

Service-users' experiences of interpreters in psychological therapy: a pilot study

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Abstract

Purpose – Working across languages is playing an increasingly important role in the delivery of mental health services, notably through psychotherapy and psychological therapies. Growing awareness of the complex processes that ensue in working across languages, including the presence and role of an interpreter, is generating new conceptualisations of practice, but there is a need now to evidence how these impact on service users. The paper aims to discuss these issues. **Design/methodology/approach** – This paper discusses the model for working with interpretation developed by Mother tongue multi-ethnic counselling service, which conceptualises the therapeutic process as working within triangular relationships consisting of service user, therapist and interpreter. Second, the paper discusses the qualitative, practice-near methods applied in, and findings from a pilot study to evaluate the interpreter's role.

Findings – Three patterns of response to interpreters were identified: negative impacts on the therapy, the interpreter as conduit for therapy and the therapist and interpreter jointly demonstrating a shared enterprise. It is concluded that the method and findings of the pilot justify a larger study that will further evaluate the experiences of service users and continue to develop and test conceptualisations for best practice. **Originality/value** – Working across languages is now recognised as an increasingly important aspect of therapy in contexts where migration has created new demographics. This paper contributes to the discussion of working therapeutically with people with mental health difficulties across languages. Its originality lies, first, in the discussion of a new clinical approach to working with interpreters, and second in the methods used to access the views of service users about their experiences of interpreters.

Keywords Multilingual, Mental health, Interpreter, Practice-near research, Psychotherapy, Triangular relationship

Paper type Research paper

Introduction and Background

Working across languages is playing an increasingly important role in the delivery of mental health services through psychological therapies and psychotherapy as, in an era of significant migration, more people are moving across borders in pursuit of work, safety and refuge (Castles and Miller 2009; Costa and Dewaele 2012). Often, inevitably, in these contexts therapy addresses issues arising from difficult, painful and traumatic experiences of migration, and fulfils the need for making sense of and mitigating the effects of difficult transitions into a different culture or country.

In these multi-lingual contexts, for therapy to be possible and effective, therapists need to be able to work in more than one language, with or without an interpreter, and to make adaptations to therapeutic practices when an interpreter is present. An emerging literature has begun to identify new conceptualisations of practice taking into account the complex challenges in working across languages and there is a need now to evidence how these impact on service users. For evaluations to be meaningful the voices, experiences and opinions of

people who have accessed mental health services, across languages - usually with the facilitation of an interpreter - need to be heard as a central focus of study. This article aims to make a contribution to the practice of working across languages through discussing the approach developed at Mothertongue multi-ethnic counselling service, and secondly, through reporting the methods applied to and findings from a small pilot study to evaluate the views of service users helped by Mothertongue to access psychological therapy.

Although the number of therapists who can conduct therapy in more than one language is growing - for example, amongst psychotherapists registered with the United Kingdom Council for Psychotherapy, 1,298 say they are able to conduct therapy in more than one language out of a membership of 7,085 (UKCP 2012) – the majority of therapists working across languages will need the assistance of interpreters for therapy to be accessible to everyone. Language is crucial for therapy; in the UK it has been identified as a key barrier to accessing psychological therapy (IAPT 2013). In her research into European migrants' experiences of accessing healthcare, De Maesschalck (2012) found that migrants felt that healthcare providers underestimated language issues and language barriers led to greater feelings of paranoia and aggression for service users. Frequently people do not access mental health services at all because of language barriers and a lack of interpreters (Bernardes, 2010).

On the other hand, it has been shown that access to trained professional interpreters or bilingual providers increases patient satisfaction and reduces errors in general medical practice (Flores 2005). Though there are very few studies of patient/service-user responses to interpreters, Bischoff et al (2003), in a primary care setting in Switzerland, assessed patient satisfaction with care received and with communication during consultation to find, not surprisingly, that patients reported feeling better understood when interpreters were made available.

However, the importance of language is heightened in mental health settings. It has been shown that people are more able to express themselves when talking about emotional and formative childhood experiences in the language in which these experiences happened. (Schrauf 2000, Harris 2006). The complexities of therapeutic communication across languages occur at many levels of therapeutic communication; understanding ways in which emotions are expressed in different languages, how speaking more than one language impacts on identity formation; how significance and meaning are conveyed and construed within cultures; people's experiences of learning a language (Costa 2010; Costa & Dewaele, 2012). Mental health patients often have deeply distressing stories to tell, full of incidents that may remind practitioners of pain in their own lives relating to, for example – relationship crises, losses, bereavements, betrayal, exile, amongst many potentially painful situations. The telling of these accounts and the often intense emotionality which characterise therapeutic sessions therefore impact on all participants, including interpreters. Thus the demands on therapists working across languages are significant, and, it becomes clear that the interpreter's role alongside the therapist consists of so much more than simply translating words; it is, rather,

about working with the subtleties of language in charged and difficult emotional contexts (Tribe and Keefe 2009).

