail. This may, therefore, be considered a new insight, worthy of further exploration.

5.4.2 Super-ordinate theme two: Knotty question of power. Almost all participants talked about an experience of power when working with an interpreter, with power overall being identified as a 'knotty' issue. Issues relating to power when working with interpreters have been explicitly addressed in only a few previous studies, despite an acknowledgement of the importance of doing so by leading authors in this area (Tribe & Thompson, 2009b). As in previous studies (such as Patel, 2003), participants acknowledged that there were numerous differences that may exist between the interpreter, client and therapist, including language, ethnicity, class, age, gender, sexuality and mental health status. From their exploration of therapists' experiences of working with interpreters, Raval and Smith (2003) concluded that to facilitate empowerment of all parties of the triad and better outcomes for therapy, practitioners should explicitly address issues relating to power imbalances and social inequalities with both interpreters and service users. The findings of the current study suggest that not all participants had previously acknowledged the power imbalances that existed between themselves and the interpreters, and, even

where they had, they had not explicitly addressed them. The experience of discomfort and pain relating to acknowledgement of power disparities, talked about by some participants, suggest that the lack of attention may relate to a process of avoidance by the therapists. The experience of a participant who found it easier to do so when supported by an organisational culture of addressing issues of power, suggests that the confidence of therapists to tackle and address power imbalances in therapy may be increased by working within an organisational context which supports and encourages this.

Participants talked in different ways about aspects of power held by each member of the triad. Their experiences of power seemed to relate to the findings of Raval and Smith (2003) regarding the paradox their therapist participants experienced in being in a powerful position, yet feeling powerless. Participants in their study experienced themselves, on one hand, as powerful due to their status as a medical professional, employer of the interpreter and with power over decisions relating to the client's treatment, and, on the other, being rendered powerless by a lack of shared language with the client. In the current study, 'language as power' featured in most participants' narratives, and not being able to communicate directly to the client through language was related by participants to a feeling of being completely deskilled as a therapist. This related to both techniques and interventions relating to their model of therapy and their general therapeutic skills. These findings fit with previous research which suggests that therapists try to adapt and simplify their interventions when working with interpreters (Mofrad & Webster, 2012; Darling, 2004), and research that has shown therapists experience challenges in communicating empathy through an interpreter (Pugh & Vetere, 2009).

Participants' concerns relating to the accuracy of translated material, and the potential for interpreters to manipulate meaning, also fit with findings of previous research (Becher & Wieling, 2015). However, participants in the current study appeared to go further by shifting to an experience of resentment of and reluctant reliance on the interpreter because of the interpreter's power of knowledge of both languages. The finding that participants subsequently attempt to minimise the power of the interpreter through using methods to bypass the interpreter (rather than simplify the communication), and to try to minimise their potential power to disrupt therapy through non-attendance, seems to be a new insight, which could be understood to relate to the

contextual experiences of the participants, which drive the anxious and threatening nature of the experience of working with interpreters.

5.4.3 Super-ordinate theme three: Dyadic and triadic alliances. The finding that participants talked in different, and often inconsistent, ways about the alliances between the interpreter, client and therapist fits with previous literature. A mix of views relating to the interpreter role held by therapists is highlighted in a number of studies (Becher & Wieling, 2015; Miller et al., 2005; Kuay et al., 2015), with the majority of therapists in these studies viewing the role of interpreter as broader than a translator, particularly valuing the cultural context the interpreter provides. Erbil (2015) found that IAPT practitioners oscillated between considering the relational nature of the therapeutic work with an interpreter as dyadic and triadic. Like the participants in the current study, these therapists moved between talking about the interpreter as a co-worker and as purely a translator. The de-humanising of the role of the interpreter by some participants was viewed by the author as an attempt by these therapists to claim the expert position (Erbil, 2015). Although this view may offer a useful understanding of the experiences of some of the participants in the current study, other elements of the participants' narratives suggest that there are further complexities to this dichotomy of viewing the interpreter as human co-worker or translating robot; again likely to relate to the contextual setting within which these participants work. For example, participants' general preference for consistency in relation to the interpreter over a course of therapy, which extended to actually trying to minimise interpreter power to minimise the impact of inconsistency, may indicate a complex view of the interpreter as an essential part of the therapeutic process (as found by Brune et al., 2011) yet interchangeable (as recommended by Baker et al., 2015).

In previous research, therapists have acknowledged the potential for interpreters to be affected by traumatic material brought by the client, and the value of separate supervision for interpreters and a space for debriefing sessions (Becher & Wieling, 2015). However, for participants in the current study, this potential was associated by the therapists with a role of being a 'protector' of the interpreter from being impacted by the client's trauma. This, and the time needed to debrief and check the well-being of the interpreter, was

experienced as a source of stress, pressure and anxiety within the demands and restrictions of the service.

Although most participants talked about an ideal of three-way working, with equal alliances between members of the triad, for many this was not realistic, or was viewed as idealistic in the context of the system within which they were working. Despite many of the participants talking about valuing three-way working, it seemed from a number of participants' accounts that the relationship between the client and therapist was prioritised, and that the interpreter was experienced as a potential threat to, or intrusion onto this relationship. The dyadic nature of most models of therapy, and the inevitable impact on the nature of the therapeutic relationship if a three-way relationship with the interpreter fully involved in the therapeutic relationship is embraced, is acknowledged in the literature (Tribe & Thompson, 2009a). This apparent difficulty in letting go of the 'prized dyad' for the participants could be, novelly, understood as relating to a need to stay with what is experienced as containing and familiar (their dyadic model), when feeling under pressure from the powerful system.

The participants' experiences of separate dyads within the triad is also evident within the theme of the 'tennis match', which captures participants' experiences of feeling excluded from the relationship between the interpreter and client. Therapists' experiences of feeling excluded appear in a number of studies (Schweitzer et al., 2013; Mofrad & Webster, 2012; Kuay et al., 2015). Participants' concerns over preventing 'blurred boundaries' relating to the client/interpreter relationship may be understood as linked to this experience of exclusion, and are mirrored in the dilemmas experienced by therapists in a study by Baker et al. (2015) over whether a close relationship between interpreter and client was a support to the client and so should be encouraged, or was detrimental to the therapy and so should be discouraged. Experiences of therapists trying to avoid the client and interpreter meeting and talking in the waiting room are shared by the current participants and by Darling (2004). However, one participant in the current study positively welcomed the development of a close relationship between the client and interpreter, experiencing it as helpful and as facilitating a shift in therapy. It is interesting to note that this participant was not working in an IAPT setting. The maintenance of a more rigid position described by many of the participants may again relate

to the experience of pressure and anxiety relating to the context of the work setting.

Psychological models and concepts featured in the narratives of almost all participants. A number of participants drew on these to communicate their experience of alliances and dynamics within the triad. Previous studies and existing literature have used concepts from CAT (Emilion, 2011) and psychodynamic theory (Darling, 2004) to conceptualise alliances when working with interpreters. However, existing research contains conflicting views relating to the viability of working psychodynamically through an interpreter, with concerns over the complexity of reading and working within the transference (Schweitzer et al., 2013; Foster, 1998). This finding is consistent with the experience of one participant in the current study for whom concerns over reading the transference, and the lack of a framework offered by psychodynamic theory for work with an interpreter, meant they felt unwilling to attempt interpreter triad work. However, other literature has concluded that it seems possible and hopeful to work psychodynamically with an interpreter (Darling, 2004). The view that interpreter work is possible within different models of therapy supports the position of one current participant who felt strongly that it was a breach of 'equal opportunities' for therapists to avoid working with interpreters on the basis that it does not fit with their model. It seems that for many of the participants of the current study, their relationship with their model for therapy is an important aspect to their experience of working with interpreters; it is experienced as a framework for conceptualising the alliances and dynamics within the triad. Although this finding has been offered by other literature, perhaps a new insight is offered by the current study in how the containing nature of the experience of the framework for working with interpreters is understood as relating to the pressured therapy setting.

In summary, many findings of the current study mirror or fit with those of previous literature relating to the experience of therapists of working with interpreters. However, it seems that contextualising participants' experiences within the systems within which they worked has offered a richer and deeper understanding of, and some new insights into, therapist experiences. It is these contextual aspects that will be the focus of the next section of the chapter.

