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Keywords: Counselling, languages, immigrants, interpreters, interpreting, mental-health, intervention.

Abstract (Research)

Background/Aims/Objectives - The role of an interpreter is instrumental for people not fluent in the new language of their host community or country where they are living. This subject is an important one and not enough is known, especially about the challenges faced by mental health interpreters.
Methodology/Methods - The study examined how interpreters drew on direct translation, cultural meanings and non-verbal information while interpreting and how they convey these to both service users and providers. An Interpretative Phenomenological Analysis was adopted to analyse three semi-structured interviews with female mental health interpreters that lasted approximately 60 minutes each. All participants were self-identified as fluent in at least two languages and had attended a minimum of six months training on mental health interpreting.
Results/Finding - The challenges of mental health interpreting were revealed in three overarching themes: (i) Sensitive nature of interpreting and challenges associated with ensuring accuracy. (ii) Multitasking to convey literal words, feelings and cultural meanings. (iii) Exposure to the risk of vicarious trauma and insufficient organisational support.
Discussion/Conclusion - The study concluded that mental health interpreters should have more access to training and development, organisational support, professional recognition and adequate acknowledgement of their essential role in service provision to people not fluent with the new language of their present community or country.

Introduction

The complexity of human interaction and linguistic challenges are inevitably revealed through the process of immigration. At present, immigration appears to be unavoidable in modern societies and worldwide migration is on the increase. For example, as of 2017, there were 257.7 million migrants worldwide (approximately 3.3% of the world's population) (International Office for Migration, 2019). Compelling reasons for immigration may include economic factors such as job seeking, study, better opportunities and joining family members, such as partners, children or parents. Reasons for forced immigration may include escaping from prosecution, war, torture or human trafficking. Mental health issues are vital in the topic of immigration. For example, refugees and asylum seekers may present multiple layers of mental health problems. Firstly, the burden of posttraumatic stress disorder (PTSD) due to experiences prior to fleeing their home country, and secondly, experiences of what happened on their way to finding refuge (Sagaltici, Alpak & Altindag, 2020). Thirdly, the experiences of racism and oppression in their new community (Hirsch, 2019).

Furthermore, in forced immigration, the new language for communicating may be challenging to immigrants in their host communities. The language barrier may be associated with fears of being misunderstood. Means of communication is essential, not only for daily interaction but also in seeking help for mental health problems (Tribe, Tunariu & Jidong, 2020). Therefore, interpreters are frequently employed to enable communication in different services such as

mental or physical health, legal, or social care. A mental health interpreter is a professional who has the requisite expertise and the adequate skills to convey linguistic and cultural information from a service-user to a service-provider, especially during a therapeutic encounter (Tribe & Thompson, 2017).

It is pertinent to note that interpreting in mental health could be very different from interpreting in legal or social services. Thus, mental health interpreting involves complex interaction that conveys not only verbal expressions of the service-users but also other non-verbal and cultural meanings of the service-user to the service-provider (Resera, Tribe & Lane, 2015; Tribe & Raval, 2003). It is especially challenging here because high-GDP Western concepts may be difficult or unhelpful to convey other cultures' important information for mental health intervention. Therefore, the present study is particularly interested in mental health interpreting because of the essential role of language and culture in the mental health context as it is often the medium for both "diagnosis" and for delivering many forms of intervention.

Mental health interpreters play an important role in aiding therapeutic dialogue between service-users and service-providers in order to improve care provision (Tribe & Thompson, 2017; Wand, Pourmand & Draper, 2020). Therefore, the quality of mental health provision for a service-user who is not fluent in the mainstream language of the service provider depends, to a great extent, on the quality of interpreting. For example, Kletečka-Pulker, Parrag, Drožđek & Wenzel (2019) stated that, due to immigrants' language barriers, the role of interpreters is essential, especially for immigrants who might not have a realistic opportunity to acquire the mainstream language of their host community within a short period of time after arrival, but who need to access mental health services. Therefore, experienced interpreters are required to provide interpreting services. Services sometimes use family members, bilingual staff and other significant persons for interpreting in the absence of certified mental health interpreters. However, numerous scholars have cautioned about the use of non-professionals due to the sensitive nature of mental health interpreting (Tribe & Thompson, 2017; Pochhacker, 2000). They have argued that it is ethically inappropriate and could have implications for issues such as confidentiality and inappropriate interpretation or possible omission of vital information that could be essential for assessment, diagnosis and for the treatment plan. Literature has consistently shown that professional mental healthcare interpreters are prone to experiencing work-related emotional distress, such as depression, anger and disdain, anxiety, paranoid ideas and nightmares (Doherty, MacIntyre & Wyne, 2010; Butler, 2009; Haenel, 1997).

