Tribe, R & Thompson, K (2022) Working with Interpreters in Mental Health. ***International Review of Psychiatry*** *http://dx.doi.org/10.1080/09540261.2022.2073202*

Working with Interpreters in Mental Health

1. Rachel Tribe & 2. Kate Thompson

1. School of Psychology, University of East London and Centre for Psychiatry and Mental Health, Queen Mary, University of London
   r.tribe@uel.ac.uk
2. Independent psychological Practitioner
   katythompson56@me.com

Abstract

281 million people were recorded as having migrated across national borders by the United Nations in 2021, this equates to approximately 3.6 percent of the world's population. Forced migrants /refugees account for 12 per cent of all international migrants. A percentage of these people will not speak the language of their new country fluently. If they are to access and utilise mental health services, they will require access to an interpreter. This paper provides guidance on working with interpreters in health settings when the work is either face to face or on-line. These guidelines are based on those written by the authors for the British Psychological Society.

Working effectively with interpreters should be a skill in the repertoire of every clinician. This is to ensure that equal opportunities are upheld and that certain groups (including forced migrants) are not denied access to mental health services. Interpreters may also assist with teaching clinicians about diverse cultural views surrounding mental health and well-being. They may also advise on idioms of distress, cultural meanings and expression of emotional problems across cultures, explanatory health models and contextual factors which may help extend the repertoire of clinicians. The guidelines cover key recommendations for practice, booking and finding an interpreter, preparation before the consultation/meeting, practical considerations, preparation with the interpreter, during the meeting/consultation, issues to address after the meeting, written translations, psychometric testing, working by telephone or online and other issues to consider when working with an interpreter.

These are reproduced below (with the permission of the BPS) in a shortened and updated form.

Key words: forced migration, interpreters, mental health, good practice guidelines

Key recommendations for practice

- Undertake a language needs analysis of the population covered by your service or Trust and consider how you will best meet needs.

- If you have not undertaken training in working with interpreters, undertake a training course. If you are working with an interpreter unexpectedly and training is not feasible, read these or other relevant guidelines and allocate time to consider the issues or discuss them with a more experienced colleague.

- Check that the interpreter is qualified and appropriate for the consultation/meeting and speaks the service user's first language.

- Allocate 10–15 minutes in advance of the session to brief the interpreter about the purpose of the meeting and to enable them to inform you about any cultural issues which may have bearing on the session.

- Be mindful of issues of confidentiality and trust when working with someone from a small language community as the service user may be anxious about being identifiable and mistrustful of an interpreter's professionalism. This has particular relevance when working with forced migrants.

- State clearly that you alone hold clinical responsibility for the meeting.

- Commit to a collaborative working relationship based on trust and mutual respect.

- Match if appropriate for gender, age or religion, avoid using relatives and never use a child.

- Create an atmosphere where each member of the triad feels able to ask for clarification if anything is unclear and be respectful to your interpreter, they are an important member of the team who makes your work possible.

- Be aware of the well-being of your interpreter and mindful of the risk of vicarious traumatisation. Consider what support they will be offered, and if they are subcontracted from an external agency, be aware that there is often little support provided by their employer.

- At the end of the session always allocate 10 -15 minutes to debrief the interpreter about the session and offer support and supervision as appropriate.

- Extreme caution should be exercised when considering the use of translated assessment measures as languages and concepts are not interchangeable and results may therefore not be valid or meaningful.

- All written translations used should have been back translated to ensure they are fit for purpose.

- Commissioners of health services need to ensure that there are clear pathways to support for all members of their local community including those who do not speak the majority language.

Introduction

Avoiding discrimination by ensuring equal access to psychological therapy for non-English speakers is fundamental to ensuring equity of service provision. Any service user whose first language is not English, should be offered the option of using an interpreter, (Chang et al., 2021). In a review conducted on behalf of the World Health Organisation, Priebe et al. (2016) noted that language barriers were considered one of the most crucial factors in restricting access to mental health services for people who had migrated and had limited language proficiency in the language of the new country. A systematic review (Ohtani et al., 2015) reported that language barriers resulted in an underutilisation of mental health services. Some studies have documented a reluctance to use professional interpreters even when it is relatively easy to do so (Gill et al., 2011; Gersowitch et al., 2021). There is evidence of better outcomes when someone has limited English proficiency and professional interpreters have been provided (Karliner et al., 2007; Chang et al., 2021).