5.5 Contextualising the Findings from a Theoretical perspective

The first part of the discussion has highlighted the relevance of contextual factors in deepening the understanding of the participants' experiences of working with interpreters. Almost every element of the analysis has related to how the participant experiences the context within which they work. This study is undertaken from a position of critical realism and therefore a key aim of the study is to uncover patterns that drive the experiences of the participants. Perhaps the most significant finding of this study is that how the context of the therapy setting is experienced by the therapist (as pressured, anxiety provoking, frustrating or supportive), drives how the therapist experiences working with interpreters. Reflecting on this key finding led me to consider whether contextualising the findings using psychoanalytic theory would offer an interesting and valuable perspective. Aware of the shift in epistemological positioning of this model to a more realist stance, and potentially of the researcher to an expert position, it felt important to offer this contextualisation separately to the analysis, and to write in a deliberately tentative and speculative tone. A brief overview of the theory is provided to enhance the reader's understanding.

The system was experienced as the most powerful thing, and it seems that most participants experienced feeling under pressure by the demands and inflexibilities of the system. In turn, working with an interpreter was experienced as an additional source of pressure, amplifying the experience of stress. Internal conflicts for participants wanting to meet the needs of LEP clients, yet preferring to avoid working with an interpreter, were apparent. Dichotomous views relating to experiences of interpreters as 'good' and 'bad', and of their roles as co-worker or translator, were expressed. Interpreter agencies were talked about as unreliable and as potentially another source of anxiety and uncertainty. Some participants were able to get in touch with painful feelings about power disparities whereas others did not talk about any experience of this. A number of the participants talked about split alliances and an experience of feeling excluded within the triad.

Kleinian psychoanalytic theory posits that in times of stress people may move from the depressive position, where we are able to relate to others as whole objects, containing both good and bad, and engage with the complexity of our internal and external reality, to the paranoid schizoid position, where

splitting occurs as people or conflicts are seen as wholly good or bad, and we project characteristics we don't like into others, and imagine ourselves to be persecuted by others (Klein, 1946). In this position people develop defences (such as denial) in order to protect themselves from difficult emotions, which may result from external threats or internal conflicts, that are too threatening or dangerous to acknowledge (Klein, 1946). Lemma (2016) offers a detailed and accessible account of these positions and of Kleinian psychoanalytic theory generally.

5.5.1 Applying psychoanalytic theory to understanding

organisational systems and behaviour. Using psychoanalytic theory to understand organisational behaviour is not a new endeavour. In their examination of 'The Unconscious at Work', Obholzer and Roberts (1994) begin by acknowledging the stress and increased pressure that organisations and their staff are placed under in the current global political climate, with its increasing emphasis on efficacy, being cost-effective and offering value for money. They propose that organisational, group and individual responses to this stress may be understood within psychoanalytic theory of the individual. Drawing on Kleinian theory, they suggest that in this environment of pressure, where survival and self-esteem are threatened, both the organisation and the individual staff move to the paranoid schizoid position. They then develop defences (including denial, splitting and projection) against the difficult emotions that result from the external threats and resulting internal conflicts. Employing the defence of denial may mean that certain thoughts, feelings and experiences are pushed out of the organisation or individual's conscious awareness, and the defences of splitting and projection, associated with splitting off and projecting out parts of the self perceived to be bad into others, create figures or groups who are hated or feared. Obholzer and Roberts (1994) acknowledge that a major source of stress for staff working in the helping professions is their constant proximity to people in pain, and suggest that there is a tendency amongst these staff to deny feelings of hatred or rejection towards their clients. Instead, the feelings are projected on to other groups or outside agencies, who are then criticised. Within a threatening and competitive environment, the gaps between different groups may be filled with denigration, prejudice and paranoia. Individuals or groups may become stereotyped or characterised, which may in

turn be maintained by lack of contact between groups, and this may unconsciously be facilitated by organisational structures or routines. Where groups are in a competitive struggle, the success of one group may be perceived to be at the expense of another, and so an envious desire to spoil the other's success by withholding necessary cooperation may occur.

In the depressive position, by contrast, the individual is able to recognise that good and bad can coexist in an individual or group, gives up the comfort of self-idealisation, and is able to face a complexity of internal and external reality, and the painful feelings of guilt, concern and sadness that accompany this. Obholzer and Roberts (1994) suggest that to return to the depressive position, space for reflection to discuss and think through these processes, instead of being drawn to act them out, is required. They propose that this then results in a lessening of conflict, better work practices and greater job satisfaction for staff.

More recently, this theoretical framework has been specifically applied to IAPT. Rizq (2011) suggests that unconscious anxieties underlie IAPT's existence and structure, for which a framework and language may be provided by understandings drawn from psychoanalytic psychotherapy. Rizq suggests that, unlike traditional health systems' role of containing anxiety, IAPT's aims of promoting wellbeing and recovery act as an unconscious agenda and a defence against the anxiety evoked by working with complex clients. Rizq identifies that IAPT practitioners are closely monitored, tasked with carrying out highly standardised protocols and achieving increasingly high activity and clinical outcome targets, and are subject to strict routines and structures relating to these. Rizq's view is that while these structures are designed to defend practitioners against the unconscious anxiety that working with stressed clients causes, that, in fact, paradoxically, they create anxiety. She identifies one reason for this being that the possibilities for emotional engagement with clients are reduced by high caseloads, assessment protocols and preference for telephone contact, which cause anxiety to the therapist as they experience guilt, anxiety and dissatisfaction about their lack of meaningful involvement with clients.

Psychoanalytic ideas have been drawn on explicitly in relation to therapists' experience of working with interpreters in a UK-based CAMHS service by Darling (2004). Darling draws on previous work which postulates that

organisations institutionalise their defence systems in response to stress in understanding her own experience of having depersonalised interpreters to a translation function. She reflects that the service was under pressure, not just through financial constraints, but also because of the disturbed presentation of clients. She suggests that her organisation's institutional defence to this situation was to adopt an approach where the emphasis was on dealing with anxiety by speedy action, rather than providing a space for thoughtful consideration of emotional realities. She identifies that this approach limited therapist opportunities for accepting uncertainty and developing capacity to bear not knowing. Darling suspects that her anxiety around needing to relate meaningfully to her clients, many of whom were complex, had prompted her to organise matters in a way which actually served to obstruct and attenuate her capacity to work with her interpreter colleagues in a meaningful and thoughtful way.

Although Rizq's work relates to a period where the IAPT programme was still being rolled out, the demanding and pressured nature of IAPT services, and the likely effects of stress on its staff, have been confirmed by a recent staff survey. Findings from the British Psychological Society and the New Savoy Staff Wellbeing Survey (2015) show that psychological professionals are feeling increasingly stressed in their jobs. Of the 1,300 psychological professionals working in the NHS who responded, 46% reported experiencing depression, 49.5% reported that they felt a failure and 70% said they find their job stressful. The authors of the survey described the overall picture as one of burnout, low morale and worrying levels of stress and depression, and relate these findings to the staffs' perception of increasing demands by the organisation. The comments made by staff in the survey specifically relating to IAPT include describing IAPT as "a politically driven monster which does not cater for staff feedback or input in any way". One IAPT employee stated, "all we are told is targets and work harder". Extra administrative demands and being prevented from providing adequate therapy due to resource cuts were also mentioned as sources of stress.

The findings of this study seem to fit with the experiences of the participants in the current study of the IAPT setting as one of pressure and increasing demands relating to therapist activity and outcomes of therapy. The Kleinian/psychoanalytic theory drawn on by Obholzer and Roberts (1994) in

understanding unconscious processes of organisations, groups and individuals, by Rizq (2011) specifically relating to IAPT, and by Darling (2004) in working with interpreters, offer one way of understanding a number of aspects of the themes identified in the experiences of the participants of this study. These works may provide an understanding of the 'splitting' apparent by therapists in relation to the interpreters and interpreter agencies. It could be that concerns about the quality of their work, and guilt over feelings of anger towards clients for putting extra pressure on them by requiring them to work with an interpreter, are experienced by the therapists as bad parts of themselves and projected onto the interpreters, individually or as a group. The good and committed therapist is then experienced in contrast to the manipulative and unreliable interpreter, and unreliable interpreter agency.