The negative impacts of interpreting on mental health interpreters are enormous. For example, Green et al (2012) examined the experiences of interpreters who have worked with Kurdish refugees in mental health services in the UK. They used Interpretive Phenomenological Analysis (IPA) to analyse six interviews. Green et al., (2012) found that most interpreters are overwhelmed with the emotional impact of mental health interpreting. In addition to the above difficulties, Haenel (1997) suggested that mental healthcare interpreters are likely to feel anxious, powerless, guilty or helpless, especially in terms of the correctness of the message flow between service users and providers.

Yick and Daines (2019) conducted a meta-synthesis of six qualitative papers using Noblit and Hare's meta-ethnographic strategy. The study explored the experiences of interpreters working

in general hospitals and mental health facilities. Their findings showed that interpreters are faced with emotionally charged stories and difficulties coping with the stress that may be associated with vicarious trauma. Yick and Daines (2019) harnessed data from six studies and did not collect data directly from interpreters; however, it may be important to acknowledge their suggestion that the culture of services that devalued interpreters should be re-examined, which appeared to be consistent across the reviewed literature.

Most reviewed literature seems to be focused on general medical and hospital context interpreting with very limited studies on community-related mental health service provision. Therefore, the present study explored the challenges faced by mental health interpreters who have worked mostly in East London communities with 'out-patient' service-users. East London is one of the most diverse parts of London with a long history of large numbers of immigrants (Wessendorf, 2020). The 2011 census showed 76.8% Newham's population in East London were immigrants with only 16.7% White British and 11.4% identified as White others (AstonMansfield, 2017; London Borough of Newham, 2011). However, immigrants in East London have suffered several decades of exclusion due to their inability to speak English or communicate amicably (Wessendorf, 2020).

This paper articulated that mental health interpreting is likely to be perceived as menial and undervalued. We further argued that mental health interpreting is complex, delicate and require high levels of professionalism. The present study's findings contributed to the body of literature in two ways. Firstly, to the best of the researchers' knowledge at the time of conducting this research, there seems to be no prior study that has examined mental health interpreters' experience and challenges of working with community-based and 'out-patient' service-users' in East London communities. Secondly, the study's implication entails practical modalities for managing interpreting work-related distress such as access to stress management opportunities, professional training and development, organisational support and impartial integration of interpreters as clinical team members in mental health provision.

Method

Design:

Interpretative phenomenological analysis (IPA) was adopted for this study from a critical realist and social constructionist perspective. This approach was adopted as it is compatible with the present study which assumed that data collated might not be a direct representation of participants' realities; however, the data was influenced by features that underpinned the core elements of critical realism and social constructionism, such as shared history, culture, language, social space and lived experiences associated with mental health interpreting (Smith & Osborn, 2015; Harper & Thompson, 2011). The challenging experiences of mental health interpreting are phenomenological; therefore, the researchers played a significant role in exploring the participants' efforts in the dataset as they made sense of their idiographic or personal lived experiences associated with mental health interpreting. Reflexive practice in qualitative research provides a context where data is located (Shaw, 2010; Etherington, 2004). For instance, the lead researcher monitored their training and experiential knowledge of working as an interpreter and cultural broker in East London communities. The researcher's

reflexive awareness helped to ensure rigour and credibility in data collection, analysis and interpretation.

Participants and data collection:

Three female mental health interpreters in East London participated in the study. All had worked as interpreters in 'community-based' mental health interpreting and had all undergone a minimum of six months of professional training as mental health interpreters. Participants have worked with service-users in community-based settings such as the British Refugee Council. Participants were recruited into the study through a purposive sampling technique. The ethnic demographic of participants were two Ethiopian-British and one Iranian-British. Of the three participants, two were in their mid-30s and one of the participants choose to remain age-anonymous. Interviews were conducted face-to-face, which lasted for approximately 60 minutes each.

Data analysis:

The audio records of interviews were transcribed verbatim in preparation for analysis. Data analysis was conducted on the basis that underpins the core elements of an IPA theoretical framework. For example, in order to ensure rigour, all interview transcripts were re-read several times which established an in-depth and detailed understanding of participants' experiences as captured in the interviews. Subsequently, data transcripts were coded within the lens of IPA coding convention that captures descriptive, linguistic and conceptual elements in the datasets as recommended in Pietkiewicz and Smith (2014). In addition, implicit and explicit detailed information that reflects participants' thoughts, feelings, perceptions and behaviours related to the experiences and challenges of interpreting-work were noted and retained. In order to ensure further rigour, salient linguistic features such as repetition of words, significant pauses and stutters were examined as essential elements of their personal experiences. All coded notes from the transcripts were conceptualised and synthesised into broader themes as shown in the results section below.

