

**A qualitative study of refugee interpreters' experiences of  
interpreting for refugees and asylum seekers in mental health  
contexts.**

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## Abstract

### **A qualitative study of refugee interpreters' experiences of interpreting for refugees and people seeking asylum in mental health contexts.**

by Kirsty Williams

**Background:** Refugees come to Britain from over forty-one countries (Home Office, 2002) and are entitled to the same health care as the local population. As there are few bilingual workers, interpreters are vital (Hodes & Goldberg, 2002). Many interpreters are, however, refugees themselves and have similar histories to their clients (Tribe & Morrissey, 2003), thus the impact that this work has on them is worthy of study. The aim of this research was to gain a better understanding of the professional and emotional needs of refugee interpreters and to use this to develop a theoretical grounding from which to inform clinical practice with interpreters.

**Method:** Semi-structured interviews were conducted with nine interpreters who were refugees. The interviews were transcribed and analysed using Interpretative Phenomenological Analysis (IPA, Smith, 2004).

**Analysis:** Three super-ordinate themes emerged. (1) *Bridging the gap*, (2) *Vocational Discord*, (3) *Vocational Catharsis*. Theme 1 draws together the interpreters' phenomenological experiences of how they did their work and what doing the work involved. Work was, however, often the catalyst for reflection, re-evaluation and reinstatement of their refugee experiences. Therefore, the impact of work formed the basis of themes 2 and 3. Vocational Discord is illustrative of the conflict and ambiguity present in their role. Work often intensified and/or brought to the fore personal, cultural and societal dilemmas and tensions. Vocational Catharsis (3) the antithesis of discord however, encapsulated how through their work, the interpreters were also able to make sense of their own experiences and in so doing satisfy some of their moral, cultural and humanitarian responsibilities.

**Implications:** The main implications as they relate to clinical work with interpreters and mental health provision to refugees were: value and compassion for the similarity of the interpreters' experiences; non-pathologising supervision and support; clearer definition of the interpreter's role; collaboration and partnership with other professionals; challenging assumptions and accommodating difference in the context of refugee mental health.



## Chapter 1. Introduction

Population studies suggest that there are currently around 50 million refugees and displaced people in the world because of war, famine, oppression and other problems (Murphy, Ndegwa, Kanani, Rojas-Jaimes & Webster, 2002). These global shifts have led to an influx of refugee clients in the health systems of many countries (Swartz, 1998). With global migration, mental health services have begun to provide services to an increasingly diverse population. Many individuals who now access services are from vastly different backgrounds to the dominant Western white culture. Moreover, research holds that those who do not speak English are more likely to encounter problems accessing mental health services (Neuberger, 1999; Jones & Gill, 1998). The most recent census revealed eighty-one nationalities living in the UK and Emerson & Hatton (1999) predict that by the year 2021 10% of the 0-30 age group will be part of a minority ethnic group. Refugees and people seeking asylum<sup>1</sup> (PSA) represent a substantial part of this group, with the number of applications for asylum in the UK increasing from 30,000 in 1996 to over 85,000 in 2003 (Home Office, 2003).

To classify refugees as a homogeneous group nevertheless would be incorrect. The refugee population in the UK are diverse in language, culture, political and religious affiliations, political histories, experiences of persecution and social class (Patel, 2003). The process of exile and profound multiple loss, however, is an experience that most refugees share. Furthermore, refugees differ significantly from other immigrant groups in that their migration is usually unplanned (Tribe & Morrissey, 2003).

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<sup>1</sup> People seeking asylum (PSA)

Refugees come to Britain from over forty-one countries (Home Office, 2002) and are entitled to the same level of health care as the local population. The National Service Framework for Mental Health (Department of Health, 1999) emphasises 'equality of access' to mental health services for refugee people<sup>2</sup>. Refugees and PSA often present to services with complex needs and therefore providing appropriate and accessible mental health provision is a challenge. At present, there are few bilingual mental health workers and interpreters become a vital commodity in this process (Hodes & Goldberg, 2002). Many of these interpreters, however, are themselves refugees and may have similar histories to their clients (Tribe & Morrissey, 2003). The voices and experiences of these interpreters are however, largely missing from the literature (Granger & Baker, 2003). This is a misrepresentation given the vital role that interpreters have in facilitating mental health assessment and therapy (Burnett & Peel, 2001).

This introduction is split into three sections. Firstly, the reader is provided with a résumé of the existing literature and current thinking around refugee mental health. This section gives an overview of current World Health Organisation (WHO) definitions, the mental health needs of PSA and refugee people, debate surrounding Western models of mental health and research on the impact of working with refugees and PSA on professionals in the field. The aim is to place the work of the refugee interpreter in context.

The second section examines the empirical literature on interpreting, with a particular focus on interpreting for and in mental health contexts. Research relating to the role of the interpreter, models of interpreting and the experience of 'professionals' who work with

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<sup>2</sup> The author acknowledges that the term **refugee** is problematic because it is based on a legal definition of immigration status and as such tends to label and compartmentalise people, which authors have claimed is dehumanising (Patel, 2003), where possible the author reverts to the phrase refugee people.



interpreters is reviewed. This section aims to provide the reader with a sense of how the interpreter's role is seen by other professionals.

The final section critically examines the small body of research that has looked at the work of interpreting from the perspective of the interpreters themselves. Following a summary of the research to date, the rationale for the present study is presented and discussed.

## 1.1 Refugees and mental health

### 1.1.1 Definitions

A refugee is someone who: **'owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his /her nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country'** (Article 1 A (2) Geneva Convention).

An individual who has received full refugee status under the United Nations Convention as determined by the United Kingdom (UK) Immigration and Nationality department is entitled to live in the UK as long as they wish. A status giving fewer rights is named **'exceptional leave to remain'** (ELR).

Whilst the terms refugee and asylum seeker are often used interchangeably they are different. An asylum seeker is the legal term that is used to describe someone who has applied for refugee status and is waiting for a decision from the Home Office. The period between applying for asylum and receiving an initial decision varies between being the same day, in very exceptional cases, to 3-4 years, with the average period being twelve months (Refugee Council, 2002).

### 1.1.2 The refugee experience

Refugee people and indigenous populations share generic risk factors for mental health problems; unemployment, relationship breakdown, and low socioeconomic status are among common triggers for poor mental health (Warfa & Bhui, 2003). The refugee experience is, however, qualitatively different in a number of respects. The literature suggests that becoming a refugee is concomitant with psychological health difficulties (Tribe, 1999). Eisenbruch (1991) suggests that given the considerable losses and associated changes that many refugees experience this is perhaps inevitable.

For many refugees, life pre-exile may have involved direct experience of political, religious or cultural persecution and loss. Exile itself results in yet further loss, life changes and adaptation pressures (Porter & Haslam, 2001). Porter & Haslam (2001), reflect that the reality of exile is such that *'refugees often lose everything , their homes, professions, loved ones, communities, culture , nations and are forced to re-evaluate assumptions about their social roles, lives and core identities'* (p. 819). Summerfield (1999) summarises the experience of exile as one of *'broken social worlds, disrupted trajectories, loss of status and cultural alienation'* (p.162).

Miah (2003) refers to the ambiguous loss many refugees face when a family member is physically absent, but psychologically present to the family. Their experience is such that they may have left partners, siblings or parents behind to escape persecution or have lost these people in the conflict. Practically, refugees experience a marked decline in their material and financial well-being as they flee (Miller, 1999). For many refugees the experience of poverty is coloured by a previous history of self-sufficiency, access to land or other forms of employment and subsistence and home ownership. In summary, refugees



face multiple losses when they leave their country, some personal, others more abstract, as well as less tangible aspects of their previous lives, status, ideology and religion (Burnett & Peel, 2001; Reynolds & Shackman, 1993).

### 1.13 Identity

Miller, Worthington, Muzurovic & Tipping (2002) contend that the various personal and professional roles we occupy are related to our sense of identity, competence and self-esteem (p.297). Exile is a process that forces refugees to leave behind many of the professional and social roles they occupied previously, and from which they derived a sense of purpose, meaning and structure.

Research in the UK has shown that unemployment is associated with higher mortality, divorce, suicide, anxiety, depression, disturbed sleep patterns and low self-esteem (Summerfield, 2001). In contrast, studies show that access to work (voluntary or paid) may enable people to resume the everyday patterns of life and re-establish a viable social and family identity (Maslin, 2003; Refugee Action, 2001). PSA are however, not permitted to work, and whilst refugees are entitled to work, many face barriers when they attempt to return to their previous pre-exile occupation/career (Murphy, I. 2002). Research with refugee communities reflects that they often feel their lives in the UK to be impotent in contrast to their pre exile life (Tribe & Raval, 2003; Miller I. 2002).

Bolton (2002) suggests that understanding the refugee patient requires an appreciation of exile and the profound influence that this has on their sense of self. He suggests that for many refugees exile involves both the loss and recreation of self (p.104). Raval (1996) infers that there are times during an individual's life when they may have course to reflect on their identity and redefine it in light of new information or situations. Warfa & Bhui

(2003) propose that when refugees come to a 'safe' destination it is often a time of self-reflection. Rousseau, Said, Gange, & Bibeau (1998) maintain that after a period of time refugees rework meanings and as such, exile may then acquire positive attributes as it provides the potential for change. Findings are nonetheless limited. Rousseau *I.* (1998) provide little detail on the method of analysis, the complexities of translation and the problems they encountered combining ethnographic data and psychiatric interviews. Moreover, Ager (1994 as cited in Tribe & Raval, 2003) suggests that for many refugees their internal representations of the world with respect to which identity has been developed are consistently challenged by the instability and changes in their external world. Goldenberg & Gorst-Unsworth (1998) suggest that this may leave '*little stable ground*' for (re)constructing a coherent self-image (p.364).

Writing from a systemic perspective, Mason (1993) discusses positions of safety in relation to identity, which provide theoretical links with Warfa & Bhui's ideas on the experience of refugees. Mason maintains that exposure to certain experiences in life may leave people vulnerable and in positions of 'unsafe uncertainty'. This phase of being is characterised by great misgivings about the future, tenuous and uncertain relationships and with people not knowing what to do. As such, there is a great sense of insecurity. Mason (1993) suggests that in a therapeutic context the aim would be to encourage people to reassimilate their lives and work towards '*embracing uncertainty*' (p. 193). He contends that identity and sense of self are always in construction and that ultimately positions of 'safe uncertainty' are the most adaptive. This position is always in a state of flow and is consistent with a respectful, collaborative, evolving identity where new explanations and experiences are placed alongside rather than instead of or in competition with old ideas.



Safe uncertainty is not a technique but an evolving state of being and is a more preferable place than striving for 'safe certainty'<sup>3</sup>, which by its nature is idealistic and unachievable.

Mason's ideas fit with Warfa & Bhui's (2003) hypothesis of the refugee experience, that over time thoughts and ideas become integrated towards a revised sense of self. The phases of the refugee experience are such that they may go through this many times as new issues, cultural differences or life events make them challenge or question their own identity or self-concept (Papadopoulos, 2003; Somers & Gibson 1994). Raval (1996) suggests that opportunities for self-reflection and evaluation of experiences can influence how an individual accommodates and deals with distress, which is again pertinent to the refugee experience. Criticisms of these papers are, however, that the ideas are based more on conjecture than measurable fact. To date these debates have been theoretical and there is little empirical work documenting the impact of becoming a refugee on identity and sense of self. Work that does exist has tended to focus on immigrant as opposed to refugee populations and is subsumed largely within acculturation theories (Papadopoulos, 2003; Ryder, Alden & Paulhus 2000; Sodowsky, Lai & Plake, 1991; Suinn, Rickard-Figueroa, & Vigil, 1987).

#### 1.1.4 Acculturation

Ryder, Alden & Paulhus (2000) maintain that when an individual moves from one culture to live in a different cultural context, as happens with exile, aspects of their self-identity modify over time in order to accommodate new information and experiences. Modern acculturation theories claim that ethnic minorities (including immigrants and refugees) can

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<sup>3</sup> Safe certainty: the search for solutions in periods of great stress and change (Mason, 1993).



favour the dominant culture, their own culture<sup>4</sup>, both, or neither (Sodowsky, 2002). Whilst various theories of acculturation exist (see Ryder, Alden & Paulhus 2000; Sodowsky, Lai & Plake, 1991; Suinn, Rickard-Figueroa, Lew & Vigil, 1987), the consensus is that individuals appear to maintain aspects of their original culture whilst assimilating and integrating aspects of the host culture (Sodowsky, 2002), although, there is no robust evidence that biculturalism is most adaptive (Rudmin, 2003 p.3)

Acculturation as a process is not without conflict and has a profound impact on identity. Papadopoulos (1999) in his work with Bosnian refugees recounted how they struggled to hold on to two opposing loyalties. They wished to remain loyal to the past, to their own country, to their original lifestyle, their culture and language and their sense of identity. At the same time, however, they described a desire to move on and become part of the UK society and to experience all that was new and seek out available resources and opportunities.

Papadopoulos (2002) talks about the uncertainty that PSA face when they are waiting to have their status confirmed. Many face a dilemma between needing to honour the past and to '*live with the climate of their homeland culture*' and at the same time move on with their lives and invest emotionally in their new lives in the UK (p.110). Papadopoulos (1999) states that these two antithetical tendencies invariably create tensions. Moreover, Tribe (1996) in describing her work with refugees observes that although fellow refugees may identify with one another's experiences, there may be conflicting opinions with regard to the extent that one of or other of them has taken on the ideas of the West.

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<sup>4</sup> Culture is defined as the 'shared history, practices, beliefs and values of a racial, regional or religious group of people' (Raval, 1996).

Herman (1992) talks about how chronic poverty, and the periodic threat of eviction from accommodation and the UK, results in an ongoing state of anxiety for refugees.

Furthermore, the loss of community is ubiquitous and may leave them feeling isolated and lacking in social support. As such, many refugees report feeling perpetually uncertain and unsafe (Herman, 1992). Eleftheriadou (1999) maintains that it is important to establish to what extent refugees feel able to reconstruct or recreate their identities in a new country and how much the new country facilitates this process, psychologically, physically and economically. Pernice (1994) in conclusion suggests that the success or failure of settling refugees and immigrants in the receiving country depends in part on governmental and societal attitudes.

In relation to mental health, Ly (2002) in a study of Vietnamese refugees found that individuals who were new to 'Western' culture viewed mental health services with a degree of fear and uncertainty, whereas individuals with 'high acculturation' expressed more positive attitudes towards mental health services. Ly (2002) found that over time in addition to maintaining their cultural views, their view of help seeking in the context of mental health had widened to accommodate Western perspectives. Faust and Drickey (1986) provide additional 'anecdotal' evidence from several interpreters, whereby the interpreters identify themselves as having integrated Western ideas with ideas from their own culture to explain and introduce concepts of mental health to clients and arrive at a shared understanding with both patient and provider.

#### 1.1.5 Concepts of mental ill health

Words relating to psychiatric illnesses, trauma, psychology, therapy, stress and mental health may not have the same meaning or resonance in other languages, or may not even



exist (Tribe & Morrissey, 2003). Moreover, the role of a mental health professional may not be culturally synonymous for refugees (Zur, 1996). Many refugees are unfamiliar with the concept of mental illness and tend to associate it with severe pathology and institutionalisation (Gong-Guy, Cravens & Patterson, 1991). Contributing to this stigma are beliefs that mental illness is familial or heritable, that illness is related to past transgressions and sin, that mental illness will lead to deportation or incarceration and/or that others in the community may find out (Turner, 2002). Mental health services are therefore regarded by many as a desperate last resort when family, traditional healers and medicine have proven ineffective (Murphy, Ndedwa, Kanani, Rojas-Jaimes, & Webster, 2002; Burnett & Peel, 2001; Reynolds, & Shackman, 1993).

Research suggests that Western mental health practitioners attach greater significance to psychological and emotional issues (Gong-Guy *I.* 1991). Many refugees, however, come from cultures in which the '*detached introspection*' of talk therapy is an alien activity (Summerfield, 2001 p.162). Therefore, a phenomenon such as counselling may be an unfamiliar concept for refugees who are unaccustomed to discussing intimate feelings with a stranger outside of the close family circle. Moreover, the social stigmatisation of mental illness in some cultures is embodied in clients' pragmatic decisions to remain silent (Summerfield 1999).

Only a subset of refugees can or will accept individual psychotherapy due to many obstacles, not least of which is stigma (Weine, Kuc, Dzudza, Razzano & Pavlovic, 2001). The pervasiveness of psychological distress within refugee communities is coupled with the reluctance of many refugees to utilise formal psychological and psychiatric services. Correspondingly, many refugees present in non-formal mental health settings (Miller, 1999). When refugees do, however, present to services, illness presentations are

typically in somatic idiom; non specific bodily pains, headaches, dizziness and weakness, which reflect both culturally ordained models of help-seeking and their view of what is appropriate to bring to a doctor (Summerfield , 2001).

#### 1.1.6 Mental health needs

Miller (1999) suggests that research examining the mental health of refugees has consistently found high rates of psychological distress, and that this has been most commonly conceptualised in the diagnostic language of the American Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, American Psychiatric Association, 1994). Depression is one of the most common problems in refugees presenting to services and has been attributed variously to a mix of pre and post exile factors (DeVries, 2001; Gong-Guy *et al.* 1991). Among the most prevalent are isolation, racism, lack of occupational opportunities and losses sustained in the home country (Murphy *et al.* 2002).

Silove (1999) in a retrospective study of 40 refugee people of varied nationalities seeking asylum in Australia found that self-reported levels of loneliness were significantly related to levels of anxiety and depression. Furthermore, Miller *et al.* (2002) found that social isolation was a powerful indicator of depressive symptomolgy and seemed to exacerbate existing symptoms of Post Traumatic Stress Disorder (PTSD). Many refugees identified social isolation, the loss of community, lack of environmental mastery, the loss of social roles, the corresponding loss of meaningful activity and the lack of sufficient income for adequate housing and basic necessities as their most pressing concerns (Miller *et al.* 2002). Moreover, Miller *I.* (2002) observed that refugees rarely perceived their distress as warranting psychological or psychiatric intervention.



Papadopoulos, (2002) extends this by suggesting that exile related stress is not readily captured in conventional psychiatric nosologies. Eisenbruch (1991) and Silove (1999) talk about the profound crises of meaning, faith and identity that may result from experiences of forced migration and exposure to extreme violence. Eastmond (1998) in a needs assessment of refugee mental health found that in contrast to, or in conjunction with medication or therapy, practical advice, empathic support, language tuition, advocacy and particularly employment were factors that maintained or promoted good mental health.

#### 1.1.7 Western diagnostic labels and refugee clients

A predominant theme in accounts of refugee mental health is that of trauma (Bracken, 1998). Mollica, Wyshak and Lavelle (1987) claimed that 92% of refugee clients in their clinical sample met the diagnostic criteria for PTSD. Kinzie and Sack (1991), however, working with a non-clinical sample found that 50% met the criteria for PTSD. Rates across studies are variable but nonetheless continue to report the prevalence of PTSD among refugees (Zur, 1996).

Papadopoulos (1999) argues, however, that whilst it is undeniable that many refugees have been exposed to traumatic experiences it may not be appropriate to label their distress as signifying mental illness. He suggests that it may be more appropriate to think of their symptoms in terms of '*normal people reacting to abnormal circumstances*' (1999 p. 111). Papadopoulos (2003) talks about the need to respect the complex realities of their lives and accept the evil atrocities they have been exposed to without pathologising them. He suggests that mental health practitioners may be guilty of overlooking the abhorrent realities of war and exile by using psychological theories to explain away inhuman and incomprehensible acts of human cruelty.



Summerfield (1999) claims that PTSD has been accorded scientific truth in the West and as such, it supposedly represents a universal and essentially context-independent entity. He suggests, however, that reducing the understandable miseries of war and exile to a discrete pathological body is a serious distortion, for the vast amount of people for whom PTSD is perhaps a pseudo condition. Burnett and Peel (2001) concur that a diagnosis of PTSD assumes that there is a universally valid and applicable model. They argue, however, that the symptoms of PTSD do not necessarily mean the same in different cultural and social settings, and many refugees whose symptoms fit the checklists continue to manage their lives. In addition, Burnett and Peel (2001) maintain that PTSD consigns the trauma to the past and research would suggest that much of the trauma that refugees experience is in their country of resettlement through isolation, hostility, violence and racism (Teuton, 2003; Turner, 2002; Summerfield, 2001; Van der Veer, 1998; Tribe 1999a).

Ignatieff (1999) found that PSA and refugee people often construed life experiences post exile as more negative than their original trauma. Many found adapting to new types of prejudices and discriminations was more emotionally draining than continuing to live in a hostile but familiar environment (Ignatieff, 1999; Van der Veer, 1998). Although in contrast Holtz (1998) found that torture had long-term effects on refugee mental health over and above the effects of being uprooted, fleeing one's country and living in exile as a refugee, although the additional effects were small.

Summerfield (1999) discusses how therapists often invest time 'sensitising' refugees to mental health issues, perceiving them to be too tolerant of their feelings and challenging their reluctance to seek professional help. Recounting his clinical work with refugees, he states that few of them considered themselves to 'psychiatrically ill', instead seeing their

symptoms as an inevitable part of war and exile. Gong-Guy *et al.* (1991) argue that mental health practitioners attach greater significance to psychological issues than do refugees.

Eisenbruch (1991) suggested that much of the existential pain of refugees has to do with difficulties in recapturing lost past and ultimately with the survival of their culture. He argues that an *'ethnocentric view of mental health may further alienate refugees from their culture's view about suffering and misfortune and may violate the cultural survival of refugees'* (p.677). He coined the term 'cultural bereavement' to give meaning to the distress and loss that many refugees experience. Eisenbruch (1991) suggests that cultural bereavement may identify those people whose condition is not reflective of PTSD but which represents a sign of normal, even constructive rehabilitation from devastatingly traumatic experiences. Cultural bereavement unlike PTSD allows for greater recognition of the refugee's existential predicament (Papadopoulos, 1999).

Muecke (1992) argues for a new paradigm based on the observation that refugees present perhaps the *'maximum example of human capacity to survive the greatest losses and assaults on human identity and dignity'* (p. 520). He states that to date the predominant paradigm for refugee mental health is one that is based on the objectification of refugees as a political class of excess people and one, which reduces their health needs to those of disease or pathology. Burnett and Peel (2001), however, maintain that for many refugees, restoration as far as possible of their normal life can be an effective promoter of mental health.

#### 1.1.8 Resilience and strength

Timimi (1998) comments that much of the emphasis on refugee mental health is based on Western notions of psychopathology whereas little mention is made of the psychological



strengths that refugees possess and their ability to survive and learn from their suffering. Summerfield (1999) maintains, however, that refugees are ordinary, unremarkable people who demonstrate a capacity to tenaciously endure and adapt. Moreover, their unique social experiences will have a powerful impact on their individual ways of functioning (Eleftheriadou 1999).

Whittaker (2003) in a study on the psychological wellbeing of young African refugees living in Sheffield identified themes of resilience, thoughts of moving on, being strong, not dwelling on problems and coping, which differs from the predominant discourse that emphasises trauma and difficulties. Porter and Haslam (2001) maintain that the decisions refugees make up, to and during exile shape their identities. In a way refugees can be seen to co-create their experiences and are therefore '*partial agents of their own future mental health*' (p 832). Mueke, 1992; Summerfield, 1999; Timimi, 1998 and Watters, 1999; 2001, provide further detailed critiques of the existing research on refugee mental health and maintain that studies have ignored the existence of resilience and wellbeing in the wake of trauma and exile experiences.

#### 1.1.9 Working with refugees and PSA

Many authors have attempted to define the personality characteristics of individuals who report success engaging refugee clients (Dinges, 1983; Kealey & Rubens, 1983 & Brislin, 1981). These characteristics include open-mindedness, minimal levels of prejudice and ethnocentrism, accurate perceptions of the similarities and differences between the host country's social context and the context of the migrant group, intercultural empathy and effective communication.

Pernice (1994) argues however, that social stereotypes, fear, prejudice and reluctance to engage with migrant groups are always present to some degree. Moreover, research suggests that health professionals often feel overwhelmed and deskilled when faced with refugee clients (Tribe & Raval 2003; Fernando 2002; Senior 2002 & Temple 2002). Furthermore, media stereotyping and political agendas reinforce public attitudes (Clark, 2004; Guardian 2002; Refugee Action, 2001; Wetherell & Potter, 1992).

Miller (1999) advocates an ecological approach to mental health work with refugees, which involves the training of mental health para-professionals, themselves, members of the refugee community. This has its roots in the health promoter model described by Werner and Bower (1991). They found that the support these paraprofessionals provided was widely valued and accepted by the local community.

Summerfield (1991) goes further to suggest that *'social healing and the remaking of worlds, that which is at the root of the refugee experience, cannot be managed by outsiders, but that these issues need to be locally owned by those who have been there'* (p.1461). Tribe (1999b) described how refugees find validation in hearing others stories. Telling one's story often has practical therapeutic significance because the emotional and cognitive work of remembering and the chronological reconstruction of events support an internal mental integration by refugees of their experiences. This makes it possible for them to begin to develop a coherent life story from a post-exile perspective, (Luebben, 2003 p.394.). This links with identity and sense of self (para 2.3).

In line with Summerfield's ideas, (1991) Teuton's (2003) needs assessment of refugees identified that refugees more often accepted and identified informal support as positive and useful as it did not pathologise them and did not necessitate involvement in



government services. She found that, in general, staff in organisations working with PSA and refugees had a broader concept of 'mental health problems' that was not consistent with health service definitions. Such literature has made a strong case for understanding mental health problems within a framework that utilises the service user's context, so that a culturally appropriate understanding is attained (Zur, 1994; Meyers, 1992 & Smail, 1990). Moreover, De Zeleueta (1995) suggests that interpreters and community workers who share a cultural heritage with the client can help with this.