The relating of participants to the interpreter as a translating robot rather than a valued co-worker may be understood, according to Obholzer and Roberts (1994), as an acting out by the therapist of an envious desire, triggered by the competitive IAPT environment, to spoil the other's success by withholding the necessary cooperation required for three-way working. This apparent survival anxiety, related to the competitive environment, may also account for participant experiences relating to difficulties in sharing power and perceptions of threat to their role. The rigid organisational structures the participants talk about, of protocols, room bookings and activity targets, may be understood, according to Rizq (2011) and Darling (2004), to act as organisational defences, which limit opportunities for contact with the interpreters, thereby facilitating an unconscious avoidance of contact by the therapist. This then acts to preserve the self-idealisation of the therapist, which then increases scope for further projection onto the interpreter.

The narratives of the participants not working in an IAPT setting generally contained experiences of relating to the interpreter as a co-worker, of embracing three-way working, and of being able to connect to some of the feelings of guilt and shame evoked by the work with clients and interpreters. These experiences fit with Obholzer and Roberts' (1994) understanding of the ways staff relate to themselves and others when in the depressive position. These experiences could be understood as relating to the context of a less pressured environment, possibly with more flexible organisational routines and structures, and more opportunities for therapist reflection. Drawing on the work

of Rizq (2011), it could be understood that the secondary care psychology setting, unlike IAPT, holds an anxiety-containing role, and so the unconscious organisational defences against anxiety about working with complex clients are not present. Similarly, lower caseloads and preference for face to face, longer-term therapy supports meaningful emotional involvement with clients, and so reduces the likelihood of feelings of guilt and anxiety and dissatisfaction relating to client engagement by therapists.

In summary, the theoretical framework of Kleinian psychoanalytic theory offers one way of understanding how the context of the therapy setting drives how the therapist experiences working with interpreters, with the current study's findings offering an extension of existing literature relating to understanding unconscious organisational, group and individual behaviour. Possible tensions and implications relating to offering this theoretical contextualisation of findings are reflected upon later in the chapter.

5.6 Reflexivity

One way in which phenomenological research may be evaluated is the extent to which reflexivity issues are addressed in acknowledging and demonstrating how the research's perspective and position have shaped the research (Willig, 2013). Personal, epistemological, methodological and ethical reflections have been interwoven throughout this thesis, and will be further expanded upon in this section.

5.6.1 Personal reflexivity. In IPA, the analysis is an account of how the analyst thinks the participant is thinking (the double hermeneutic) and so the status of any findings must be acknowledged not as truth, but an interpretation (Smith et al. 2009). It is therefore accepted that different, and equally valid, interpretations could have been made by a different researcher. My own experiences as a High Intensity CBT therapist working in an IAPT service, and as a trainee Counselling Psychologist working in both an IAPT and secondary care psychology service, will have inevitably influenced my analysis, including relating to the contextual understanding of the participant's experiences. It may have been that my own experiences of pressure and activity targets in IAPT have, on some level, influenced me to attend to this in my participants' accounts.

The dual role I held as a clinician/researcher would have impacted on every stage and aspect of the research, and was highlighted particularly during interviews, as at times participants' responses indicated that they were responding to me as a clinician. There were also occasions during the interviews where I became aware of my own views and experiences relating to working with interpreters being very much in contrast to those of the participant. These experiences highlighted to me both the ease with which assumptions can be made about others' views; mine of theirs, theirs of mine, and also the potential impact of my insider/outsider position on the co-creation of the narrative.

Whilst guided by the earlier stages of analysis, my knowledge of and personal interest in psychoanalytic theory inevitably influenced my choice to draw upon this theoretical framework in contextualising the findings. There are other possible theoretical frameworks that may be drawn upon in understanding individuals' responses to threat and stress.

Although all of these aspects inevitably influenced the research process, and reflection upon their impact is essential, they are not viewed as limitations of the study. Instead, my position and experiences are viewed as offering a unique position from which to understand the participants' experiences.

5.6.2 Epistemological and methodological reflexivity. This study was conducted from an ontological and epistemological position of critical realism, using data collected using the methods of diagrammatic elicitation and semi-structured interviews, analysed using IPA. This choice of positions was driven by the aims of the research, and the compatibility of the approaches in their view of experience being accessible through a process of interpretation, and their contextual focus. It is acknowledged that these positions and methodology, along with my personal beliefs, values and experience, would have influenced the research and analytic process, and that investigating the topic from alternative positions and approaches may have offered different, and valuable, perspectives on the therapists' experiences.

5.7 Limitations of IPA in Relation to Language

Whilst IPA may be a suitable methodology with which to explore individuals' experience of a phenomenon, there are a number of limitations of

this approach. One of the main possible limitations of IPA is that it is based on the phenomenological view of language; that language precedes experience and constructs experience, and on an assumption that language provides the participants with the necessary tools to capture their experiences and describe them to the researcher (Willig, 2012b). The findings of the current study relating to the facilitative role of the diagrammatic task (discussed further shortly), may support the position that in fact language alone may not always adequately facilitate expression of experiences.

Adopting a more critical social cultural slant to understanding and interpreting the participants' experiences could have particularly supported further exploration of issues and experiences relating to power and oppression.

5.8 Other Possible Methodologies

Whilst IPA aims to provide a detailed and rich account of experience, it is acknowledged that no single qualitative approach can illuminate human experience in its entirety (Willig, 2013). Although, ultimately, IPA seems an appropriate choice of methodology to meet the research question, it is acknowledged that the use of other methodologies may have produced interesting findings relating to the research area. For example, Grounded Theory may have produced a helpful theoretical account of how therapists draw on psychological models in relating to interpreters, and undertaking a Discourse Analysis, particularly Foucauldian, of the data, could have offered insights into the linguistically constructed nature of the therapists' experiences, particularly with regard to power relations.

5.9 Considerations Relating to Making Links to Theoretical Frameworks in IPA

In this study I chose to contextualise the findings using Kleinian psychoanalytic theory. While I do not claim that this framework offers an understanding of all aspects of the participants' experiences, it does seem to support an understanding of the impact of the context of the therapy setting on the participants' experiences. However, despite the potential value for new insights generated by having done so, I am aware of a number of epistemological, methodological and ethical tensions in offering these links.

Moving to making more theoretical connections may be considered to mark a boundary for IPA (Smith et al., 2009). It involves a move from a close to a more distant textual analysis, from outside rather than from within the text, and to a position of suspicion rather than empathy. This shift is connected to providing an explanation, rather than an understanding, of participants' experiences. Although this position of suspicion is compatible with critical realism, it may be considered to be further towards the realist end of the realist-relativist continuum (Willig, 2013), therefore involving an epistemological shift in my position. In order to support the readers' understanding of where the shift occurs, the theoretical contextualisation of the findings is presented as part of the Discussion rather than Analysis.

A move to theoretical levels of interpretation involves ethical issues around potentially misrepresenting participants' experiences by imposing meaning on them (Willig, 2012b). Whilst I have tried to remain aware of this risk and be reflexive throughout the analysis about the impact of my interpretations on what will come to be known about the participants' experiences, I believe that the opportunity to gain a deeper understanding of what motivates and drives my participants' experience, particularly at an unconscious level, is potentially too valuable to ignore. Willig also highlights the potential for theoretical level interpretations to pathologise or stereotype 'the other' (Willig, 2012b). My view is that rather than pathologise the participants' experiences, my endeavours sought to explore what may be unhealthy or pathological within the context of the experience, which, effectively, normalises the participants' responses to the context.

5.10 The Contribution of the Diagrammatic Task

The data was collected using the methods of semi-structured interviews and diagrammatic elicitation. Reflexive comments relating to the process of each are included in the methodology chapter. The finding that the diagrammatic task seemed, for a number of participants, to facilitate reflectiveness, and support representation of their understandings of their experiences of the alliances and power relations, fits with existing literature relating to use of diagrammatic elicitation (Umoquit et al., 2013; Copeland & Augusto, 2012). Additionally, although a few participants seemed a little unsure when beginning the task, generally participants engaged well with the task, and

a number spontaneously commented that the task had helped them to think about and reflect upon their experiences.

However, perhaps the most significant finding relating to this method was that new personal insights, sometimes contradicting experiences or views given earlier in the interviews, were expressed during the task. Examples include one participant, having drawn out their ideal scenario of equal power and alliances, then observed, 'aha, that's interesting', and reflected that they had actually experienced the patient and interpreter as close and themselves as far away. This suggests that the use of diagrammatic method helped to get closer to the participant's experience than verbal language alone, or facilitate reflection which is then expressed through verbal language, and may therefore be considered to be a valuable method for use in collecting data, alongside interviews, in research which aims to explore experience.