Ethics:

The research was conducted in line with the ethical guidelines of the British Psychological Society (2014). Ethical approval for the study was given by the School of Psychology Research Ethics Committee of the University of East London in the UK. Anonymity and confidentiality were ensured through the use of pseudo names to replace participants actual names.

Results

Three main themes emerged from the analysis (see Figure 1). The themes are described and later discussed in accordance with the IPA guidelines.

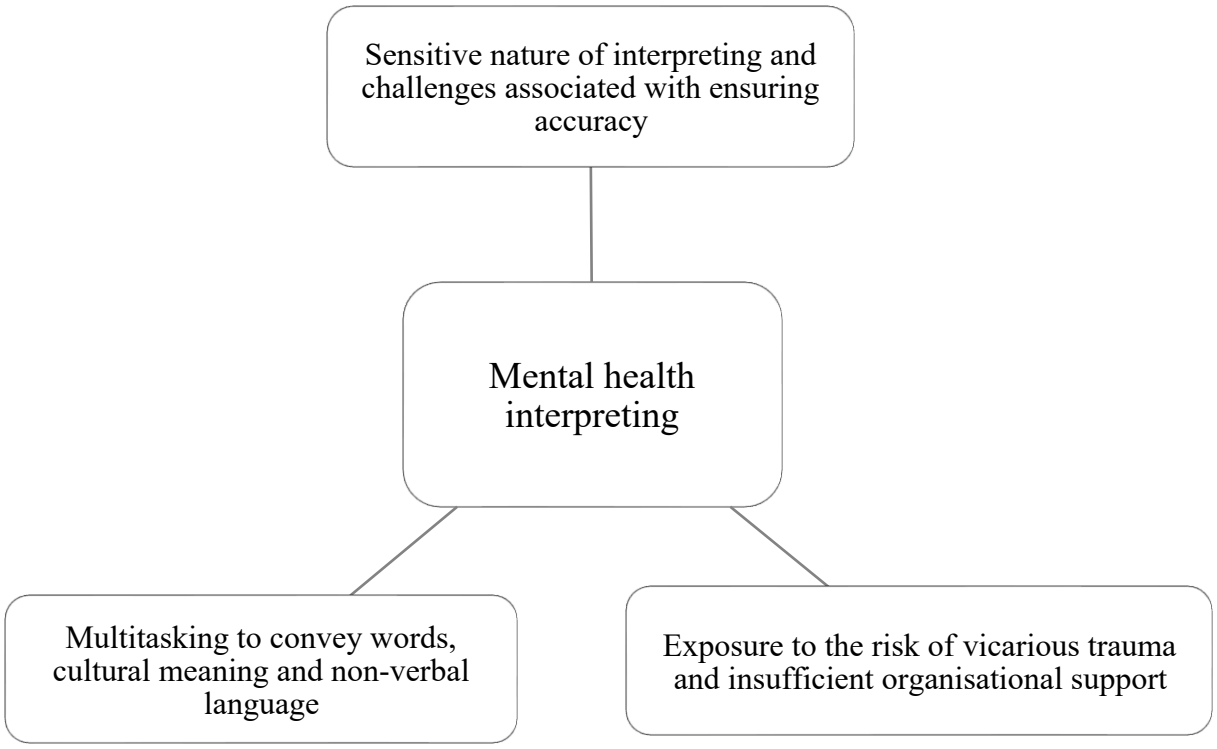

Figure 1: Identified themes across the dataset

Sensitive nature of interpreting and challenges associated with ensuring accuracy

A common experience amongst the interviewees was viewing interpreting as a sensitive task and feeling that ensuring accurate information is conveyed between the service provider and service user is a very challenging task. The following extract emphasised the importance of conveying detail, including emotional information, between the parties involved in a therapeutic session. However, what is seen as more daunting is that the role of the interpreter might be forgotten in the therapeutic session. This is often evidenced when an endless communication ensued with no allowance for the interpreter to interpret short bits of what has been said, as shown in the second half of Alice's extract below:

> *Basically, you have to interpret the words the client says without missing any [words], you have to be there for the client to show the emotion the client is presenting during that time of interpreting, you have to catch every word from what the client is saying and interpret it right to the professional and as well as this you have to catch the words from the professional and interpret them correctly to the client. However, what happens most frequently is that, during a therapeutic session when a clinician or service user is talking, it is most challenging to keep long sentences in your mind, and there is the temptation of interrupting the session by saying 'Stop! Stop! I need to interpret what you have said first'. In such situations, it appears awkward and it is not easy because I'm interfering and that is a big challenge. I think in the triadic relationship, the interpreter multitasks and has more responsibilities in comparison to the service user and the clinician (Alice).*

In the first part of the above extract, Alice listed what is expected of a mental health interpreter in ensuring that accurate information is conveyed between service-user and provider. Alice

further contextualised what often happens in a typical therapeutic session whereby the interpreter might be tempted to interrupt the communication flow in order to interpret what had been said from the originating person to the receiver in the triadic process. On such occasions, Alice expressed self-disappointment at having to interrupt the smooth flow of the session. She believed that interpreters are pressured and engaged in multiple tasks with more responsibilities than both the service user and professional. This suggests that mental health interpreting is complex, and that therapeutic success might largely depend on the interpreter. More so, the delicate nature of interpreting suggests that poor interpreting could lead to incorrect or inappropriate assessment, diagnosis and therapy. For example, Bola, in the following extract, summarised the power that lies in the hands of interpreters in determining the fate of service users in a therapeutic encounter:

> *Someone's life is at stake; you know that the outcome that can happen to somebody in court is the same as what can happen to someone in mental health. They can, in a way, be given medication the wrong way and it can affect their family life; it can affect in court the sentencing: very sensitive, you have a lot of responsibility, you have a lot of power as an interpreter. So you need to make sure you make the right decision and if you don't understand you need to be clear, so, in essence, they are the same though different fields but with the same consequences: you affecting how someone's life turns out (Bola).*

Bola drew parallels between interpreting in a legal and mental context whereby the desired outcome is dependent on the quality of the interpretation. Some of the consequences of poor interpreting could be life-changing; therefore, interpreting is very sensitive and sophisticated and requires precision. Bola further provided an account of her experience of mental health interpreting as being a sensitive role and the lack of accurate corresponding vocabulary as being a major challenge:

> *Because of the sensitive nature of what I'm interpreting, not having the right vocabulary can change the meaning or I might not be able to get the correct message across; that's a problem [...] if you don't understand the message yourself how can you expect them to understand it? So, it's really important you understand and also you understand the way of getting that message across in the way they understand, and if they don't understand let them know that the professional didn't understand so that they can rephrase it (Bola).*

As conveyed in the above extract, Bola sees a lack of existing appropriate vocabulary as a potential challenge that is likely to be misleading and possibly result in conveying the wrong message in a therapeutic session. Bola emphasised that an interpreter cannot interpret what they do not understand. This expression suggests that mental health interpreting is highly sensitive and entails the process of paying attention to details in order to ensure accuracy. However, this aim could be frustrated with less corresponding words for both languages. Double-checking with participants to ensure that accurate information is conveyed in areas of doubt is essential. Cindy explained the challenges of interpreting the same language and culture with multiple sub-dialects.

> *Coming from a different dialect from your client's own dialect can make you stumble on some words or phrases that may be different in your region. The misunderstanding can be chaotic and cause uneasiness or discomfort for your client or yourself to continue to interpret further- being able to understand and retrieve information as repeating lots of information can make you forget previous other sentences that need to be interpreted and a miss-out on any crucial information can affect a client's needs being met. And putting feelings aside work ah mm not becoming emotional and adding excess information that may favour the client's side and interfere in professional conduct (Cindy).*

Cindy's experience is extended to the challenges associated with sub-dialects. That is to say, even within her native language of interpreting there is the likelihood of encountering other sub-dialects that could be particularly challenging to understand or interpret. The key point here is that even for native speakers there are variations in dialects which could cause difficulties in interpreting and of which service providers should be aware, although, the best practice could ensure dialect is matched; however, this may not always be possible.

As earlier stated by Alice, interpreters can only interpret what they understand; otherwise, it might not be possible to convey the correct message. This challenge is not only associated with incorrect messages but can also cause uneasiness and discomfort to the interpreter. Cindy also looked at mental health interpreting as multitasking in which the interpreter may be overwhelmed with information overload, which is often difficult to manage with a high chance of missing other valuable content. Finally, Cindy highlighted the importance of staying focused and being professional in guiding personal emotions.