Singh (2003) found that non-clinical workers and voluntary staff were often perceived as more acceptable to refugee clients. Mulhall (2003) notes that practically there is often no budget to provide ongoing health services to PSA and refugees and therefore voluntary agencies, ancillary staff and interpreters are also the people most likely to fill the gaps in service provision. Reynolds and Shackman (1993) found that remarkably few refugees present to mainstream mental health services for help as such, teachers, voluntary workers and interpreters were the most likely people to whom refugees would turn to share problems.

Summerfield (2001), suggests that the support they provide is often simple, consisting of an eclectic mix of '*streetwise advocacy and practical advice which refugees find psychologically beneficial*' and is often what is needed (p.162). He proposes that refugee organisations and settled refugees are invaluable in supporting refugees and acting as advocates. Many provide information and orientation and reduce the social isolation experienced by so many refugees (Burnett & Peel, 2001). Furthermore, these people are likely to have knowledge of the political landscape from which refugee clients have fled (Davies & Webb, 2000).



#### 1.1.10 Refugee mental health section summary

A major critique of this review is the lack of research in this area. The research that exists is heterogeneous and therefore makes findings somewhat unsupported and specific.

Evidence is limited by small sample sizes, unclear methodologies and analytical procedures, and very specific settings. In addition, variety exists within host cultures and more research is required with refugees who live outside of capital and port cities.

In summary, Clark (2004) argues that the diagnostic models that dominate Western mental health and social care systems may be incongruent with some cultures' beliefs. Tribe (1999b) suggests that diagnostic labels should be applied to refugee people with caution. She argues that the methods people use to maintain their psychological equilibrium and to find help are defined largely by the cultural, societal and health rules and meanings in their '*world*' and that mental health professionals need to take account of this and may need to take the lead from others in this process (p.569).

To date, little has been written about the role of the interpreter and their significance in mental health work with refugees. The small body of literature that exists in relation to interpreters in either therapy, counselling or medical settings has concentrated on how other professionals contend with work in a triad as opposed to a dyad. Researchers have relatively ignored the experience of the interpreters (Adams, 2002, 1998; Bolton, 2002; Perez-Stable & Nápoles-Springer, 2002; Culross, 1996; Phelan & Parkman, 1995; McIvor, 1991 and Roe & Roe, 1991). Research that has dealt with this subject has generally been restricted to anecdotal and general observations made during practice (Tribe & Raval, 2003; Haenel, 1997).

The primary relationship in mental health work has traditionally been theorised to exist between the client and practitioner (Tribe & Raval, 2003). While other interpreting situations allow the interpreter to be less involved with the client, in the mental health setting the interpreter becomes part of the process. Kaufert and Putsch (1997) argue that interpreters are essential because they facilitate clients' access to mental healthcare by providing culturally appropriate explanations of how the Western system works. McCay and Miller (2001), maintain that this is difficult because it involves more than translating it requires the interpreter to form a bridge between two cultures and usually between two different types of individuals.

## 1.2 Interpreting

### 1.2.1 Definitions

The dictionary definition of an interpreter is succinct; “a person who interprets (explains the meaning of words) and translates speech orally, or who clarifies or elucidates, the meaning of words” (Collins, 2003). Ball (2001) extends this definition by distinguishing between interpreters and translators suggesting that although they are all linguists they do different things. Translators transfer documents and texts from one language to another and typically work in isolation. Interpreters use their skills to transpose the spoken word in one language into another so that the parties in a conversation understand one another.

### 1.2.2 The role of interpreters

Whilst dictionary definitions of interpreting appear straightforward, a review of the literature reveals a variety of descriptions, which attempt to define and describe the role that interpreters take in clinical / mental health settings (Tribe & Raval, 2003). The role has been described variously as one of ; **cultural broker** (interpreter explains and gives



cultural and contextual understanding, Raval, 2003) ; **cultural consultant** (interpreter acts as cultural consultant to the clinician, Drennan & Swartz 1996); **advocate** (interpreter represents the service user's interests and speaks on behalf of the user, Wadensjo, 1997, 1998) ; **intermediary**, (interpreter mediates on behalf of the clinician and service user, Kaufert & Koolage 1984) ; **conciliator** (interpreter resolves conflicts which arise between the clinician and service user Roberts, 1997) ; **link-worker** (helps mental health workers identify unmet needs of service user and has a supportive role with the service user to help them make informed choices concerning their health care, Tribe, 1999a) ; **bilingual worker** (takes a more involved therapeutic role in addition to providing translation, Tribe & Raval, 2003).

Kaufert and Putsch (1997) in their study of medical interpreters observed that the interpreters often expanded or adapted the original communication from the health care provider. Many described the cultural values and personal preferences of patients and gave explanations or provided additional information to patients not offered by their doctor. Likewise, the interpreters were observed to mediate conflicts or broker misunderstandings, and to protect patients from bad news that from the perspective of the patient's culture ought not to be shared so directly. A criticism of this study, was that there was no exploration of the reasons the interpreters gave for extending their role in this way. Furthermore, observations of the interpreters' role were gleaned from the perspective of medical personnel and not from dialogue with the interpreters themselves.

There is debate among professionals and among interpreters themselves (Granger, & Baker, 2003; Kaufert & Putsch, 1997) about what the role does and/or should entail. Whilst some descriptions are inclusive and collaborative and place the interpreter in a position of 'para-professional' (Gong-Guy *et al.* 1991) or co-therapist (Temple 2002),

there is support for the opposing view held by Marcos (1979) and Warfa and Bhui (2003) that interpreters should keep strictly to the role as neutral translator. Warfa and Bhui (2003) warn against allowing the interpreter to speak for the patient and maintain that interpreters should apply judgement only when asked to help assess the significance of certain expressions and symptoms in the patient's worldview<sup>5</sup>.

Temple (2002), however, argues that if we accepted that the clinician and the client can have an effect on the session then the interpreters too must be worthy of consideration. In a similar argument Raval (1996) maintains that interpreters bring their own context and beliefs into therapy and that against this backdrop the interpreter's role cannot be seen as merely translating software. Papadopoulos, (2003) argues that the interpreter's presence will '*inexorably colour therapy*' (p.249). Bolton (2002) and Gong-Guy I. (1991) concur and suggest that the role clearly invites more of a contribution from the interpreter as culture broker or as fellow clinician. This view, however, remains controversial.

Westermeyer (1991) acknowledges the difficulties that clinicians and interpreters face in bilingual mental health settings. He describes and contrasts the triangle model of interpretation with the black box model. In the triangle model, relationships between the patient, health worker and interpreter are acknowledged and the relationship is more collaborative, whereas in the black box model the interpreter is treated as a perfunctory '*word unscrambler*' who merely takes messages from one person and passes it to another (p.468). Kline, Acosta, Austin and Johnson (1980) and Amodeo, Grigg-Saito and Robb (1997), in discussing standards for interpreters identified four key elements of a 'competent interpreter'; accuracy, completeness, impartiality and confidentiality. It was

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<sup>5</sup> Worldview has been defined as the way in which an individual perceives his or her relationship to the world and is essentially defined by a person's culture.



suggested that effective interpreters attempt to be fair, to convey information with precision and are unobtrusive (Amodeo, Grigg-Saito & Robb, 1997).

As the preceding debate implies, the role of the interpreter is ambiguous and unclear.

Whilst some health professionals regard the interpreter as tangential or incidental to their work (Raval 1996), others acknowledge the role as complex, requiring a range of skills over and above the ability to speak two languages (Tribe & Raval, 2003; Swartz, 1998 & Sande, 1998). McCay & Miller (2001) suggest that the interpreter's skills and the information they possess should not be wasted, but instead be utilised to assist clients. They suggest that interpreters may have personal experience of exile and or immigration, which may be beneficial to clients and professionals alike. Furthermore, Kaufert and Putsch (1997) suggest that the interpreter's role should be developed to support and legitimise their involvement in mediation, explaining cultural differences and practices, cultural brokerage and advocacy.

In contrast, Drennan and Swartz, (1999) express concern that the primary task of interpreting may be lost in the welter of conflicting responsibilities and duties that interpreters have. Whilst they accept that mediation, cultural education, consciousness-raising and advocacy are at times necessary, they suggest that the task of communication may be compromised or lost if too much is expected of the interpreter.

Tribe and Raval (2003), maintain that conflicts and uncertainties arise when interpreters are not valued or sanctioned by clinicians to take on a broader role and when interpreters themselves become unsure about taking on a role that goes beyond their job description or level of skill. Raval (1996) however, argues that interpreters' not having a distinct professional status raises issues about power and professional boundaries. He maintains

that the professional status of interpreters needs to be acknowledged, but that this will be difficult to achieve until a proper career structure for interpreters is established. Moreover, at present, very few interpreters are employed within designated services and health care services are still characterised by insufficient interpreting resources, untrained interpreters and reliance on bilingual staff and family members for interpreting (Tribe & Raval, 2003; Granger & Baker, 2003).

### 1.2.3 Working with an interpreter

Research suggests that when health care providers and patients share a language and culture, communication between them is often fraught with complexity, arising from different expectations, backgrounds, educational levels, age and class among other factors (Senior, 2002). When an interpreter joins the interaction, communication becomes even more complex (Faust & Drickey, 1986), as interpreters bring with them their own histories, beliefs and emotions (Clark, 2004).

A résumé of the literature that exists reveals that an extended role for interpreters may be experienced as problematic by clinicians on both a personal and practical basis. From a personal perspective, reports suggest that clinicians fear being scrutinised (Kline, *et al.*, 1980); fear a loss of control in their work (Roe & Roe, 1991); and feel threatened, unsure and impotent in their work, especially with refugee clients (Patel, 2003). Moreover, many experience conflict when the interpreter becomes allied, or assumes an advocacy role, with the client (Kaufert & Koolage, 1984). Crawford (1994) suggests that a lack of cross cultural training or strict adherence to medical knowledge (that is both culturally and socially constructed) may give rise to conflict in their relationship with both the interpreter and the client. Furthermore, Tribe and Raval (2003) maintain that the socio-political issues



on service delivery mean that issues of power imbalance between clinicians, interpreters and clients are omnipresent and as such create tension.

Swartz (1998) in a paper based on observations from clinical practice describes the dynamics that take place when an interpreter joins therapeutic work. Firstly, she refers to the **interpersonal level** (the interpreter, is a person with feelings, beliefs and desires as are the patient and doctor). The interpreter may feel close to the patient by virtue of being able to speak the person's language and by sharing their culture. Tribe (1999b) suggests that interpreters working with political refugees and victims of war and violence may over-identify with client's accounts. Haenal (1997), however, suggests that the fact that the refugee interpreter and client are compatriots can be a disadvantage, if the interpreter has been living in the UK for a longer period and feels under an obligation to the client because of conscious or unconscious feelings of guilt or solidarity.

Conversely the interpreter may feel close to the interviewer as a representative of the new society to which they now belong, and as a member of the mental health team. Thus, Swartz suggests that interpreters may oscillate uncomfortably between feeling like the agent of the interviewer or the client at any one time. Papadopoulos (1999) suggests that many refugees regard interpreters as belonging to the wider socio-political system of the host country, whereby they may be seen as having 'sold out'. Green (2003) notes that sometimes interpreters find themselves alienated from their communities due to their bilingualism, where being able to speak English is seen as representing social mobility or selling out to the dominant culture. Therefore, the triadic relationship is not without conflict.



Secondly, at the **institutional level**, Swartz (1998) maintains that the interpreter in keeping with a hermeneutic view of language is often seen as more than someone who is able to provide the correct words. Swartz argues that they are seen as a 'culture broker' someone to inform the provider about the cultural background and assumptions of the client. Tribe (1999a) defines the role as one of 'bicultural worker' whose primary task is to interpret for a client the spoken word, cultural symbols and beliefs to the health practitioner. Other accounts refer to the role variously as a 'cultural bridge' or 'psychotherapeutic bridge' between therapist and client, whereby the interpreter's bilingual and bicultural heritage enhances health workers understandings of the patient's culture and language (Mc Ivor, 1991; Acosta & Cristo 1982). Solomon (1997), suggests that sometimes interpreters take on the role of client advocate, helping patients to navigate the system to receive the help they need.

Finally, at the **socio-political level** the chances are that the power relationship between coloniser versus colonised is to a degree mirrored by the clinician-client relationship with the interpreter being somewhere in between these extremes. Furthermore, therapeutic work may be complicated by the complex agenda of Western governments being involved in the trauma that some refugees have fled from. (Woodcock, 2001).

On a practical level, clinician's report that work with interpreters is often; more complicated (Faust & Drickey, 1986); time-consuming (Raval, 1996; Crawford, 1994; Freed, 1988); that psychiatric history taking is compromised (Hitch & Rack, 1980) and that the most common mistakes interpreters make include distortion, omission, addition, condensation, substitution, and role exchange (Pernice, 1994; Vasquez & Javier 1991).

#### 1.2.4 Interpreting section summary

In summary little has been written about the work of interpreters in mental health and what does exist is anecdotal in nature and is often subsumed by larger research aims. What is more, much of the research relates to the work of deaf sign language interpreters (Young, Monterio & Ridgeway 2000; Culross, 1996; Roe & Roe 1991; Steinberg, 1991). Although there are similarities this is a skill, which is qualitatively different to language interpreters.

Numerous commentaries exist however, on the problems of cross cultural mental health assessment (Baxter, 1996; Braftman, 1995; Bamford, 1991; Gong-Guy *et al.* 1991; Westermeyer, 1990, 1993), the role of the indigenous therapist/mental health worker (Pérez-Stable & Nápoles-Springer, 2000). Vasquez and Javier, (1991) provide an apposite review of the distortions commonly made by interpreters and a few commentaries exist on how to increase the effectiveness of working with interpreters (Ball, 2001; Phelan & Parkman, 1995; McIvor, 1991; Faust & Drickey 1986). Several articles discuss the multi-faceted and complicated role of the interpreter in health settings (Amodeo, Grigg-Saito, & Robb, 1997; Swartz, 1998; Kaufert & Putsch, 1997).

Cox, (1977) however, reports that interpreters can improve the accuracy of a mental health diagnosis and improve the quality of care to the client. Moreover, Kline *I.* (1980) found that clients who were interviewed by interpreters felt understood, considered themselves to have been helped and expressed a desire to return to services. Eytan, Bischoff, Rrustemi, Durieux, and Loutan (2002) found that refugee clients subjective ratings of communication were poorest when no interpreter was used, better when relatives were used and best when trained interpreters were used. Whereas, Eytan *I.* (2002) found that verbal communication, dialogue and cultural information provided by an interpreter



became increasingly important when clients moved from describing physical symptoms to the expression of psychological and emotional suffering.

The literature on psychiatric/mental health interpreting is scant (Tribe & Raval, 2003).

Research to date has focused on the problems associated with interpreters in clinical settings, whereas their own feelings as witnesses to therapy have assumed a peripheral role (Van der Veer, 1998). The interpreter however, is the first one to hear the client's words and emotions and as well as hearing the words the interpreter has to emotionally process these words and meanings for themselves (Tribe & Raval 2003; Raval 2002).

A common complaint from interpreters is that others regard them as interpreting machines or 'senseless tools' (Tribe, 1996 ; Sande, 1998 p.405). A review of the literature at the present time suggests parallels with the features of dysfunctional teams; these include role confusion, power imbalance, conflict or uncertainty over tasks and inadequate leadership (Yank, Barber, Hargrove & Whitt 1992), all of which parallel the relationship between interpreters and professionals. Tribe (1999) suggests that this is exacerbated by the fact that it is often not clear to whom interpreters are responsible, whether the client, the practitioner or the amorphous organisation.

It remains that the voices and experiences of the interpreters themselves are largely missing from the literature (Granger & Baker, 2003). All words are filtered during translation when they are conveyed through the medium of an interpreter. They are thus coloured by the ideas, and value judgements that the interpreters unconsciously or consciously add to them. Therefore, in addition to the lives and histories of the mental health worker and patient those of the interpreter play a role in the therapeutic relationship (Haenel, 1997).



### 1.3 So, what of the interpreters themselves?

Granger (1996) provided one of the first empirical accounts of interpreting from the perspective of the interpreter. In a questionnaire study of interpreters across settings, she found that the interpreters identified feeling frustrated by their lack of professional status and that they often felt excluded from the professional team. They felt as though other professionals did not value their contribution to sessions they perceived themselves as having little power in relation to clinicians, and that the boundaries of their role were unclear. Granger (1996) reports that unlike practitioners the interpreters were offered little support or supervision to cope with stressful aspects of the work (p.117). Moreover, the study revealed that at times the interpreters struggled to manage the cultural insensitivities of clinicians and ancillary professionals, and recalled that they felt personally affronted by gauche or culturally insensitive remarks that were directed at clients (p.18).

Granger and Baker (2003) and Granger (1996) remark on the apparent contradictions and ambiguity in the interpreters' accounts the most striking being that they reported a high level of job satisfaction, but saw their role as interpreters as transient, and as such, they were keen to find other jobs. Whilst Granger's study provided an initial attempt to document what interpreters themselves had to say about their work, the generic focus was perhaps too inclusive and as such the intricacies of health service work and in particular mental health work were lost in the wider research aim. As such, recommendations for practice were lost.

Ball, Golds and Matturi (2001) compiled a report for Manufacturing and Service Union (MSF) of employment conditions among interpreters and translators in the UK. The postal survey received 153 responses from public service interpreters who worked for the courts,

police, NHS and some spheres of local government. Key themes to emerge from this report were that 52% of interpreters said that there was 'significant emotional stress' arising from their work especially when working with PSA, while 6% of respondents felt that this stress was 'acute' (p.20). The interpreters experienced their work as ill defined and felt as though their job had little or no status and as such, they felt of little value. Contrastingly, and in line with the findings of Granger (1996), the interpreters interviewed described the 'intrinsic pleasure' they received from facilitating communication and helping clients, despite the difficulties inherent in their role (Ball, 2001).

### 1.3.1 Interpreters experience of mental health work.

Mental health assessments are a very different way of working to other assignments that an interpreter may be asked to undertake for example; assisting with a housing application (Bolton, 2002). They often involve complex history taking where clients may be asked to discuss traumatic, personal and intimate details. Mellman (1995) states that "*interpreters like therapists are involved in an emotionally intimate relationship with their clients and often experience intense counter-transference reactions*" (pg.468). As a profession however, the interpreters rarely have access to supervision or organised support to recognise and manage these emotions. (Sande, 1997). Furthermore, few interpreters have received training in mental health (less than 19% according to Granger & Baker, 2003) and may feel uncomfortable sharing in the emotions of their clients, especially if they identify with their experiences (Ball, 2001: Kaufert & Putsch, 1997; Granger, 1996). Drennan and Swartz (1991) suggest that interpreters may be unprepared for their role to encompass these additional factors.



Amodeo, Grigg-Saito and Robb, (1997) summarise the difficulties experienced by interpreters in interviews with clients who experienced problems with substance abuse. They reported feeling annoyed, disgusted and embarrassed by clients behaviour and described how they wanted to protect the therapist from the clients' anger, but also protect the client from the negative consequences of his/her answers. This reiterates the issues of divided loyalty and blurred boundaries that emerged in earlier discussions of the interpreters role (para 3.2). One criticism of this report however, is that the commentary provided is the result of anecdotal discussion with sessional interpreters employed by the service, as opposed to excerpts that were grounded in participant accounts.

Tribe (1999a) provides an anecdotal account of the experiences of bicultural interpreters and refugee clients at the Medical Foundation for Victims of Torture (M.F.V.T). Tribe (1999a) states that these interpreters undertake an extremely stressful and complex job. They are subject to clients recollections of their experiences leading up to the flight from their countries of origin, many of them were tortured and / or have suffered life-threatening events. Interpreters are then expected to translate and recount these events in a different language immediately with little if any time for their own emotional processing or consideration of the issues raised.

### 1.3.2 Impact of work

Sande (1998) reports that interpreters often describe their job as '*lonely, complicated and challenging*' (p. 408). In many interpreting situations, the interpreter may carry a 'significant proportion of the emotional impact' of the work by virtue of the fact that they have more direct contact with the person (Raval 2002 pg.15). Nowhere is this more so than in mental health assessment and therapy, which may often involve the expression of



quite raw emotions (Bolton, 2002). Tribe (1999a) provides anecdotal evidence from interpreters which relates to them feeling '*overwhelmed*' by client's material or fearing that they might be overwhelmed in a session' (p.575).

Harvey's paper (2002) represents one of the few studies to date to consider the impact of work on the interpreter. He interviewed sign language interpreters and found that through the course of their work they encountered many 'traumatic' situations and experienced empathic injury, self-victimisation, grieving, reconciliation of one's privileged minority status and counter transference issues. Harvey, (2002) suggests that an interpreter is never a neutral presence and will always become an object of transfer.

Granger (1996) reports the experience of one interpreter who described how when working with refugees, the situation brought back vivid memories of her own experiences, which she found difficult to cope with. She described the difficulty she had remaining objective, which compounded by her sense that she was their only link to the new society and system (p.53). Furthermore, the fact that the refugee interpreter and client may be compatriots can be a disadvantage if the interpreter has been living in the UK for a longer period and feels under an obligation to the client because of conscious or unconscious feelings of guilt or solidarity, (Haenal, 1997).

Sande (1998) shares his reflections of 5 years experience in-group supervision offered to a group of refugee interpreters working with PSA in a psychiatric service in Norway. Salient themes to emerge were; valuation and devaluation, the double role, the interpreter as the enemy, vicarious trauma and indirect therapy. Many of the interpreters felt that it was of substantial significance and support to have a meaningful job during what was otherwise a

chaotic period of their lives. They however, reported feeling devalued by the health professionals with whom they worked.

Sande (1998) found that in response to their double role, a common problem was that the refugee interpreters felt torn between the conflicting expectations of them by professionals and their own refugee communities. Problems were exacerbated for refugees who worked as interpreters with voluntary refugee organisations. Sande (1998) reports that interpreters had been excluded from their own national group, others had voluntarily or with pressure from their employers isolated themselves from other refugees to manage their job.

Moreover, they felt that they had become prisoners of their work as both sides viewed their interactions critically. The interpreters reported feeling a strong emotional involvement with clients, often feeling torn between compassion, guilt and disbelief and sometimes with urgent wishes to contradict refugee clients or tell the other side of the story. Interpreters reported finding it hard to remain professional and control themselves with some of the things clients reported (Sande, 1998).

Additional accounts (Tribe & Morrissey 2003; Temple 2002 ; Eleftheriadou. 1999) suggest that being able to speak the language of the host culture can place interpreters in a position of responsibility and obligation. Having to translate and distance themselves from the emotional valence of situations means that they may suppress or deny their own feelings. Eleftheriadou (1999) talks about this in terms of counter-transference whereby interpreters may perceive themselves as hopeless, impotent or fragmented in terms of their own feelings.



### 1.3.3 Vicarious trauma (VT)

‘You cannot understand the misery and hardship these people have had to face until you meet them and talk to them. Tales of rape and torture, it is very distressing, especially when it involves women and children...and even if you do not experience their trauma, you cannot but be touched by it. I think about it, I can’t stop myself...’ (Ball, Golds, & Matturi 2001 pg.24)

Research suggests that those who work with survivors of trauma are vulnerable and may be at risk of developing trauma symptoms similar to those experienced by their traumatised clients. Trauma has been defined as a ‘distressing or emotionally disturbing experience’, Oxford English Dictionary (2002). Freud (1975, 1969) suggested that in the psychological domain trauma refers to that which attacks the psyche in terms of emotional shock and breaks through the defence system with the potential to significantly disrupt one’s life. Van der Kolk, McFarlane and Van der Hart (1996) amplified this by suggesting that *‘trauma occurs when one loses the sense of having a safe place to retreat within or outside of oneself to deal with frightening or emotional experiences’* (pg.31).

Most recently, the literature exploring PTSD has shown something of a paradigm shift, recognising that in addition to the noted effects of direct trauma, simply learning about another’s involvement in a traumatic event carries traumatic potential, which may have deleterious effects on those who work with the traumatised (Arvay, 2001, 1996, Figley, 1999b, and Follette, Polunsky & Milbeck, 1994). However, although DSM-IV would appear to allude to this (figure 1 p.34) as yet, it is not a standard DSM-IV diagnosis and there is no elaboration given to its implications (Arvay, 2001). As such, the field struggles with a degree of nomenclature.

After an extensive review of the literature, Stamm (1997) commented that *‘the great controversy about helping-induced trauma is not can it happen, but what to call it?’* (pg.5). Ortlepp and Friedman (2002) and Arvay (2001) in separate reviews identified the five most cited terms ; Compassion fatigue (Figley, 1999b, 1995, 1988), Secondary traumatic

stress (Figley,1999b, 1995, 1986 & Stamm,1997), Burnout (Maslach & Jackson, 1984 & Maslach, 1976), Counter transference, (Dalenberg, 2000, Pearlman and Saakvitne1995a, Mellman, 1995 & Wilson and Lindy ,1994) and Vicarious trauma (VT), (Pearlman & Saakvitne,1995 b, McCann & Pearlman, 1990). <sup>6</sup> VT is nonetheless a well recognised problem within the clinical and academic communities (Ehrenreich, 2002, Arvay, 2001 & Stamm, 1997).