5.11 Attending to Quality

Issues of rigour and quality have been attended to throughout the study, particularly in relation to considerations regarding how my own position and perspective and underlying theoretical assumptions have shaped the research. Transparency and coherence have been striven for by reporting a clear description of all stages of the process of the research, and in the clear linking of quotes to interpretations and themes.

Due to IPA's idiographic concerns, the sample of this study was relatively small. Findings of IPA studies do not claim to be generalisable, and the findings of the study may only be said to say something about the experiences of this particular group of therapists. However, rather than generalisability, theoretical transferability is offered by the findings through providing a rich, transparent and contextualised analysis of the accounts of the participants. It is hoped that readers can therefore evaluate the analysis' transferability to other similar persons in these contexts.

The findings were not discussed with the participants. Although to do so may be considered to increase rigour, concerns have been highlighted over the usefulness of seeking this due to the inaccessibility of academic analysis to people not familiar with the methodology, and due to the discomfort of participants in giving potentially critical feedback (Giorgi, 2008). The decision was therefore made not to pursue this. The themes and findings were

discussed and explored with my supervisor and with fellow IPA researchers at my University.

5.12 Implications of the Findings for Counselling Psychology and Mental Health

Broadly, the findings of the study suggest that the therapists in this study (particularly those working in an IAPT setting) experienced some anxiety and uncertainty around how to conceptualise the role of the interpreter, and in working within a triadic rather than dyadic relationship. The analysis suggests that at least some aspects of this anxiety and uncertainty were driven by the experience of the context of the therapy. Given that therapists are required to work proficiently with interpreters (NICE, 2009; NICE, 2011), it follows that there are significant implications of the findings of this study, both for Counselling Psychologists and mental health practice generally.

5.12.1 Informing Therapeutic Practice. One of the key findings of the analysis related to the understanding of the context of the therapy setting as a driver of therapist experience of working with interpreters. This finding has important implications for therapeutic practice when working with interpreters and, if a broader contextual understanding of the experience of these participants is accepted, then it follows that the implications of the findings for practice should apply at the system level, as well as a more individual level. According to previous work cited relating to organisational, group and individual responses to stress it could be expected that if the demands, pressures and rigid structures of the context remain, then therapists will continue to experience stress and anxiety, (rendering them in the paranoid schizoid position), resulting in a way of relating to interpreters which is driven by this experience and position. Therefore, it would follow that only if pressures could be reduced and individuals could experience a less competitive and threatening environment with more opportunities for reflection, could a move towards the depressive position and a more open and less defensive way of working with interpreters follow. A shift at a governmental policy level regarding the nature, scope and practices of IAPT and other NHS psychology services could support this at a national level.

However, there are a number of changes which could be made at a more local or individual level that could help the development of a context which supports therapists in working collaboratively with interpreters. At a service level, it is important that senior management and line managers help foster a culture which supports reflexive practice, encourages explicitly attending to issues of power, and discourages rigid and inflexible routines and structures. Regular individual supervision which encourages reflexivity and team discussions which include a focus on work with interpreters could provide space for therapists to think through any process issues. Providing a flexible system of therapy room bookings would allow for extra time for the therapist to meet with the interpreter to brief and de-brief sessions. Developing close working relations with the service's provider of interpreter services, including regular meetings and possibly some joint training sessions, could improve therapist confidence and lessen frustration in the process of booking an appropriate and consistent interpreter, as well as facilitate the development of relations with interpreters and of interpreters' working knowledge of mental health and therapy models. Where possible, the development of an 'in-house' interpreter service could be considered. Additionally, on-going training for therapists in best practice in how to work with interpreters using current guidelines (such as those by the BPS, 2017) in order to ensure high standards of working practices, should be provided. Ideally, this training would first take place during the clinician's training, and would be specifically in relation to the therapist's model of therapy.

5.12.2 A role for Counselling Psychologists in effecting change. This study provides an in-depth view of therapists' experiences of working with interpreters, particularly relating to power and therapeutic alliances, and examines contextual factors. This may be considered to be highly relevant to Counselling Psychology, with its commitment to values around non-hierarchical relationships and the therapeutic alliance. The findings of the study may be of interest and value to Counselling Psychologists, and other therapists, in considering both their own practice, and their service's practices and policies relating to working with interpreters in therapy, and in developing pre- and post-qualification training courses.

Understanding of the impact of the context of the work setting on therapist experience is of relevance to Counselling Psychologists. A survey by

the Division of Counselling Psychology (DCoP, 2013) showed almost 40% of the Counselling Psychologists who replied stated that the NHS was their primary employer. Although no data relating to the number of Counselling Psychologists who work in IAPT could be found, with the ongoing expansion of IAPT services, it could be assumed that increasing numbers of Counselling Psychologists are working in this setting, and therefore potentially share the experience of the current participants of the demands and pressure of the system. Historically, Counselling Psychologists have been identified as influencing the NHS 'from within', particularly relating to challenging the dominant medical discourse in mental health (Walsh, Frankland & Cross, 2004). Counselling Psychologists are therefore well-positioned to offer a critical viewpoint and to challenge any existing structures, policies or organisational cultural practices which function to maintain power disparities or are detrimental to the well-being of staff and clients, both at a local and national level.

5.13 Implications for Future Research

The findings of this study have highlighted a number of aspects of therapists' experiences that could benefit from further exploration. The finding that therapists experience challenges in conceptualising the triadic work with an interpreter using their model of therapy, and in communicating techniques and skills specific to their model through an interpreter, suggests that it would be of value for future research to explore how different models of therapy might be adapted or interpreted to support 3-way working. Counselling Psychologists, many of whom work from a pluralistic / integrative model, may be well placed to be involved in such research.

Understanding the contextual setting of the therapy as a driver of therapist experience of working with interpreters is a little-researched aspect of this topic and would benefit from further exploration. It may be helpful for future research to focus on trying to understand which specific factors or structures within different therapy settings are experienced as supportive or threatening by therapists, to inform a view on the optimal environment to support therapists working with interpreters. It is acknowledged that this study has explored the experiences of only one element of the triad and of only two different therapy settings in one Trust. Understanding the experiences of clients and interpreters

in different therapy settings may deepen the understanding of the impact and relevance of contextual factors in triadic working.

In acknowledgement of the impact of working in a stressful NHS environment highlighted by the staff survey, the BPS has launched a charter (The Wellbeing Project Working Group Joint Initiative between the BPS and New Savoy Conference, 2016) which aims to re-set the balance in the drive to improve access for people in accessing therapy, with a focus on support for staff wellbeing. However, currently this charter is focused on trying to understand how and why the interaction of psychological staff with NHS organisational systems is generating poor wellbeing in staff, rather than driving tangible change. It may be that findings of qualitative studies, such as the current study, which explore aspects of practitioners' experiences within an NHS context, may be helpful in achieving this understanding

The findings of this study suggest that using the method of diagrammatic elicitation may be of value in supplementing interviews in studies which aim to gather knowledge about experiences, particularly where participants are asked to explain personal understandings of relationships, experience and concepts. Although the method seems to fit well with Counselling Psychology values and qualitative methodologies, the current use of this method in Counselling Psychology research is limited. Dissemination of the findings of this study may encourage other psychology researchers to consider using this method in future research.

5.14 Summary and Conclusions

This study aimed to explore experiences of therapists of working with interpreters, particularly in relation to issues of power and the therapeutic alliance, using a methodology that supported the contextualisation of the experiences. The findings suggest that, for the ten participants who were interviewed, working with an interpreter was understood and experienced in terms of the power of the system within which they were working, of the 'knotty' question of acknowledging and working with power-related issues, and of issues relating to the interpreter and client within dyadic and triadic alliances. For many of the participants the experience of working with, and relating to, the interpreter was one of complexity, anxiety and uncertainty. What was held to be

ideal and valuable in working in a triadic way, was not generally experienced as realistic within the setting within which they were working.