A small but increasing number of studies have begun to explore the issues relating to interpreting in therapeutic settings. Initially it was noted that clinicians found the area 'fraught with difficulty'; they feared the loss of depth and accuracy of communication and experienced difficulties in establishing a constructive working alliance with interpreters, and thus also with the clients (Raval and Smith 2003). Potential confusion for clinicians in moving out of their traditional one-to-one method of work to a three-way relationship including the interpreter was illustrated recently by Cambridge (2012), who quoted clinicians preferring a clear delineation of role for interpreters, and feeling excluded from the insider-ness of the shared language and culture of the interpreter and the client:

"I've had once again the Arabic lady trying to explain things, [...] I remember her saying 'oh that's an expression that they use' kind of a thing.[...] there'd be a bit of a smile and a smirk and I wouldn't really understand so I'd ask and she'd say 'well, that's a kind of expression that they use for this.'" (p308)

On the other hand, there are examples where interpreters have found the need to go beyond the strictly prescribed role of translating words in order to achieve a closer level of relatedness with the client, to attempt to stretch the interpreter role to "*be very intimate with the patient*" (p308) gain the trust of the client through familiarity to "*bolster their ability to place abstract trust in professional interpreters*" (Alexander et al 2004, p 57)

Robb and Greenhalgh's (2006) discussion of the mediation of trust in interpreted consultations in primary care showed that patients preferred interpreter mediated consultations based on voluntary trust, rather than relying on an expert (coercive trust), or lack of knowledge of alternatives (hegemonic trust). Developing this idea Farini (2012), studying interpreting as mediation in Italy, found that patients' emotional expression was more likely to be relayed by an interpreter who had an additional role of mediator as well as interpreter, otherwise, patients' feelings could be neglected. Farini's research was conducted with patients accessing healthcare in obstetrics, paediatrics, gynaecology and neonatology. In mental health contexts, the interpreter's role of mediation, is in conflict with the therapists role of working with emotions through the therapeutic relationship. Thus the potential for role confusion could be exacerbated by the interpreter assuming a mediating role and the therapy hindered rather than helped. Alternatives to the mediating role thus need to be found in therapeutic settings. Though it is tempting to deal with the interpreter, as an addition – perhaps wanted, perhaps unwanted - to the consultation, unless the interpreter is incorporated into the whole as an equal and integral component of the dynamic, the result could lead to a splitting off of vital elements which would be counter therapeutic. (Costa 2011)

A further strand of recent research has focussed on the emotional impact of interpreting on the interpreter. Doherty et al (2010) interviewed 18 interpreters; just over half reported being

emotionally affected by mental health interpreting. 12/18 (67%) said that they could find it hard to put clients out of their mind and 6/18 (33%) reported impacts on their personal lives. Thus the interpreter cannot be treated as a bystander, a fly on the wall simply translating words. In therapy it is necessary for all the people involved to be fully attentive and emotionally present. Professional formation of therapists prepares them to listen deeply to people's painful and dark stories and to be fully present with their emotions even when what they are hearing may have very real connections with their own experiences. In order for interpreters to work effectively in the therapeutic frame, the same is asked from them and yet they come to the job without the same professional preparation (Costa 2011).

Tribe and Thompson (2009) explore different dynamics in the triangular relationship between therapist, client and interpreter, emphasising the different patterns of alliances that occur, within power relations, in the "changing shape of the triangular relationship between the three parties" (page 20). These authors prefer the term 'complex emotional reactions' to the psychodynamic transference and counter transference. However, the latter takes into consideration the unconscious stimulation of feelings towards a person in the present, which have their origins in earlier more significant relationships. Once the interpreter enters the mix, they become part of the transference and therefore contribute to the ways in which the therapist and the client will be trying to make meaning of the experience together. The unconscious will not ignore the fact that there is a third person in the room.

The emotional impact of these triangular relationships on interpreters is evidenced by Doherty et al's (2010) study of interpreters working in a mental health context which found that interpreters' stressors in this work included: working with distressed clients; identifying with clients' stories, having problems in their own lives and containing their own emotions. Interpreters also reported that they felt challenged to maintain boundaries when they heard such powerful stories and when clients had expectations of them beyond their role. Sande (1997) recounts that in supervision groups with interpreters, interpreters would refer to the anxiety produced by being given responsibility beyond the scope of their role, by the professional and the client. The interpreters that Costa (2010) interviewed also mentioned the challenge of being in the role of "bystander" – witnessing and communicating intense and distressing material, but unable to take any action to provide relief. It is important to build on the picture being developed through these studies to evidence in particular the experience of clients, which is under-reported to date.