Figure 1. Section A, extract from the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (APA, 1994)

Diagnostic Criteria for Post-traumatic Stress Disorder (APA, 1994)	
<b>A: The person has been exposed to a traumatic event in which both of the following were present:</b>	
1.	The person experienced, <i>witnessed</i> , or was <i>confronted</i> with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or <i>others</i> .
2.	The person's response involved intense fear, helplessness, or horror. Note: In children, this may be expressed instead by disorganised or agitated behaviour.
DSM-IV (APA, 1994) Pg. 309:81	

Harvey's paper (2002) represents the only work to date to consider VT from the perspective of interpreters. From 15 structured interviews with Sign language interpreters and an ongoing web site survey ([www.Michaelharvey-phd.com](http://www.Michaelharvey-phd.com)) he found that through the

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<sup>6</sup> For clarity, VT or vicarious trauma has been adopted as the umbrella term to describe helping induced trauma in this review.



course of their work interpreters encountered many traumatic situations and experienced empathic injury and counter transference issues. Harvey, (2002) suggests that an interpreter is never a neutral presence and will always become an object of transfer. Tribe (1999b) and Sande (1998) in their papers variously describe the establishment of support groups for interpreters who worked with refugees and survivors of torture. These were established in response to inferences from previous papers that were suggestive of interpreters reporting emotional experiences parallel to VT (Tribe & Raval 2003, Tribe, 1999b). Direct investigation of whether interpreters experienced something akin to VT is however, noticeably absent from these accounts.

Green (2003) conducted a postal survey of 110 translators and interpreters to assess the presence of VT among this group and to assess for potential risk factors. Responses to the Post-traumatic Cognitions Questionnaire, Secondary Trauma Questionnaire, Maslach Burnout Inventory and Impact of Events scale were however, not indicative of VT although individuals with a history of trauma had higher scores overall on the questionnaires. A criticism of this research would be the reliance on Western ethnocentric symptom checklists, when they may have been culturally inappropriate for the immigrants or refugees interpreters included in the sample. Furthermore, Green (2003) provides no explication or discussion of his finding that past trauma related to higher symptom inventory scores.

Haenel, (1997) maintains that interpreters, like therapists, may be included in the patient's transference. On the other hand, they may develop counter transference reactions and feel devalued or over valued by the patient and can experience helplessness, anxiety, powerlessness, anger, guilt, and feelings of failure. In other words, interpreters like therapists can experience counter transference reactions that make them feel impotent or

incompetent and will actively seek to avoid these uncomfortable feelings. Haenel, (1997) argued that interpreters are no more immune than therapists are to the danger of vicarious traumatisation (p.69).

Tribe (1999a) further identifies that the trauma experienced by non-English speaking clients may be exacerbated by more insidious factors such as separation from loved ones, loss of country, job and identity and the ability to be understood through language. Therefore, the interpreter is often viewed as an ally and as such is potentially at risk of contending with emotional “*need to rescue*” clients (Villarreal, 1994 pg. 6). Furthermore, interpreters in close-knit ethnic communities may find themselves interpreting for neighbours or extended family, which may exacerbate emotional stress (Amodeo I, 1997).

The research is ambiguous concerning the issue of history of personal trauma as a factor in the development of secondary trauma or VT and is based largely on ‘anecdotal accounts’ (Sexton, 1999 pg.396), which casts some aspersions on validity. Mc Cann and Pearlman (1990) however, infer that VT is more likely to occur when ‘the material is salient and relates closely to an individuals psychological needs, past trauma or life experience’ (pg.143). Interpreters with their own histories of trauma may therefore be susceptible (Raval & Tribe, 2003; Harvey, 2002). In terms of research, four research studies (Arvay & Uhlemann, 1996; Pearlman & Mac Ian, 1995; Kassam-Adams, 1995 & Joseph, Williams & Yule, 1992) found that personal trauma was a factor whilst four other studies (Otlepp & Friedman, 2002; Munroe, 1995 & Follete , 1994) claimed that it was not.

Conversely, Harvey (2002) whilst validating the presence of VT in interpreters, maintains that exposure to trauma can be an important catalyst for personal insights and growth. In so much as VT is a potential hazard and reveals a persons emotional vulnerability, it is a



potential teacher. Harvey (2002) named this phenomenon 'endarkenment' suggesting that having access to a richer, dualistic and more complex view of the world provides the interpreter with an opportunity to learn about their own duality, to explore that which makes them proud and that which causes them shame. Harvey (2002) maintains that endarkenment describes the archetypal wisdom that comes from going into the darkness and coming back again. The sign language interpreters who participated in Harvey's study recounted their emotional reactions to the oppression of deaf people. An excerpt from the study illustrates this point '*I have come to realising that my bearing witness to respect and disrespect of others, joy and sorrow , laughter and pain is at the root of what it is to be human*' (p.11). Harvey (2002) maintains that if people learn to manage VT correctly it can benefit the individual in profound ways and become a transformative experience. One caveat to this research paper is that it is largely conversational making it subjective and difficult to quantify. Furthermore, the verbatim quotes are all from the same participant.

Blackwell's (1997) ideas dovetail with those of Harvey he, suggests that bearing witness is a personal and political activity whereby we constitute ourselves as some sort of testimony to the history with which we are engaged. It is through the context of this recognition that both interpreter and their refugee client can piece together the shattered pieces of their subjective continuity, and recover a sense of integrity as a whole person. He suggests that refugees are often dealing with a present that is overwhelmed by the past, a past that contains the present and the future but held in abeyance. He suggests that as witnesses interpreters and professionals can begin to constitute a present that moves out of the past, bringing the past with it. This present will then contain the past rather than be bound by it. Blackwell (1997) talks about bringing forth humanity through encounters with, and recognition of, the experiences of others. In so far as refugees have often had their

humanity violated, they seek a context whereby their humanity may be reaffirmed through the kind of meeting and making present that Blackwell describes.

Human beings inherently experience counter transference and other unconscious reactions to what others say and do. In order to make sense of these thoughts and feelings Mellman, (1995) argues that a person needs to understand how their own emotional life can surreptitiously influence their thinking, words and actions. Mellman (1995) in her study of counter-transference reactions in court interpreters suggested that 'self awareness' was the key. She suggested that interpreters who repeatedly found certain situations and types of clients elicited over reactions or responses should be encouraged (when they were emotionally ready), to understand their own reactions, and to thereby defuse, and demystify them (p.471).

Sande, (1998) in his account of group supervision with refugee interpreters working with PSA in a psychiatric service in Norway, found that interpreters who interpreted for therapeutic sessions said that although it had been troublesome and sometimes awful, they had acquired a deeper understanding of what psychotherapy was about and even felt that their own personal problems had been touched on as a kind of indirect therapy. In contrast, however, they discussed how they perceived shedding tears during therapy as personal defeat and a sign of incompetence, a sense that others would perceive them as unprofessional. Sande (1998) is however, not without criticism, in relation to the retrospective methodology of the study, the absence of description of analytic technique and/or the quality control methods he employed. Moreover, although he spoke in depth about what the interpreters had said, no verbatim quotes were used to ground examples in participant's accounts.



Therefore, in addition to the negative consequences associated with difficult and emotional work, positive consequences have been noted, amongst which personal growth (Zarif-Hashyar 2002; Wasco & Campbell, 2002 & Danieli, 1981), spiritual connection (Bricker and Fleischer, 1993), hope (Arvey, 2001), validation (Zarif-Hashyar 2002; Tribe, 1999a) and respect for human resilience have been identified (Ortlepp & Friedman, 2002). Furthermore, the data concur that the potentially deleterious effects of VT can be lessened by way of education and training (Ehrenreich, 2002, Arvey, 2001, Shalev, 1996), peer led support groups (Sande, 1998, Tribe, 1998b & Saakvitne & Pearlman, 1996) and to some extent structured de-briefing (Carlier, Voermann, & Gersons, 2000, Deahl, Srinivasan & Jones, 2000, Kinzel & Nanson, 2000). These accounts relate in part to points made earlier (Leubben, 2003 & Tribe, 1999b page 17 section 2.8), which suggest that refugee interpreters may find hearing others stories validating and affirming. So far, however, empirical evidence of this is largely absent.

#### 1.3.4 Supervision

Support for professionals working with refugees in mental health work is vital if they are to be able to make sense of their own emotional reactions to clients (Eleftheriadou 1999 p.228). Sande (1998) however, states that many interpreters are left to themselves with little professional support.

Stansfield (1981) maintains that whilst interpreters are warned of the need to remain 'professional' and to keep their feelings out of the therapy session, it is detrimental for them to behave as though those feelings do not exist. Tribe (1999b); Abdallah-Steinkopff (1999) and Sande (1998) variously propose that like their refugee clients many of the

interpreters are likely to have experienced traumatic events and may require education and supervision to manage their own needs.

Stansfield (1981) however, suggests that interpreters may need support to be comfortable and in tune with the feelings that therapeutic sessions may invoke in them. Practically however, workers in the private or voluntary/charity sector have less access to statutory supervision, support and education or the financial means to secure it (Harvey 2002; Wasco & Campbell 2002 & Tribe 1999a). Moreover, Tribe (1998b) raises the issue that interpreters are often poorly paid and may be freelance or sessional relying on commissions for work, in which case they may be afraid to ask for support in case they lose out on future work. Tribe (2002, personal communication) suggests that many interpreters are wary of expressing how they feel for fear it will be construed as them '*not being up to the job*' (Tribe, 1999b pg. 575).

Penney and Sammons, (1997) identify that interpreters may need support when they experience dilemmas and dissonance that arise from dealing with different models of health care. Furthermore, they require may require support from colleagues in dealing with loyalty issues, managing anger and acquiring strategies to prevent stress or burn out. Tribe and Raval (2003) suggest that this support should be offered as a constructive part of their personal and professional development just as supervision has become synonymous in Western health care systems as good practice.

Sande (1998) cautions however, that supervision for Western health professional's is a well known and accepted method for debriefing work, for other professionals though and in other cultures, it may be a strange and unfamiliar phenomenon. Sande (1998) questions whether by emphasising such values as autonomy and individuality, supervision may



enforce the acculturation from a collective to a more individually based culture and as such dismiss cultural adaptations to trauma and stress that interpreters may employ. Elements of this debate have resonance with the discussion of Western models of mental health (2.6). Sande (1998) however, concedes that supervision may serve to support and stabilise interpreters, prevent burnout, increase their competence and encourage other them to professionalise themselves. Tribe (1998) advocates that familiarity with the job, opportunities for discussion and time passed since own experiences are factors that further enable the interpreters to integrate client's experiences with their own.

Others (Tribe, 1998b; Haenel, 1997; Saakvitine & Pearlman, 1996; Westermeyer, 1990; Shackman, 1984) reiterate the importance of providing support and supervision groups for interpreters working with refugees. In addition, Black *in press*, and Follete, Polunsny and Milbeck, (1994) found work-related support to be effective perceived social support was found to be an emotional buffer in four of the studies (Ortlepp & Friedman 2002, North, Tivis, McMillen, Pfefferbaum & Munroe, 1995). Tribe and Raval (2003) however, caution that this should not preclude additional time spent with interpreters post-session if a session is emotionally stressful.

Sande (1998) suggests that the status and quality of their work could be increased by support from their employers, supervision and more extensive and obligatory training for both interpreters and professionals on mental health related matters. In addition, Granger and Baker (2003) found that interpreters sought collaboration, inclusion and teamwork as factors that would improve the quality of their working lives.

### 1.3.5 Refugee interpreters<sup>7</sup>

A theme that many refugees and PSA have in common is that they have experienced the abuse of power by a dominant regime and generally undergo many hardships and losses before and during their flight to exile (Van der Veer, 1998 and paragraph 2.2 p.). Tribe (1999a) argues that as such refugee interpreters may run the risk of over identifying with their refugee clients. Little has been written however, about the experiences of refugees who are themselves interpreters.

Zarif- Hashyar (2002) and Fox (2001) are the only accounts to describe the experience of what it is like to be a refugee interpreter working with refugees. Fox (2001) relays having profound empathy with some of the clients. She states that that often interpreter-client boundaries were hard to define because the interpreter may come from the same sociocultural or ethnic background as the refugee client and as such, their lives may be intertwined outside of the consultation.

There is the potential for value conflict when interpreters come from different cultural and class groups to their client. Although a language may be shared, differences across caste, gender, age, religious and political lines may be deeply rooted which may result not only in differences of opinion and belief but different ways of every day living and different systems of meaning (Clark, 2004 ;Cheatham, Ivey, Ivey & Simek-Morgan 1993; Acosta & Cristo, 1982; Cox, 1977). Zarif-Hashyar (2002) defines the ambiguities inherent in the role. She states that whilst a position of co-therapist is seductive, she feels that to assume a role for which she has had no professional training would be wrong. However, she asserts that her contributions to the therapy are based on instinct, common sense, life experience

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<sup>7</sup> Refugee interpreters are interpreters who are themselves refugees.



and gut reactions and not on qualified clinical contributions. Tribe (1999a) however, questions whether refugee interpreters are at present ‘bridging the gap’ or ‘stemming the flow’ (p.1) in view of the lack of culturally appropriate and accessible services for refugees.

#### 1.3.6 Section summary

In addition to the difficulties faced by other interpreters working with refugees and PSA in mental health contexts, refugee interpreters are different in that their route into interpreting may have been opportunistic, borne out of necessity as opposed to vocation. These interpreters receive little if any formal training in this work and their personal histories are such that they may identify with and have shared experiences to those of their refugee clients.

### 1.4 Present study

#### 1.4.1 Research aim

The aim of this research was to explore the experience of interpreters who work with refugees and PSA in mental health contexts. To date few studies have sought to explore the experience of this work from the perspective of the interpreter and an academic lacuna exists with regard to the experiences of interpreters who are themselves refugees (Raval, 2003). Moreover, the literature in this field is limited to anecdotal or descriptive reports about the difficulties that arise in clinical work with interpreters (Tribe & Raval, 2003). In view of what is known about the impact that this work has on other health professionals (Luebben, 2003; Maslin, 2003; Tribe & Raval 2003; Tribe 1999a, 1998a) the experience of the refugee interpreters, who are integral to this work, is worthy of study.

#### **1.4.2 Clinical relevance**

2003 saw the publication of the book 'Working with interpreters in mental health' the introduction states that 'the idea for this book came out of the author's concern that such a book did not already exist', and states that there needs to be much more research in this area (Tribe & Raval, 2003 p. 259). At present there are few bi-cultural therapists trained in refugee languages, therefore an understanding of the relationship between client, clinician and therapist is of importance, as the interpreter remains the aid for communicating with clients.

Furthermore, if these interpreters experience a degree of emotional distress following assignments with refugees and PSA then mental health workers need to be mindful of this and incorporate a debriefing session with the interpreter following sessions. At present due to the lack of comprehensive training for many regional interpreters, this is overlooked. Haenel (1997) posits that refugee interpreters may suffer from 'vicarious traumatisation', experiencing the same difficulties as their clients. He draws attention to the ways in which interpreters can experience the refugee client's transference as well as developing their own countertransference reactions. Therefore professionals have an ethical obligation to ensure that interpreters have access to support and supervision outside of the context of their work with the client.

In the case of refugees and PSA, many mental health professionals will have made assumptions and generalisations about working with the complex needs of this client group. With this in mind, there is considerable support for the belief that clinical psychologists as a professional group have neither promoted themselves adequately in culturally diverse groups, nor established strong links with leaders of culturally diverse



communities (Aitken, 1998; Kazarian & Evans 1998). This belief extends to suggest that clinical psychologists (and other mental health professionals) have not sufficiently explored issues of cultural diversity with refugees/PSA and specifically the use of spoken language interpreters within their practice (Temple, 2002).

In line with the current government plan for the dispersal of refugees and PSA together with the omnipresent debate that surrounds equality of access to mental health services it would appear that mental health workers might see more referrals for PSA and refugees. To date much of the specialist work has been done in London by organisations such as the M.F.V.T, however the NHS is being called upon more and more to supplement the work of these organisations. Working with an interpreter is however, something that many mental health workers view with some uncertainty.

Research in this area will provide a better understanding of the professional and emotional needs of the refugee interpreters engaged in this work and in turn may provide mental health workers with an empathic understanding of their role. There is a need to develop a theoretical grounding from which to inform the clinical practice with interpreters.

#### 1.42 Present study

Using a qualitative methodology, in depth, semi-structured interviews were conducted with refugee interpreters. The study aimed to provide an understanding of the impact and lived experience of their work and to offer an empathic appreciation of the dilemmas, and difficulties, inherent in their role. In addition, the interpreter's role as pivotal and not ancillary to the delivery of mental health services to refugees and PSA was explored and recommendations for practice outlined.

## Chapter 2 Methodology

This chapter provides a brief overview of qualitative research, a description of Interpretative Phenomenological Analysis (IPA) as a method for collecting and interpreting qualitative data and a rationale for using IPA as opposed to other qualitative approaches in this study. This is followed by a description of the research aim, design and sample size. Details of how research participants were identified and recruited and the position of the researcher with respect to the data are then discussed. The final part of this chapter is concerned with the development of the interview schedule, the procedures prior to data collection and those used to analyse data. Issues pertinent to methodological rigour and the criterion used to measure quality within this study are examined.

### 2.1 Qualitative research

Qualitative research is not a homogeneous field, however, whilst qualitative methodologies represent a broad church of epistemological and ontological positions the paradigm is characterised by a number of common characteristics, which distinguish the approach from positivist or realist ontologies, which have dominated in health service research to date (Henwood & Pidgeon, 1992). Whereas, positivist epistemologies are concerned with establishing objective and reliable methods of investigation (Madill, Jordan and Shirley, 2000), qualitative research shares a commitment to researching in a naturalistic and interpretative way, whereby the representation of reality is through the eyes of the participant.

The research process is viewed as generating working hypotheses rather than immutable empirical facts, and emphasis is placed on the emergence of concepts from the data set as opposed to working from *a priori* theories or assumptions. Good qualitative research



respects the complexity of the phenomenon under investigation, encourages active engagement of participants and researcher and enhances understanding (McLeod, 1994). Moreover, there is a commitment to recognising the importance of viewing the meaning of experience and behaviour in context and in its full complexity. Greenhalgh & Taylor (1997 pg. 740) illustrate succinctly the distinction between qualitative and quantitative methodologies:

*“...quantitative research begins with an idea, usually articulated as an hypothesis, which then through measurement generates data and by deduction allows a conclusion to be drawn. Qualitative research, in contrast, begins with an intention to explore a particular area, collects ‘data’, via observations or interviews and generates data through what is known largely as inductive reasoning. The strength of the quantitative approach lies in its reliability or repeatability ...the strength of qualitative research lies in its closeness to the truth, validity”.*

### 2.1.2 Interpretative Phenomenological Analysis (IPA)

Smith (2004) suggests that the characteristic features of IPA can be captured in a three part list: idiographic, inductive and interrogative (p.41). Interpretative Phenomenological Analysis (IPA) is a strand of qualitative enquiry, which is informed theoretically by phenomenology and symbolic interactionism. IPA however, does not represent a ‘consensual label’ or a definitive paradigm; it represents more of a research philosophy or a way to think about and conduct research (Smith, 2004).

Phenomenology, as defined by Giorgi and Giorgi (2003 p.26, 1995) and by the writings of Husserl (1900/1970), is broadly concerned with ‘capturing as closely as possible the way in which individuals perceive objects or events within the context in which they occur’.

This is as opposed to reducing phenomena to a convenient number of variables or attempting to produce an objective statement of the object or event itself (Smith, 1996).

Symbolic interactionism (Denzin, 1995) is again a rejection of the positivist paradigm and argues that the meanings individuals ascribe to events should form the crux of social research. Denzin (1995) maintains that these meanings are accessible to the researcher through a process of interpretation and that meanings occur and are understood as a result of social interaction.

IPA as defined by Smith (2004; 2003; 1996 p.264) signifies the dual nature of the approach, one that is both interpretative and phenomenological. Combining ideas from phenomenology and symbolic interactionism. IPA is 'strongly idiographic' (Smith, 2004 p.41) and seeks to 'explore the participant's view of the world' and to adopt as far as possible an insider's perspective' (Conrad 1997). An underpinning assumption of this approach is that verbal statements can meaningfully reflect the internal world and underlying cognitions of the individual. This is where mainstream positivist psychology and IPA could be perceived to converge in that they are both interested in examining how people think about what is happening to them; they however, diverge in deciding how this thinking should be studied (Smith, 2003 p. 52).

IPA employs a double hermeneutic with regard to data interpretation (Packer and Addison, 1989), whereby, whilst participants are trying to make sense of their experiences, the researcher is trying to make sense of the participants trying to make sense of their experiences. IPA encourages considering research participants as co-researchers. Stiles (1993) argues that this sort of engagement fosters an internal, and thus usually compassionate, view of human experience. Moreover, it deepens understanding, aesthetically and emotionally as well as cognitively (Stiles p.605). The aim of IPA is to explore how participants make sense of their personal and social worlds and the meanings particular experiences, events and states hold for them.



Smith (2003) maintains, however, that the process of interpretation involves a filtering of participants accounts through the researcher's own perceptions and biases. Therefore, although IPA provides a structured analytic framework with which to make sense of personal meanings, this is with the caveat that the research exercise is seen as a dynamic process in which the researcher assumes an active role. IPA is an idiographic as opposed to nomothetic approach. The researcher starts with a detailed examination of one case until a degree of gestalt has been achieved and then moves on to a case-by-case analysis of further transcripts. The aim is to produce an interpretative account of the perceptions and understanding of the participants in the study, which is grounded in what they have said.

### 2.1.3 Rationale for using a qualitative research method and IPA

Bryman (1998 pg 108) suggests that the distinction between qualitative and quantitative research is: *“a technical matter whereby the choice between them is to do with their suitability in answering particular research questions, that is to say that methods are not so much valid in and of themselves, but rather will be more or less useful for particular research questions”*.

It was thought that the aim of this research together with the paucity of existing research in this field, indicated the use of a qualitative methodology. Rennie, Watson and Monterio (2002) suggest that qualitative methods are well suited to research questions that include;

- i. new fields of study where there are few definitive hypotheses and little is known about the phenomenon
- ii. process evaluation, as processes are dynamic and participants' perceptions are a key consideration in this situation.
- iii. for adding depth and detail to existing quantitative studies.

Moreover, Turpin, Barley, Beail, Scaife, Slade, Smith and Walsh (1997) suggest that the use of qualitative methods may be particularly useful for revealing patterns of meaning, interpretation and understanding inherent within an individuals experience (pg.4).

The interpreter's perspective of working with refugees and PSA in mental health settings is something that has been ignored empirically. Furthermore, of the research that exists, accounts have been either anecdotal (Tribe, 1991) or presented as single case data (Granger & Baker, 2003). The issues that arise for interpreters in this context (both psychologically and practically) are poorly documented and understood and are often underestimated. The interpreter's role has traditionally been seen as perfunctory and ancillary to that of the health professional. It is assumed that this and other issues would be reflected within participants' narrative accounts of their work in this field.

As the principal aim of this study was to understand, what it is was like to be a refugee interpreter working with refugees and PSA in mental health, Interpretative Phenomenological Analysis (IPA, Smith *et al.*1999) appeared an apt methodology because as a method IPA *'has a theoretical commitment to the person as a cognitive, linguistic, affective and physical being and assumes a chain of connection between their thinking and emotional state'* (Smith , 2003 p.52). Therefore, IPA was chosen because of the emphasis it places on exploring the participants' personal perspective on the topic under investigation. Moreover, IPA is a distinctively psychological approach, centred on the psychosocial world of the individual (Smith, 2004).



Furthermore, emic<sup>8</sup> approaches to researching refugee issues are pertinent when one considers that the majority of the world's refugees come from non-Western societies. Quantitative approaches are however, fundamentally temporal in nature. The researcher argues therefore, that the refugee interpreters' experiences cannot be understood without knowing something of their lives before they went into exile and their reasons for exile, as life prior to exile becomes a central point among refugees for the evaluation of their present life circumstances. Therefore, by definition narrative methods such as IPA emphasise the temporal or sequential description and evaluation of experience.

The researcher elected to use IPA in place of other qualitative methodologies because the suggested framework for data collection and analysis appeared academically rigorous yet flexible. The benefit of this is that it affords the researcher freedom to explore the participant's world with them. Furthermore, the dynamic and flexible approach offered by IPA, fosters creativity and interpretation at the stage of data analysis and as such it is perhaps less constrained than other qualitative methodologies.

#### 2.1.4 Aim of the research

To explore the experience of refugee interpreters who interpret for PSA and refugees in mental health contexts.

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<sup>8</sup>Anthropologists distinguish between etic and emic systems of cultural classification. The former are those imposed from without by the social scientist, the latter are those used by the native informant him or herself. Therefore, universal (etic) and culture-specific (*emic*) is the distinction between insiders' (experts' perspective) and the outsiders' points of view (Headland, Pike & Harris 1990)

## 2.2 Design

The research employed IPA. This study followed the guidelines suggested by Smith and Osborn (2003) regarding the collection and subsequent analysis of data. An underpinning assumption of IPA is that verbal statements can meaningfully reflect the internal world and underlying assumptions of the individual. Semi-structured interviews were used to provide the researcher with a corpus of data. IPA then provided the structured analytic framework within which the personal meanings in participants' accounts could be organised and made sense of. Engaging with the data enabled interpretations to be produced for each individual and then to progress to forming collective links across participants. IPA as a research tool recognises that interpretation involves a 'filtering' of participants' accounts through the researchers own perceptions and biases, in this sense the research exercise was a dynamic and iterative process.

### 2.2.1 Sample

In general, the sample size in qualitative research is designed to be theoretically rather than statistically representative. Data collection and analysis occur concurrently, and the eventual sample size is determined by the quality of the data collected. Unlike some other qualitative methods, IPA studies are based on small purposively selected samples (Smith, 2003). They do not necessarily set out to achieve "data saturation", which assumes that there is a theoretical end-point to the analysis; rather they aim to reach a degree of internal coherence or persuasiveness (Smith, 2004; 2003a).