Multitasking to convey literal words, feelings and cultural meanings

The complex nature of mental health interpreting as contrasted with legal interpreting involves the process of not only conveying words but also conveying feelings, cultural meaning and non-verbal language that are essential for informing and enabling appropriate intervention. One participant said:

> *I previously thought that the essence of [mental health] interpreting was just to translate the words to the service users. Then [prior to professional training], I didn't know that it is very challenging, because I didn't consider the client's feelings as an important factor […] I later found out it was very challenging because when I am now interpreting, the way they express their feelings and the way they are talking to me to convey their emotions, it was quite difficult for me […] when I went for the course in [mental health] interpreting and I found out that you have to interpret everything the service users say, both verbal and non-verbal; you have to interpret showing the emotions, the body language, and facial expressions of the service user. When I used to interpret, I didn't consider all these factors. But my current exposure made me understand the core values of interpreting as very sensitive and more challenging than I earlier thought (Alice).*

Alice described a trajectory whereby her experience and knowledge of interpreting has evolved over time: from the perception of mental health interpreting as a process of merely translating

words to seeing interpreting as a process of conveying detailed verbal and non-verbal cues such as feelings, emotions and cultural meanings. Furthermore, Alice acknowledged that it is a difficult task to receive and convey feelings and emotions during mental health interpreting. Alice's experience of mental health interpreting suggests a particular challenge associated with the appropriate means of interpreting emotions, cultural meanings, and non-verbal information.

Cindy narrated her experience and perception of service users' perspective of the triadic process in the therapeutic encounter. She considered that the service users are likely to feel frustrated about their inability to communicate directly with the service providers, especially in culturally and personally sensitive interventions such as sex therapy.

> *The client can feel overwhelmed due to their inefficiency in a language and pressure to express certain types of information, for example, sexual information can be seen as taboo or embarrassment to oneself, and the gender of the interpreter can affect the client's performance, Some prefer male or female interpreters from their culture to feel more comfortable to express their needs and not letting the emotional or personal side get into their professional practice […]. Being culturally aware and sensitive allows me to remain focused and be prepared in advance (Cindy).*

Aside from the interpreter's uncomfortable feeling of having to interpret culturally sensitive issues such as sex, this may be more daunting for cultures that consider issues of sexuality as taboo or embarrassing with the third-party involved. Cindy's extract suggests that genderappropriate matching in their cultures may be helpful. However, it may be challenging too to get gender matching in the presence of scarce mental health interpreters. The concluding aspect of Cindy's extracts highlighted the importance of professionalism as an interpreter and being culturally sensitive beforehand. Professionalism is therefore essential in ensuring good practice and minimising exposure to risks, such as vicarious trauma.

Exposure to the risk of vicarious trauma and insufficient organisational support

Like other professional practices, mental health interpreting services were also identified as being associated with certain work-related risks. As previously stated, interpreters are often exposed to a wide range of emotionally disturbing stories from the service-users they work with. As a result of this, some interpreters may find it difficult to interpret and manage those traumatic stories without it having an impact on their personal lives. One interviewee said:

> *It is hard to put aside personal feelings during emotional conversations with clients. Setting boundaries and emphasising the purpose of your practice with the professional and client means the process will be more successful in mitigating any issues that may arise in advance and in putting contingency plans into place where necessary (Cindy).*

Cindy mentioned setting boundaries as essential for mitigating against intrusive emotions from the traumatic expressions of service-users. Self-reflection on the part of an interpreter could be achieved through emphasising the purpose of the interpreting services being provided.

Contingency planning is also identified by Cindy as an essential aspect of safeguarding the interpreter. In the following extract, Bola contrasted the different challenges faced by interpreters and therapists by stating that:

> *[For some] interpreters, I don't think they know how [to manage their emotions during therapy], because they are not well-trained or have years of training that teaches you not to be or to cry; for example, when someone is telling you these things [traumatic stories], obviously sometimes you will cry but as a therapist, you wouldn't usually cry because you know these things, you know how to deal with it emotionally, you have the support, you have a therapist of your own, you have a supervisor, you have a better understanding, but interpreters don't have any support emotionally for the things they are hearing (Bola).*

Bola spoke of other interpreters as not knowing how to manage emotions. Bola's extract suggests that therapists have access to resources and sources of support that interpreters do not have. Bola comments on her experience of the inadequate training and support for mental health interpreters. These inadequacies may include limited knowledge of how to manage exposure to the hearing of traumatic stories in their work because they are not well-trained. Unlike the therapists who may have received several years of training about how to potentially manage professionally related distress, mental health interpreters are unlikely to have access to such training and support. In another interview with Alice on the challenges faced by interpreters, she said:

> *Because it is your job and you are going to face such challenges day-to-day in your work as an interpreter, you may find a way of adapting to suppressed negative feelings that come with your working experience. I do this through a separation of my work from my social or personal life. Although it is not easy you have to do that as a matter of professionalism […]. In interpreting, there is no enjoyment because you are faced with numerous challenges. If the client, let's say, for example, in mental health the service user is suffering from something traumatic, maybe was abused, and maybe raped or whatsoever. The client narrates their story to you to interpret to the clinician, such traumatic stories get through you and you are likely to take it with you. These kinds of experiences are disheartening and not enjoyable because as humans you feel sorry for the clients. Although, as a trained professional interpreter, you are not supposed to take everything into you, to your house, you are human and the things you heard someone explain to you may not go away easily, and, therefore, it is very frustrating. Even though interpreting work is good when the service users discuss enjoyable issues, you will certainly enjoy it, but when it comes to the client's suffering you are likely to suffer the effects as well (Alice).*

In the introductory part of the above extract, Alice narrated her experience from a 'third-person perspective' starting with 'because it is your job'. This may suggest some effort to dissociate her work as an interpreter from her personal life by establishing boundaries for safeguarding her emotions and feelings that could be disturbing as a result of work experience. However, Alice lamented that hearing traumatic stories is unforgettable and disturbing. Extracts presented

showed that interpreters are often exposed to a wide range of emotionally disturbing stories from interpreting.

Discussion

The study's findings will be discussed in the perspectives of the three overarching themes that reflect the challenges faced by mental health interpreters. Firstly, the sensitive nature of interpreting and challenges associated with ensuring accuracy. Secondly, multitasking nature of interpreting to convey literal words, feelings and cultural meanings. Thirdly, exposure to the risk of vicarious trauma and insufficient organisational support for mental health interpreters.

Firstly, as found in the present study, mental health interpreting is a sensitive role and ensuring that accurate information is conveyed between service-user and service-provider is a challenging task for interpreters. A number of studies have supported this position (Yick & Daines, 2019; Butow et al., 2012; McDowell et al., 2011). For example, Yick and Daines (2019) conducted a meta-synthesis of interpreters' experiences in health and mental health. Their study found that interpreters are faced with several layers of challenges in their quest to ensure clearer and accurate information is conveyed between service-users and serviceproviders. These challenges include juggling with unfamiliar words and with the ability to make a swift decision in the choice of words that would accurately communicate the underlining meanings in a therapeutic session. This would be more challenging in native languages of the service-users that have no adequate corresponding vocabularies with the mainstream language of the service-provider or diagnostic language (Bot, 2020). However, this may not always be the case as problems with the corresponding vocabulary may depend solely on the individual interpreter's expertise, the languages and dialects involved and, perhaps, the type of mental health intervention or diagnosis.

The second overarching finding of the present study is the nature of multiple tasks associated with interpreting, especially in mental health such as conveying of words, cultural meaning and non-verbal information that are relevant for the intervention. Juggling these multiple tasks rapidly is one of the challenging cognitive tasks that interpreters faced in their role. This finding is consistent with McDowell et al (2011) who explored the experience of interpreters and their perspectives about resources in healthcare interpreting. They found that the complex nature of language interpretation is invisibly complex and exhausting. This includes the interpreter's ability to engage in higher mental processes that may include concerted efforts to capture underlying meaning as it might be in simultaneous conflict with a direct translation of unfamiliar terms at the same time, advocating for cultural meanings. This may suggest that the mental processes and multitasking of an interpreter are largely ignored and unacknowledged because they are not physically visible. Unlike interpreting in physical medicine or legal settings, what appeared to be unique about mental health interpreting is the ability to not only interpret literal words but also the ability to capture and convey cultural meanings and nonverbal cues that could be essential for intervention. Therefore, the present study and other existing literature have revealed that mental health interpreters are engaged in complex and demanding tasks. Yet, mental health interpreters have little professional recognition with poor remuneration for their professional services (Guo et al., 2017; Butow et al., 2012; Yick & Daines, 2019).