Language is a multifaceted, rich and complex phenomenon which forms one of the cornerstones of human communication and should be accorded particular attention in providing mental health services. Interpreters are often not recognised for the unique skills and expertise that they can contribute by enabling clinicians and service users to communicate with one another.

The exact relationship between language and meaning is still contested. Many theorists argue that language not only transmits meaning but also constructs and shapes it at the individual and societal level (Anderson & Goolishian, 1992) and this should be kept in mind when

working with an interpreter. The psychological relationship between a person's first language and a second or subsequent language is also an area of debate (Marian & Kaushanskaya, 2004; Schrauf, 2000). de Zuleta et al. (2001) reported differential psychotic symptomatology in polyglot service users. While Paradis (2008) notes that a range of indicators which might be defined as psychotic (including auditory hallucinations, delusions, conceptual disorganisation, anxiety and depression) have been found to affect service users' differentially; sometimes being evident in first languages only, sometimes in second or subsequent languages and sometimes in all languages. This may carry resonance when working with interpreters and should be considered. In addition, certain conditions, for example dementia can diminish the ability to speak a second language (Shah, 2017).

Similarly, it may be helpful for clinicians to seek to educate themselves about the cultural background of a non-English speaking or forced migrant service user both through their own research and through exploration with their service users and interpreters. This may be particularly pertinent when working with forced migrants who are survivors of persecution and violence. It is also important to be mindful of the way in which power differentials originating in the country of origin may affect the relationship between clinician, interpreter and service user, particularly in the light of political and social conflict. Many asylum seekers and forced migrants report feeling that they were 'silenced' or their voices were 'taken away from them' by political regimes which did not allow for multiple accounts or voices which stifled criticism prior to them seeking asylum. Thus, talking about psychological problems may have been and may remain difficult, issues of trust may have become compromised and secrecy may have been a functional and key survival strategy (Tribe, 2010).

Furthermore professionals should recall that interpreters are entitled to support in the same way as any other professional colleague and a duty of care applies, whether or not they are employed by an outside agency; employment responsibilities cover all employees. Geiling et al. (2021) in a systematic review of mental health and work experiences among interpreters in the mental health care of refugees found interpreters reporting high levels of stress. Service providers should consider the ways in which they might support the interpreters they use. Few have had a comprehensive mental health training which would cover such topics as boundaries and self-care, thus

they may be susceptible to vicarious traumatisation.

In addition, it is important to recognise that being unable to fluently speak the language of the community in which you live, can be a frightening and disempowering experience. Racism and power differentials can also play a role in limiting access to services. and as such appropriate provision needs to be considered in providing interpreters for all service users.

Furthermore, interpreters frequently find themselves obliged to convey very difficult information to service users, for example explaining that a service user is to be detained in a psychiatric hospital, has been given a particular diagnosis or prognosis. Suggestions for supporting interpreters are considered in section 7.

It can be helpful to consider the implications of working with an interpreter in advance of doing this. Working with an interpreter and communicating through a third person can initially feel challenging. However, there can be definite gains in developing skills in this area. For instance, becoming skilled at working with an interpreter will also enhance service delivery through ensuring that access to psychological services is not limited to those fluent in the host language, irrespective of need.

These guidelines provide some working principles to help inform and direct practice.

The guidelines

1. Relevant guidelines and legislation

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

2. Booking/finding an interpreter

2.1. Language Needs Analysis

Psychological service providers may need to consider conducting a formal needs assessment relating to interpreting services. This might include obtaining baseline data on the language needs of the communities they serve and whether the needs of their population are best served by employing in-house interpreters or using an external interpreting service.

2.2 Locating an appropriate interpreter

The professional concerned should find out the service user's first language and try to book an interpreter who speaks this language and dialect. (A guide to languages by country can be found at www.ethnologue.com/). It is good practice to work with the same interpreter if a series of meetings will take place.