In conclusion, the findings of this study support much of the pre-existing research relating to therapists' experience of working with interpreters, particularly in relation to how therapists view the role of the interpreter and move between dyadic and triadic working. However, the analysis seems to have offered new insight into how contextual factors may drive therapists' experiences. The majority of the participants worked in an IAPT service. Their experiences therefore give an important insight into how factors relating to this setting may impact on therapists' ability and willingness to approach working with interpreters as a triadic alliance. Using a Kleinian theoretical framework has offered one way of understanding the participants' experiences of working with interpreters, including how organisational factors have impacted on these. These findings can become a part of the literature that relates to this topic, and can contribute to current research investigating the interaction between organisational systems and the experiences of NHS and IAPT psychological therapists.

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Appendix A: Notice of Ethics Review Decision (UEL)

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants
BSc/MSc/MA/Professional Doctorates

REVIEWER: Dr Tim Lomas

SUPERVISOR: Dr Rachel Tribe

COURSE: Professional Doctorate in Counselling Psychology

STUDENT: Chloe Gerskowitch

TITLE OF PROPOSED STUDY: How do Psychological Therapist describe their experiences of working with language interpreters, particularly with regard to issues related to power and the therapeutic alliance?

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)

Minor amendments

Minor amendments required (for reviewer):

- Please confirm that interviews will be on public premises, and that you'll let your supervisor know when and where interviews are taking place.
- Re. protection of participants, on the debrief sheet, in addition to recommending they contact their GP and/or line manager, please also include some details of other relevant support services that they could contact (e.g., Samaritans)
- Re. protection of the researcher, please amend so that it applies to you as a researcher (e.g., that you'll contact your supervisor if you find an interview challenging or upsetting. At the moment it seems like you've just copy-pasted from the protection of participants section.
- You state that you have sought permission from two external organisations. Written permission from these will need to be granted before you commence your research. As such, please let your supervisor know when you've obtained these permissions, after which point you can begin the research.
- On the information letter, please give more details about what will happen to the data (e.g., the details that you include in the ethics form itself, such as the participants' right to withdraw data up to four weeks after interview, the deletion of files after 3 years).

Major amendments required (for reviewer):

ASSESSMENT OF RISK TO RESEARCHER (for reviewer)

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

☐

MEDIUM

☒

LOW

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

Reviewer (Typed name to act as signature): Tim Lomas

Date: 27.2.17

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

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 u1520789

Student number: Chloe Gerskowitch

Date: 09.03.17

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

PLEASE NOTE:

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, 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 the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, travel approval from UEL (not the School of Psychology) must be gained if a researcher intends to travel overseas to collect data, even if this involves the researcher travelling to his/her home country to conduct the research. Application details can be found here: <http://www.uel.ac.uk/gradschool/ethics/fieldwork/>

Appendix B: Confirmation of UEL Sponsorship



12th March 2017

Dear Chloe

Project Title:	How do psychological therapists describe their experiences of working with interpreters, particularly with regard to issues relating to power and the therapeutic alliance?
Researcher(s):	Chloe Gerskowitch
Principal Investigator:	Chloe Gerskowitch

I am writing to confirm that the application for the aforementioned NHS research study IRAS reference **222782** has received UREC ethical approval and is sponsored by the University of East London.

The lapse date for ethical approval for this study is **12th May 2021**. If you require UREC approval beyond this date you must submit satisfactory evidence from the NHS confirming that your study has current NHS R&D ethical approval and provide a reason why UREC approval should be extended.

Please note as a condition of your sponsorship by the University of East London your research must be conducted in accordance with NHS regulations and any requirements specified as part of your NHS R&D ethical approval.

Please confirm that you will conduct your study in accordance with the consent given by the Trust Research Ethics Committee by emailing researchethics@uel.ac.uk.

Please ensure you retain this approval letter, as in the future you may be asked to provide proof of ethical approval.

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

Yours sincerely,



Catherine Fieulleateau
Research Integrity and Ethics Manager
For and on behalf of
Dr Lisa Mooney
University Research Ethics Committee (UREC)
Research Ethics
Email: researchethics@uel.ac.uk

Appendix C: HRA Letter of Approval



Health Research Authority

Mrs C Gerskowitch
[REDACTED]
[REDACTED]
[REDACTED]

Email: hra.approval@nhs.net

21 April 2017

Dear Mrs Gerskowitch

Letter of HRA Approval

Study title:	How do psychological therapists describe their experiences of working with interpreters, particularly with regard to issues relating to power and the therapeutic alliance?
IRAS project ID:	222782
Protocol number:	1520789
REC reference:	17/HRA/1459
Sponsor	University of East London

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from www.hra.nhs.uk/hra-approval.

Appendices

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval

The attached document “*After HRA Approval – guidance for sponsors and investigators*” gives detailed guidance on reporting expectations for studies with HRA Approval, including:

- Working with organisations hosting the research
- Registration of Research
- Notifying amendments
- Notifying the end of the study

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

Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at <http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hsc-rd-review/>.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

User Feedback

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

IRAS project ID	222782
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HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details at <http://www.hra.nhs.uk/hra-training/>

Your IRAS project ID is **222782**. Please quote this on all correspondence.

Yours sincerely

Isobel Lyle | Senior Assessor

Health Research Authority

Room 002, TEDCO Business Centre, Rolling Mill Rd, Jarrow NE32 3DT

Hra.approval@nhs.net or Isobel.lyle@nhs.net

T: 0207 972 2496

www.hra.nhs.uk

*Copy to: Ms Catherine Fieulleateau, Sponsor contact, University of East London
Ms Jennifer Liebscher, R&D contact, South London and Maudsley NHS Foundation Trust (IoPNN, King's College London)
Professor R Tribe, Academic Supervisor
Dr L Fellin, Academic Supervisor*

Appendix A - List of Documents

The final document set assessed and approved by HRA Approval is listed below.

<i>Document</i>	<i>Version</i>	<i>Date</i>
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [insurance 1]	1	27 January 2017
Interview schedules or topic guides for participants [interview schedule]	1	27 January 2017
IRAS Application Form [IRAS_Form_10032017]		10 March 2017
IRAS Application Form XML file [IRAS_Form_10032017]		10 March 2017
IRAS Checklist XML [Checklist_10032017]		10 March 2017
Participant consent form [consent form]	2	12 April 2017
Participant information sheet (PIS) [PIS]	2	12 April 2017
Referee's report or other scientific critique report [Referee report]	1	07 February 2017
Research protocol or project proposal [research protocol]	1	13 February 2017
Summary CV for Chief Investigator (CI) [PI CV]	1	27 January 2017

Appendix B - Summary of HRA Assessment

This appendix provides assurance to you, the sponsor and the NHS in England that the study, as reviewed for HRA Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England to assist in assessing and arranging capacity and capability.

For information on how the sponsor should be working with participating NHS organisations in England, please refer to the, *participating NHS organisations, capacity and capability and Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* sections in this appendix.

The following person is the sponsor contact for the purpose of addressing participating organisation questions relating to the study:

Name: Ms Katherine Fieulleateau
 Tel: 02082236683
 Email: researchethics@uel.ac.uk

HRA assessment criteria

Section	HRA Assessment Criteria	Compliant with Standards	Comments
1.1	IRAS application completed correctly	Yes	No comments
2.1	Participant information/consent documents and consent process	Yes	No comments
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	South London and Maudsley NHS Foundation Trust as the Trust organisation hosting the study has determined that it has acquired the relevant information on this study, and therefore does not require a Statement of Activities or Schedule of Events.
4.2	Insurance/indemnity arrangements assessed	Yes	Insurance information provided is Sponsor's public liability Where applicable, independent contractors (e.g. General Practitioners)

Section	HRA Assessment Criteria	Compliant with Standards	Comments
			should ensure that the professional indemnity provided by their medical defence organisation covers the activities expected of them for this research study
4.3	Financial arrangements assessed	Yes	No application for funding is being made and no funding is being provided to supporting NHS organisation(s)
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	No comments
5.2	CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed	Not Applicable	No comments
5.3	Compliance with any applicable laws or regulations	Yes	No comments
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Not Applicable	No comments
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments
6.4	Other regulatory approvals and authorisations received	Not Applicable	No comments

Participating NHS Organisations in England

This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.

This is currently taking place at a single site, therefore, all activities are being undertaken at this site.

The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation.

If Chief Investigators, sponsors or Principal Investigators are asked to complete site level forms for participating NHS organisations in England which are not provided in IRAS or on the HRA website, the Chief Investigator, sponsor or Principal Investigator should notify the HRA immediately at hra.approval@nhs.net. The HRA will work with these organisations to achieve a consistent approach to information provision.