Smith, Jarman and Osborn (1999) state that eight to ten participants is as an appropriate sample size for research using IPA. Smith (2004) suggests that it is useful for the researcher to be able to hold a mental picture of each individual in mind during the



analysis as this enables themes to emerge that may connect across participants accounts. Thus, it was felt that validity was not compromised by the small sample size because of the different assumptions, which underlie the philosophy of qualitative enquiry (Smith, 2004).

IPA methodology denotes the selection of a 'fairly' homogeneous sample. Therefore, a purposeful sample of refugee interpreters who had experience of working with PSA and refugees in a mental health context was obtained. It was thought that this method of sampling would find a more closely defined group for whom the research question would be significant. In recruiting the sample however, the researcher wished to represent the fact that refugee people represent a fluid and dynamic population and not a homogenous group. Therefore, no attempt was made to restrict the sample to particular languages spoken, ethnic, or religious group. The criteria of refugee, interpreter and experience of mental health work were the basis for recruitment.

### 2.2.2 Recruitment

A large city in the East Midlands provided the local context for the research, it was felt that this would provide a regional perspective on the existing literature which to date has been predominantly London based. This city has a diverse refugee population. Figures suggest that there are approximately 2000 PSA and roughly 900 refugees out of a population of 266,988. Records suggest that these represent 56 nationalities; Eastern Europe, the Middle East, Asia and Africa. A large percentage of PSA are Iraqi, Turkish, Iranian, Afghan, Pakistani, Somali, Eritrean, Zimbabwean, Congolese, Angolan and Rumanian. (Teuton, 2003). Whilst this city provided the focus for recruitment, the researcher obtained ethical approval to recruit participants from an interpreting service in

an additional city in the East Midlands region to ensure that there would be enough participants for the research.

### 2.2.3 Method of recruitment

Five organisations<sup>9</sup> were approached to see if they would facilitate access to the interpreters they used. Each of the agencies replied with letters of support stating that they were happy to facilitate access to the refugee interpreters. In the first instance, letters of introduction were sent to each of the organisations. Interpreters who fitted the sample criteria were then given the letter and an informal outline of the research by the organization. Those who wished to participate, were asked to complete the tear off sheet on the letter of introduction and return it to the researcher in the stamped addressed envelope provided. If they preferred they could give the slip to a named contact at one or other of the above organizations (Appendix A).

Potential participants were then contacted by telephone or letter and a time and date for the interview within the proceeding three weeks was arranged. They were then sent a further information sheet (Appendix B), consent to be interviewed form (Appendix C), and were asked to read these forms and to bring them to the interview. From the seventy letters sent, nineteen interpreters agreed to be interviewed and of these ten were appropriate. The nine participants excluded did not meet the inclusion criterion, they were interpreters but were not themselves refugees.

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<sup>9</sup> Names of participating organisations have been omitted for reasons of anonymity – at additional points in the text, the reader will observe the use of X where identifying or personal information has been withheld again to maintain anonymity and privacy.



#### 2.2.4 Participants

The sample population comprised nine interpreters, four women and five men, who had experience of interpreting for PSA and refugees in mental health contexts and who were themselves refugees. Participants' ages ranged from 25 to 45 years of age. The mean length of time they had been interpreting was 3 years and 1 month. Six years experience was the longest and 9 months the shortest. Four of the participants had attended a formal course run by the City Council on interpreting, two had passed the Metropolitan examination (this enables an interpreter to be on a national register for the police and the judiciary). Six of the interpreters had received no formal training as interpreters.

Eight of the nine interpreters were university educated in their country of origin and one had a postgraduate qualification. In terms of their employment prior to exile they ranged from, nursing sister, professional footballer, senior house officer, restaurant manager, lawyer, student, university lecturer and office worker. Participants were exiled from, Kosovo Albania (4), Rwanda (1), Iraq (1), Iran (2) and Turkey (1)

Many of the participants spoke several languages to include; Farsi, Arabic, Persian, French, Albanian, Greek, Russian, Czech, Portuguese, Amharic and Congolese. Prior to coming to the UK, none of the interpreters had been fluent English speakers. Six of the interpreters interviewed had full refugee status under the United Nations Convention as determined by the United Kingdom (UK) Immigration and Nationality department and were entitled to live in the UK as long as they wished. Two of the interpreters had been granted 'exceptional leave to remain' (ELR) which is a status giving fewer rights (see p. for definition). Further details of each participant's background and reasons for exile is provided in (Appendix G).

### 2.2.5 Stance

Prior to the research endeavour the researcher had had limited experience of qualitative research, but perceived the value of qualitative approaches to be in their ability to capture rich and detailed information about personal experience. In epistemological or ontological terms, the researcher regarded herself as a **contextual constructionist**. Contextualism asserts that ‘all knowledge is local, provisional and situation dependent’ (Madill, Jordan & Shirley, 2000). Moreover, this implies that there is not one reality that can be revealed, simply by using the correct methodology, contextualism maintains that results will vary according to the context in which data are analysed (Madill *et al*, 2000 p.9). The constructionist element invokes the idea of assuming a critical stance towards taken for granted ways of understanding the world and ourselves, together with a commitment to the importance of language (Smith, Jarman & Osborn, 1999).

The researcher is however, aware of an important distinction between social constructionist epistemologies as they pertain to discourse analysis, DA (for reviews see Potter & Wetherell, 1987) and conversation analysis, CA (for reviews see Potter, 1996; Schegloff, 1991) and constructionist ideas as they relate to IPA. IPA differs from DA and CA in that IPA is concerned with cognitions and with understanding what participants think or believe about something. IPA assumes that by analytically engaging with participants accounts the researcher will be able to say something about how they perceive an object or event, moreover IPA will go beyond the text to illustrate how something has been understood. In contrast, social constructionist epistemologies are agnostic that verbal reports can be mapped to underlying cognitions and are therefore more concerned with how participants orient themselves in language and what purpose the language they use serves in their interactions with others (Potter, 1996).



Smith (2003, 1996), in his accounts of IPA suggests that access to a participant's personal world is both 'dependent on and complicated by the researcher's own conceptions which are required in order to make sense of that world through interpretative activity' (Smith, 2003 p.264). Therefore, it is argued that the researcher should articulate the personal perspective from which they approach their material (Madill *et al.* 2000, Radley, 1994). This facilitates reader assessment of the extent to which the researcher and participant share basic cultural assumptions and its affect on the data. In adopting a contextual constructionist stance, the researcher acknowledges and accepts the inevitability of bringing her personal and cultural perspectives to bear on the analysis.

#### 2.2.6 The Researcher

The researcher was a white, thirty-five year-old trainee clinical psychologist in her final year of training. Her interest in the role of interpreters was fuelled initially by her own experience of sign language interpreting for profoundly deaf adults prior to embarking on clinical training, and her awareness of the difficulties and dilemmas inherent to that role.

Through the process of training, she was exposed to working with interpreters, but in the contrasting role of therapist. This work was largely in relation to refugee clients and included working with interpreters for assessment sessions and therapeutic interventions.

This prompted further consideration of the impact that this work has on the interpreter.

The researcher's expectations regarding the research were such that she anticipated that interpreters were unlikely to have been asked about the impact of their work. Informal liaison with these interpreters post-session enabled the researcher to gain an awareness of their diverse backgrounds and personal accounts of exile. She was aware that many of the

refugee interpreters received little by way of training or support, which was something she felt, might leave them vulnerable to the more difficult aspects of their work. Moreover, the role of 'interpreter' seemed undefined and ambiguous and the interpreters seemed aware of this. By way of contrast, however, there was a sense that these interpreters were themselves examples of the human capacity to survive the greatest losses and assaults on human identity and dignity.

The researcher's expectation regarding the outcome of the research is that the refugee interpreters will have a sense of connection or shared experience with their refugee clients. Throughout the study her expectations and assumptions, her sense of emerging themes and general thoughts about the research were recorded in a reflective diary. The aim of this was to enhance awareness of issues regarding reflectivity and to be aware of her decision making regarding interpretation of the data.

In terms of therapeutic stance, the researcher considers herself eclectic. She, however, acknowledges an interest in systemic and narrative approaches and their application to supervision, therapy and the impact of wider systems on peoples understanding of events.

#### **2.2.7 Interview Schedule**

A semi- structured interview schedule (Appendix D) was constructed based on a set of predetermined questions. These followed the guidelines described by Smith (2003, 1996) and subsequent discussions with both research and field supervisors. The interview schedule was also informed by informal discussions with non-participant interpreters at the projects inception and by a review of the literature on the topic.



The interview schedule although semi-structured was suggestive not prescriptive and was used as a guide. This allowed the researcher to explore specific areas more deeply and to follow the priorities and concerns of the interviewee. Smith (2003 p.56), suggests that this method of data collection is flexible and responsive in that it facilitates rapport and empathy, allows greater flexibility of coverage, produces richer data, and enables the researcher to explore novel areas that may be of concern to participants but which the researcher had not thought of. Moreover, the interviews with each participant were understood as interactions, which further enable the researcher to enter the social and psychological world of the participant.

Smith (2003) suggests the following sequence for compiling an interview schedule:

- i Identify the broad range or issues to be discussed. For example, being a refugee, being an interpreter and impact and experience of mental health work.
- ii Arrange the topics in a logical sequence; general broad questions first followed by areas that are more sensitive, for example, the emotional impact of the work and similarity to own experiences.
- iii Generate questions that expand and explore the main themes.
- iv Avoid questions that are over-empathic, manipulating or leading *e.g., I can imagine that there must be times when you feel like crying.*
- v Utilise, descriptive, narrative, structural, contrasting and evaluative questions *e.g. can you tell me about how you came to be working as an interpreter?*

In addition to the above, prompts (*e.g. can you tell me a bit more about that, what do you mean by....*) were used when necessary to offer alternative routes through which to access the experience of the interpreters.

Smith, Jarman and Osborn (1999) maintain that constructing the interview schedule in advance is beneficial because it enables the researcher to contemplate areas they wish to cover. The researcher was aware that certain topics might be sensitive, for example participants' accounts of exile. Thought was therefore given to how these questions might be worded and how, if participants became distressed, this would be acknowledged and handled. Furthermore, a working knowledge of the schedule enabled the researcher to concentrate on what participants were saying, whilst remaining aware of the interview topics she wished to cover.

The structure of the interview schedule involved an opening question to help participants feel at ease and to enable them to introduce and talk about themselves, this established a rapport with the participant. The interview was nominally split into four sections. The first section (the introductory question) enabled the interpreters to talk about their experience of exile and their status as a refugee. They were then asked about being an interpreter and how they perceived their role. The third part moved into talking about their work with refugees, and fourthly their experience of mental health work with refugees.

The sections outlined were however, arbitrary in the sense that the questions on the interview schedule were designed to gain insight into the holistic experience of what it was like to be a refugee interpreter working with refugees in mental health contexts. The aim of the interview schedule was to facilitate discussion of the research question, and allow participants to do so from their own perspective and with their own emphasis. It was intended that, as experts on the subject, participants would be given the opportunity to tell their own stories. Following each interview the researcher wrote down her immediate perceptions and thoughts about the interview in a reflective journal.



## 2.3 Procedure

### 2.3.1 Literature review

IPA as a method places emphasis on the researchers' interaction with participants' accounts and subsequent interpretation of data. By doing this, it is understood that the researchers will draw on their own frames of reference to inform the analysis. Therefore, the researcher made a conscious decision not to revisit the literature, prior to the interviews or during the first stages of the analysis. It was felt that this would enable her to gain more of an insider's perspective on how the participants saw their lives, as opposed to matching participant's experiences to the researcher's expectations or to existing accounts in the literature.

### 2.3.2 Ethical considerations

Ethical approval for the research project was granted by the Research Ethics Committees covering the NHS regions and districts from where participants were recruited (Appendix E). There were a number of ethical considerations outlined in the proposal that influenced the research process. These were as follows:

#### *i Consent*

Informed consent was obtained from the interpreters who took part and they were informed that they were free to withdraw their interview data from the study at any time.

#### *ii Confidentiality of Information*

The researcher was aware that participants might be wary of discussing information relating to their clients, and sensitive political information and that they may have concerns that information may get back to their employers resulting in their own employment status being compromised. Therefore, transcripts were anonymised and

assigned pseudonyms and a script identifier so that as individuals they were not identifiable.

### *iii Role boundaries / Access to support*

The researcher remained aware that although there might be times during the research process where she may provide information, reassurance and emotional support to participants, her major role was that of a researcher interested in gaining understanding of the phenomenon. She was aware that some participants would know of her dual position as a trainee clinical psychologist and researcher, and that there might be times when it would not be easy to make clear her role boundaries as one of researcher as opposed to therapist. This she considered might become an issue if highly charged emotional material was shared, unresolved issues revealed or advice was sought. Patton (1990) suggests that the researcher needs to adopt a stance of 'empathic neutrality', whereby they engage empathically with the stories participants share but remain neutral towards the content of the material that is generated.

Grafanaki (1996) has identified that interviews have the potential to re-stimulate painful memories or unresolved emotional conflicts on the part of the participants both during and after the qualitative enquiry. In view of this, the researcher set time aside at the end of each interview for a de-briefing discussion. Furthermore, qualities such as active listening, accurate understanding, warmth and acceptance were adopted during the interview to build rapport with the participant. Although no participants took up the offer, access to further counseling/ emotional support was negotiated in the locality of the interviews. This was for participants who felt they wished to talk to someone about their experiences and to enable the researcher to remain separate from this. Grafanaki (1996) however, suggests that giving people a voice to tell their stories in their own words can be cathartic and



therapeutic in itself. Testimonies, to this idea were the letters of thanks that the researcher received from four of the participants following the interviews.

#### *iv Loss of Earnings*

The researcher was mindful of the potential for loss of earnings on behalf of participants. Many interpreters hold temporary contracts, or are paid intermittently as and when work is available, whereby time is money. The researcher therefore secured a small sum from the research budget to reimburse the interpreters at the rate of £30.00 per interview to cover loss of earnings.

### **2.3.3 Recruitment**

Participants were recruited via letters of introduction with attached consent to contact forms (Appendix A). Participating agencies were requested to give letters to interpreters who matched the inclusion criteria. Completed forms were then returned to the researcher in the stamped addressed envelopes provided. Participants were then contacted by the researcher either by telephone or letter and were given further details of the study. If they were happy to proceed, an interview date was then arranged. Prior to the interview taking place interpreters are sent a detailed information sheet about the research (Appendix B).

### **2.3.4 Data collection (interviews)**

Interviews took place either in the participant's home or in a room at the local Refugee Action. Both settings afforded privacy and anonymity from employers. Participants were asked to complete a consent form (Appendix C) and consent to be audio taped during the interview (Appendix C). Participants were offered the chance to receive feedback from the research and eight participants requested feedback from the final report. The interview

procedure was explained to participants and the generics of the interview schedule (Appendix D) were outlined.

### 2.3.5 Transcription

The researcher transcribed the audiotapes so that she could remain close to the data and retain a 'mental picture' of each individual who had been interviewed. The interviews were transcribed verbatim and included significant non-verbal events such as laughter and crying. Due to the interpreters' accents, it was thought that an audio-typist might have difficulty understanding participants' speech due to the quality of the recordings, this was another factor in the researcher's decision to do the transcription herself.

### 2.3.6 Data analysis

The data were analysed using interpretative phenomenological analysis (IPA) (Smith, 2003; Smith, Jarman & Osborn, 1999 and Smith 1996). As explained earlier this approach is both phenomenological and interpretative, viewing the analytic outcome as resulting from, an interaction between participants' accounts and the researcher's frameworks of meaning. This involves the researcher engaging in an 'interpretative relationship' with each transcript (Smith, 2003 p.64).

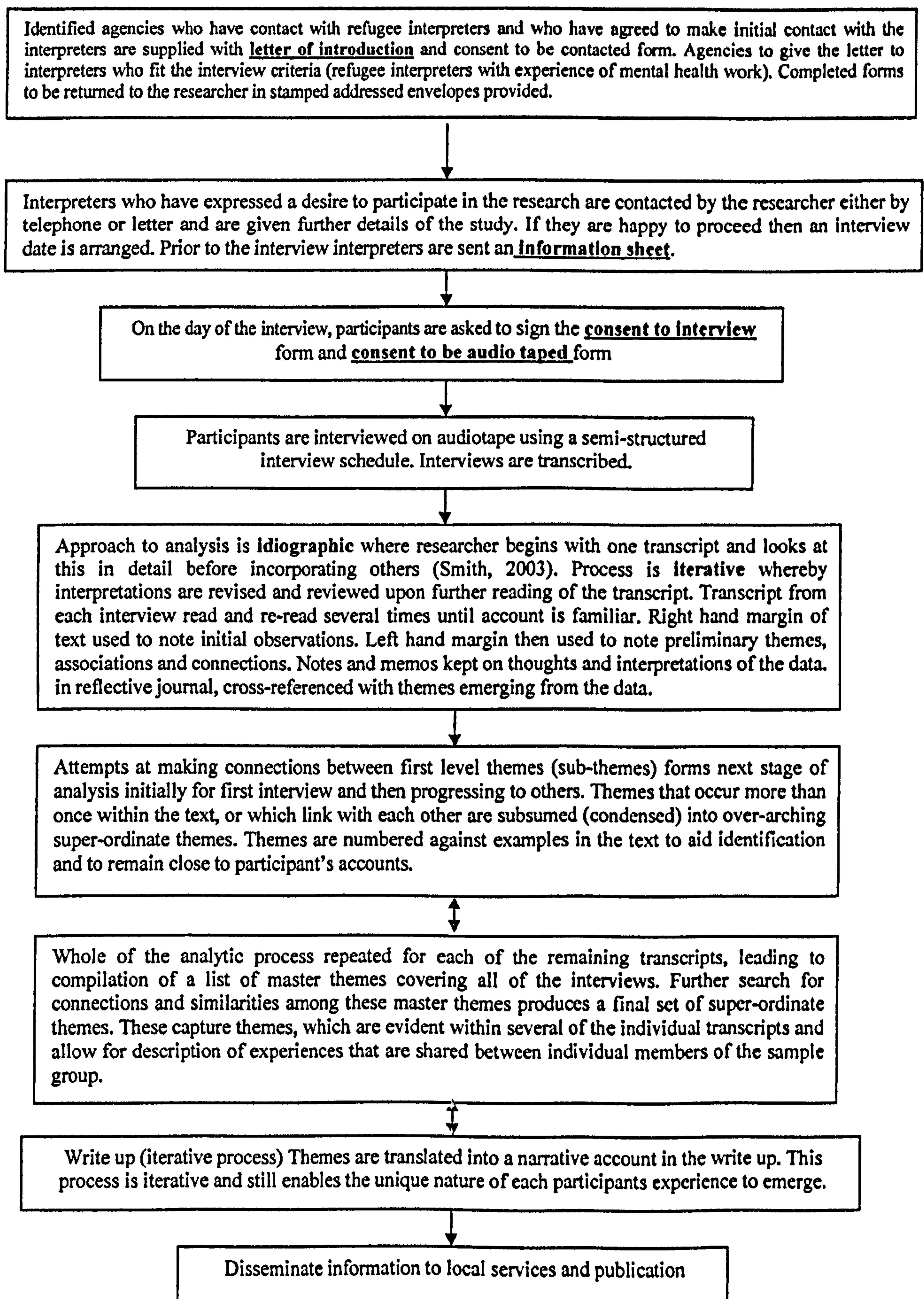
Each interview was analysed separately, following an idiographic approach that starts with specific examples before moving up to more general themes (Smith, 2003). The analytic process procedure followed a number of steps and was iterative, in that each level of the analysis informed the understanding of other levels.

Figure 2 (p. 66) provides a flow chart of the research process, from data collection to theoretical outcome. Whilst the diagram is linear, the research process itself is iterative the



interviews and analyses were the source of constant reflection and review. The arrows on the diagram illustrate this. During the process of data analysis notes were made in a reflective diary about how the clusters of themes related together and how they might fit within a coherent framework. The analysis of the data continued during the writing up of the results. A section from an analysed transcript is included in Appendix F.

**Figure 2. A flow diagram to illustrate the research process**





### 2.3.7 Methodological rigour and quality criterion

The centrality of researcher subjectivity and the application of the researchers interpretative frameworks in IPA mean that traditional quantitative criterion for evaluating research quality, such as objectivity and reliability that are based on assumptions of researcher objectivity and disengagement from the analytic process do not transfer readily to qualitative research (Madill *et al.* 2000). Several attempts, have however, been made to explicate ways in which the validity of qualitative research can be assessed (for reviews see, Stiles, 1993; Henwood & Pigeon, 1992; Packer & Addison, 1989; Hammersley, 1987).

Within the field of qualitative enquiry, effort has been made to articulate what constitutes good qualitative research (Elliott, Fischer & Rennie, 1999). Elliott *et al.* (1999) produced a set of ‘evolving’ guidelines for the publication of qualitative research studies in psychology, seven of these guidelines were considered pertinent to this study and were applied as follows:

- i.       Owning one’s perspective

There is a strong rationale in qualitative research for the researcher to articulate the perspective from which they approached their analysis, this is because the researcher functions as a channel or filter through which participants experiences are conducted and constructed (Madill *et al.* 2000). Details such as gender, ethnicity, age, therapeutic orientation and other factors, are used to inform the reader about the position from which the researcher writes.

**ii. Situating the sample**

Pen portraits of participants, providing a brief description of them and their life experiences were included to enable prospective readers to know who was interviewed and to whom the findings might be relevant.

**iii. Grounding in examples**

By 'grounding the interpretation in examples' (Elliott, Fischer & Rennie, 1999 p. 222 ; Smith 1996) the researcher utilises extracts from the data set to illustrate both the analytic process and to enable chains of inference and interpretation to be open to scrutiny and reflection, thereby enabling the reader to interrogate the interpretation.

**iv. Providing credibility checks**

Smith, (2004, personal communication) suggests that there are some valuable functions in having someone (or several people) look at the data and analysis. He maintains this can serve the function of a kind of 'audit' to check that the analysis is sufficiently grounded in the data, that the researcher has been transparent, and that the analysis is plausible. In addition, it can provide new perspectives that can enrich the analysis, so that it is still interpretative, but with the benefit of added insights that dialogue with others can offer. Furthermore, consulting with others may help the researcher to recognise some of their own 'taken for granted' assumptions. In this way reflection is enriched, as another's take on the analysis may help the researcher to recognise how certain of their own interpretative frameworks have informed the analysis. Smith (2004 personal communication) suggests that the aim is not to 'remove' such preconceptions, but be more conscious of them.

For this study consensus about the direction of the interpretation was achieved to some extent through supervision. Furthermore, the researcher attended a qualitative research support group of peers throughout the research process. The group comprised of four



trainee clinical psychologists who were all conducting qualitative research, and was facilitated by an experienced qualitative researcher. The researcher felt that this group served to decrease her biases and preconceptions and at times provided possible alternatives for approaching and interpreting the phenomena in question. Checking back (respondent validation) with participants to assess the credibility and reliability of the interpretation was not done. Barbour (2001) suggests that for interpretative research, going back to participants may corrupt rather than enrich the data and the researcher's thoughts were in line with this.

#### v Coherence

Internal coherence is the need to concentrate on whether the argument presented by the research is internally consistent and is justified by the data. Smith (2003) suggests that sufficient verbatim evidence (participant extracts) should be included in the research report to qualify the interpretation. Moreover, Elliott *et al.* (1999) suggest that the data should be interpreted in a way that is integrated and structured whilst 'preserving nuances' in the data (p.223).

#### vi Accomplishing specific research tasks

The researcher aimed to describe the research in a coherent and comprehensive manner so that the reader has a sense of how she approached the research question and came to form subsequent interpretations. Moreover, each stage of the analysis was clearly documented which enabled chains of inference and interpretation to be open to close scrutiny and reflection.

#### vii Resonating with readers

The researcher felt, that data should remain close to the experiential world of the participants, but be presented in such a way as to form a narrative or framework that was plausible, credible and meaningful to the reader. The researcher's aim was to expand

reader's appreciation and understanding of the work of refugee interpreters in mental health contexts whilst seeking to complement and extend the existing literature in this area. The researcher presented the framework at both peer and research supervision to check whether the framework of themes had resonance and were coherent in there presentation.

Additional methods of quality criterion employed, aside from those advocated by Elliott *et al* (1999), were; reflective listening and reflective validity. The researcher used reflective listening skills during the interviews (Stiles, 1993) and reflected back and summarised participants' responses to check that her understanding was compatible with the meaning intended by the participant. Mason (1993) suggests that empathic and reflective listening enables the researcher to gain an insider view. He suggests that 'the more quickly we understand the less opportunity there is for dialogue and the more opportunity there is for misunderstanding' (p. 192). This strategy has also been termed 'data credibility' (Streubert, 1994).

Stiles, (1993) describes this as the degree to which the way of the researcher's thinking was changed by the data. This is demonstrated by the researcher's ability to change initial views about the phenomenon, to be surprised or to come to new understandings. The researcher employed a reflective diary to assist with this process and shared her thoughts in the peer research group. Reflexivity requires an awareness of the researcher's contribution to the construction of meanings throughout the research process, and an acknowledgement of the impossibility of remaining outside of the subject matter whilst conducting research. This disclosure helped the researcher recognise the role her own assumptions, values and interests played in her interpretation of the data, and facilitated



consideration of how her personal and cultural perspectives may have coloured the research.

Yardley (2000) argued that the decisive criterion by which research should be judged are by impact and utility. In the discussion section of this report, the interpretations of this data are related to previous work in this field and resonant, accessible conclusions regarding the clinical implications of working with refugee interpreters in mental health and related fields are outlined.