If an external interpreting agency is used, it must meet the appropriate quality criteria and be accredited by the requisite body. Each interpreter should not only be fluent in two languages but have an understanding of the two different cultural contexts (Tribe & Raval, 2003) and they should have undergone a recognised language testing. In Britain, the Register of Public Service Interpreters (www. nrpsi.co.uk) provides a helpful benchmark.

Interpreting is a skilled role and the use of family members, friends and colleagues should be avoided. Children should never be used as interpreters.

2.3 Telephone Interpreting

In some settings, there may be pressures to make use of telephone rather than face-to-face interpreting services. The experience of many clinicians, however, is that telephone interpreting has limited value in mental health consultations, with their emphasis on accurate assessment using a wide range of visual cues. It also creates distinct disadvantages for interpreters, who are unable to use facial cues to accurately determine meaning in the same way as is possible when seeing a service user's face. This said, one advantage of telephone interpreting is that confidentiality can be safeguarded to a higher degree, which may be helpful when service users come from small ethnic groups or are embarrassed about needing an interpreter. In the main, mental health work with its complex and relational context is better conducted with a face- to- face interpreter, either in person or using video conferencing.

2.4 Conducting online consultations

Some interpreters and service users may have limited experience of using online platforms for video appointments and may be working from a phone rather than a computer. Equipment including a phone needs to be in a fixed position so that the individual (interpreter or service user) can be seen clearly and the screen is not wobbling due to being handheld. Clinicians may wish to explore this ahead of time to make sure that the appointment can go ahead effectively. It is also recommended that specific guidance is prepared for service users about how to get the most out of a video appointment and is translated into relevant languages if appropriate. Instructions on how to use online platforms in a range of languages can be found at www.burc.org/how-to-use-zoom-in-different-languages/.

There are ways in which connecting online using video can change behaviour for clinicians themselves, for interpreters and for service users. A further discussion of this is beyond the scope of these guidelines, but clinicians may wish to consider further training for online

mental health work with its added complexities. At the very least, clinicians need to be mindful of the ways in which service users may respond to the use of different remote media (including telephone) and find ways to talk about this with service users and interpreters, as well as monitoring their own reactions. At the most practical level, clinicians should be aware that some service users may not have easy access to a private space to use for their appointment where confidentiality can be assured. Again, this is something that can be explored with them to determine what adjustments to usual practice are required to keep them safe and maximise access to assessment and treatment.

2.5 Written translations

All written translations should be back-translated (i.e., documents being translated from one language into another by one translator and then translated back to the original language by a different translator, the two versions then being compared for concordance of meaning). This may be particularly important when the implications of this are paramount or information is being reported in a forced migrant's legal case. Written care plans should be available in the service user's first language.

2.6. Training issues

The provision of appropriate training for both practitioners and interpreters, as well as the use of effective guidelines can improve the quality of service offered. More experienced interpreters tend to recognise this need, and are more likely to advocate training both for themselves and for the professionals for whom they interpret (Granger & Baker 2003). Tribe and Raval (2003) provide a template for a possible training curriculum. Interpreters and clinicians both require appropriate induction and training in working together. Gryeste, et al. (2021). Joint sessions where professionals and interpreters are trained together allow for better understanding of each person's role as well as the development of a genuine sense of co-working.

3. Preparation before the consultation/meeting

The service provider should have written guidelines and a contract for interpreters covering such aspects as confidentiality, roles, responsibilities, ethics and boundaries. In developing these, clinicians are encouraged to maximise opportunities for non-English speaking service users to maintain self-determination (as for any user of services) ensuring that this key principle is in no way compromised by the use of an interpreter for any given service user.

3.1 Changes to the dynamics in interpreter mediated relationships

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

by service users. Similarly, clinicians sometimes report feeling anxious about needing to depend on an interpreter as a conduit and may even feel excluded from the interaction (Tribe & Tunariu, 2009).