Confirmation of Capacity and Capability

This describes whether formal confirmation of capacity and capability is expected from participating NHS organisations in England.

It has been confirmed by the supporting NHS organisation that, on this occasion, this study should be treated in the same way as a single site sponsored by that site or an associated educational establishment. The R&D office will confirm to the CI when the study can start and as previously stated, Statement of Activities and Schedule of Events is not required.

Principal Investigator Suitability

This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and the minimum expectations for education, training and experience that PIs should meet (where applicable).

The Sponsor has assessed that the student undertaking this educational project will also act as the Chief Investigator. The Chief Investigator is undertaking all research activities apart from initial approach. Should this study extend to other NHS organisations in England, the Sponsor is required to restate their position.

GCP training is not a generic training expectation, in line with the [HRA statement on training expectations](#).

IRAS project ID	222782
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HR Good Practice Resource Pack Expectations

This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken

An Honorary Research contract for the Consent research activity listed in A18 or A19 of the IRAS application form if undertaken at NHS sites by researchers not employed by that organisation would be expected on the basis of a Research Passport (if university employed) or an NHS to NHS confirmation or pre-engagement checks letter (if NHS employed).

These should confirm enhanced DBS checks, including appropriate barred list checks and occupational health clearance.

Other Information to Aid Study Set-up

This details any other information that may be helpful to sponsors and participating NHS organisations in England to aid study set-up.

The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

Appendix D: SLaM R&D Approval Confirmation

From: Fanigliulo, Adriana [REDACTED]
Sent: 09 May 2017 13:53
To: Gerskowitch, Chloe
Cc: Young, Allan (KCL); [REDACTED] Liebscher, Jennifer (KCL)
Subject: SLaM confirmation of capacity and capability IRAS ID: 222782

Dear Chloe,

IRAS ID: 222782

Study Title: How do psychological therapists describe their experiences of working with interpreters, particularly with regard to issues relating to power and the therapeutic alliance?

Sponsor: University of East London

Trust R&D Ref: R&D2017/032

Please take this e-mail as confirmation that South London and Maudsley NHS Foundation Trust (SLaM) has the capacity and capability to host this research study. This study can therefore now commence at SLaM. Your Trust reference number has been quoted above and should be used at all times when contacting this office about this study. Please read the conditions outlined below and keep a copy of this email for future reference.

The confirmation of capacity and capability to host this research study relates to work in the Psychological Medicine and Integrated Care CAG and to the specific protocol and informed consent procedures described in approved by the HRA. Any deviation from this will be deemed to invalidate this confirmation.

You have committed to recruit 10-12 participants between 09/05/2017 and 30/07/2017.

Honorary contracts: Members of the research team must have appropriate substantive or honorary contracts or letters of access (as appropriate) with the Trust prior to conducting any research on Trust premises. Any additional researchers who join the study at a later stage must also hold a suitable contract or must contact the R&D department to arrange an honorary contract/letter of access. For any researchers requiring an honorary contract or letter of access via their research passport, please contact the R&D office to organise this for you.

Protocol Amendments: Please alert the R&D Department if there is an amendment to the study. An amendment may include changes to study documentation, a decision to use advertising, changes to staff or revisions to study timelines. Trust confirmation of capacity and capability must be issued prior to the implementation of any amendment.

Study status, annual progress reports and end of study declaration

reports: Under the Research Governance Framework, SLaM maintains responsibility for keeping an accurate record of study status for all research on Trust premises. Please notify the R&D department if your study ends before the end date declared on your original application.

Annual Progress Reports: <http://www.hra.nhs.uk/resources/during-and-after-your-study/nhs-rec-annual-progress-report-forms/> The Chief Investigator must submit an annual progress report to the Health Research Authority, sending a copy to the R&D department at each participating site. These reports must be sent each year on or before the anniversary of the Health Research Authority Ethics approval.

End of study declaration forms: <http://www.hra.nhs.uk/research-community/end-of-study-and-beyond/notifying-the-end-of-study/> The Chief Investigator of a study must

notify the Health Research Authority, within 90 days of the end of a study, sending a copy to the R&D department at each participating site.
Within SLAM, please also send a copy of any reports or publications which result from this study to the Trust Departments involved in the study if requested.

Compliance with Trust policies and procedures: All policies and procedures of the Trust which relate to research must be complied with: <http://www.slam.nhs.uk/about-us/policy-and-publications/policies-and-procedures>

Adverse events / complaints: Please inform the Trust's Health and Safety Coordinators and/or the Complaints Department or of any adverse events or complaints, from participants recruited from within this Trust, which occurs in relation to this study in line with Trust policies. Contact details are available from the R&D Office if required.

Audit and Inspection: The Chief Investigator must notify the R&D department as soon as they receive notification of an inspection by an external body. Your study may be inspected by the Trust internally at any point.

Kind regards,

Adriana

Ms Adriana Fanigliulo
Research Governance Facilitator
Joint R&D Office of South London and Maudsley NHS Foundation Trust
and Institute of Psychiatry, Psychology & Neuroscience (IoPPN)
Box P005, Institute of Psychiatry, Psychology & Neuroscience (IoPPN)
De Crespigny Park
London SE5 8AF

(Room W1.08, Main IoPPN building)

Tel: [REDACTED]

Read SLAM's R&D Operational Capability Statement at R and D SLAM Operational Capability Statement 2013-2014 Visit the R&D Office web pages at Research and Development Office

Appendix E: Participant Information Sheet



IRAS project ID: 222782
12.4.17 Version 2
Participant Information Sheet

UNIVERSITY OF EAST LONDON

School of Psychology
Stratford Campus
Water Lane
London E15 4LZ

The Principal Investigator

Mrs Chloe Gerskowitch, Counselling Psychologist in Training

Email: [REDACTED]

Telephone: [REDACTED]

Consent to Participate in a Research Study

The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate a research study. The study is being conducted as part of my Professional Doctorate in Counselling Psychology at the University of East London.

Project Title

How do Psychological Therapists describe their experiences of working with language interpreters, particularly with regard to issues related to power and the therapeutic alliance?

Project Description

This project aims to gain an understanding of how psychological therapists (including Counselling and Clinical Psychologists and Psychotherapists) experience working with language interpreters when delivering therapy to clients. Research suggests that there may be an impact on the Therapeutic Alliance (TA) and power dynamics between the therapist, client and interpreter when an interpreter is used in therapy. There is very little current research which explores in detail therapists' experience of the development of the alliances between the interpreter triad or issues of power relating to these dynamics, and most previous research has been undertaken in specialist 'Victims of Torture' Centres outside of the UK. By talking to therapists who work in primary and secondary care psychology services about their experiences and perceptions of the development of alliance and power relations over the course of therapy with clients, it is hoped that a greater understanding will be achieved of how to best conceptualise alliances and power dynamics within the interpreter triad. This information will be used to help inform the training of psychological therapists who work with interpreters in therapy, with the aim of improving the experience of clients requiring the services of an interpreter to access psychological therapy.

What are the criteria for participating in this study?

In order to participate in the study, you must be a qualified Counselling or Clinical Psychologist or Psychotherapist, with at least 1 years' experience of working with language interpreters in therapy, to include at least 2 different clients.

If I took part in the research, what would I have to do?

This is an interview-based study. If you choose to take part, you will be asked to attend an interview during which you will be asked questions about your experiences of working with language interpreters in therapy. You may also be asked to draw a simple diagram to assist in communicating your reflections. There will be no right or wrong answers – the researcher is interested in your experiences. The interviews will take place on South London and Maudsley (SLaM) premises, at a time that is convenient to you.

It is not expected that the nature of the discussions or the process of the interview will cause any discomfort or distress to participants. But in the unlikely event that you do experience any distress during or following the interview, you will be directed for support to your line manager within SLaM.

Confidentiality of the Data

The interviews will be audio-recorded and then transcribed. The transcriptions will be labelled only by participant number.

The computer files will be password protected, kept on a private computer and be accessible only by the research team. The audio files will be deleted when the research is complete. The anonymised transcripts will be kept in order the research may be developed for publication. In the write up of the research participants will be given a pseudonym and will only be referred to by this pseudonym, professional background, whether they work in primary or secondary care and the model of therapy they use, in order to preserve their anonymity.

What will happen to the results of the research study?