### Chapter 3 Analysis/Discussion

The traditional format of a separate results and discussion section has been substituted for an amalgamated analysis and discussion section where the main themes are presented and interpreted. This is due to the narrative presentation of findings associated with IPA and has been the format for other IPA studies (Coyle & Rafalin, 2000). This is followed by a conclusion and general discussion where consideration is given to the methodological, research and clinical implications of the findings.

Audiotaped interviews with nine refugee interpreters, lasting between forty-five minutes and two hours were transcribed to form the corpus data for analysis. All of the participants demonstrated an ability to reflect and describe the lived experience of their work.

Accounts, however, differed according to use of metaphor and/or descriptive clarity, while some accounts were florid, others gave more tentative, less wordy accounts.

#### 3.1 Structure of Analysis

The method (chapter 2) provides an overview of data analysis in IPA and Figure (2) supplies an overview of the research process. A comprehensive account of the analytic

process for one transcript from the data set is included in Appendix (F). Its inclusion demonstrates transparency of process and as such contributes to the methodological validity and reliability of this study.

The following conventions were used in relation to excerpts: Square brackets [ ] denote repetitive or irrelevant text omitted for clarity, a series of three dots indicate a pause in speech. Where relevant, non-verbal information was included to contextualise the excerpt or facilitate clarity, for example (*laugh*) or name (*interpreting agency*). All of the data excerpts appear *italicised* to distinguish them from the text.

Participants were assigned pseudonyms to illustrate the range of nationalities interviewed and to enable the reader to connect and identify with the participants as individuals. Whilst there was a tension that cultural pseudonyms would compromise participant anonymity, anglicised pseudonyms felt inappropriate and numerical identifiers awkward and too distant. Therefore, participant extracts were allocated a name, gender marker, transcript number and a line number that corresponded with the start of the excerpt in the transcript. For example, **Vezire F1.L307** would relate to Vezire, female (F), transcript 1, and line 307.

### 3.1.2 Overview of themes

A total of fifteen clusters or sub themes emerged, which reflected the participants' experiences. From this, three super-ordinate themes were elicited via a process of collating and amalgamating groups of sub-themes that were common across transcripts. These themes captured the essence of the interviews and drew together the psychological content and interrelatedness of themes. The process was cyclical, moving back and forth between



themes, transcripts and super-ordinate themes. Incongruous themes were revised and replaced with themes that provided more apt summaries of their collective experiences.

The super-ordinate themes were then organised to form a narrative account, drawing upon the experiences of individuals to illustrate the features of the shared sub and super-ordinate themes. Excerpts from the data illustrate and ground the narrative in participant accounts. Within this, some themes emerge as descriptive and phenomenological, whilst others seek to extend the analysis to a higher level of abstraction and researcher interpretation, which may go beyond participants' conscious awareness.

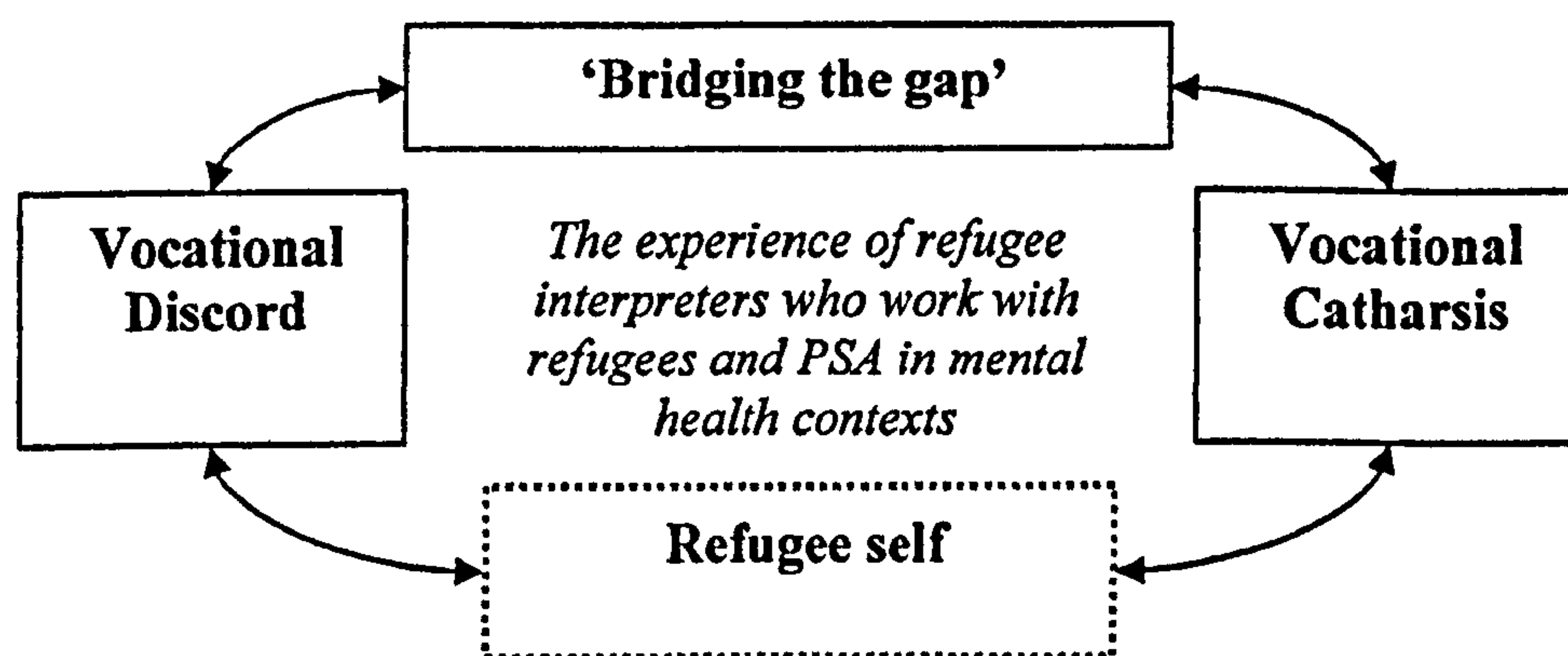
Figure 3 depicts the broad shape of the analysis. It is, however, not a static model, but one that is dynamic and fluid, reflecting the interconnectedness of participants' experiences. The model is recursive and illustrates how working with refugees and exposure to the wider mental health system affected how they came to understand or question their own experiences as refugees, and their lives post-exile. Whilst, in turn their own experiences informed their work and contributed towards their understanding of factors that contributed to mental well being or were deleterious to refugee mental health. The themes therefore, symbolise the interpreters' perception of their role with PSA and refugees in mental health contexts, and the impact that their work had on them as refugees themselves.

A caveat to the model is that 'refugee self' does not constitute a theme. The proceeding analysis however, starts by orienting the reader to identify with the interpreters in this study as refugees themselves. Whilst a detailed biography of participants is beyond the scope of this report, individual pen portraits are provided in Appendix (G). The fact that the interpreters were refugees, informed their work, therefore, any interpretation of their

experience of work would be incomplete without knowing something of the background to their own refugee experience.

**‘Bridging the gap’** (figure 3) emerged as an overarching theme. It is illustrative of the way the interpreters’ job as intermediaries required them to bring together two incongruent worlds. This theme explores their observations of this role and the mechanisms by which they sought to achieve it.

Figure 3. Process model of super-ordinate themes



The super-ordinate themes ‘vocational discord’ and ‘vocational catharsis’ could be regarded as the antithesis of one another. They encapsulate the **impact** the work had on the interpreters. These themes were, nevertheless, not mutually exclusive, whereby catharsis emerged from some accounts and discord from others, nor were they privileged in terms of efficacy or preference. As themes, they further elucidate the ambiguous and contradictory nature of the interpreters’ work. Aspects of the model will now be discussed in more depth.



### 3.1.3 Refugee self

For many refugee interpreters their experiences are synonymous with those of their refugee clients (Tribe & Raval, 2003). They too may have had direct experience of political, religious or cultural persecution and will almost certainly have sustained multiple losses (paragraph 2.2). These similarities often extend to the flight from their countries and to resettlement and life post-exile. The interpreters in this study were no exception to this. Each account of exile was, however, unique. As refugees, the interpreters were able to reflect on their own experiences of exile and their resettlement in the UK. Their recollections support much of what is known of this experience (Papadopoulos, 2003). Furthermore, their reflections of this time (Appendix G) contextualise the proceeding analysis and illustrate how their subsequent work with refugees often connected with their own experiences.

The accounts they gave of these early experiences, however, had a raw unprocessed quality and differed from the more reflective stance that emerged in their work related discourse (super-ordinate themes 1-3). This is perhaps an illustration of what Papadopoulos, (2003), refers to as ‘the phases of the refugee experience’. This may be due in part to the structure of the interview, as initially the interpreters were invited to share their ‘stories’ of exile. The use of the word ‘story’ is not used pejoratively, rather it describes the quality of these recollections. To some extent they resembled accounts that had been rehearsed and retold and are perhaps indicative of the asylum process whereby refugees are required to reiterate their ‘story’ to numerous professionals (Porter & Haslam, 2001). It was, however, apparent that through their work they had course to revisit these narratives. As such the following themes (in particular vocational discord and vocational

catharsis), illustrate their ability to revise, review and question their experiences both pre and post exile. The first of the super-ordinate themes to be discussed is ‘bridging the gap’.

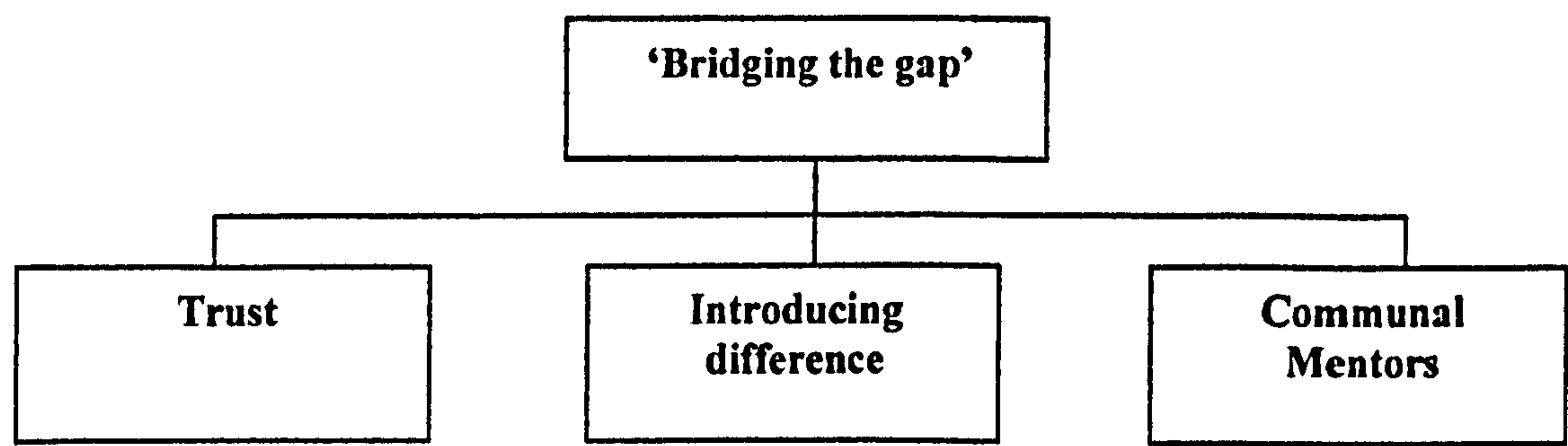
### 3.2 Super-ordinate theme 1 – ‘Bridging the gap’

‘Bridging the gap’, is the starting point of the analysis because it draws together the interpreters’ experiences of how they did their work and what doing the work involved. The theme is illustrative of how their job required them to ‘bridge the gap’ between culturally diverse refugee clients and Western mental health professionals by facilitating effective communication within the confines of a system where the dominant model was ‘one size fits all’. Whilst the later super-ordinate themes of catharsis and discord represent the **impact** that doing this work had on them as individuals, ‘bridging the gap’, provides a broader perspective on how the interpreters contend with having to do this. From a phenomenological perspective, the sub-themes illustrate their experience of how to and how they as refugee interpreters bridge this gap. As a theme, bridging the gap provides their perspective on factors that affect mental health service provision to refugees and refugee mental health.

Figure 4 depicts the three sub themes that constitute ‘bridging the gap’. Note that the process model of themes (figure 3) is cyclical and as such where appropriate this theme will be cross-referenced with themes 2 and 3. Each sub-theme will now be discussed in more detail



Figure 4. Bridging the gap – diagram of sub-themes



3.2.1 Bridging the gap sub-theme 1: Trust

There were several elements to this theme, all of which relate to establishing trust. Intercultural empathy and effective communication are often cited as core components for establishing trust (Pernice 1994), as is mutual respect. When they are present in a relationship, they serve to lessen the presence of uncertainty, fear and mistrust. The interpreters spoke of the importance of taking time to establish trust with clients. Once established this enabled clients to extend trust to other allied professionals. Trust was cultivated in several ways. Several of the interpreters chose to share their personal histories with clients. This was affirming for clients because as a fellow refugee the interpreter was someone whom clients felt could empathise with their experience as the following excerpt illustrates,

**George:** *'I like to introduce myself to the client and say don't be afraid, it's ok, because myself have been though what you are living, so talk to me freely' [ ] 'they like that, they knew (...) I think that they, they knew that I knew what they felt' (M8.L191& 522).*

Others in the system however, often construed this as overstepping 'professional' boundaries. Furthermore, identification with clients in this way had the potential to compromise professional distance (vocational discord). The interpreters would also seek to engineer trust by overtly endorsing mental health professionals and the mental health

system. As the following excerpt illustrates, sanction by the interpreter that seeking help for emotional difficulties in the UK was accepted, safe and beneficial meant that refugee clients unfamiliar with the mental health system were more likely to perceive needing to see a mental health professional as acceptable. For many of the interpreters however, this required confronting their own internal prejudice and stereotypes regarding mental health (vocational catharsis).

**Farrokh:** *'I explain to them if you go to see that lady you will feel better to talk about the stress and it is safe to go there, to talk with her yeah and they made the appointments yeah. Sometimes they need umm, the interpreter or me to explain in their language that it is Ok. (M3.L267).*

The interpreters themselves were, however, not immune as objects of fear and distrust. As intermediaries and perceived envoys of the system they were often distrusted by clients and to some extent 'feared' by professionals in terms of their cultural knowledge and expertise. Several alluded to the aura of fear and mistrust they observed was present among both clients and the system. They saw this as pervasive, encompassing refugee's perceptions of the system and the wider system's perceptions of refugees. Therefore, the potential for fear and mistrust was widespread.

As refugees, they were able to identify that the basis for many of their clients' fears (regarding contact with mental health services), stemmed from their clients association with previous systems, that were often allied with experiences of oppression and persecution. This concurs with Ly (2002) who found that refugees who were new to 'Western' culture tended to view mental health services with a degree of fear and uncertainty. As such, mental health professionals, and to some extent the interpreters, were perceived certainly initially as authority figures and were viewed with mistrust and suspicion. Furthermore, Western concepts, like permission to talk in confidence and



without reprisal, were ideas with which many clients were unfamiliar, as the following excerpts substantiate:

**Farrokh:** *'People are suspicious when they are asked to talk here [ ] at first they are scared they can't trust people'* (M3.L324).

**Rabet:** *'In most cases peoples trust has been destroyed they don't trust us, they don't trust doctors'* (M2.L 1103).

Being regarded as allies of the system, and as such mistrusted by fellow refugees, emerged as something that connected with the interpreters on a personal level. The interpreters nevertheless, saw their role as one of establishing trust with clients and offering reassurance with regard to the function of professionals in the mental health system. Many of the interpreters overtly facilitated trust, by assuming responsibility for the therapeutic relationship until it was established, as the following excerpt illustrates,

**Zahra:** *'I learn to really let the client benefit of the professional [ ]. Sometime [ ] I'd say some more positive things about the G.P toward the patient to feel they are not alone, they are not just left by themselves that somebody wants to take care of them [ ] I try to build a therapeutic relationship between my clients and the professionals'* (F9.L 656).

Fear and mistrust were, however, also evident in professionals and several of the interpreters alluded to this. Firstly, there were issues that related to working with an interpreter. Kline, *et al.* (1980), uphold that the presence of an interpreter may cause health professionals to fear being scrutinised (Roe & Roe, 1991). This may be more so in work with refugees where lack of knowledge and inexperience has the potential to evoke feelings of uncertainty and impotence. Research suggests that health professionals often feel overwhelmed and deskilled when faced with refugee clients (Tribe & Raval 2003; Fernando 2002; Senior 2002 & Temple 2002). The interpreters' observations were that many of the professionals they worked with feared being professionally usurped, as roles potentially reversed and the interpreter became 'the expert'. The following excerpt is

illustrative of many that suggested tension when the professional perceived the interpreter to be over-stepping their role,

**Azad:** *'There are sometimes where I teach them (the professional) something and there are sometimes where I have to say hang on a minute this is wrong and I think that the appropriate way is this, rather than this, umm.*

**Researcher:** *What sort of response do you get?*

**Azad:** *Well, I think that some of them get a little bit abusive some of them, because they think that you are teaching them something, you the interpreter teach them. (M5.L264).*

It was apparent that fear and mistrust were endemic in the wider system. Media stereotyping and political agendas appeared to colour professional attitudes towards PSA and refugees and served to fuel xenophobia and generic mistrust (Clark, 2004; Guardian 2002; Refugee Action, 2001; Wetherell & Potter, 1992), to the extent that many of the interpreters spoke of needing to contend with this in their work. As the intermediaries, the interpreters often bore the brunt of societal and professional ignorance towards their refugee clients. Many, however, were empathic that war and persecution were beyond the lived experience of most Western health professionals and as such they were aware that this had the potential to produce apprehension, fear and distance in terms of ability to empathise. They sought to challenge this by raising awareness and promoting intercultural empathy and compassion for the refugee experience. As the following excerpt illustrates, several achieved this by highlighting their own experiences as personal examples of the issues they felt many refugees faced.

**Veziire:** *'I tell them I know what it is to feel that, to feel so afraid (...), how these people must feel, war is the most terrible, terrible thing that can happen to people (...). It affects people so much that in twenty years time the experience with the war is still there it has affected me personally so much (F1.L716).*



As interpreters, they saw their role as helping to establishing effective relationships between the system and clients. There was, however, a sense that professionals frequently overlooked or were negligent of the fact that the interpreters were themselves refugees. As such, they would often forget to afford the interpreters due compassion or thought when their own experiences might have been similar to those of the client.

**Mahmood:** *'They asked me yes, are you all right what happened to you in there, why are you (...) you show a sympathy for him or (...). I told them no it's not a sympathy because he is talking about this evil it is similar to mine trauma that happened to me, yeah that's why' (M4.L 673).*

Ignatieff, (1999) and Van der Veer, (1998) suggest that adapting to new types of prejudice and discrimination are potentially more emotionally draining for refugees than continuing to live in a hostile but familiar environment. Many of the interpreters were aware that as refugees their clients were the recipients of racial harassment and that they often felt alienated by the host culture. They would seek to remedy this either by providing practical solutions or by permitting clients to 'off load' problems in their own language, wherein as the interpreter they would be the sounding block.

**Mahmood:** *'They are coming down and find the broken window, or (...) yes because they should not be there, people they just think we are foreigner and something like that [ ] They say, I didn't do any things to him, I'm respecting him, I'm not doing anything noisy. I'm not doing anything that is wrong to him, and they ask me, why do they do this to me, what can I do. So I tell them about reporting to the police and I tell them about the organisation called Victim Support where they can organise a person to visit you and sometimes I will talk to them, but I tell them who they can go to for help, (...), but I feel angry it has happened to them, that we can't be accepted here (528 -533).*

As the above excerpt illustrates there were, however, occasions when clients' experiences would resonate with their own (vocational discord). Therefore, whilst they often provided clients with an outlet for feelings, a 'wailing wall' (Sande, 1998) the fact that they facilitated this was either overlooked, or seen as a transgression of the interpreter client boundary by the wider system. This was despite the fact that by doing this they met a

need, one which they felt the largely under-resourced, language illiterate mental health system colluded with yet at the same time condemned.

Therefore, whilst the interpreters in their role as intermediaries endeavoured to cultivate trust between clients and the system, there was a potential for them to feel personally undermined when clients' experiences evoked fear and mistrust of the system in the interpreters themselves. These and similar themes form the basis of super-ordinate theme 2 'vocational discord'.

### 3.2.2 Bridging the gap sub-theme 2: Introducing difference

One of the ways the interpreters served to 'bridge the gap' was to invite difference. The fact that they were refugees and interpreters afforded them a dual perspective on the meanings each side held in relation to mental health and was one from which they were able to put forward ideas of difference to clients and professionals. This was achieved in several ways, as Gong-Guy, Cravens & Patterson, (1991) suggest many refugees are unfamiliar with the concept of mental illness and tend to associate it with severe pathology and institutionalisation. In relation to clients, the interpreters used the basis of clients' cultural fears to compare and contrast the known with the unknown and to introduce difference. In the following excerpt, Esmê explains how she allays her client's cultural fears that they might be thought of as crazy, by 'normalising' how mental health is perceived and treated in the practice of the host culture.

**Esme:** *'It is not that you are crazy or that you are mad or that something is wrong with you, it is just that we proceed like this in England. So its better to make it like an English thing, because in your country if people are stressed they go to see that kind of doctor or whatever if people have got headache they got to see a different doctor so the client know yes this is the doctor for me, for headache or for heart or whatever (F6.L1240)*



Many of the interpreters alluded to the absence of readily transferable taxonomies. Words or concepts relating to mental health often did not have the same meaning or resonance in their own language, whereas some did not even exist. This concurs with the work of Tribe and Morrissey (2003). The absence of cultural synonyms meant that the interpreters needed to find explanations that would have meaning for their clients. In the following excerpt Vezire explains how she would go about this.

**Vezire:** *'Yes sometimes it is quite hard because for example we don't have counsellors back home they are no counsellors (...) so it is quite hard to translate for the patient when they see the counsellor to explain what is their role..... there is no word for counsellor in my language so I had to try and match that is a part of psychology which where the people listen to their feelings and their opinions and you can say anything you want and you are not judged by them, this is my explanation to people' (F6.L530).*

For many of the interpreters, the concept of 'mental health' was also new to them. As such, many reflected on how they had needed to adjust to these ideas before they were able to incorporate and integrate them into their own idiolects and frameworks. The following example is one of many that highlight the process of accommodation that takes place in relation to integrating new ideas and explanations alongside existing ideas (vocational catharsis). The interpreter alludes to her own experience as being similar to those of her clients. From this perspective, however, she was able to both empathise with clients' existing frameworks and introduce difference.

**Zahra:** *'I didn't know what I had. I didn't know the mental illness... I thought maybe I have got sinus or something going on... and I went to the doctor, he was very good and he helped me and he realised what I might have and he gave me some tablets for the mental health. (F7.L269). \**

The perspective of the interpreters enabled difference to enter the system. Several of them gave examples of occasions where they had been able to offer another point of view, to challenge an assumption made by a professional with regard to the actions of a refugee client. Often this involved augmenting and contextualising observed behaviour with

cultural knowledge. The following example is typical of many where ideas of difference were introduced to broaden the wider systems perspective,

**Assieh:** *'But in that surgery they think that she (Partially sighted Afghani client) is cheating the system and I say no, I know her culture [ ]. You have to understand she was oppressed for forty years. She is a forty years old woman and she never had make up before...and the practice manager called me and she said how can she look in a mirror. (...), and I said look, I said I understand what you saying because you try to umm really, really you see so much maybe wrong things and you are suspicious and maybe it happening and I am sorry for all that, but this case is not like that. This woman after forty years, first time she feels she can do whatever, she wanted.'* (F9.L 895).

The provision of supplementary background information often enabled professionals to amend and extend their formulations of why refugee clients might present as they did. The interpreters', dual perspective also allowed them to contest some of the dominate discourses that surround causes of mental ill health in both cultures. There were several examples of this. Several served to ameliorate entrenched somatic presentations of distress by culturally endorsing the idea that overt expressed emotion was an equally acceptable way to vent feelings. Often, this involved augmenting clients' cultural expectations of what treatment they felt was necessary to alleviate their symptoms. As the following excerpt illustrates, many refugee clients experienced and expressed emotional difficulties as somatic symptoms (Zahra's own experience was illustrative of this pg. 85 \*). As such, clients often perceived medical intervention as the panacea to their problems. Invariably, the interpreters were the ones who were charged with introducing difference. Often they would do this by explaining that there were additional and supplementary approaches to treating emotional problems.

**Vezire:** *'I had a case where a young man was thinking that he had come to see a surgeon for his stomach problem [ ] I told him she is not a surgeon she is nothing to do with surgery, she is a counsellor, his sadness was in his body, not his head to him you see'.* (F1.L533)



Of interest, was that the combination of cultural heritage and post-exile experience seemed to permit the interpreters to entertain parallel explanations for mental distress. They appeared able to uphold cultural explanations in conjunction with Western concepts and not see this as particularly problematic or contradictory. This meant that they could introduce difference to clients in a non-confrontational and culturally empathic way. The following excerpt is illustrative of many that show the interpreters' ability to accept that clients may benefit from what they know in addition (or as opposed) to what the system thinks will be beneficial.