The Mothertongue interpreting service

Aiming to respond to the challenge of providing therapy in the language of the client, since 2009 Mothertongue (www.mothertongue.org.uk), a culturally and linguistically sensitive professional counselling service for people from black and minority ethnic communities, has created a training programme in collaborative working for interpreters and clinicians, and a dedicated Mental Health Interpreting (MHI) Service which is funded by the local Health Authority. It provides mental health interpreting for Mothertongue's own clinical work and

the clinical work of local mental health practitioners. This includes therapy delivered within the Improving Access to Psychological Therapies (IAPT) service in an NHS Trust.

The IAPT initiative was piloted in 2006 and rolled out nationally from October 2008. Its aim is to make psychological therapies as accessible as possible in the UK, based on many years of clinical research, which have demonstrated that "talking therapies" can be as helpful as medication to treat anxiety and depression. The most frequently delivered therapy in IAPT is Cognitive Behavioural Therapy (CBT), focussing on the connections between thoughts, mood, behaviour and physical sensations. It is frequently delivered by Psychological Wellbeing Practitioners (PWP) who provide initial assessments, minimal intervention and guided self-help, and High Intensity (HI) Therapists – trained to deliver approximately 16 ongoing sessions of CBT.

Mothertongue's approach involves the training and guidance of interpreters. This focuses not only on language, but also on appropriate relationship skills, and in particular the challenge of working as a third party in a traditionally dyadic therapeutic relationship. A code of conduct (Mothertongue 2012) has been drawn up to guide interpreters and the training aims to help interpreters put the codes of conduct into practice. Key features of the training and codes of conduct include:

(a) Interpreters must have an appropriate command of the spoken languages in which they interpret, including dialects, current idioms and cultural background knowledge

(b) Therapists and interpreters need to work together before, during and after the therapy to establish the working alliance and to process the emotional impact on both

(c) Interpreters need to recognise boundaries between themselves and clients and to follow guidance about what to do, and what not to do in sessions

(d) Therapists' responsibilities to assist interpreters with any strong emotional impact of the session is recognised. Thus Mothertongue's approach attempts to generate an integrated way of working to overcome limitations of traditional thinking about clinician and interpreter roles and apply recent conceptualisations of these as triangular relationships. It is important to gain some evidence of how this approach is experienced by clients in practice. This article discusses a small scale pilot research project which aims to better understand the effect of accessing therapy through an interpreter, where the interpreter is trained and works collaboratively with the clinician in the Mothertongue model. The aim is to generate evidence so that service delivery can be improved through taking into account the experiences of service users who have interpreters in a therapeutic context.

The focus on service user perspectives appears to us crucial; it can be argued that not to take into account patients' experiences, because of the practical and ethical challenges of so doing, poses a further set of ethical dilemmas about inclusion, exclusion and power. Secondly, we aimed to pilot a methodology for conducting research with this client group, taking into account the complex ethical and practical issues that are raised in this kind of work, to offer

thus encouragement to others who wish to conduct research in this under researched area and, to assess how a larger scale study of patients' experiences of using interpreters in a mental health context could be conducted.

Method

The absence of studies that access the perspectives of service users in mental health contexts is likely to be caused by the manifest and many practical, ethical and methodological issues raised. These include methods and skills to interview vulnerable mental health patients, (Zimanyi 2009, p35036). As with clinical work, research across languages relies on understanding the sometimes subtle meanings of words (Tribe and Keefe 2009) and, misunderstandings can easily occur. As Temple notes:

“... there is very little reflection on the implications for qualitative research of language difference and the use of third parties in communication across languages ... This is a strange omission given that qualitative approaches are steeped in a tradition that acknowledges the importance of reflexivity and context.” (Temple 2002, page 2)

However, the importance of the potential contribution of service users' voices is a powerful reason for persisting in the face of these difficulties (Alexander et al 2004; Greenhalgh et al 2006; Pochhacker 2006; Zimányi 2009). A key task for this project was the development and application of a methodology that could take into account -especially - the need to pay attention to the issues of understanding across languages. The methodology needed to be capable of addressing potential misunderstandings that could be distressing or confusing for service user research participants, such as perhaps expecting the research interview to provide clinical or advocacy services for the participant/service user (Telvi 2006). Thus some difficult ethical issues are raised, and it was necessary to be able to demonstrate robustly that these issues could be attended to, and confirmed by a research ethics committee (in the NHS). Additionally, the project required working closely with an organisation that provides MHI services and that was agreeable to participating in the study.