The study is being carried out as part of the researcher's Doctoral degree at University of East London. The researcher is a clinician at Talking Therapies Southwark, SLaM. The study will be written up and submitted as a thesis to UEL. It may also be developed for publication in a Psychology Journal. The results are likely to be disseminated within and outside of the Trust. In all cases the anonymity of participants will be preserved.

Disclaimer

You are not obliged to take part in this study and should not feel coerced. You are free to withdraw at any time. Should you choose to withdraw from the study you may do so without disadvantage to yourself and without any obligation to give a reason. If you choose to withdraw within four weeks of the interview, your data will be withdrawn from the research. However, if you withdraw after this time, the researcher reserves the right to use your anonymised data in the write-up of the study and any further analysis that may be conducted by the researcher.

Please feel free to ask me any questions. If you are happy to continue you will be asked to sign a consent form prior to your participation. Please retain this invitation letter for reference.

If you have any questions or concerns about how the study has been conducted, please contact the study's supervisor Professor Rachel Tribe, School of Psychology, University of East London, Water Lane, London E15 4LZ. Telephone. Email address

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr. Mary Spiller, School of Psychology, University of East London, Water Lane, London E15 4LZ.



Thank you in anticipation.

Yours sincerely,

Chloe Gerskowitch
Counselling Psychologist in Training

Appendix F: Participant Consent Form



South London and Maudsley NHS Foundation Trust

IRAS ID: 222782

12.4.17 Version 2

Participant Identification Number for this trial:

CONSENT FORM

Title of Project: **How do Psychological Therapists describe their experiences of working with language interpreters, particularly with regard to issues related to power and the therapeutic alliance?**

Name of Researcher: Chloe Gerskowitch

Please initial box

1. I confirm that I have read the information sheet dated..... (version.....) for the above study, and have been given a copy to keep. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. I understand what is being proposed and the procedures in which I will be involved have been explained to me. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without disadvantage to myself and without being obliged to give a reason. I also understand that should I withdraw more than 4 weeks after the interview, the researcher reserves the right to use my anonymous data in the write-up of the study and in any further analysis that may be conducted by the researcher. ☐
3. 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. ☐
4. I agree to take part in the above study. ☐

Name of Participant

Date

Signature

Name of Person
taking consent

Date

Signature

When completed: 1 for participant; 1 for researcher site file; 1 to be kept in medical notes.

Appendix G: Interview Schedule

Demographic / background details

Please describe your professional role and the setting within which you work

Is there a particular therapy model you work with? Typical length of treatment, types of psychological difficulties worked with?

Years post qualification

Number of years having worked with language interpreters. Approximately with how many clients?

Intro: I am interested in learning about therapists' experiences of working with language interpreters, particularly how therapists perceive the development of alliances and power relations between the client, therapist and interpreter over the course of therapy.

Feelings: How do you feel / what comes to mind when you know you will be working with an interpreter?

Prompts: What, if anything effects this?

Experience: What has been your experience of working with language interpreters?

Prompts: Can you describe the best experience you've had of working with an interpreter? What made it such a good experience? Can you describe the worst experience you've had of working with an interpreter? What made it such a bad experience or difficult experience?

Are there advantages that you see of working with interpreters? Disadvantages? In what ways, if any does your practice change if you are working with an interpreter?

Roles: How would you describe the role of a language interpreter within therapy?

Prompts: In what, if any, ways does your role as therapist differ from the interpreter's role? How did you come to learn about these roles? (training, conversations, classes)

Therapeutic Alliance: In traditional psychotherapy the therapeutic alliance is dyadic, between the therapist and client. What has your experience been of the therapeutic alliance between the different members when working with an interpreter triad?

Prompts: What, if any, differences have you experienced between the therapeutic alliances between the client and interpreter, interpreter and therapist, therapist and client. In what ways, if any, have these therapeutic alliances developed or changed over time during the therapy? What are the stages in this process? What do you think the client and interpreter think about this?

Power: Sometimes in relationships things like people's ethnic backgrounds, levels of education, gender, and economic status can impact their relationships with others, these are typically referred to as power and privilege. How, if at all, do differences in race / age / gender / education etc affect the relationship between the interpreter, you and the client. How do you view the power relations between the client, therapist

and interpreter. What, if any, differences have you experienced between the power relations between the client and interpreter, interpreter and therapist, therapist and client. In what ways, if any, have these power relations developed or changed over time during the therapy? What are the stages in this process? What do you think the client and interpreter think about this?

Relationships between: What has been your experience of any relationship between power relations and the therapeutic alliances between the client, therapist and interpreter?

What has been your experience of any impact of the particular therapy model you work with or the setting in which you work on the therapeutic alliances or power relations you have described?

Participatory diagramming (say won't be used, just to facilitate discussion)

Could you draw a diagram which shows these alliances and dynamics (and their development)? Using different size circles for the therapist, client and interpreter. Use proximity to each other to depict alliances and the size of the circles to depict power. Then use solid or dotted lines to depict the strength and / or direction of alliances or relations.

How would it look ideally?

How does it look in reality?

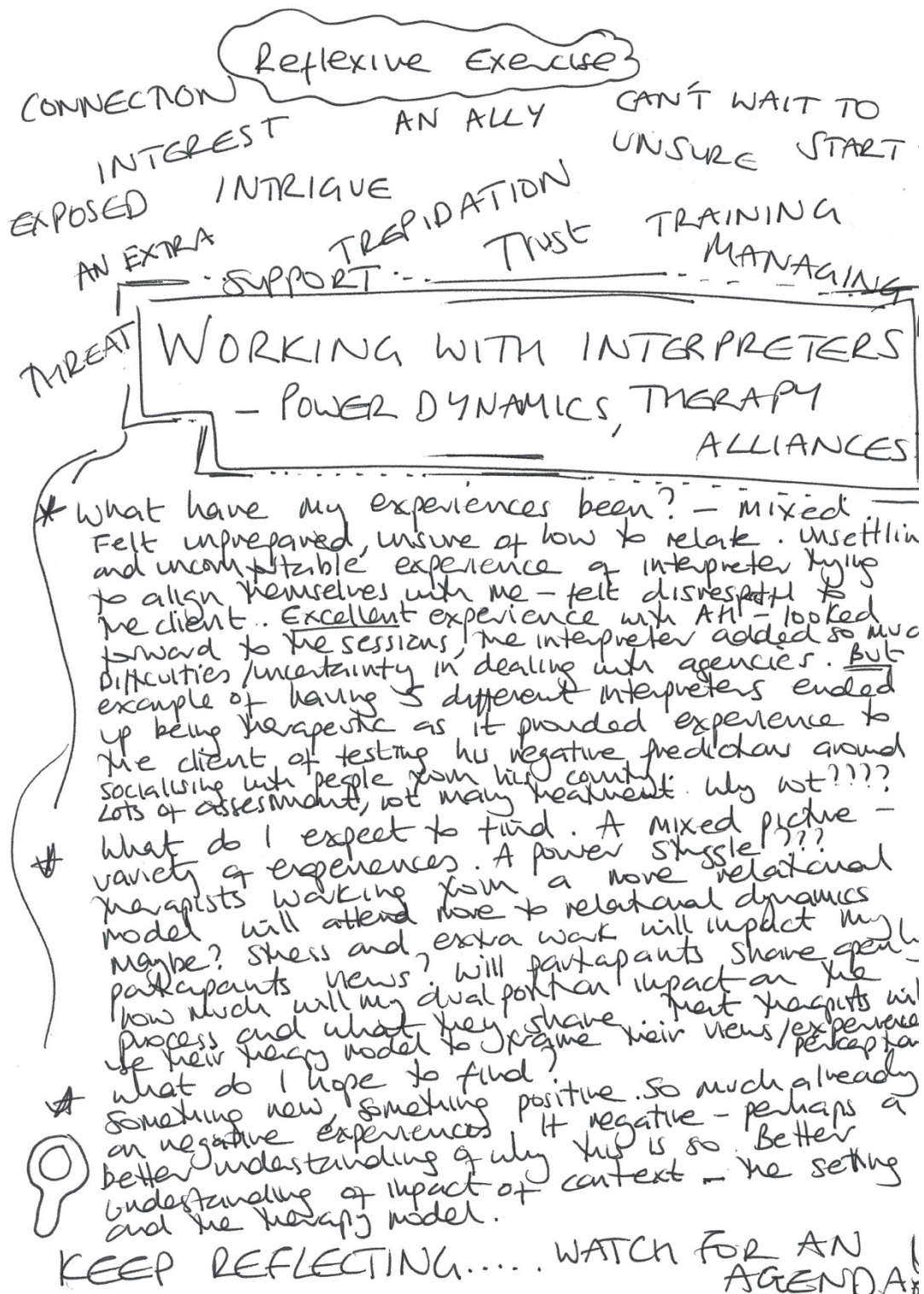
What influences the difference, if any, between the ideal and reality?