3.2. Language and culture

Oquendo (1996) notes that cultural nuances may be encoded in language in ways that are not readily conveyed in translation. Languages are not directly interchangeable; meanings may be coded, emotionally processed and internalised in one language in ways that are not directly accessible in another (Antinucci, 2004). There may be no appropriate word in one language for terminology that is commonplace in another. In addition, health beliefs and views about emotional wellbeing, as well as idioms of distress can vary with an individual's cultural and religious background. Thus, it is important to think about the languages being used and it can be helpful to discuss these issues with native speakers, including your interpreter, in advance of the session and explore any phrases or concepts you wish to use that may be difficult to translate. For example, metalinguistic strategies common in mental health work such as intentionally open questions or hanging sentences are nearly always different in their effect across languages.

When working with an interpreter the communication is mediated through a third person and given that interpreters must process the material through their own subjective experiences, the act of interpreting will always involve the interpreter shaping the material in some way. This is best managed in dialogue with the interpreter.

4. Practical considerations

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

- If you are meeting in person, consider the layout of the room and the positioning of chairs before the session starts. A triangle usually works well as the parties are equidistant and the interpreter is accessible to both the clinician and the service user. In some cases, however, clinicians prefer the interpreter to sit behind the service user and literally become their voice, taking a lower profile in the session. While this is a matter of personal preference, it is important to be clear that wherever the interpreter sits, they are an active part of the therapeutic triad, and cannot be considered as a simple mouthpiece.

- Remember the meeting may take longer when working with an interpreter and consider allocating additional time in advance of the meeting.

- If you are meeting via video conferencing, you may wish to consider how big or small to make the faces on your screen and what sort of positioning will help you to work effectively.

- Clinicians should also be aware that the slower pace of interpreted sessions can make it easy to lose concentration or can make the thread of the session disjointed.

- Avoid using complicated technical language.

- Be wary of using proverbs or sayings which may be culturally located.

- If you are going to see the service user for a number of sessions, try to use the same interpreter throughout to encourage rapport and build trust in the triadic relationship. However, a service users' request to change the interpreter should be explored within the work and accommodated whenever possible.

- Thompson and Woolf (2004) suggest giving the service user a form, at the end of the first session (which they can take away, fill in and send back to the clinician) so that they can confirm whether they are happy with the interpreter. Most people can find someone to translate the form or understand a little of the majority written language and this allows them to have a say in whether to proceed with the interpreter offered.

- The issue of using the 1st or 3rd person is complex, the use of the 1st person may be better in a mental health consultation but discussing this with the interpreter is recommended. In some cases, interpreters may prefer to use the 3rd person, particularly when material is triggering and highly emotional and as such it is important to protect the interpreter.

- Try and avoid discussing any issues with the interpreter that do not require interpretation.

- If working with a family and some members do not speak the language of the session an interpreter should be provided.

5. Preparation with the interpreter

It is rare for interpreters to have previous training or experience of mental health. Therefore, the clinician should always aim to arrange a pre-session interview with the interpreter. Spend 10 or 15 minutes to establish a relationship, decide how you will work together, explain the objectives of the meeting and share any relevant background information. If your meeting is using video-conferencing, start your video meeting early with the interpreter, before admitting your service user . This may also be an opportunity to clarify technical concepts which are likely to be used, as well as to check whether or not there are any cultural issues of relevance. You can also decide which mode of interpreting is to be used (Tribe, 1999).

Brief definitions of these four models are:

- The linguistic mode, where the interpreter tries to interpret (as far as is possible) word-for-word and adopts a neutral and distanced position.

- The psychotherapeutic or constructionist mode, where the meaning/feeling of the words is most important, and the interpreter is primarily concerned with the meaning to be conveyed rather than word-for-word interpretation.

- The advocate or community interpreter, where the interpreter takes the role of advocate for the service user, either at the individual or wider group or community level and represents their interests beyond interpreting language for them.

- Cultural broker/bicultural worker, where the interpreter interprets not only the spoken word but also relevant cultural and contextual factors.

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

6. During the meeting/consultation

- The service user may initially be uncomfortable with an interpreter being present. It may help to explain at the beginning of the first meeting that the interpreter is a professional doing their job, has no decision-making powers and is bound by the confidentiality policy of the agency and their professional body. You may also wish to explain the limits of confidentiality which relate to your place of work.