Design

For an exploratory study such as this, a small scale qualitative design appeared most appropriate, into which we could build features to address the specific requirements for researching across languages and the significance of emotionality in the therapy. Qualitative approaches have been used in other studies of interpreters, including IPA (Raval and Smith 2003) and grounded theory (Robb and Greenhalgh 2006). For this study, to interview a small number of individuals who had accessed therapy with an interpreter a semi-structured interview was thought to offer an appropriate model.

Additionally, some innovative features were added to the design specifically to address the aims and potential difficulties we have identified, above, for this study. Firstly, it was thought paramount to interview participants in their first language. This necessitated recruiting a range of interviewers who could work with the languages used by the therapy clients. Thus

the impact of language differences would be held in the research team, and this required processes for teamwork, training researchers, translating protocol first into the language of the researcher (and service user) and then back into English for analysis and for achieving consistency across the research team. To facilitate these processes, a training day was devised and delivered by both authors to the researchers, individual support was provided by one of us for setting up and conducting the interviews (BC), and data analysis was conducted by the team or panel method (Wengraf 2001) now used routinely in practice-near research (Froggett and Briggs 2012). This process of data analysis, discussed further below, aims to generate and then test emergent hypotheses from different perspectives. It also enables focus on the emotional and relational aspects of the interview, brings to the forefront the researcher's own emotional experiences and aims to understand these in the context of the interview. Moreover, the approach attends to identifying ambiguities and other nuances in the data.

Participants

Talking Therapies in an NHS Trust (IAPT) agreed to take part in the study. A series of discussions with the service clarified the way the project would be conducted. NHS ethical agreement was obtained on the basis of conducting this pilot to inform Mothertongue's practice. Between 10 and 15 IAPT patients, who had undertaken a course of individual IAPT therapy and who used the Mothertongue Mental Health Interpreting Service were identified as potentially suitable for the project. IAPT's usual channels for communicating with patients were used to give the participants information about the project, to invite them to take part and to agree to give their informed consent. Introductory letters were translated into Farsi, Polish, Portuguese and Punjabi. It was emphasised that this was an evaluation interview and not part of their treatment. Nine participants agreed to take part and their own languages were Punjabi, Urdu, Farsi, Polish and Portuguese.

Research interviewers

Research interviewers were required to conduct interviews with participants in their own languages, and to not have any sentient connections with participants. Earlier studies have warned us that researchers who are independent of the clinical relationships, but who have other relationships with the research participants may introduce a bias into the interviews (Robb & Greenhalgh 2006).

Building on the relationship of one of us (BC) with the Psychology Department, Queen Mary, University of London, multilingual undergraduate Psychology students speaking Punjabi, Urdu, Polish, Portuguese, Farsi, Dari were recruited. The students were offered training in research methods, expenses reimbursement and a small fee for translations of the interviews into English. In return, they gained work experience which was valued by all the participants. For small organisations like Mothertongue it is important to be creative with minimum resources and a successful by-product of this initiative is that an ongoing resource has been created; all the participants of the training have asked to be considered for similar roles in the future.

The interviewers were trained through a one-day workshop led by one of us (SB). The workshop focused on developing research skills for conducting in-depth interviews with people who are patients in psychotherapy. An overview of IAPT included some fictionalised case examples. How to conduct the interview was discussed in detail and practiced through exercises and role-plays. As the challenges of working across languages are frequently underestimated, the training included a process of trialling and checking translation of the interview schedule, role plays in different languages and adapting the schedule for telephone interviewing. Close attention was paid in the training to developing the capacity to maintain the position of a researcher and not become, for example, embroiled in clinical issues, or as an advocate for the client. It transpired that these steps were justified as the data will show that the interviewers were indeed put under this kind of pressure.

If any information needed to be conveyed back to the therapy, Mothertongue would take appropriate action and feed back to IAPT. Disclosure and Disbarring Service checks, mandatory in the UK for all people working with vulnerable people were completed in the training day. A procedure for the administration and safety of all was devised and explained to the trainees on the training day.

The interview schedule

The main part of the schedule was a semi-structured interview, with 7 questions and prompts which aimed to encourage participants to develop their own narratives of their experiences. Additionally, a structured section consisted of 6 statements seeking ratings of agreement or disagreement. The schedule was refined during the training day and was designed to be used in face-to-face and telephone interview settings. The full schedule is appended.