The third main finding showed that interpreters are exposed to the risk of vicarious trauma with insufficient organisational support. As shown across the present dataset, a mental health interpreter interprets for service-users who are likely to be victims of trauma, such as refugees and asylum seekers, and who have experienced hardship from wars, natural disasters or torture. This population present with numerous traumatic stories that would be recounted in the therapeutic encounter for interpreters to convey the same to the service-providers. The finding of the present study suggests that, in the process of interpreting traumatic stories, interpreters may suffer from emotional distress. Numerous other studies have supported the current findings (Green et al., 2012; Butow et al., 2012; McDowell et al., 2011; Splevins et al., 2010).

Other mental health professionals such as counselling psychologists, psychiatrists or psychotherapists are likely to be supported in numerous ways to deal with work-related emotional distress. These may include briefing and debriefing, supervision and periodic reviews of case reports with colleagues (Butow et al., 2012; Green et al., 2012). However, interpreters are less likely to receive similar or adequate support for dealing with their workrelated emotional distress. For example, Yick and Daines (2019, p. 107) wrote that "interpreters said their peers, supervisors, and clinical staff had little notion of how difficult interpreting was and did not view them as colleagues, let alone as key team members". More so, despite the sensitive and delicate nature of an interpreter's role, they experienced their position in the mental healthcare system "as precarious, with little status, low pay, little respect, and minimal training and support'' (Green et al., 2012, p. 231). Therefore, the emotional distress of mental health interpreters is compounded with feelings of been unappreciated or undervalued within their work settings. Interpreters could build coping strategies and reduce secondary trauma by being as adequately integrated as other professional team members with access to similar support systems including other professionals by having access to supervisory support and stress management training (Butow et al., 2012; Green et al., 2012; McDowell et al., 2011; Splevins et al., 2010; Butler, 2008).

The present study's strength is attributed to the data collected with the used of interviews to obtain deeper and richer datasets. The rigour of data analyses is strengthened as underpinned by IPA theory and philosophy. Mental health interpreters are 'hard-to-reach' population and under-researched. The study's implication has increased our understanding of the challenges faced by mental health interpreters and the potential recommendations for improving interpreting service provision. For instance, access to adequate support to manage interpreting challenges and the integration of interpreters as members of the mental health clinical team has the potential of improving the quality of service provision to service-users. However, the present study is limited in terms of a sample size of three participants with only female interpreters. More participants with varied gender perspectives would have been beneficial to strengthen the study's transferability.

Conclusion

Mental health interpreting is a sensitive role which poses numerous challenges, especially in ensuring accurate information is conveyed between a service-user and provider. In addition, the study finds that interpreting involves multitasking to simultaneously convey detailed information such as words, cultural meanings and non-verbal language, and, finally,

interpreting exposes the interpreters to the potential risks of vicarious trauma and low morale due to insufficient organisational support. There were only three participants in the present study; however, the interviews and data analysis were in-depth considering the fact that this is a 'hard-to-reach' population. Yet, the present study showed some consistencies with the findings of previous literature which suggests that mental health interpreters should have more access to training, organisational support and the acknowledgement of their professional services in the mental healthcare sector. Finally, the present study specifically advocated for more specialised training in higher education for mental health interpreters and they should be accorded relevance as part of mental health practitioners similar to guidance counsellors, counselling psychologists, psychotherapists and psychiatrists.

References

Aston-Mansfield Community Involvement Unit (2017). *Newham key statistics 2017*. London, UK: Aston Mansfield.

Bot, H. (2020). Interpreting in Mental Health, Anything Special?. In *Handbook of Research on Medical Interpreting* (pp. 210-226). Pennsylvania: IGI Global.

Butler, C. (2008). Speaking the unspeakable: Female interpreters' response to working with women who have been raped in war. In *Clinical Psychology Forum* (Vol. 192, pp. 2226). British Psychological Society.

Butow, P. N., Lobb, E., Jefford, M., Goldstein, D., Eisenbruch, M., Girgis, A., ... & Schofield, P. (2012). A bridge between cultures: interpreters' perspectives of consultations with migrant oncology patients. *Supportive Care in Cancer, 20*(2), 235-244.

Doherty, S., MacIntyre, A., & Wyne, T. (2010). How does it feel for you? The emotional impact and specific challenges of mental health interpreting. *Mental Health Review Journal, 15*(3), 31-44.

Etherington, K. (2004). *Becoming a reflexive researcher: Using our selves in research.* London: Jessica Kingsley Publishers.

Green, H, Sperlinger, D. & Carswell K (2012). Too close to home? Experiences of Kurdish refugee interpreters working in UK mental health services. *Journal of Mental Health, 21*(3), 227–235.