**Rabet:** *'In terms of what people actually get into mental health umm there has been in past things like going to (spiritual healer) to, to non-medical doctor and to a religious person that they probably would trust and umm probably they would feel better talking to so, they are other ways that people would deal with it. In terms of depression and umm stress people actually try to cope in their own way [ ] Umm, I think, well you know (.), sometimes you need to introduce new ideas slowly to them, the new things here and also to know about how they see things as well, to know a bit about how they make themselves better because that is what they know' (M2.L997).*

Difference was also introduced in terms of challenging the pervasive Western assumption that all refugees are traumatised and as such require therapy (Papadopoulos, 2002). Whilst many of the interpreters acknowledged the presence of emotional distress in their clients and were empathic to this, they sought to challenge the assumption that this was solely result of pre-exile experiences. Many of the interpreters sought to elucidate the factors that they felt impacted on refugee mental health. In doing this, they chose to accentuate their intrinsic strengths as survivors. Research suggests that mental health professionals often fail to capitalise on the strengths many refugees possess as a result of their experiences and instead opt for discrete models of trauma and diagnostic criteria for mental health (Miller *et al.* 2002).

In line with Miller *et al.* (2002), many of the interpreters saw social isolation, the loss of community, lack of environmental mastery, the loss of social roles, the corresponding loss

of meaningful activity and the lack of sufficient income as clients' most pressing concerns. Furthermore, they regarded practical advice, empathic support, language tuition and advocacy as practical solutions to these problems. These findings correspond with those of Eastmond (1998) and Papadopoulos (2002). The following excerpts are illustrative of many that give the interpreters' perspective on the main causes of *purported* anxiety and depression in refugee clients and what might be done to alleviate it.

**George:** *'These people, these asylum seekers and refugees they are strong people, they have been through so much and they have survived that (...). But, when they are here I don't think they know where to go, what to do, I don't think that they are ill they just need the (.), umm, network, to meet people and to feel part of this world, to be treated like people yeah and that umm, that will help with this the mental health, They are not crazy or mad, they are just alone and maybe they afraid of what will happen to them next. Umm, I think that people, professionals they forget that they are strong people from what they have seen, they forget that, you need to help them know that they are survivors and they will be well'* (M8.L 751).

**Rabet:** *'So umm, usually you will have a chat in the waiting room, find out what their problems are and some of them you can just sort out, they are easy things yeah (laughs) by just talking with them and to listen and sometimes they haven't, umm perhaps they haven't met anyone who can speak to them for maybe a week and they want to talk about everything really, they are often worried, just lonely people'* (M2.L555)

An important distinction was that the interpreters did not seek to reduce the impact that pre-exile experiences may have had on clients' mental health, in view of the fact that they had often had similar experiences themselves. It was rather that they saw post-exile factors as equally important. An important theme was being able to integrate and be accepted by the host community. They saw themselves in part as able to facilitate this, which links with their sense of 'bridging the gap'. Moreover, they perceived the sense of belonging and security that refugee status bestowed as helping to lessen the impact of pre-exile distress. This was reiterated frequently and had resonance with their own experiences. This will be discussed in more detail in vocational catharsis, although the following is excerpt illustrative of what many felt that refugee clients wanted from the system in relation to their emotional needs,



**Rabet:** *'I think lots of people, umm asylum seekers who come here all they want is a chance, all they want is to be treated as humans [ ] So, you know umm people come here for, it is for them to be treated as humans and to feel wanted and safe and umm, well (.), to be allowed to fit in.'* (M2.L 202).

To some degree, this provided a forum for more holistic formulations and ideas to be entertained in relation to refugee mental health. The interpreters' input as intermediaries or cultural brokers (Raval, 2003) constituted a degree of flexibility in what the research fraternity frequently describe as a mental health system constrained by diagnostic labels and models (Eisenbruch, 1991). Moreover, their contribution may lessen the temptation for professionals to attempt to force square pegs into round holes by adopting a one-size fits all approach to mental health, thereby running the risk of potentially treating illness that refugees do not have (Eisenbruch, 1991).

Murphy, Ndedwa, Kanani, Rojas-Jaimes, and Webster (2002) suggest that for many refugees mental health intervention is regarded as a desperate last resort when family, traditional healers and medicine have proven ineffective. It may be that by permitting different perspectives to exist, emic and etic solutions to mental health would be less polarised. Several of the interpreters alluded to this,

**Farrokh:** *'It is getting better now because people have started realising [ ] They are thinking about these issues, so it is getting somewhere, but it is still not you know perfect (laughs), it doesn't really umm it has not been part of their world to know these things, they don't have to know these things the same, but some they try or they will ask how it is for them'.* (3M.L189).

Access to training was perceived by all of the interpreters as vital. There was the sense that professionals would also benefit from training on culture, refugee issues and on how to work with an interpreter. This concurs with Sande (1998) who found that the status and quality of interpreting could be improved by more extensive and obligatory training for both interpreters and professionals. Finally, several of the interpreters proposed integration

training for refugees to alleviate their sense of isolation and to orient them to the new system, several saw this as an adjunct to their role although this again was a point of tension with other professionals.

**George:** *'Integration training, to help people integrate in the system, to help people understand this country, understand the culture, understand how to use facilities around them [ ] That is what I do as interpreter, until they can do it for themselves and not be so lost, feel so lost'* (M8.L154).

A caveat to both integration and assimilation of Western ideas is that health professionals must be mindful of indoctrinating interpreters in Western models of mental health. It might not be prudent to discourage refugees from traditional methods of alleviating mental distress. The healthy balance appears to be one whereby alternatives, as opposed to solutions, are introduced.

Moreover, whilst services may be content to use interpreters as adjunctive therapists, cultural intermediaries and/or cultural consultants, the scope of the interpreters' role as yet remains ambiguous and professionally undefined (Granger & Baker, 2003). As such many interpreters whilst feeling culturally and empathically obligated to 'bridge the gap', gave the sense that at times they felt as though they 'plugged' this gap. Whilst this had the potential to enhance self-esteem and utility, (vocational catharsis) it had the potential to harbour feelings of exploitation and disempowerment (vocational discord).

### 3.2.3 Bridging the Gap sub – theme 3: Communal mentors

The third sub-theme accentuates the role that the interpreters took in relation to their refugee clients. Whilst 'introducing difference' described how they introduced new ideas, this theme describes how they saw themselves as bridging the gap between the needs of both clients and professionals. There were several facets to this, the first of which was cultural etiquette. The interpreters often used their cultural expertise to tutor mental health



professionals on how best to negotiate cultural differences. The following example is indicative of many where the interpreter would use their shared heritage to take the lead on the best way to proceed with a client and therefore establish effective relations,

**Esmê:** *'Umm on this appointment we go and see the doctor and her husband comes as well and he says I have to ask the man to leave the room, so how do I do it you know in the way that he is not going to be insulted, he is not going to take wife with him, you know. So we have to find the proper words to say to him because if he's there, wife can't talk, she can't speak and she knows that when he is not there she can say something [ ] so we have to find proper way to say umm, you know I am a Kosovan woman, she is Kosovan woman I have to ask something for a woman's side do you mind if we would be half an hour. (...) And then he will go in nice way but if you say look something happened to your wife we have to talk about it would you please go out and then he would be insulted. (F6.L 855)*

The term communal mentors reflects the sense they gave of their role being collective in that they saw themselves as being able to provide both sides with the practical, bi-lingual and cultural information they needed to be able to achieve meaningful communication. Being a refugee was important in that they felt this enabled them to engage and empathise with what their clients said. For many, interpreting inevitably involved connecting with the clients' material to some degree such that the emotional cadence and content of what was said was not lost in translation as the following excerpt implies,

**Farrokh:** *'For my clients it is important yeah, I know what they mean, what they are talking about, for you they need to explain, for me they don't need to do that, I know and that helps I think, yeah. When they say something, if you come from that region, yeah and you have seen what client is saying yeah, so you can feel it yeah, you can (...), you know pass it to the professional properly and so that is very important, I, I bring their worlds to meet each other a bit yeah (3M.L493).*

A caveat to this is that whilst this fostered therapeutic alliances between the clients and professionals, the potential impact on the interpreter of connecting and sharing similar experiences with the client was something that was often neglected. Moreover, the ad-hoc nature of their job in terms of professional standing and structure meant that formal

support systems were often absent, and as such, the interpreters were frequently left alone to manage any feelings brought up by the sessions.

Fulfilling a role as mentor meant that often the interpreters supported clients by acting as a 'metaphorical scaffold', supporting clients whilst they learnt to negotiate their way around the new system/society. Their sense was that they may themselves available to counsel and tutor supposedly for a transient period, until others took over, or the client felt confident enough to negotiate the system alone. Again, in terms of clients needs, the scaffolding the interpreters provided was multifaceted and constituted emotional as well as practical support. The following identify the various elements:

**Farrokh:** *'Many times when we meet the clients, they talk about their problems and they need someone to listen to them, they can talk to us because we understand and it is simpler to talk, they can just use their own voice, their words. I listen yeah, I, I just listen to them sometimes until they stop telling the story, until they make friends , join (name), then they can look after themselves yeah, when they are read. (M3.L879).*

**George:** *'That is what I have to do. Take people show them the facilities, show them how to use the facilities, show them the people around them, the neighbours how to behave how to talk to the neighbours. How to use the bin, how to take the bin back out, when to take it out, because I knew that they don't know, you know and as well the mental health (.), what it is the mental health' (M8.L145).*

In terms of their role, the interpreters as survivors of the refugee experience exemplified optimism in the face of adversity and they would use their own experiences and knowledge to engender hope and optimism in others. As discussed, many Western health professionals report the sense of impotence and helplessness they feel in the face of providing adequate services to refugee clients (Burnett & Peel, 2001). By reiterating the strengths of refugee people, however, and their ability to accommodate life-changes, the interpreters encouraged renewed optimism and realistic goals in those who were attempting to provide a service. Furthermore, the interpreters used their own experiences of life post-exile to promote optimism in clients with whom they could empathise. For



many, mentoring involved empowerment and pointing out the positives in a society that for some felt unaccommodating and alien as the following excerpt illustrates:

*Assieh: 'These people don't have community and this is the interpreter to bring them to the new society. To say you are not any more victim, you are not any more umm in danger because that sort of sense of insecurity in society is still there. They don't easily trust, so the interpreter may be bringing sort of, building sort of connection to new society, to help them to come to the new culture, learning from positive side of culture' (F9.L831)*

### 3.2.4 'Bridging the gap'- section summary

Many authors have attempted to define the characteristics of individuals who are able to engage and achieve success working with refugee clients (Dinges, 1983; Kealey & Rubens, 1983 & Brislin, 1981). These include open-mindedness, racial tolerance and an accurate perception of the similarities and differences between the host country's social context, and the cultural heritage of the refugee client. The dual perspective of the refugee interpreters was such that it afforded them these qualities. As refugees they were able to provide a unique perspective on the social and emotional needs of this client group, and were well placed to comment on the similarities and differences they perceived between systems, and how best to negotiate these.

Whilst their work appears valuable, it often went unrecognised by the wider system. The literature on interpreting supports this observation (Granger & Baker, 2003; Tribe & Ravel, 2003). Therefore, the task of 'bridging the gap' between the worlds of their refugee clients and the Western world was often the catalyst for them to reflect, re-evaluate or at times reinstate their own experiences as refugees. The effect working with refugees and PSA in mental health contexts had on the interpreters as individuals forms the basis of the two subsequent themes, vocational discord and vocational catharsis.

As a theoretical approach IPA often has a secondary critical focus on language, meaning and context (a 'macro level' analysis). It was at this point in the analysis that the researcher chose to draw on and apply some existing theoretical and psychological constructs to develop her interpretation of the experiential accounts that emerged from the data. Smith (2004) posits that the parameters of IPA are such that it allows a 'hermeneutics of questioning and critical engagement' (p. 46) which enable the researcher to ask questions and suggest readings that the participants would be unlikely, unable or unwilling to see or acknowledge themselves. It therefore follows that super-ordinate themes 2 and 3 have a greater interpretative focus than super-ordinate theme 1.

### 3.3 Super-ordinate theme 2 - Vocational discord

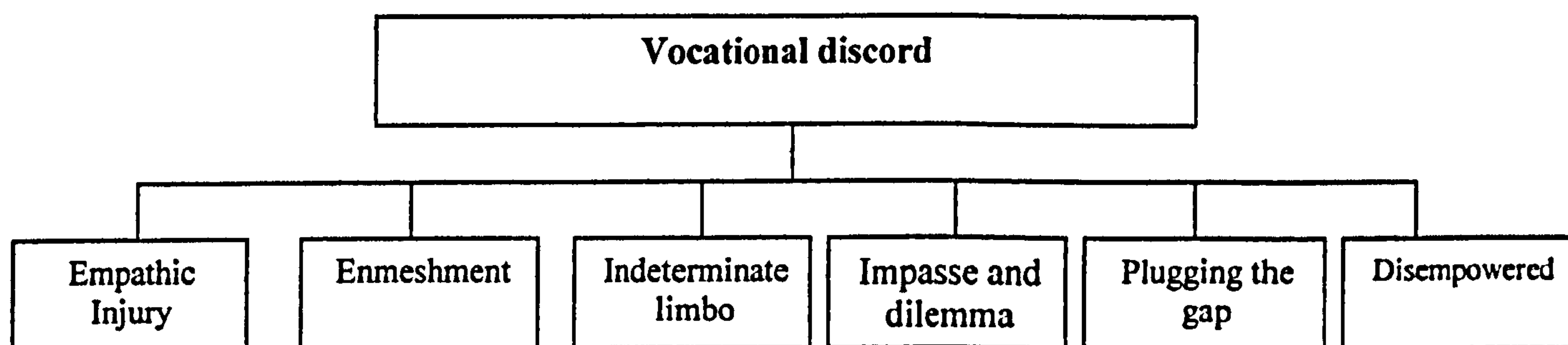
Vocational discord is the first of two parallel themes that describe the impact that working with PSA and refugees had on the interpreters themselves. Vocational discord is illustrative of the conflict and ambiguity that is present in the role of refugee interpreters who work with PSA and refugees. The theme explores the interconnection between their experiences of work and the effect this has on them as people. Figure 5 (p. 94) depicts the sub themes that constitute this theme.

Whilst work was potentially fulfilling and validating (super-ordinate theme 3), it could be destabilising and difficult. Work with clients when difficult and emotive feelings were evoked could stir up feelings of loss and insecurity and affect fundamental issues of identity. Their work often intensified and brought to the fore the cultural and societal tensions and divisions that were inherent in their dual role as both refugees and interpreters. Moreover, their own internal conflicts with regard to loyalties and obligations habitually forced them into positions of compromise and unsafe uncertainty. There was



then a potential for them to feel exploited, disempowered and alienated. This was to some extent reinforced by the ambiguous position they occupied in the wider mental health system.

Figure 5 Vocational discord – table of sub-themes



### 3.3.1 Vocational Discord sub-theme 1: Empathic injury

Through their work, the interpreters were frequently exposed to distressing and emotional situations. Ball (2001) found that 52% of generic interpreters reported significant emotional stress arising from working with PSA. As refugee interpreters however, this was intensified because they often had similar histories to those of their clients and in relation to mental health work, many had received little by way of training or formal support.

The descriptions the interpreters gave of sessions that they had found difficult had resonance with the literature on vicarious trauma and compassion fatigue. They suggest that there were aspects of their work that were emotionally deleterious. Pearlman and Saakvitne, (1995a) describe ‘vicarious trauma’ (VT) as *‘the transformation in an individual’s inner experience that comes about as a result of empathic engagement with other’s traumatic material’* (pg. 31). The effects of VT are pervasive, affecting all realms

of an individual's life, and are cumulative in that each new encounter with trauma can reinforce gradually changing schemas (Pearlman & Saakvitne, 1995b, McCann & Pearlman, 1990). Such exposure can have profound psychological effects, affecting sense of self-identity, worldview, spirituality, ability to tolerate strong affect and central cognitive schemas (e.g. core beliefs about safety, trust, esteem and control).

Exposure to clients' accounts of traumatic material meant that at times, the interpreters felt as though they had no safe place to retreat either within or outside themselves to deal with frightening or emotional experiences. Van der Kolk *et al.* (1996), maintain that not having a safe place to retreat is a pre-requisite for VT. Fundamental fears and insecurities that related to being unsafe were often situated in their pre-exile experiences and were reflected in their desire to (re)negotiate safety, and/or to reassert or reassure themselves that they were now safe:

**Zahra:** *'You have to tell yourself it's gone, it is gone'* (F7.L500).

**Vezire:** *'She was so scared and I could see her frustration and her misery in her face and she was just so scared. I have no need to be scared because there is no need to be scared'* (F1.L464)

Often these feelings served to strengthen and maintain core beliefs about vulnerability and locus of control and served to re-establish feelings of personal loss. Feelings of vulnerability were compounded by the fact that their work positioned them 'in the middle' such that they were often left feeling emotionally isolated and abandoned by both their own communities and the wider system.

To some degree, isolation was reinforced by their reticence to disclose their own experiences. This related in part to cultural expectations about being 'strong' and internalising emotions, but in addition, many perceived their personal experiences as



potentially toxic. Therefore, their fear that disclosure would harm others exacerbated their sense of isolation as described in the following extracts:

**Vezire:** *'I don't want them to understand because it just breaks your heart so much (F1.L739)*

**Mahmood:** *'When I talk to someone, it will remind them of the worst, the anxiety, the nasty things that happened to them' (M4.L575).*

Reluctance to share and disclose was at times compounded by a belief that 'others' (the wider system) could not or did not share their experiences and as such lacked empathy. This served to strengthen feelings of segregation and difference. At times, the energy of advocacy and introducing difference were subsumed by incredulity, fatigue and doubt.

Whilst professional supervision would be advocated as a possible outlet for these feelings, Sande (1998) cautions that whilst supervision for Western health professionals is an accepted method for debriefing, for people from other cultures it may be a strange and unfamiliar phenomenon and as such may be rejected.

Counter-transference (CT) reactions in relation to work with clients were evident. CT issues arose in two ways. Firstly, the interpreters' own experiences and emotional dilemmas were activated in the course of their relationships with clients. For some this was apparent in their inability to tolerate strong affect:

**Mahmood :** *'When he started to talk (...) he started crying and it's a bit difficult for me, even I am crying as well with him because it remind me of the evils that happened to me. He said I was detained and tortured because of this thing. He stopped talking and started crying and immediately, I couldn't do it any more ...and I'm crying as well with him...when he start crying, (...) immediately I am as well' (M4.L 629/649).*

**Vezire:** *'I had to stop I had to cry, to give a good cry first and then we had to carry on again but it was a very hard' (F1.L138).*

Secondly, refugee clients would often communicate powerful information about their emotional position at an unconscious level, which the interpreter came to know not

through direct verbal or non-verbal communication, but rather by finding themselves feeling or enacting the client's emotions or dilemmas (Flaskas, 1996). Therefore, the interpreters were often objects of transfer for their clients' emotions. Several described experiencing the emotions of their clients,

**Esmê:** *'You think oh it's just job and you don't know what will happen during the job, and then you feeling upset and scared and lonely in your life and I don't know why, you just feel like asylum seeker again yeah, so scared'* (F6.L1310).

The emotional impact of their work permeated their personal lives, to the extent that difficult thoughts and feelings often remained with them after they had finished with clients. This was indicative of the transformation in inner experience that comes about because of empathic engagement with others' traumatic material (Pearlman and Saakvitne, (1995a). A recurrent theme was that they found it difficult to get back to being themselves following stressful and emotional sessions with clients this suggests that encountering traumatic situations had a potentially pervasive and insidious affect on the interpreters lives. The following excerpts are illustrative of many that capture this experience,

**Vezire:** *'I came home and I just couldn't bring myself back to normal'* (F1.L16).

**Esmê:** *'I couldn't be, umm I couldn't be steady umm let's say, I want to do that at my home I want to clean but I couldn't finish my job or if I had to write a letter I couldn't concentrate'* (F6.L492)

Many of the interpreters spoke of feeling emotionally overwhelmed and exhausted by the work. Whilst emotionally charged sessions with clients could instigate these feelings, so too could feeling professionally isolated and devalued by the wider system. One way they were able to resolve these feelings was to withdraw and distance themselves when their work became too much. Parallels are drawn with the literature on burnout or compassion fatigue in helping professions. Neumann and Gamble (1995) argue cogently that over time unacknowledged and unprocessed VT or counter-transference may set the stage for



‘emotional exhaustion, depersonalisation, and reduced feelings of personal accomplishment’ (pg.344). These three components of burnout as conceptualised by Maslach and Jackson, (1986) were manifest in the interpreters’ accounts as the following excerpts illustrate.

i emotional exhaustion

**Farrokh:** *‘I didn’t go back to (name) for a month yeah. To be honest I didn’t want to see a refugee, an asylum seeker, or some people who are working with them yeah very deeply. I wanted to be (name), who lives in UK now, not one of them. I just didn’t want you know’* (M10. L460).

**Mahmood:** *‘I just couldn’t do it (...), I remember thinking I just want to get away. I needed to be somewhere else right then’* (M4.L 649).

ii depersonalisation

**Assieh:** *‘You feel like a cattle at market’* (F9.L1159)

**Rabet:** *‘They never really ask about me, umm I don’t think they see us that way’* (M2.L77).

iii reduced feelings of personal accomplishment

**Zahra:** *‘You feel useless’* (F7.L813).

**Esmê:** *‘I felt like I was stupid [ ] I thought what will they think of me’* (F6.L 1067).

### 3.3.2 Vocational Discord sub-theme 2: Enmeshment

At times, the cultural and experiential similarities of the interpreters and their clients overlapped to the extent that their emotional boundaries and responsibilities became blurred. The unmitigated sense of responsibility and obligation the interpreters felt, as a fellow refugee was palpable in their discourse. They gave the impression that as refugees they were, by fate co-participants in events of humanitarian adversity and as interpreters, they

were duly obligated to help. This was evidenced by the predominance of the word **should** in many of the accounts.

**Assieh:** *'I think the interpreter is really dragged to this sort of situation and they feel responsible as a result of they been there. (F9.L1071).*

**George:** *'I have been through it [ ] I am as a refugee myself. I should help them now. (M8.L93).*

Villarreal, (1994) maintains that many refugees view the interpreter as an ally both culturally, and in terms of someone who can identify with their experiences. Whilst the interpreters used their refugee identity to forge alliances and establish trust, they were often forced to contend with an emotional need to rescue clients. This was recursive in that it connected with them feeling personally responsible to make things better for others, which was reinforced by recollections of their own experiences.

Their job invariably meant that they were the only person who could understand or communicate with the refugee client. This was exacerbated in the context of mental health appointments where clients often presented as distressed and did not understanding what was happening. For many of the interpreters, experience of psychiatric settings was new to them and for some this evoked fear, uncertainty, and cultural prejudice appertaining to madness. Moreover, mental health staff who were themselves complacent with this setting lacked compassion and seemed unaware of their needs. In the extreme, some of the interpreters saw their own role with clients as emulating their former oppressors, as the following excerpts illustrate:

**Rabet:** *'About three o'clock in the morning they (the nurses) were trying just to umm give him an injection and restrain him. But he was shouting so much and he was kind of, I was nearly well, (...), I was nearly crying because he was just saying, why are you doing this to me, I'm not doing anything to anybody, I'm not hurting anyone and this it was all in Albanian, pleading with me to stop them (.). I felt so bad like I was his persecutor, like I should stop them, umm it was about four o'clock in the morning when we were finished and the nurses obviously were used to that because they were like dealing with every day clients, (.), but for me it was my first time and I kind of I just*



*couldn't sleep that night. Umm ... the only person that he could speak to me was me and I was actually listening to him talking when six or seven nurses were trying to hold him down to give him the injection. He was telling me that this was what had happened back home when he was tortured. I felt terrible. Yeah, I guess I felt responsible for just being there and not helping him more, he must have thought me like the devil (M2.L 679).*

The cultural and refugee identities of the interpreters were entwined with those of their clients to the extent that they too were personally offended and affected by culturally insensitive remarks that were made to their clients. As the intermediaries, they would deal with this 'professionally' by challenging assumptions and advocating for clients. However, such instances often reinforced their own feelings of anger, mistrust and insecurity.

**Azad:** *'I felt that as it was happening to me and it's just that poor lady was explaining was explaining what was happening to her and how it happened and then this doctor started talking about oh well numbers of asylum seekers are getting higher. I thought hey what's going on what have numbers got to do with what this lady was saying, your not Home Office are you, you don't own this country do you, no you don't' (M5.L900).*

Clients' negative experiences of the system and society were often analogous with those of the interpreters. Whilst this had the potential to rekindle cultural allegiance, it appeared to inhibit acceptance of the host culture and reinforce difference.

### 3.3.3 Vocational Discord sub-theme 3: Indeterminate limbo

This sub-theme reflects the conflict of identity that arose for the interpreters in relation to their work, with their dual identity as interpreters and refugees. This was compounded further by their sense of themselves 'bridging the gap'. Whilst there was potential to identify and ally with clients (enmeshment), work evoked existential dilemmas and discord. This appeared to impact on the interpreter's sense of who and what they were. As such, complex jumbles of feelings and personal and cultural loyalties were commonplace. The job placed the interpreters in a kind of 'identity limbo' whereby they would vacillate

awkwardly between their cultural self, refugee self and their evolving acculturated, professional interpreter self.

Wilson (2002) suggests that often identity goes from being 'liminal'<sup>10</sup> and multiple, where an individual's role or social category is temporarily or spatially suspended, before they reconfigure who they are and ultimately become more stable. During this transition individuals are, however, briefly dipped into non-identity and as such dwell in a threshold state of ambiguity and indeterminacy (Turner 1974). The following excerpt is one of several that allude to this; **George:** *'I am not sure who or where I am'* (M8.L336).

A number of characteristics mark the transition period. There is a process of removal of status and identity, with 'threshold persons' being treated as outsiders or exiles. For the interpreters their life choices post exile and/or their involvement with the system often meant that they were marginalised and seen as separate from the refugee community and/or their cultural group. The following excerpts are illustrative of this:

**Zahra:** *'Because I am married to English so many thoughts goes in their heads'* (F7.425)

**Mahmood:** *'They (client) say the government they book you and they will snub you and talk about you sitting on a chair or whatever...They see me as an outsider definitely yes'* (M4.L849).