The interviews

The researchers were matched to participants on the basis of sharing a similar language. The IAPT administration team arranged the research interview appointments for the participants, offering a choice of face-to-face or telephone interviews, in order to provide participants with the opportunity to choose which setting would feel more comfortable, and also for practical reasons as the research interviewers and participants were based in different locations. From the nine selected participants, seven interviews were conducted. One participant had moved away without leaving a new address and another had not begun therapy at the time of the interviews. Four participants preferred telephone interviews and three opted for face-to-face. However, one of these went to the wrong location for the interview and the interview was rearranged on the telephone. The interviews were conducted in Punjabi (3), Polish (2), Portuguese (1) and Dari (1). All interviews were audio recorded and then translated and transcribed in English by the research interviewers. A second researcher, with the appropriate language knowledge then tested the accuracy of the translated transcriptions by listening to the audiofile. Most participants (6/7) were continuing in therapy at the time of the interviews, and one had completed the 16 sessions of high intensity therapy

Data analysis

Three of the 7 semi-structured interviews were analysed using the team, ‘panel’, method as described above. The team, as in a seminar, responded to a segment of text from the interview, providing thoughts and associations, and then made suggestions about what would happen next in the interview. The next segment of text was then read and discussed in the same way. Suggestions from the group were recorded on flipcharts. Recurring themes were progressively linked to each other to generate categories. The same procedure was followed for further interviews and similarities and differences across the interviews were explored. Overarching themes were identified from this comparative process. As Wengraf (2001) has noticed, this process has a family resemblance to the constant comparative method of grounded theory. The open discussion of the data from the interview transcript permitted the inclusion of diverse points of view, and attention to discrepancies and ambiguities. Following the team analysis exercise, which undertook in effect a structural analysis of the interviews, the remaining interviews were analysed by individual members of the research team to make comparisons with the themes and categories from those studied by the team method. Responses to the structured component of the interview were collated and summed.

Findings:

The structured questions in the interview showed that a majority of the participants had positive experiences of interpreters. A majority (6/7) judged that they could talk about emotional issues through the interpreter, that they could trust the interpreter who communicated clearly and was sensitive to their issues. 6/7 also preferred to have the therapy conducted in their own language rather than in English. A small majority (4/7) preferred to have a neutral interpreter rather than a family member (see **Table 1**)

Table 1: Responses to the structured questionnaire

INSERT TABLE 1 HERE

Analysis of the semi-structured part of the interview, through the panel method, provided a deeper, more nuanced and ambiguous analysis, in which tensions and contradictions surfaced. The identified themes were contextualised by reference to qualities in relationships between the participants and the research interviewers. Participants attributed connections to IAPT and/or Mothertongue to the interviewer, and their perceptions of these links appeared to influence how they reported their experiences of therapy. For example, in some accounts a tension appeared between compliance, on the one hand, and complaining, on the other hand. Participants appeared to have some conflict about whether to try to give routine or matter of fact responses to the questions, or to allow stronger feelings, such as distress to surface. One participant (A) showed that she thought the interviewer could pass messages to the therapy team:

“I wanted to tell you something. The last time I had gone, I was not pregnant and didn’t know, they had asked me there and I had said I was not pregnant, and last week I had a pregnancy test and I am pregnant and want you to let them know this.

This had the quality of a communication of importance, aiming to correct a misunderstanding. There was a contrast between participants’ communications which had the air of recollection in tranquillity after the event, and those showing them still to be in the moment of the therapy, involving the interviewer in its current emotionality; most were in fact continuing in their therapy at this point in time. One example of a reflective view of therapy was made by an Urdu speaker (I1):

“ ...during therapy, many times you are not in a normal state of mind, and you aren’t very conscious”

Participants made explicit connections between the research interviewer and the interpreter:

P: Forgive me, you are also a translator [interpreter] and... I do not want to upset you but the only matter was that the translator did not actually give me any help in particular or to guide me in any way.

The wish to spare the feelings of the interviewer flowed from role similarity - *“you are an interpreter (translator) too”*. Other similarities between interpreters and interviewers which were drawn out included subtleties of shared idiomatic language. For example, one participant used a phrase –*“thank you for giving me some of your time, live long”* - which she expected, correctly, that the interviewer would locate as an Afghan expression used to express appreciation. Thus interviews did not take place in neutral space but were imbued with meanings and connections with experiences of therapy which were important to explore.

The overarching theme of participants’ experiences of interpreters in their therapy identified from these interviews was that explicit or suggested wishes, feelings and experiences of both the therapist and the interviewer were predominant, and these were grouped into three categories:

a. The interpreter was invested with attributes which impacted negatively on the therapy

Amongst s critical comments about the interpreters, a key thread was the concern, raised specifically by three of the participants, about how interpreters were perceived as interrupting the communication flow in therapy. Two of the participants mentioned that *“they did not like speaking in small chunks”* as they reported was requested by the interpreters. For example:-

“I wanted to say something more and then the interpreter was saying that in rather short sentences, because then she wouldn’t know how to say it. And like that it is simply not possible” (K).