Guo, P., Tang, C. S., Wan, Y., & Zhao, M. (2017). *The impact of reimbursement policy of patient welfare, revisit rate and waiting time in a public healthcare system: Fee-*

forservice vs. bundled payment. Accessed September 14th 2018: https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3058734

Haenel, F. (1997) Aspects and problems associated with the use of interpreters in psychotherapy of victims of torture. *Torture, 7*(3), 68–71.

Harper, D., & Thompson, A. R. (Eds.). (2011). *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners.* Sussex, UK: John Wiley & Sons.

Hirsch, S. (2019). Racism, 'second generation' refugees and the asylum system. *Identities, 26*(1), 88-106.

International Office for Migration, (2019). International migrant stocks. *Migration Data Portal.* Accessed April 15th 2019: https://migrationdataportal.org/?i=stock_abs_&t=2017.

Kletečka-Pulker, M., Parrag, S., Drožđek, B., & Wenzel, T. (2019). Language Barriers and the Role of Interpreters: A Challenge in the Work with Migrants and Refugees. In *An Uncertain Safety* (pp. 345-361). Cham: Springer.

London Borough of Newham (2011). *Newham key statistics based on Mayhew data*. London, UK: London Borough of Newham.

McDowell, L., Messias, D. K. H., & Estrada, R. D. (2011). The work of language interpretation in health care: complex, challenging, exhausting, and often invisible. *Journal of Transcultural Nursing, 22*(2), 137-147.

Miller, K. E., Martell, Z. L., Pazdirek, L., Caruth, M., & Lopez, D. (2005). The role of interpreters in psychotherapy with refugees: An exploratory study. *American Journal of Orthopsychiatry, 75*(1), 27-39. Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Psychological Journal, 20*(1), 7-14.

Pochhacker, F. (2000). Language barriers in Vienna hospitals. *Ethnicity & Health, 5*(2), 113–119.

Resera, E., Tribe, R., & Lane, P. (2015). Interpreting in mental health, roles and dynamics in practice. *International Journal of Culture and Mental Health, 8*(2), 192-206.

Sagaltici, E., Alpak, G., & Altindag, A. (2020). Traumatic life events and severity of posttraumatic stress disorder among Syrian refugees residing in a camp in Turkey. *Journal of loss and trauma, 25*(1), 47-60.

Schouler-Ocak, M., Graef-Calliess, I. T., Tarricone, I., Qureshi, A., Kastrup, M. C., & Bhugra, D. (2015). EPA guidance on cultural competence training. *European Psychiatry, 30*(3), 431-440.

Shaw, R. (2010). Embedding reflexivity within experiential qualitative psychology. *Qualitative research in psychology, 7*(3), 233-243.

Smith, J. A., & Osborn, M. (2015). Interpretative phenomenological analysis as a useful methodology for research on the lived experience of pain. *British Journal of Pain, 9*(1), 41-42.

Splevins, K. A., Cohen, K., Joseph, S., Murray, C., & Bowley, J. (2010). Vicarious posttraumatic growth among interpreters. *Qualitative Health Research, 20*(12), 17051716.

The British Psychological Society (2014). *Code of Human Research Ethics* (2nd edition). Accessed September 24th 2018: https://www.bps.org.uk/news-and-policy/bps-codehuman-research-ethics-2nd-edition-2014

Tribe, R., Tunariu, A. D. & Jidong, D. E. (2020). Civic engagement and social justice: Making a difference through improving communication across language and culture in community settings. In D. Moussaoui, A. Ventriglio & Bhugra, D. (eds) *Migration and Mental Health*. New York: Springer.

Tribe, R. & Raval, H. (2003). *Working with interpreters in mental health.* London: Routledge.

Tribe, R. & Thompson, K. (2017). *Working with interpreters: Guidelines for psychologists.* UK: The British Psychological Society.

Tribe, R., & Tunariu, A. (2009). Mind your language: working with interpreters in healthcare settings and therapeutic encounters. *Sexual and Relationship Therapy, 24*(1), 74-84.

Wand, A. P. F., Pourmand, D., & Draper, B. (2020). Working with interpreters in the psychiatric assessment of older adults from culturally and linguistically diverse backgrounds. *International Psychogeriatrics, 32*(1), 11-16.

Wessendorf, S. (2020). Ethnic minorities' reactions to newcomers in East London: Symbolic boundaries and convivial labour. *The British Journal of Sociology, 71*(2), 208-220.

Yick, A. G., & Daines, A. M. (2019). Data in–data out? A metasynthesis of interpreter's experiences in health and mental health. *Qualitative Social Work, 18*(1), 98-115.