For most members of a cultural community, however, the liminal period is a point of transition, a state entered into briefly and a passage to something else. One could surmise that for PSA, resolution of the liminal period might be refugee status and for refugees, ultimately acculturation and acceptance into the host community. For some, however, the period of transition becomes the status quo. In this context, the idea of being betwixt and between seemed to fit with what the interpreters described. Their work frequently placed

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<sup>10</sup> Liminality: is the state of being neither-this-nor-that, betwixt and between, neither me nor not me.



them in the 'middle', a position that was often untenable but one, which, by virtue of their dual identity and the acquiescence of the wider system, was often inescapable. Being in the middle resulted in personal, cultural and professional tensions, whereby allegiance to one or other identity would invariably result in cognitive dissonance. In the face of this pressure, one option was to remain in indeterminate 'limbo', not able to move on and not able to go back. Esmê's excerpt is one of many that alluded to this.

**Esmê:** *'If I go back to my country, no one will accept me there, my behaviour or (...) or nothing of mine. I am now used to something else. I can't change all this nations' mind how I am used here and this is not good, I am isolated, I am in the middle'* (F6.L1138).

The interpreters were aware that clients would move on and become less dependent on them and to some degree they felt as though they were instrumental in facilitating this. This was however, bittersweet because 'bridging the gap' both perpetuated and necessitated remaining in limbo. For some it was as though as interpreters they became prisoners of their work, not permitted to move on, by clients or the system whilst they occupied the role. These findings echo those of Papadopoulos (2002) and Tribe (1999) in that many of the interpreters experienced the dilemma between needing to honour the past and to '*live with the climate of their homeland culture*' and at the same time move on with their lives and invest emotionally in their new lives in the UK (p.110). These antithetical tendencies invariably create and sustain internal discord and tension.

#### 3.3.4 Vocational Discord sub-theme 4: Impasse and dilemma

In addition to fundamental issues of identity, work presented the interpreters with cultural and existential dilemmas. Whilst confronting pre-exile tensions and loss had the potential to be cathartic, some encounters appeared to defy reparation and solutions and served only to extend and reignite internal conflict and cognitive dissonance. Moreover, their exposure

to situations was often not choice, but instead the result of mental health systems and policies that were naïve to the socio-political reasons people were in exile. The following excerpt is illustrative of such an encounter. Here a Kosovo Albanian interpreter recounts her dilemma when she was required to interpret for a Serbian client (appendix G) provides an historical context for the Balkan conflict), she found herself in this situation because the hospital had asked for an Albanian interpreter without establishing the ethnic group of the client.

**Vezire:** *'They said oh we need an Albanian interpreter and when I went there he was a Serbian-Croatian and I was in very difficult position because I was still (...) I still have anger and hatred towards Serbian people for what they have done, but going there I think that that was the worst time of my interpreting experience because I felt very sorry to leave a poor old man who was going to go in theatre soon and he had no way of understanding the doctors about his illness..... On the other hand, well I was well, very angry doing translation for him because, it might be his son, nephew or maybe his family who live in Serbia and who has killed my uncle, so I was in the middle of feeling what should I do' (F1.L618 -625).*

In addition, the following excerpt is illustrative of a similar dilemma. Here Esmê describes the conflict of emotions she felt interpreting for a Serbian client, when they were the reason she had fled her country.

**Esmê:** *'He said look its not my fault whatever my fathers did, so my grandparents did, it's not my fault that you know I am where I am and you have to do interpreting for me. I said umm I can't say oh no, you know umm inside you feel you know, also your face shows that you don't like that person, you know when you see him you say, oh my god I have to do it, I need to do this to let it be past and then we have to say the words like they say and then you have to indicate also to put the words on your face to all the reaction and everything umm and you think what right has he to feel that way umm, it is because of him I am here' (F6.L346).*

Many of the interpreters were fiercely loyal to their nationalities and culture. There were however, dilemmas maintaining these against the expectations inherent in their role as interpreters. Confidentiality was often one such area of professional/cultural conflict, there being times when the interpreters were ostracised by clients because they were perceived to have transgressed cultural expectations.



Their role was such that compassion, guilt, collusion and adversary co-existed with feelings of disbelief and anger. At times, they would collude with clients against the system and/or would actively seek to absolve themselves of potential blame in the face of diagnoses or decisions that were culturally contentious. In contrast, however, although as fellow refugees they could identify with one another's experiences, there was conflict with regard to the extent that they had taken on the strictures of the West. The following excerpt is illustrative of many that captured the interpreter's sense of the frustration and conflict at having to occupy the middle ground and their sense of feeling powerless to challenge things:

**Zahra:** *'Sometimes I feel which I shouldn't as interpreter I feel like, god they lying, why should I interpret all these lies... Sometimes even, I know that they lying, it's not my place to tell, or I can't tell to the professionals or you know it should be like umm (...). If you know that they lying just turn the job down (.) say I don't want to do this job any more but they are so shortage of Albanian interpreters and you can't do that because they keep asking you, you know so many times for the same client and you can't really say no, so I just interpret whatever they say, even though they lies ... It makes me feel like I am betraying the professional so I feel bad yes because I'm have interpret lies, but interpreter is interpreter. I have to interpret the clients words (.) to you and your words to the client nothing else is involved in interpreting'* (F7.L 623-639).

Positioned in the middle as they were necessitated placating both clients and the system.

As such, ambiguity and conflict regarding the interpreter's professional identity and the extent of their role was ubiquitous, among the interpreters, their clients and the wider system. Multiple roles were common and were apparent in the way they described their job and to some extent themselves, as the following excerpts imply:

**Farrokh:** *'These people, refugees or asylum seekers don't, I don't think they understand your role as interpreter. They think, yeah, you are doctor, you are engineer, you are interpreter, you are everything yeah, even to help with the spirits yeah'* (M4.L 694).

**Zahra:** *'You are counsellor, you are taxi driver, you are supporter you are money lender you are, umm informing about things the services. You umm just umm, you are even a childminder...'* (F7.L244).

Their vocational self-perception fluctuated, whereby they would provide contradictory accounts of their role. Sometimes they presented themselves as the interpreter and nothing else however, these would be juxtaposed with accounts of themselves as generic community workers. Expansion or contraction of the role, however, invoked internal conflict and tension. On one level they would be welcomed as fellow refugees, but ostracised by the system, whereas moving in the other direction invariably had the opposite effect and would result in them feeling excluded by society and professionally as the following illustrate:

**Mahmood:** *'I try to tell them (refugee clients) but sometimes it makes no difference, they see me as like one of you then' (M4.L.769).*

**Assieh:** *'They ('professionals') criticise the interpreter because we are doing so much, sometimes they criticise us because of doing so much umm they say we don't know the professional barriers, boundaries' (F9.L785).*

Estrangement was a potential consequence of acculturation, whereby being allied with health professionals resulted in alienation from the community. This had the potential to reinforce fundamental feelings of non-acceptance, distance and perpetuate vocational limbo. In essence, this was perpetuated by the general nomenclature and absence of professional structure that surrounded the interpreter's role.

### 3.3.5 Vocational Discord sub-theme 5: Plugging the gap

One hypothesis to emerge from the data was that perhaps the interpreters sought to manage internal discord and issues of status and non-identity by 'plugging the gap' in service provision. Tribe (1999a) posed the question of whether interpreters 'bridge the gap' or 'stem the flow' in relation to their work with PSA and refugees (p.567). Research suggests that there is often no budget to provide ongoing health services to PSA and refugees and several of the interpreters alluded to this. Voluntary agencies and interpreters



are therefore the people most likely to fill the gaps in service provision (Mulhall, 2003). A common theme to emerge was that of 'limited resources' and as such the interpreters often saw themselves as the ones obligated to provide a service. This, was however, often less by volition and choice and more by circumstance as the following excerpt illustrates,

**Farrokh:** *'I mean if, if the world wasn't like that yeah, if people didn't need help then I wouldn't have done it yeah, I would have done something else (...) but I don't think that there are enough people to do such a work (M10.L479).*

Their conviction that no one else who could provide support meant that they occupied a position where there was no clear distinction between what constituted personal and professional involvement with clients. As such, contact with clients invariably extended beyond contracted time and into the realms of their private lives, blurring work/life boundaries.

**George:** *'Sometimes I have to tell my boss at work, I am sorry tomorrow I will not be at work because I have a client who really needs support, and sometimes that gives me trouble at work, because my boss does not like me to do that, he says that is not your job' (M8.L.291).*

**Assieh:** *'I've been interpreting for a few people which is they very suicidal and I give my telephone number so I can be there to listen.' (F9.L 391).*

Protracted contact with clients and role extension served a purpose in that it appeared to assuage their sense of personal and humanitarian responsibility. In doing so however, there was the potential for enmeshment, which entrenched them in the role of rescuer and compromised professional distance. Whilst their work had the capacity to foster self-esteem and personal utility, there were often overwhelmed by the burgeoning demands of the role. This was expressed in various ways, most notably, as dissatisfaction with the demands and ignorance of the wider system. Furthermore, the demands and omnipresence of clients affected their sense of personal space and ability to distance themselves from

their job and contributed to their sense of feeling overwhelmed as the following excerpts imply.

**Farrokh:** *'I mean sometimes I am scared to go to town yeah (laughs) because I get like ten or twenty people (...). I think the majority of the refugees or asylum seekers know me yeah (M10.L681).*

**Rabet:** *'They (clients) see you as theirs, not as someone with their own life (laughs), now they even ask my wife, do you know where (x) is , where can I find him (.), sometimes I have to hide from them (M2.L579).*

Their multifaceted role was often the forerunner for increased status and power in the community. Indispensability came at a price, however, because it held the potential to foster dependence and insecurity whereby refugee clients came to rely on the interpreters as the solution to their problems. Moreover, many perceived PSA as vulnerable, which was reinforced by their own recollections of vulnerability. This in turn served to fortify their inflated sense of personal responsibility and was a potential contributory factor for professional burnout and compassion fatigue.

Tribe and Raval (2003) propose that conflicts arise when interpreters are not valued or sanctioned by clinicians to take on a broader role, and when interpreters themselves become unsure about taking on a role that goes beyond their job description or level of skill. Raval (1996) argues that interpreters' not having a distinct professional status raises issues about power and professional boundaries that may result in them feeling vulnerable and disempowered. Many of the interpreters felt overwhelmed by the multiplicity of their role. This was however, a role that they had in part engineered in an attempt to reconcile their own personal and emotional needs, which on some level it met. It was, however, a role that an under-resourced system, naïve to the needs of PSA capitalised. Therefore, the interpreters by continuing to 'bridge the gap' were in some ways caught in a catch twenty-two situation as the following excerpt illustrates.



**Farrokh:** *'You are expected sometimes by professionals to act like a professional and you do get involved you know in stuff and circumstances and I think you don't realise what you are doing and then, you say bloody hell! I was the counsellor there (laughs) and you think I shouldn't do such a thing, but you do, yeah you do (M10.L779).*

### 3.3.6 Vocational Discord sub- theme 6: Disempowered

Disempowerment had several facets, the first of which was value. Being or feeling valued was intrinsic to the cathartic experience the interpreters had of their work (vocational catharsis). Just as feeling valued was associated with empowerment and self-esteem, feeling devalued was allied with issues of disempowerment and self-doubt on a professional, personal and humanitarian level.

Their sense of value was linked intrinsically to their work. On occasion however, they perceived themselves to be nothing more than commodities, human stock to be bought or sold. For some the metaphorical references to 'machines' and 'cattle' in the following excerpts were synonymous with their experiences pre-exile where they had felt dehumanised:

**Assieh:** *'I feel like it is a supermarket like umm the Safeway, buying people [ ] you have people looking at us like that, do you understand? Very, very cheap profession and very unrespected and I, the most I hate is people looking at me in a material way, which is I really, really umm hate to feel that I'm seen like that, but that's the way that we are seen (F9.L.1159 -1171)*

**Rabet:** *'Yeah sometimes I feel like a machine' (M2.L776).*

Their status as commodities did, however, provide opportunities for them to capitalise on their language skills and knowledge (reciprocal gain), although promoting themselves in this way meant that there was potential for them to feel manipulated and exploited by the system. There was a sense that work represented hard economics and invariably privileged those professionals who had the power,

**Rabet:** *'They buy your service, don't they and then when the job is done you go, for them I think that is all it is, all there is to it. After we have gone (.), umm, I don't think they think about the interpreter umm (M2.L77).*

A recurrent theme was that being an interpreter did not confer professional status in the eyes of other professions. In an attempt to reinstate professional value and respect, the interpreters would compare their pre-exile profession and status with their current situation, and at times, they would flirt with reinstating aspects of their former professional identity. This was however, often a precursor for conflict. Several questioned the wider system's inability to acknowledge what they themselves had endured as refugees. The following excerpt from Assieh, who was a solicitor pre-exile, encapsulates this. In addition, the excerpt from Zahra illustrates how feeling disempowered in relation to work often reinstated core schemas of powerlessness as a person.

**Assieh:** *'This is when it comes to me I was a professional in my country , I was doing everything in my country and I just so humiliated in this country, how much I have to pay the price (F9.L1159).*

**Zahra:** *'You feel so powerless and just umm like little ant, they step on you with their foot and they don't care (F7.L321).*

### 3.3.7 Vocational discord - Section summary

This theme emerged in response to the position the interpreters found themselves in when they were required to 'bridge the gap'. Vocational discord is the antithesis to vocational catharsis, yet both themes describe the impact work had on them as refugees themselves. Vocational discord reflects the potential for their work to reinstate feelings of emotional enmeshment, insecurity and cultural alienation, all of which are potential prerequisites for compassion fatigue. Working with refugees had the potential to create internal conflict, uncertainty and ultimately compound rejection. Other contributory factors were the attitudes and ignorance of the wider system towards the interpreters as refugees

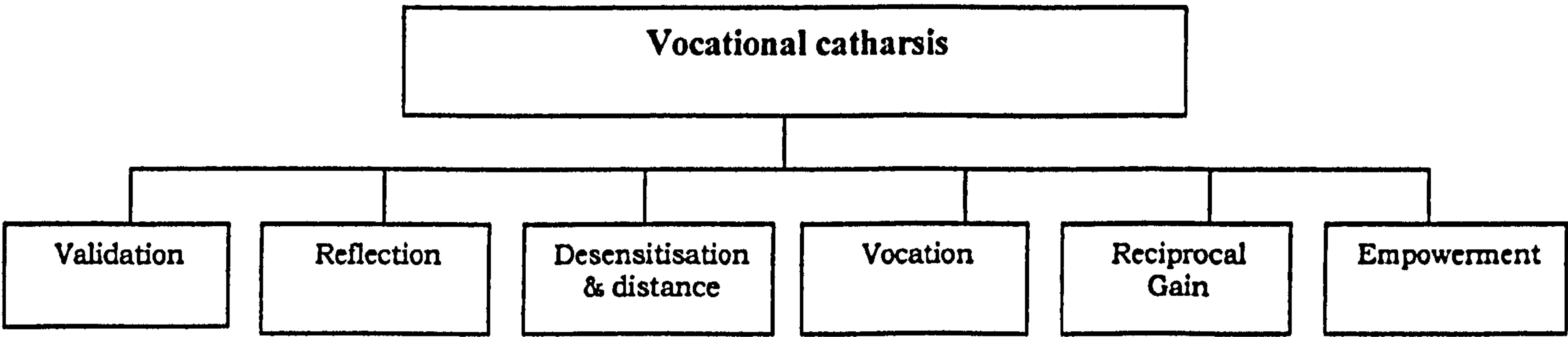


themselves and a lack of professional recognition for the contribution they made to understanding refugee mental health.

3.4 Super-ordinate theme 3 -Vocational Catharsis

‘Vocational catharsis’ is the second of two parallel themes that deal with the impact of the work on the interpreters. It encapsulates the sense that through their work, the interpreters were able to make sense of their own experiences as refugees and in so doing, they were able to satisfy some of their moral, cultural and humanitarian responsibilities. Moreover, work appeared facilitative in that it enabled them to meet aspects of their emotional, financial, psychological and societal needs. Figure 6 depicts the various sub themes that constitute vocational catharsis.

Figure 6. Vocational Catharsis – table of sub-themes



The dictionary describes catharsis as ‘the bringing of repressed ideas or experiences into consciousness, thus relieving tensions or the purging or purification of emotion’ (Collins, 2003). The word catharsis brings to mind for many, however, the sense of a bittersweet experience, potentially painful yet ultimately beneficial. Vocational catharsis is essentially an interpretative theme.

### 3.4.1 Vocational Catharsis sub-theme 1: Validation

This theme reflects the sense the interpreters gave of having their own experiences validated through their work with refugees. This concurs with the work of Leubben, (2003) and Tribe (1999b) who state that exile and loss is a collective experience and that to hear others' stories can be both validating and affirming. There were several facets to feeling validated. Validation came in the form of hearing that others had had similar experiences, which reinforced the interpreters' sense that it was not just them. The task of translating meant that as interpreters they were the voice for their clients' stories. These stories however, often resembled their own, allowing them to hear and validate their own stories through someone else's voice. Sande (1998) likens this experience to indirect therapy. The following excerpt alludes to this.

**Mahmood:** *'Work sometimes really helps me, because you say something and although it is not your story it is somebody else's story you are saying to doctor or you are translating the language but it helps you because you say exactly the same and you hear yourself'* (M4L186).

Esmê's quotes are further examples of the process of validation. In the first excerpt, she recounts her own experience, whereas the second is illustrative of her reflecting on a client's experience and relating it to her own. The third is a reflection that this was not something that just happened to her.

**Esmê:** *'I umm (...) do remember that there were five together (Serbian guards) when they came in] then they push me around and they said where is your brother, tell me where he is (...) and then someone comes down and he came close to me and starts touching me like this and umm then (...) umm then (...) umm it happened (...) they did rape me actually'* (F6.L63).

**Esmê:** *'She was telling the story of being raped ... it is similar to my experience'* (F1.L195).

**Esmê:** *'Lots of ladies were raped (...) it happen to them in the war, same as for me'* (F6.L914).



Blackwell (1997) suggests that bearing witness to others' stories in this way may enable refugees to recover a sense of continuity as a whole person. He suggests that in this context it is possible for a sense of humanity to be reaffirmed.

Authenticity was a factor in this, 'having been there' themselves enabled the interpreters to verify and corroborate the accounts others gave. Whereas genuineness legitimised what had happened, attempts to deceive invalidated their experience.

**Rabet:** *'I would actually understand that the client was not making it up because you know I was there myself and he was just explaining exactly the same as happened to me in a way'* (M2L 332).

**Farrokh:** *'Mmm, yes, yes, because we know it has happened we can accept and know their stories, they are ours as well, yeah'* (M10.L505).

The impression they gave was that validating their own experiences enabled them to move on. This links with Luebben (2003) who suggests that the emotional and cognitive effort of revisiting the past may help to support an internal mental integration by refugees of their experiences and make it possible for them to begin to develop a coherent life story from a post-exile perspective. This extended to the fact that as refugees themselves they were in a position to offer validation to clients (exemplifying optimism).

#### 3.4.2 Vocational Catharsis sub-theme 2: Reflection

Work with refugees, often prompted the interpreters to reflect on their sense of who they were and where they had come from. In line with Harvey (2002) opportunities for reflection, although at times painful, appeared to benefit the interpreters in a number of ways and were often a transformative experience. There were again several facets to this. The first was acknowledgement, both of personal pain and of the cost of difference. Bolton (2002) suggests that this happens when people feel themselves to be in positions of

'relative safety'. Their refugee status and occupation as interpreters afforded a position of relative safety, from where, they were able to begin to revisit and reflect. Moreover, from this position it appeared easier to admit and not underestimate the significance of their experiences:

**George:** *'When I am in bed I will be thinking ohh my god, that happened to them as well at that time. I think about it, you know, I think that thing, those things that happened to us, those things yeah, they were terrible things to happen'* (M8L450).

Through their work, the interpreters often encountered refugee clients from rival communities and in some cases people with whom they had been in conflict. Whilst these situations inevitably invoked strong feelings, they were also cause for reflection and sometimes a degree of absolution. There was a sense that for some such encounters enabled them to start a process of closure and possibly reconciliation in terms of humanity. The following excerpt from Vezire, a Kosovan interpreter, illustrates the potential for this.

**Vezire:** *'And then I was thinking again he (Serbian client) is the same human being as everybody else and war is war it is in the past so I decided to carry on the session and I stayed in the theatre because he was having Hickman line and was fully awake and I held his hand for two hours and we were talked and we cried (...) He was just so grateful that I was there for him ... When I went home, I phoned my dad, he was very happy that I decided to continue the session. Because that is a good step forward for me to try and get my hatred away, it will make me stronger, a stronger person'* (F1.L635 - 672).

For many, however, this was a bittersweet experience whereby relief at being safe was tempered by profound loss and a desire to remember why they were where they were. In addition, whereas for some reflection led to a sense of clemency or providence, others clearly differentiated between the ability to accept rather than forget what had happened to them. Implicit in many of the accounts was a sense of personal growth, which again seemed to stem from the opportunities work gave them to reflect on their experiences. The term ego strength or resilience encapsulates the essence of what they described. Through



work, they appeared to refine internal resources, which fostered strength in dealing with their own distress:

**George:** *'I have been through a lot but I think I am a strong person now. (...), I live my life now and umm (.), yeah I am stronger person I think'* (M8L 421).

### 3.4.3 Vocational Catharsis sub-theme 3: Desensitisation and distance

Working in the context mental health meant that the interpreters were often exposed to others distress. Whilst there was the potential for this to be emotionally deleterious when combined with other factors (see empathic injury), several of the interpreters felt that the emotional effects of what they heard, lessened over time. Repeated exposure appeared to enable them to separate their own emotions from those that belonged with the client.

Moreover, repeated exposure appeared to increase 'self awareness' and in doing so sanctioned them to separate and distance themselves from others' distress, which prepared them emotionally for difficult sessions. The following excerpts are illustrative of desensitisation and self-awareness,

**Mahmood:** *'I have heard their stories, such stories lots of times now, they are still hard to hear, but they belong to them not to me although they may be similar to my experience....It can be hard but umm I just don't allow my emotions to take over my job'* (M4L698).

**George.** *'You need to have time umm, time to have thought on your, on your experience, your pain and to know that it is their pain umm, that you are hearing (...), and you, not yours, not you now so much. Then umm, then you can as I say be emotionally ready to work with them'* (M8L810).

In line with the last excerpt, many of the interpreters employed self-reflection as a means of achieving distance. Several described how they chose to remove themselves mentally by means of meditation to a place where they felt able to review and reflect. This ability to self-heal was something that many felt they had acquired through their experiences of exile and is an area that more formal support or supervision for them as 'professionals'

might seek to capitalise and harness. Supervision when it was offered (and accepted) was another mechanism by which the interpreters achieved distance. This was a forum where counter-transference and clients' projections could be explored and discussed. De-briefing afforded professional distance together with a sense of emotional purging and catharsis:

**Esmê:** *'When you get all those problems interpreting you know, you have and when you talk to him, you feel (exhales) he has took it all out, you feel again to go. I have given it to someone else to worry for me, it is good yes (F6.L1300).*

**Zahra:** *'psychotherapist he was [ ] talking like you got feelings, you are hurting, these sessions they are hard not just for the client but for us too, I liked that to share that with them' (F7.L 664).*

This process has resonance with Mellman's (1995) account of court interpreters' ability to recognise and deal with counter transference and projection from clients (4.1). For several of the interpreters supervision was, however, unfamiliar and something they allied with counselling. As such, many framed their needs in terms of wanting mutual respect from professionals. This concurs with the work of Tribe and Raval (2003) who maintain that 'supervision' should be an empowering, collaborative act as opposed to one that pathologises the interpreter or their distress. The following excerpt illustrates what many felt they needed:

**Rabet:** *'I don't think that, well I don't think that interpreters need counselling same as clients, they are strong people themselves, but well, (.), they need to feel respect and maybe for the professional to ask after them and to talk about the client, that's what I think (M2.L1064)*

Opportunities to conceal themselves behind the professional façade of 'interpreter' also afforded distance from clients, and offered protection from the complications of becoming emotionally enmeshed with clients or the issues contact with them evoked.



#### 3.4.4 Vocational Catharsis sub-theme 4: Vocation

**Esmê:** *'We have a saying who's been sick can come and see me because he knows what sickness I have got.'* (F6.L 440).

The above excerpt is one of many that encapsulate the sense the interpreters had of themselves as 'wounded healers' who by fate were charged with a humanitarian role. Esmê uses sickness as a metaphor to describe the collective experience of being a refugee and how being through that experience qualifies her to understand and empathise with others. This concurs with Summerfield (1991) who suggests that social healing and the remaking of worlds, that which is at the root of the refugee experience, cannot be managed by outsiders, but that these issues need to be locally owned by those who have been there.

In contrast to the weighty sense of responsibility and obligation that contributed to enmeshment, vocation reflects the more constructive side of obligation and responsibility, one that was tempered by the interpreters' sense of being able to utilise their own pain and experiences in a constructive way to help others. The following extract encapsulates this:

**Assieh:** *'You grateful for the pain you have been through and you grateful for this job, your pain is not wasted. You are using some of the pain, which you always feel as a lost, as a pain, but not any more this pain transfer to give benefit to others'* (F9L586).

Working with refugees was often a means by which they felt able to fulfil their humanitarian and cultural obligations. Often having shared heritage and similar experiences meant that the interpreters were able to empathise with clients and their work as interpreters enabled them to feel as though they could do something constructive to help. In this sense, vocation was analogous to what might be described as a 'moral calling' or duty to help others in need, but one that enabled them to feel positive as opposed to

overwhelmed and enmeshed. Furthermore, this propensity to help was reinforced when and if their contribution was acknowledged and valued by professionals and the system.