The interruption to communication flow was seen as breaking up the participant's direct contact with the therapist. One participant gave this example as occurring when the interpreter's request to use short phrases was seen as slowing down the process and as a barrier to direct access to the 'doctor', as if the interpreter were not necessary:

P: the doctor ... communicated with me with in a good manner and calmly and I was very happy with my doctor.

A: And can you tell me the roles of the two people who you had met? What were the differences between them

P: Well, there wasn't much of a difference, but for me the only difference was that I believe that without the translator I could say my problems...P: Because I wanted to, and I had said that it has been approximately 3-4 years that everyday my memory has got weaker and everything that I wanted to say, the translator would tell me to wait and to tell him one word each time

A: Ok

P: And while waiting, everything I wanted to say would be forgotten

Interpreters were also thought to have had a struggle with meanings of communications which could not easily be translated:

"...when the doctor said something, she didn't know, because you know it's sometimes difficult to translate something into X (language)". (K1)

On the other hand, the interpreters were criticised for staying 'in role'; one participant (A) contrasted unfavourably her current interpreter – who was characterised as "not so good and not so bad, she was ok" –with a previous experience where an interpreter had provided added help, outside the therapy, a role which is outside the Mothertongue code of conduct for interpreters. Alongside this there was some confusion about the extent and limitations of the role of the interpreter. One participant commented on the absence of social niceties:

"..there was never something like "let's talk" or something only right Ok goodbye but maybe that's the way it should be, I don't know (she smiled)". (E1)

One interview mentioned an interpreter's inappropriate response to painful material; the interpreter laughed:

"I: I do know that sometimes I said something that made her laugh. For me it was something important and she found it funny. I didn't really like it, so to say.

R: I see, so it seemed like unprofessional behaviour?

I: Exactly. I mean, I'm saying that she was professional and suddenly I'm saying there were a few situations, but as I say, I tried not to think about her, what she was like.

R: Do you remember such a situation?

I: No, I don't remember it right now, what it was about, there were so many meetings that I don't know, I don't know; but it was a bit out of order, because something is painful for me and the same thing makes her laugh, it's not fair, but ok.

R: Did the therapist react somehow? Did he say anything to the interpreter?

I: No, he didn't say anything to her. Neither he, nor I, I only looked [at her] and that was it. I didn't tell her anything, because maybe I lacked courage (laugh). I just thought you were there just to interpret and your feelings...

R: Should be kept to yourself?

I: Exactly.

This interaction between the participant and the research interviewer shows, firstly, how the interpreter's laughter impacted on the participant and, secondly, the therapist's lack of response left the participant isolated, at what might be called the lonely end of the triangle:

b. The interpreter as the conduit for therapy

The second theme, in contrast, focuses on the role of the interpreter as the conduit for therapy, especially when the feelings that brought the participant to therapy were turbulent, and when the participant felt distressed, depressed or desperate. In these states, participants were grateful for someone who would help, and the presence of a third person in the therapy was not a problem:

"...but just like I said I really needed it, I was feeling so very low that it didn't matter whether there would be one person or three or five, so..." (E1)

The Urdu speaking participant, quoted above, emphasised the importance of being able to speak in one's own language when in a distressed state:

"...during therapy, many times you are not in a normal state of mind, and you aren't very conscious so during that time if you are speaking in your own language to someone sitting in front of you, then it is much easier in Urdu" (I1)

Thus the interpreter is seen as necessary for facilitating the process of therapy and its outcome:

"I think that if I didn't have an interpreter, I wouldn't have been able to express myself. I wouldn't have been able to, err, have had the help that I had, for the evolution of my problem. And I was able to put up with a large part of my problem because of the interpreter. If I didn't have them there, I think I wouldn't have been able to achieve the good result that I did."(C1)

The opportunity to have an interpreter from outside the family was seen as helpful as it freed family members from the potential burden of undertaking this role:

“Because the family wouldn’t be able to, I wouldn’t want it anyway, for example my daughter to interpret for me. These are such things, they aren’t very nice, she’s too young” (K).

Another participant was grateful to the interpreter for a whole-hearted commitment to the task, going beyond what was thought to be strictly necessary and providing opportunities to be well understood:

“She spoke Portuguese, which helped a lot, right? Erm, with how I expressed myself, right..... Oh I think they did more than they needed to! Because sometimes I needed to express myself in a certain way..... any expression that I wanted to say but couldn’t, he would help me even more. Erm, err, so I think that they helped me even more than was necessary”(C1)

c. The therapist and interpreter help the participant between them as a shared enterprise.