Ending

Are there any other thoughts, feelings or reflections that you would like to share that I haven't asked about?

Appendix H: Initial Reflexive Exercise

Exercise undertaken at the start of the research process to reflect on my relationship to the research topic, in order to identify any presuppositions or a personal agenda.



Appendix I: Example of Transcript Analysis

Excerpt from one participant's initial analysis, showing exploratory comments and emergent themes alongside the transcript.

Line no.	Transcript	Exploratory Comments	Emergent themes
169	R: In what way? How do you think it impacted?	<i>Descriptive Comments</i>	Neutrality vs friendship
170		Therapeutic relationship should be neutral – not a friendship though there is genuine care	
171		Triad should be working collaboratively, as a team, limited and guided by therapeutic model or framework (CBT)	
172	P: I guess I think that probably the	This is disrupted by a dyad within the triad having a separate relationship	Separate dyads disrupt the triad
173	therapy involving interpreters tends to	Interpreter's feelings of protection spill into her interpreting	
174	work best when there's an element of	Friendships may lead to misuse of power	
175	neutrality there and in the same way		
176	that I don't become friends with my		
177	patients I will develop a kind of		
178	therapeutic relationship with them where	<i>Linguistic Comments</i>	Therapy model of collaboration underpinning triad working
179	I genuinely care about them and want to	'Neutrality' – suggests perceived clear boundary between caring therapeutic relationship which allows for neutrality	
180	help them with the problems that they're	and a friendship which does not	
181	coming with in a kind of collaborative	'putting her own spin' – using her powers to interpret in a way that protects the patient (from what? Perhaps from the therapist)	Spill or leakage of relationship into therapy
182	way, working as a team, in a CBT kind		
183	of framework. And when there's another		
184	person within the... or when there's a		
185	triad and one person... then there's a	'not malicious or malignant' – participant may find it difficult to consciously acknowledge this is his view	Interpreter power used to protect the patient ?and therapist
186	separate relationship within the triad		
187	which is actually outside of the room I		
188	think in just subtle ways it can show	<i>Conceptual Comments</i>	
189	itself, not in a kind of malicious or	Therapeutic model (CBT) used to justify and guide limits to relationships. Neutrality prized and seen to allow for care and collaborative whereas friendships mean neutrality is not possible and viewed as dangerous in some way to the therapeutic process as evidenced by the interpreter's use of their interpreting power to protect the patient	Interpreter spin
190	malignant way, per se, but more in a		
191	kind of... I think there are a few times		
192	where the interpreter actually said things		
193	that kind of were a bit protective of the		
194	patient and wasn't always directly		
195	translating what was being said, it felt		
196	like sometimes she was kind of putting her spin on what was being said and		

Appendix J: Clustered Emergent Themes for P7

<p>A Cautionary Tale A lesson for the therapist / I should have known previous positive view of friendly burnt' by experience – now more rigid Experience has influenced attitude caution and suspicion Move from view of friendly chat as nice to threatening Bias caution – interpreters' not neutral Friend vs professional Dangerous for interpreter to be more than a translator Interpreter as manipulating communication to develop own relationship with client</p> <p>Unknown entity An unknown entity Unease lifted with familiarity 2 layers of uncertainty will they be who I need them to be? Unknown = unease, familiarity = confidence Agency as unreliable, untrustworthy, faceless Consistency of interpreter valued</p> <p>Translator or therapist? will they be who I need them to be? The 'ideal' interpreter Interpreters should have therapist skills Interpreter as pure translator Interpreter must be 'right' for therapy to be effective The struggle to find the right interpreter There is a right way of interpreters being Therapist needs of interpreter may differ from clients Accurate direct translation is not enough Learning about working with interpreters through experience Cultural context valuable Interpreter as not understanding aims of therapy Not all interpreters have these skills Mismatch between views of successful translation</p> <p>Therapist as police Stern teacher role Therapist as monitor Interpreter requiring clear guidance</p>	<p>Communication through another Simultaneous translation too fast – space for listening is lost Total communication Time needed for digestion Presence of interpreter allows for headspace Pride skill of interpreter not wanted Couple communication compromised by translation</p> <p>Reluctant reliance Reliant on interpreter Interpreters cannot be trusted to know what is needed Therapist powerless without the interpreter Resentment and reliance Reliance on each other</p> <p>Time Time Time pressure leads to resentment Service pressures increase reliance</p> <p>Alliances as helpful Alliance between client / interpreter positive Shared experience between client and interpreter Good working relationship prized Therapist may benefit from halo effect of interpreter / client relationship Need for client to feel comfortable with the interpreter Cultural connection Connection with another as empowering Other therapy triads – working with couples</p> <p>Welcoming in Co-operation and sharing of information Involving the interpreter Sharing information so they understand therapy aims</p> <p>Alliances as splitting/threat Alliances should be shared not separate Separate alliances as a threat Potentially for splitting Interpreters at risk of overstepping boundaries due to shared connections Interpreter – client viewed as a dyad like the couple on couples work</p>
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<p>Therapist as custodian of boundaries A firm line must be maintained Concern about being seen as punitive Therapist as policing Therapist as policing boundaries Concern that therapist may be seen as withholding Need to 'watch the dyad' Policing interpreter interference</p> <p>Boundaries Blurred boundaries Clear role which may be 'overstepped' Boundary issues taking away from real work of therapy Interpreters at risk of overstepping boundaries due to shared connections Contact outside therapy room Therapist as custodian of boundaries Interpreters must hold boundaries Boundaries to avoid complications The interpreter cannot be trusted to maintain boundaries Tension between what is 'right' and what is helping the client</p> <p>Interpreter power as threatening Interpreter power is ideally minimized Potential to disrupt viewed as threatening Interpreter power to hijack</p> <p>It's not the same Therapist and interpreter taking on opposing / complementary roles Presence of interpreter impacting on therapist interpersonal style</p>	<p>Therapist as owner of therapy Therapist as owner of the therapy Interpreter fitting in Therapist responsible for managing dynamics Therapist-client relationship must not be interfered with</p> <p>The Real Work The real work is the technical therapy (EMDR) Boundary issues taking away from real work of therapy</p> <p>Interview / task process Uncertainty about task Diagramming task facilitates reflection</p> <p>Commitment Therapist commitment to client Interpreter as less committed to therapy Interpreter as unreliable in attendance</p> <p>The power Shared language as power Power through status Power through pay Client power not considered Client's multiple struggles Choice as power Equal power</p>
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Appendix K: Theme Recurrence Table

Table showing recurrence of each super-ordinate and sub-ordinate theme and in which participants' accounts they are reflected.

	1	2	3	4	5	6	7	8	9	10
The Most Powerful Thing Is the System	✓	✓		✓	✓	✓	✓	✓		✓
Time Pressure	✓	✓		✓	✓		✓	✓		✓
The Knotty Question of Power	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Attending to Power	✓		✓		✓	✓			✓	✓
Unwanted Power			✓			✓				✓
Language as Power	✓	✓		✓			✓		✓	✓
Reluctant Reliance	✓	✓	✓	✓			✓	✓		
Status as Power	✓	✓	✓			✓	✓	✓	✓	✓
Sharing power		✓	✓	✓	✓	✓		✓		
Dyadic and Triadic Alliances	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Human co-worker or translating robot? Or Both?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
The Prized Dyad		✓	✓		✓	✓	✓	✓	✓	
The Tennis Match	✓	✓	✓	✓		✓		✓	✓	✓
A Cautionary Tale		✓		✓	✓	✓	✓		✓	
I Am Not Like Her, I Am Like You			✓			✓	✓	✓		
Models And Psychological Concepts Used to Conceptualise Alliances		✓	✓		✓	✓	✓	✓	✓	
A Three Legged Stool		✓	✓	✓	✓	✓	✓		✓	✓