- Service users can put interpreters under considerable pressure to take on additional roles. Making clear issues of accountability, explaining the role of each party and the limitations of their responsibility may assist in containing such pressures.

- It is important to make interpreters feel at ease and ensure that they have the best opportunity to use their language skills and cultural understandings in the service of the service user. A warm and supportive atmosphere between clinician and interpreter is likely to facilitate the therapeutic relationship for the good of the service user.

- Some interpreters use the first person when interpreting, while others feel more comfortable using the third person. In practice, most interpreters move between the first and third person, and it can be revealing to keep a check of this and reflect on what might be happening in the therapeutic situation to lead to such switches. It is important that you create an environment where the interpreter feels able to ask for clarification if s/he does not understand what you are saying.

- Do not become impatient if the interpreter takes longer to interpret than you would have expected.

- You may need to adjust the pace of delivery and break your speech into shorter segments. Conversely, if you speak in short bursts, you may find that your speech becomes fragmented and you lose the thread of what you are saying. You will find that with open communication and trust, a natural rhythm becomes established with which everyone feels comfortable.

- If meeting in person, look at the service user as much as feels natural, rather than at the interpreter unless speaking specifically to the interpreter. It is important to be aware of the three-way relationship and make sure that the service user does not feel excluded. Although this is of less relevance when working using video-conferencing, it may be important to make clear to whom you are speaking so that the service user is aware of your focus on them.

- At the end of a session, a summary of what has been decided and clarification of the next steps can be useful. It can also be helpful to review the session, including reflection on what the experience of having an interpreter present was like.

7. After the consultation/meeting

When meeting in person, interpreters often prefer to leave after the service user so that there is no pressure to get involved in a personal relationship with the service user or in helping or acting as an advocate. Showing the service user out can facilitate this. It also offers a structured opportunity for debriefing.

Schedule 10-15 minutes with your interpreter after the session to review how you worked together and consider any other issues relevant to the session (if the interpreter is being paid on a timed basis, this time must be included). This time can be used to:

- Allow time to ask the interpreter their perceptions of the meeting and to inform you of any cultural factors that may be relevant and that you may have missed. This also allows you to check with them about anything you may have noticed, for example from non-verbal communication or expressions.

- Allow you to ask them about any areas that are unclear to you and which their knowledge of the home country or region or hearing of the account first hand could clarify.

- Ask the interpreter how it was working with you and whether you could usefully change anything in the way you are working (e.g., pace of speaking, length of speaking).

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

- Clinicians as well as the organisations that employ them have a responsibility towards the interpreters with whom they work.

8. Using interpreters in specific settings, for example psychiatric inpatient units or residential special schools

It is important that service users are offered interpreters when in secure setting. Each facility should have its own protocol and procedures and provision of interpreters might include:

- At the point of admission to an inpatient word
- When medication is being prescribed (informing them of the side effects, self-management relating to the medication
- During ward rounds
- Consultation in which the service user cannot make a decision without full information, for example consent for interventions, referral to other services

9. Translated assessment measures

Clinicians need to be extremely cautious in the use of translated measures. In the first place, such measures may not have been adapted for the population from which the service user originates. Psychometric measures tend to have been designed with one particular group in mind and the concepts used may not be applicable to other groups. Fully adapting a measure includes back translation (as described in section 2.5), measures of equivalence of construct, reliability, validity and norming. See the I*nternational Test Commission Guidelines on Test Adaptation* (2005) for a fuller discussion of this. Rahman et al. (2003) advise the use of key informant interviews and focus groups for mental health screening rather than questionnaires, which often incorporate complex conceptual and construct issues. *Neglect of adaptation procedures compromises the meaning of any results gleaned from the use of such measures* (Holt Barrett, 2005).