In this third theme the complementary roles of the therapist and interpreter working together on behalf of the participant are recognised. The communication between the patient and therapist are seen to take place ‘in the presence of’ a benign interpreter:

“Because it’s not your first language, so it is a good option to have an interpreter with you, otherwise you may not be able to put forward correctly your message of what you want to say. In the presence of an interpreter it happens with much ease.” (II)

The therapist, interpreter and patient are seen as collaborating together, as the same participant expresses:

“... if I wanted to convey anything, any kind of message to my therapist, then in a very good way, like when I was talking to them, as it is, they presented to my therapist what I was saying. It was very helpful”. (II)

Another participant, stressing the accuracy of interpretation, emphasised the collaborative triangularity of the process:

“the interpreter is a person that like interpreted all that, exactly what I, erm, needed, right. Everything I said, she would say exactly, to, to the therapist what I realistically needed to hear. I think that they, err, completed the therapy. Between them, they really helped me.

In contrast to those who felt the interpreter was an interruption to the process, these comments emphasise the interdependence of the therapist and interpreter –and the patient’s own role:

“I wouldn’t have changed anything, when it comes to work performed by the doctor, the interpreter and, well, me (she smiles)”. (K1)

Discussion of the findings

The project applied a method, practice-near research, to access service users’ views of the role of interpreters in therapy, and to systematically evaluate these views. This in-depth approach facilitated the aims of the project and enabled some potentially serious obstacles to be overcome, including, primarily the issues of working across languages in research and thus being able to address issues of understanding - and the potential for misunderstanding.

These findings illustrate that interpreting relationships take place in emotionally powerful contexts and that the interpreter becomes invested with feelings driven by the intense emotionality of the therapeutic encounter. Participants voiced different views of interpreters; their responses cohere around contrasting views of the triangular relationship, between therapist, interpreter and patient. Specifically these views express differing perceptions of a collaborative relationship between the therapist and interpreter, on the one hand, and a divisive or interrupting relationship, on the other hand. These can be thought of as illustrating two sides of the same coin; when the tensions and anxieties can be tolerated, by the participant, the collaboration between interpreter and therapist appears benign, containing and necessary. There is here an interdependence which underpins the process and outcomes of therapy. On the other hand, perhaps for the more conflicted and fragile participants, the roles of therapist and interpreter are felt to be less a collaboration and more in conflict with each other. It is noticeable that a particular criticism is that the interpreter brings an unwanted disturbance to the dyadic relationship with the therapist, and is an interrupting influence. Potential triggers for a shift from the collaborative to the ‘interrupting’ mode of relating to the interpreter include the patient’s fragility, and less capacity to tolerate a ‘couple’ working together. It would be interesting to be able to explore more systematically the relationship between experiences of therapy with an interpreter present and the patient’s customary reactions to stress and anxiety. Some of these participants were grateful for the help they received (it would not matter, as one participant said if 3, 5 or more people were present) and more able to put themselves in the trust of the therapists and interpreters. For others the need for therapeutic help generated defences against anxiety which include splitting the therapist and the interpreter, blaming the interpreter, as discussed by Costa & Dewaele (2012), for example, through being protective of the therapist and blaming the interpreter (for example, for breaking the communication flow). Though interpreters may vary in their standards and effectiveness, it is interesting nonetheless to contrast the appreciation of the participant who felt her interpreter went beyond the minimum, and with whom it appeared possible to have a fine attunement, with participants who experienced interpreters as interrupting.

Participants in this pilot study were at different points in their therapy and this may have led to differing perceptions in evaluating interpreters. Those participants who could look back with some satisfaction or gratitude on the help they received are also more likely to have positive feelings for the interpreters than those who were still in the throes of the process and

perhaps anxious about how much it would help, or those who after the therapy still have problems and would wish to feel they have been more helped by their therapy. These factors can be taken into account in the design of future studies.

The findings from this small pilot do indicate that future studies could take as a starting point the importance of the triangular relationship, to explore and assess the dynamics in these relationships. This would help to refine understanding of the interpreter's role in therapy; there is, at least, at this time a firm hypothesis that there is a transferential relationship between patients and interpreters and understanding this is vital for conducting therapy

These findings are indicative because they come from a small pilot, but they do add support to the key ideas that underpin Mothertongue's ethos and practices; that the interpreter is invested with intense emotions and is therefore an integral part of the therapeutic process, that therapists and interpreters need to explore the dynamics routinely in order to work together, that interpreters need to be trained to work with the relational aspects of their role, and that therapists need to be trained in how to work collaboratively with interpreters.