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

Even when a measure or test has been adapted and can be used or at least referred to in order to support an interpreter's translation, the test should be used with caution because some items may make assumptions about how recently the service user has been in their country of origin, or fail to account for ethnic, regional or education differences sufficiently. Any given individual varies in terms of the familiarity they have with concepts used in psychometric testing, with testing-type situations and with the degree to which they can understand the

purpose of assessment. There is always a risk that the process itself and tasks appear meaningless to the individual, thus negatively affecting their level of engagement with the task involved.

It is not difficult to identify the multiple cultural biases within psychometric tests where normative data is primarily available for English or other host-language speaking populations. For example, different words have different frequency rates, interpretations, and difficulty levels depending on the specific language involved. It is also essential that the interpreter understands the importance of adhering to standardised instructions, e.g., restrictions on paraphrasing and repetition, which are particularly crucial for cognitive assessments. Research evidence on differences in cognitive test performance in interpreter mediated assessments is scarce, but one study indicated that scores on verbal tests (WAISIII Vocabulary and Similarities) increased when interpreters were used, compared to when service users were assessed in their native language (Casa et al., 2012).

Clinicians should:

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

10.Other issues to consider

Commissioners need to ensure that there are clear pathways to support for all members of the local community including those who do not speak the majority language. Service users need to know how and where to access services if they require them and this should include language support services.

It has also been shown to be advantageous to view interpreters as part of a mental health team, showing them appropriate collegial respect and involving them in relevant departmental, agency or hospital meetings. Interpreters can contribute to service provision and delivery and gain a better understanding of how organisations function and the context of the work they undertake.

11. Recommendations for improvements in the future

It is recommended that each clinician takes individual responsibility for ensuring they are skilled at working with interpreters. This may have training implications both at a pre, professional and continuing professional development level. Lack of skills should not be used to justify not engaging in therapeutic work via an interpreter.

Further, individual clinicians, as well as the organisations that employ them, have a clinical responsibility towards the interpreters that they employ. In this way, opportunities for debriefing must be offered whether by individual clinicians or through supervision groups as appropriate.

Each organisation should develop a clinical strategy on language support to consider the ways in which interpreting, translation, advocacy and the work of bilingual staff is integrated into the overall activities of the organisation. This should feed into race equality policies.

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

Disclosure of Interest: The authors report no conflicts of interest

References

Alexander, C., Edwards, R. & Temple, B. (2004). *Access to services with interpreters: User views.* London: South Bank University.

Anderson, H. & Goolishian, H. (1992). Client as expert. In S.Mcnamee & K.Gergen (Eds.), *Therapy as a social construction.* London: Sage.

Antinucci, G. (2004). Another language, another place: To hide or be found. *International Journal of Psychoanalysis, 85,* 1157–1173.

British Psychological Society (2020). Guidance on Taking trauma related work home - advice for reducing the likelihood of secondary trauma. https://www.bps.org.uk/coronavirus-resources/professional/taking-trauma-home

British Psychological Society (2020). Guidance on Working with interpreters online or via the telephone. https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/Working%20with%20interpreters%20online%20or%20via%20the%20telephone.pdf

Belfast Unemployed Resource Centre (2022). www.burc.org/how-to-use-zoom-in-different-languages/ accessed 1.3.22.

Casa, R. Guzman-Velez, E., Cardoba-Rodriques, N.,Quinones, G., Izaguippe, B. & Tranel, D. (2012). Interpreter-mediated neurological testing of monolingual Spanish speakers. *The Clinical NeuroPsychologist, 26,1,88-101*

Chang, D.F. et al (2021). Rethinking Interpreter Functions in Mental Health Services. *Psychiatric Services, 72, 3,353-357.*

de Zuleta, F., Gene-Cos, N., Grachev, S. (2001). Differential psychotic symptomatology in polygot patients: Case reports and their implications. *British Journal of Medical Psychology, 74, 277-292.*

Ethnologue (2022). https://www.ethnologue.com/ accessed 1.3.22.

Geiling, A., Knaevelsru, C., Böttche, M., & Stammel, N. *(2021).* Mental Health and Work Experiences of Interpreters in the Mental Health Care of Refugees: A Systematic Review. *Frontiers in Psychiatry, doi:10.3389/fpsyt.2021.71078.*

Gerskowitch, C. & Tribe, R. (2021) Therapists' experience of working with interpreters in NHS setting: Drawing upon a Psychoanalytic theoretical framework to contextualise the findings of an IPA study. *British Journal of Psychotherapy, 37,2,301-318*

Gill, P., Beavan, J., Calvert, M. & Freemantle, N. (2011). The unmet need for interpreting in UK primary care. Public Library of Science (*PLoS ONE*) June 13, 2011. http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0020837.

Granger, E. & Baker, M. (2003). The role and experience of interpreters. In R. Tribe & H. Raval *Undertaking mental health work using interpreters.* London: Routledge.

Gryeste, J.R., Broderson, K.J., Lindberg, LG, Carlsson, J. & Poulson. S. (2021). Interpreter-mediated psychotherapy – a qualitative analysis of the interprofessional collaboration between psychologists and interpreters. *Current Psychology doi.org/10.1007/s12144-021-01345-y*

Holt Barrett, K. (2005). Guidelines and suggestions for conducting successful cross-cultural evaluations for the Courts. In K. Holt Barrett & W H George (eds) Race, Culture & Law. Thousand Oaks, California: Sage

International Test Commission (2005). Translating and Adapting Tests Final Versionv.1.0 https://www.intestcom.org/files/guideline_test_adaptation.pdf accessed 1.2.22

Karliner, L.S., Jacobs, E.A., Chen, A.H. & Mutha, S. (2007). Do Professional Interpreters Improve Clinical Care for Patients with Limited English Proficiency? A systematic Review of the literature. *Health Service Research, 42, 726-754.*

Marian, V. & Kaushanskaya, M. (2004). Self-construal and emotion in bicultural bilinguals. Journal of Memory and Language 51(2): 190–201. https://doi.org/10.1016/j.jml.2004.04.003

National Register of Public Service Interpreters (2022). https://www.nrpsi.org.uk/ Accessed 1.3.22.

Ohtani, A. Suzuki., T., Takeuchi,H ., &Uchida, H. (2015). Language Barriers and Access to Psychiatric Care:A Systematic Review, *Psychiatric Services* 66(8):798-805.doi: 10.1176/appi.ps.201400351.

Paradis, M. (2008). Bilingualism and neuropsychiatric disorders. *Journal of Neurolinguistic, 21, 199-230.*

Priebe, S. Giacco, D.; El-Nagib, R. (2016). *Public Health Aspects of Mental Health among Migrants and Refugees: A Review of the Evidence on Mental Health Care for Refugees, Asylum Seekers and Irregular Migrants in the WHO.*

Rahman, A. Iqbal, Z., Waheed, W. & Hussain, N. (2003). Translation and cultural adaption of health questionnaires. *Journal of the Pakistan Medical Association, 53,3,142-147.*

Schrauf, R.W. (2000). Bilingual autobiographical memory: Experimental studies and clinical cases. Culture and Psychology 6: 387–417.

Shah, A. (2017). Mental Capacity and Ageing in P. Lane. & R. Tribe, R. (Eds.) *Anti-discriminatory practice in mental health for older people.* London: Jessica Kingsley.

Thompson, K. & Woolf, T. (2004). *Guidelines for working with interpreters.* Goodmayes Hospital, Goodmayes, Essex: North East London Mental Health Trust.

Tribe, R. (1999). Bridging the gap or damming the flow? Bicultural workers: Some

observations on using interpreters when working with refugee clients, many of whom have been tortured. *British Journal of Medical Psychology, 72,* 567–576.

Tribe, R. (2010) Mental Health of Refugees and Asylum Seekers. In D. Bhugra, S.Cross & R. Bhattacharya (Eds*) Cultural Topics in Clinical Psychiatry.* London: Royal College of Psychiatrists Press. 27 -38

Tribe, R. & Raval, H. (2003). *Undertaking mental health work using interpreters.* London: Routledge.

Tribe, R. & Tunariu, A. (*2009*). Mind your language? Working with interpreters in Health Care Settings and Therapeutic Encounters. *Journal of Sex and Relationship Therapy, 24, 74-84.*