Conclusions and Implications for Practice

In this pilot study, clients have shown that, as interpreters also report (Doherty et. al. 2010) there is a potential for complex and ambiguous relatedness with interpreters and therapists. Sometimes clients can feel confused about the nature of the interpreter's role and disappointed when expectations of a broader role are not met. On the other hand these findings suggest that there are areas of satisfaction with interpreters, and that these trained interpreters communicated both capacity to facilitate the therapy –as a conduit – and also working as shared enterprise with the therapist. The Mothertongue model of training thus appears to have merit and hold promise for future developments. These conclusions align with findings from Bischoff's (2003) study in general medicine where, when clinicians had been trained to work with interpreters, patients noticed improvements in clinicians' effectiveness and their systematic use of trained interpreters also increased. Training for therapists in managing the triangular relationship process could impact positively on the level of satisfaction for clients. Further research, which builds on the work of this pilot, could test this out, and this could include study of couple and group as well as individual therapy.

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Appendix. Interview schedule

Introduction: Thank you for coming to meet with me today. As you know, we are evaluating how people experience therapy when an interpreter is present. The focus is on the role of the interpreter in the therapy. This is explained on the participant sheet which I would like you to read now (go through this with the participant).

If you are happy to proceed, please may I ask you to sign the consent form (If this has been completed before the interview; ask the participant to say if they are happy to continue). What happens now is that I will ask you some questions and I will listen to your responses. As we have said (in reading the participant sheet) I will record our meeting.

Question 1

In overall terms, can you tell me how you experienced having therapy in the service?

Prompt: what were the main factors that lead you to this view or judgement?

Question 2 (skip or amend if covered above, e.g. if the participant says "I felt really understood" as answer to Q1).

When you were in your therapy, did you feel you were well understood?

Prompt: what was it about the therapy that you feel most helped or hindered feeling understood helped/hindered this process?

Further prompt if needed: do you think the people in the session helped by making you feel at ease/listening well/communicating clearly, for example.

Question 3: can you describe the roles of the two people you met with?

Prompt: what did they do differently? Similarly?

Further prompt: what was it like having two people in the therapy?

Question 4: let us now focus on the person we have described as the interpreter: in your view, what do you think they did that was helpful?

Prompt: please can you give an example/"for instance"?

Question 5: in your view, what do you think the interpreter did that was not helpful?

Prompt: please can you give an example?

Question 6: in your view, what (if anything) should the interpreter have done, that they didn't do?

Prompt: and were there things you felt the interpreter did they shouldn't have done?

Question 7: can you imagine what it would have been like NOT to have the interpreter present along with the clinician?

Prompt: have you for example had meetings where English is the language being used? And if so how did you find these compared with the therapy here?

Thank you for your responses. Finally, I would like to ask you to give your responses to the questions on this sheet:ta

1. It was difficult to speak about my emotional issue through an interpreter? Agree/disagree/don't know.

2. I felt I could trust the interpreter. Agree/disagree/don't know.

3. I felt the interpreter was sensitive to my issues. Agree/disagree/don't know.

4. I felt the interpreter communicated clearly and accurately. Agree/disagree/don't know.

5. I would have preferred to have had someone from my family interpret for me.

Agree/disagree/

don't know.

6. I would have preferred to have tried to have the therapy in English without an interpreter.

Agree/disagree/don't know.

About the authors

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Appendix

Interview Schedule

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When you were in your therapy, did you feel you were well understood?

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Further prompt if needed: Do you think the people in the session helped by making you feel at ease/ listening well/ communicating clearly, for example

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Prompt: please can you give an example/ 'for instance'?

Question 5: In your view, what do you think the interpreter did that was not helpful?

Prompt: please can you give an example?

Question 6: In your view, what (if anything) should the interpreter have done, that they didn't do?

Prompt: and were there things you felt the interpreter did they shouldn't have done?

Question 7: can you imagine what it would have been like NOT to have the interpreter present along with the clinician?

Prompt: have you for example had meetings where English is the language being used? And if so how did you find these compared with the therapy here?

Thank you for your responses. Finally, I would like to ask you to give your responses to the questions on this sheet:

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Agree/Disagree/ Don't know
2. I felt I could trust the interpreter Agree/disagree/don't know
3. I felt the interpreter was sensitive to my issues Agree/disagree/don't know
4. I felt the interpreter communicated clearly and accurately Agree/disagree/don't know
5. I would have preferred to have had someone from my family interpret for me
Agree/disagree/don't know
6. I would have preferred to have tried to have the therapy in English without an interpreter
Agree/disagree/don't know