#### 3.4.5 Vocational Catharsis sub-theme 5: Reciprocal gain

Whereas vocation may be construed as the more altruistic side of their work, reciprocal gain is more egotistic. There were aspects to their work that had intrinsic benefits for them as individuals. Work often enabled them to satisfy their own needs and provided several with a vocational 'stepping stone' to other things. Many of the interpreters were explicit about the benefits their work bestowed. There were several facets to reciprocal gain.

Firstly, work was a means by which they were able to maintain important links with their community and compensate for the cultural distance work enforced. Moreover, their job meant that they could maintain links without compromising the progress and acculturation that work conferred. Two interpreters provide examples of this:

**Zahra:** *'Although I don't you, know I don't go in and out with Albanian people or with Kosovan people. I feel as part of the community just by being an interpreter, that how I can still fit with them (F7.L 406).*

**Assieh:** *'Umm you have to choose and you can be friends but (...) umm but you never can get too close. It is something that you cannot have, umm I guess that it is another loss. It is not umm safe to have friends in the community umm, my contact with them is through my work (F9L 1230).*

For many of the interpreters their relationship with clients imparted a degree of substitution or surrogacy for the loss or limited contact they were able to have with their own families. Several of the interpreters had lost family in conflict, and for many the familial closeness they felt with clients went some way towards compensating for personal loss. Here George, a Rwandan interpreter, recollects the loss of his family and later reflects on his relationship with his clients:

**Researcher:** *So your family are back home or (interruption).*



**George:** *Lost in the war, killed (.) they have all been killed. I lost almost everyone* (M8.L25)

**George:** *'They become like family. 'I have become like part of the family, Oh, yes most of my clients are friends to me, like a family,'* (M8L566/190-191).

Through work, many of the interpreters were able to regain a sense of industry, occupation and structure in their lives. This concurs with Sande (1998) who found that having a meaningful job during what was otherwise a chaotic period was often a constructive experience for refugees. This was supported by the interpreters' recollections of when they had first arrived which were coloured by their profound sense of powerlessness and enforced inactivity. The following excerpt is indicative of many, which reflected the impotence and frustration they experienced as PSA in contrast to their pre exile lives:

**Rabet:** *'I wasn't allowed to work for six months and that was not good because I couldn't actually support myself, I just sat'* (M2.L129).

Therefore, the sense was that access to work was generally beneficial and contributed towards their sense of mental well being, integration and acculturation. Their job had reciprocal benefits in that it was a means by which they could further their own learning, aspirations, acculturation and independence. Work provided them with opportunities to expand their knowledge and skills and to connect with their new society. This concurs with the work of Tribe and Raval, (2003) and Miller *et al.* (2002) on the importance of 'work' as a means of promoting mental wellbeing in refugee populations (paragraph, 2.3, this review) and in the general population.

Furthermore, whilst their service was constructive to clients this was reciprocated in the sense of personal self-worth and satisfaction that the interpreters obtained from doing the work. This was in turn cathartic as it served to lessen feelings of impotence and obligation.

**Farrokh:** *'If I can help, it makes me feel good too'* (M10.L866)

**Zahra:** *'I felt like I helped her (laughs) that was a good feeling for me'* (F7.L576).

#### 3.4.6 Vocational Catharsis sub-theme 6: Empowerment

Empowerment was the antithesis of feeling disempowered (vocational discord) and refers to the potential their work had to promote self-efficacy and value. This in turn empowered them to challenge the largely ethnocentric system. Empowerment was both personal and collective.

Work contributed to increased self-esteem, self-efficacy and self-worth and enabled them to feel valued as people, both by their clients and the wider system. This renewed self-importance was cathartic in that exile and asylum fundamentally challenge these aspects of self (Bolton 2002). The following excerpts indicate the effect that feeling valued by the wider system had on their sense that they could be fundamentally valued as people.

Feeling valued often related to professional courtesy, praise and acknowledgement for the knowledge and skills they brought to their work.

**Veziro:** *'I was very valued there which made me feel very good because they were expecting me and waiting for me .... just giving me that confidence that they couldn't do their job without me'* (F1.L383).

**Rabet:** *'I don't know it made me feel different when finally I saw some people actually looking at me for who I was and not where I come from my religious background and everything else and I thought well there are people in this world that can treat you as humans'* (M2.L91).

These excerpts provide a nice link with what as interpreters they strived to achieve for their clients by 'bridging the gap' and introducing difference. In doing this, the interpreters were able to translate their own needs as individuals into what they felt clients needed from the system. This demonstrates the recursive way their experiences as refugees



informed their work and vice versa how their experiences of work informed and identified their own needs.

Increased self-efficacy and status often resulted in the interpreters feeling empowered to question the system and advocate on behalf of clients. In some ways, their role as interpreters provided a safer and perhaps more legitimate position from which they could challenge fundamental issues of human rights that had both collective and personal significance:

**Azad:** *'Then this doctor started talking about oh well numbers of asylum seekers are getting higher. I thought hey what's going on what have numbers got to do with what this lady was saying, you're not Home Office are you, you don't own this country do you, no you don't. You leave your government you leave the numbers to your government and you do your job as a doctor. Then I explained to the client how she behaved and what she was saying and I told the client that she should just have told her off, in fact, I told her off (M5.L900).*

Recognition as an interpreter had the potential to ensue status within the community and with the wider system of mental health professionals. Status, personal and professional was something that many of the interpreters felt they had lost during exile. Through their work a degree of status was reinstated. For many, however, this involved constructing and placing themselves in a social hierarchy where PSA were afforded the least status.

Therefore, whilst work increased their status, in doing so it often distanced them from others in their community. The following excerpt alludes to this.

**Vezire:** *'It is usually people are not wanted here and are treated like asylum seekers ... for me it is the opposite, because of the job I do I am always highly (...) valued from Home Office or any public member, which is quite nice because there is not many people with that' (F1.L 93).*

Status, conveyed power, whereby as interpreters they perceived themselves as further on than their clients in terms of their knowledge of the system, refugee status and language prowess. There were times when they used their status to assert authority and to subjugate

others who were in more vulnerable positions in a bid to enhance their own sense of security and status in society:

**Esmê:** *'I said look here I could call the police and they could come to your doorstep and you could be back to your country in five minutes'* (F6.L1335).

Whilst to some extent this alleviated their own insecurities, when they too felt subordinate as agents of the wider system, their newly acquired 'status' enabled perceptible 'us and them' hierarchies to develop in terms of themselves as interpreters in comparison to PSA and non-English speakers. In summary whilst self-efficacy and empowerment were potential enablers in the interpreter's ability to move on and build new lives post-exile, there was a sense that with acculturation there was the potential for them to become less accepting. As such, they allied further with the system and less with their own communities.

#### 3.4.7 Vocational Catharsis section summary

Vocational catharsis reflects some of the 'benefits' experienced by interpreters in their work with refugees. Work would be a vehicle for self-exploration, understanding and ultimately self-healing. Through their work, the interpreters were able to reinstate self-esteem and self-worth from collaboration with other health professionals and from the refugee community. These aspects of self are those that are so often lost or damaged in the flight to exile.

### Chapter 4. Conclusions and general discussion

This section will briefly review the findings from the analysis and the discussion. This will be followed by the clinical implications, methodological issues and the researcher's reflections on the research process, suggestions will be given for future research.



#### 4.1 Summary of findings

The current study used Interpretative Phenomenological Analysis (IPA) to analyse the transcripts of nine interviews with interpreters who were themselves refugees. The aim of the study was to investigate the experiences of refugee interpreters who worked with refugees and PSA in mental health contexts.

The overall findings of this study revealed a number of similarities between participant's accounts. These were represented by the three super-ordinate themes described in the analysis and the process model in figure 3 (p.74). Theme 1: 'Bridging the gap', Figure 4 represents the overarching experience the interpreters had of **doing** their work and describes the means by which they negotiated and facilitated communication between refugee clients and the mental health system.

The **impact** their work had on them was represented by themes 2 and 3. Impact of work was sub-divided into two domains, vocational discord figure 5 and vocational catharsis, figure 6. The sub-themes that constituted vocational discord connected with the literature on vicarious trauma, burnout and compassion fatigue and were illustrative of the emotionally deleterious aspects of their work. Vocational discord resembled a position of 'unsafe uncertainty' (Mason, 1993) whereby it described the sense of isolation, fear and alienation the interpreters felt at times in their work. As such, vocational discord re-captured and re-instated some of the negative feelings that were associated with life pre and immediately post-exile.

Vocational catharsis theoretically represents the more advantageous side of the interpreters work. The sub-themes illustrate that through work there was potential for them, to integrate and assimilate aspects of their pre-exile experiences, which assisted them in

cultivating a more integrative post-exile self. Catharsis could therefore be perceived as more constructive because it nurtures a position of safe uncertainty, and fosters empowerment, status and self-esteem, qualities that many refugees lose during exile (Mason, 1993).

Evidence of both catharsis and discord were however, present in their accounts and they appeared to vacillate between these two positions. It was hypothesised that this vacillation was a result of the interpreter's role which required them to 'bridge the gap' between the world of the refugee client (their old world) and the host culture (their new world).

'Bridging the gap' inevitably summoned comparison with their experiences. Some situations/experiences had the potential to be cathartic whereas others evoked discord.

Being valued for their contribution and having their own experiences validated by clients and professionals were factors that facilitated catharsis. Feeling devalued, overwhelmed and professionally unsupported were key contributors to discord.

#### 4.1.1 Catharsis or discord?

As these two themes emerged, the researcher was forced to question why for her catharsis represented the more palatable account, one that could easily have taken precedence and negated or obscured the presence of discord in the overall analysis. She was aware that the sub-themes that constituted discord generated in her a sense of discomfort and guilt. As such, there was an initial temptation to place greater emphasis on the capacity for their work to be cathartic, so what was this about?

To an extent, catharsis fits with existing models of immigrant/refugee mental health.

These accentuate the benefits of acculturation, supervision, individualism and the transferability of Western taxonomies (Papadopoulos, 2003). In some respects, catharsis



colludes with the idea that the interpreters are happy to 'bridge the gap'. Therefore, Vocational Catharsis represents the more comfortable of the two themes because it suggests that the interpreters are 'doing fine' and to some degree are benefiting from their work. Moreover, this would have enabled the researcher, herself a health professional to collude with the ambivalence that surrounds the professional definition of their role.

In contrast, Vocational Discord identifies some of the conflicts that are inherent in the assumption that catharsis is the more facilitative. One dilemma of catharsis and ultimately integration is that the interpreters as 'agents of the system' may lose touch with their cultural identity. If they become too acculturated this may result in them being less able to empathise and connect clients. Whereas, catharsis demonstrates absolution, discord highlights the tensions that confronting xenophobia and occupying the middle ground may evoke. As a theme, it is less palatable because the roots of discord are partially the result of the multi-faceted role that the interpreters feel obligated to fulfil. Discord invites recognition of this and is less attractive because it highlights gaps in service provision, the potential for exploitation and an absence of compassion for the position this puts the interpreters in as refugees themselves.

Further examination of why as interpreters they often felt devalued and alienated lead the researcher to contemplate the wider questions this evoked. Many of the interpreters saw value as an interpreter as analogous to being valued as a person, as the following excerpt illustrates:

**Zahra:** *'If you don't value the role then you don't value the person and they go together'* (F9.L753).

Already vulnerable as employees, the interpreters' self-esteem was further undermined by the value society placed on them as refugees. Returning to the suggestion that discord is less palatable, the researcher suggests that this may be because it reflects the presence of fear and mistrust in the wider system in response to refugees and PSA. It is hypothesised that as overt xenophobia is considered unacceptable by many these attitudes are subverted and are instead projected as problems with the interpreters and clients for example, overstepping professional boundaries and non-compliance. Furthermore, by remaining ambivalent towards the professionalisation of the interpreters' role, they continue to do the job that benefits both clients and the system, but without being afforded the status that would confer equitable professional status and value in the wider system.

## 4.2 Clinical implications

A number of clinical implications arise from the research, some of these relate directly to the interpreters, whilst others are broader and extend to refugees and mental health.

### 4.2.1 Value and compassion

A common complaint from the interpreters was that others saw them as merely commodities or 'interpreting machines' (Tribe, 1996). Tribe and Raval (2003) suggest that the interpreters presence is such that they cannot be expected to work as is they were a 'mouth piece' (p.257) without their own feelings, views and opinions being taken into account. The findings of this study suggest that depersonalising the interpreter in this way fosters vocational discord. Tribe and Raval, (2003) suggest that this may be overcome by taking the 'personhood' of the interpreter into account (p.257).



Health professionals, naïve to the refugee experience often see the interpreter as solely a means by which they can communicate with the client. In so doing they often become complacent that these interpreters are themselves refugees. As such, they may forget to acknowledge the affect this work may have on the interpreters. Furthermore, the fact that many refugee interpreters have no previous knowledge or training in mental health and may share similar fears to their clients is again overlooked.

As a resource however, these interpreters contribute a wealth of experiential and cultural knowledge to clinical work with refugees. Their experiences mean that they are often able to empathise with the situations and difficulties their clients describe both pre- and post-exile. This enables them to advance cultural and experiential explanations for their clients' distress based in part on their own experiences, these provide a different perspective to Western models of mental distress. Therefore, as research suggests they are often suitably qualified by way of their own histories to offer advice and support on the needs of refugees (Papadopoulos, 2003). As such, the interpreters provide a vital and not ancillary link. The researcher suggests that mental health professionals should not be complacent of the fact that these interpreters are also refugees and as such, there may be occasions when their work connects with their own experiences. Therefore, in addition to valuing their contribution, health professionals need to afford these interpreters due compassion for the similarity of their own experiences.

#### **4.2.2 Supervision and support**

This study suggests that aspects of the interpreters work were emotionally deleterious and connected with their own experiences. Research suggests that interpreters may require support from colleagues in dealing with loyalty issues, managing anger and acquiring

strategies to prevent stress or burn out (Raval & Tribe 2003; Penney & Sammons, 1997). Few of the interpreters in this study however, had access to formal supervision. Many were sessional and worked for several different employers. As such, it was often unclear to whom the interpreters were responsible and who was responsible for their needs, whether it was the client, the practitioner or some amorphous organisation (Tribe 1999).

The few interpreters who had experienced supervision directly, found it useful. Several however, described a process of adjustment whereby it had taken time for them to get used to the idea of talking things through with someone else. Tribe and Raval (2003) suggest that supervision among refugee workers works best if it is introduced gradually as a constructive part of personal and professional development, just as supervision has become synonymous in Western health care systems as good practice. This resonates with the approach the interpreters took towards introducing difference to their clients and reiterates the fact that mental health professionals should be mindful that refugee interpreters may themselves have had little or no experience of mental health and may have similar fears and reservations to their clients. As, such supervision should be a collaborative and empowering act as opposed to one that pathologises the interpreter or their distress.

By assuming that the interpreters will find the sessions difficult and painful, and by imposing supervision and support on them, professionals run the risk of immersing them in Western models and assumptions to the extent that their own tenacity and resilience to cope with problems may be negated. Therefore, supervision may be more accepted and may work best if it is mooted as an adjunct to existing cultural and experiential coping mechanisms that individuals have in place, which may continue to be functional for them.



#### **4.2.3 Defining the role of the interpreter in the context of refugee mental health**

Whilst the interpreters continue to 'plug the gap', the parameters of their role remain a source of ambiguity and conflict. The findings of this study reiterate this and concur with existing research (Granger & Baker, 2003; Tribe & Raval, 2003). Working with an interpreter is something that more health professionals are now being required to do as many individuals who access services are from vastly different backgrounds to the dominant culture (Neuberger, 1999; Jones & Gill, 1998). Furthermore, provision of appropriate and accessible mental health services to refugee clients is still in its infancy and few definitive practice guidelines exist (Aitken 1998; Muecke 1992). Refugee interpreters, by way of their experiential knowledge and cultural awareness, may therefore represent a panacea to health professionals who lack knowledge and experience in this field. Debate, however. Continues as to how to define the interpreters' role and to what extent they should contribute to mental health work (Tribe & Raval, 2003). This is amplified in the case of refugee interpreters because in terms of the functions that they undertake with refugee clients their role is even less circumscribed.

The researcher proposes that the boundaries that are relevant to clinician, client relationships and other interpreter client relationships, may be too rigid in the context of working with refugees, which would explain the interpreters frequent role transgressions. The findings of this study and others in this field (Papadopoulos, 2003; Rea, 2003; James, 1998) suggest that the needs of refugee clients are often qualitatively different to other clients who may require an interpreter and as such, the role of interpreters in this context may need to reflect this.

The findings from this study suggest that the interpreters fulfil a variety of roles with their refugee clients and that they often cater for unmet needs. As discussed earlier to an extent the system colludes with this because their extended input and involvement with clients currently meets a need. Several authors have proposed that interpreters should take on a broader more flexible role in their work with refugees that go beyond that of strictly language interpretation Temple 2002 & Gong-Guy *et al.* 1991).

In order for this to work however, the extent of their eclectic role as cultural brokers, cultural consultants, client advocates, intermediaries, conciliators and link-workers would need to be acknowledged, accepted and legitimised by other professionals. Tribe and Raval (2003) suggest that opportunities for joint working may increase the level of confidence and willingness of the clinician to encourage the interpreter in taking on a broader role in their work. Co-working and relationship issues would however need to negotiate between the interpreter, clinician and refugee client if this relationship is going to work well. Unequal and exploitative relationships on all sides however have the potential to break down and may result in vocational discord, distrust of interpreters and the reluctance of clients to engage with mental health services.

#### 4.2.4 Collaboration

The researcher proposes that more effective working alliances need to be established between mental health professionals and interpreters. This could be achieved by providing individual and joint training for interpreters and clinicians such that both parties could gain an appreciation of the others role and learn how to work together effectively. Granger and Baker (2003) found that interpreters sought collaboration, inclusion and teamwork as factors that would improve the quality of their working lives, the interpreters in this study



expressed similar wishes. The interpreters associated inclusion with being valued both as people and as refugees.

Tribe and Raval (2003) maintain that time is needed for both the interpreter and the clinician to brief and debrief following sessions. The interpreters in this study spoke of the benefit of time pre and post session to discuss issues related to clients, to impart cultural knowledge to the clinician and to be able to prepare themselves for potentially difficult sessions. Several of the interpreters felt that knowing what would be discussed helped them to cope better with client's material during the session. Research suggests that time spent with an interpreter pre and post-session is of benefit to health professionals (Granger & Baker, 2003). Moreover, the interpreters associated time afforded by the clinician as conferring value to them as people.

#### 4.2.5 Challenging assumptions introducing difference

The experiences that affected the interpreters in their working lives often mirrored the personal experiences of their refugee clients. As such, the dichotomous experiences of catharsis and discord provide a window on the lived experiences of refugees and the factors that impact on both their mental well being and/or mental ill health. The interpreters' dual status means that they are ideally placed to provide an insider's perspective on this phenomenon, which at present is a field of mental health where Western health professionals lack both knowledge and experience.

It is through the dilemmas and lived experiences of the interpreters, that a broader picture of the contributory factors in refugee mental health emerge. Through their work, and life experiences the interpreters were participant observers in factors that affected their own mental health, (vocational catharsis and vocational discord), these in turn provide

professionals with an insider's perspective on their needs as individuals from which we can extrapolate the needs of refugee clients.

#### 4.2.6 Mental health contexts

Research suggests that many refugees present in non-clinical settings and that non-clinical workers and voluntary staff are often the first port of call for problems. Moreover, findings suggest that the people in these settings are often deemed more acceptable to refugee clients (Singh, 2003). The findings of this study confirmed this and the following quote is one of many that illustrate this point.

**Zahra:** *'They do not know when umm where, they are supposed to be talking about feelings, sometimes it comes up in other places because something happens and often the interpreter is the only one who can listen to this (...). The housing people don't umm haven't the time to sit and hear it when their part is done (...). So it may be me, on the bus on the way back or whatever (F7.L486).*

This has implications for clinical practice and how services to refugees should be configured. It may be important in planning and implementing future provision to establish which people are best placed in terms of skill and resources to provide such a service. Several researchers have suggested a more involved role for interpreters in the refugee context (Mulhall, 2003; Tribe & Raval, 2003). Miller (1999) advocates training mental health para-professionals, themselves members of the refugee community, to consult and assist health professionals in providing accessible and appropriate services. Greater emphasis on community-based services that tackle the collective social/environmental and contextual factors that affect refugee mental health may alleviate some of the post-exile factors that are known to contribute to poorer mental health in refugee communities.

Moreover, in terms of cultural differences these may be received better than traditional western therapeutic approaches, which have traditionally tended to be more



individualistic, situating the problem in the individual as opposed to acknowledging it as a collective concern. Once again, this may require services to adopt a more flexible, collaborative and less ethnocentric approach to mental health service provision.

### 4.3 Limitations of the study

#### 4.3.1 Ethical

The researcher chose to tape-record the interviews with participants. Whilst she was aware that interviews have the potential to re-stimulate painful memories on the part of the participants (Grafanaki 1996) and had made provision for this by incorporating a post interview de-brief and facilitating access to a counsellor. The act of recording and the impact this might have on participants was something that was overlooked. Several of the participants were reticent about the tape-recorder, for some it brought back memories of their interrogation pre-exile and of the asylum process. Several were concerned about what would happen to the tapes after the research. In view of this, arrangements were made to return the interview tapes to those participants who wanted to keep them, once they had been transcribed.

#### 4.3.2 Sample

The participants who agreed to take part in this study may have differed in a number of respects from those who chose not to take part. Several of the interpreters had been politically active pre-exile and many channelled their energies post-exile into the humanitarian needs of PSA and refugees, for some the interviews may have provided an audience for these concerns.

In general, it was felt that participants saw the interview as a rare opportunity to discuss their work and the needs of interpreters. Whilst personal investment in the interview was

high and contributed to the richness of the data produced, some interpreters saw the interview as overtly therapeutic. Therefore, for some the interview met an emotional need. Whilst provision had been made for post-interview support, there was a tension that the researchers dual position of researcher and clinician may have mislead participants in some way and/or the researchers interviewing style may have been too closely allied with a therapeutic as opposed to objective stance.

The researcher chose to illustrate the heterogeneity of refugee people and interview refugee interpreters from a range of nationalities and religions, whose reasons for exile were diverse (Appendix G). Although the sample size was sufficient to allow for the emergence of rich data, varied descriptions, and was homogeneous in that the participants were all refugees and interpreters, a more homogeneous sample in terms of nationality and country of origin may have been advantageous. A criticism of this sample is that interpreters with experience of genocide and war, such as those from Rwanda and Kosovo may have had fundamentally different experiences to those who had fled for reasons of oppression and political persecution. Further research in this field might seek to elucidate the affect these different experiences might have or might seek to recruit refugees with similar reasons for exile.

#### 4.33 Analysis

As a method, IPA is strongly idiographic and seeks to explore language to examine and interpret the meaning participants make of their experiences. For participants in this study English was their second language. Analysing transcripts from participants whose first language was not English meant that the researcher needed to be cautious when interpreting grammatical nuances, for example changes in tense and pronoun use. There



were many examples in the text where for example personal pronouns were of interest for example,

Mahmood: *'I feel angry it has happened to them, that we can't be accepted here.'* (M4.L525)

The researcher was however, aware that these may have been slips in language fluency, as opposed to indicating for example a collective concern. There were other occasions when the interpreters struggled to articulate what it was they wanted to say, whilst these could be interpreted as hesitation or uncertainty, they may also reflect an absence of terminology or misunderstanding of a concept or idea.

Qualitative analysis is time consuming, which is a potential drawback with a time limited research project. The researcher however, felt that the ends justified the means in that the analytic endeavour produced an in-depth, nuanced and idiographic analysis. Questions however, remain about how reliably the individual experience of participants can be reflected in the overall findings when one considers that the interview itself only provides a snapshot of the participant's experience. Taken as a whole, however, the drawbacks of the methodological approach used in this study were outweighed by its capacity to produce a narrative account that reflected the dynamic processes involved in the interpreters experiences of their work.

#### 4.4 Reflections on the research process

Qualitative researchers often study concepts or topics that are personally significant and thereby involve them in self-examination, significant personal learning and change. The researcher's interpretations transform, evolve and change as the researcher becomes infused with observations (Stiles, 1993 p.604). As a result of conducting this project, the views and perceptions of the researcher of the difficulties and dilemmas that arise for

refugee interpreters increased. There were points during some of the interviews however, when there was a temptation to act as a therapist rather than a researcher. When participants became upset and tearful and struggled to talk about their experiences it was difficult not to intervene. During some of the interviews, the researcher experienced strong emotional reactions and there were times when the questions the interpreters asked of themselves would prick the conscience of the researcher as the following excerpt illustrates:

**Rabet:** *'And well, I, well sometimes I think why has that umm, why does it need to happen to people at all, sometimes when you think about what happens in the world it doesn't make much sense, why these people are treated in that way'* (M2.L 650).

The research process was one, which encouraged reflexivity and self-exploration and in doing so increased the researcher's awareness of her own assumptions and biases. As a white agnostic female, working in a predominantly positivist system, the researcher was mindful that she might produce an ethnocentric interpretation of the data. As such, it was often necessary to navigate psychological, British, Muslim, Christian, Islamic and non-Western beliefs. The sense the interpreters gave of being able to acknowledge and accommodate religious, cultural and Western explanations for mental ill health was refreshing and in some respects facilitated the researcher to accept and accommodate difference. Furthermore, this process enabled the researcher to curb her initial inclination to seek unnecessary structure and control of the research process.

Aspects of the analysis surprised the researcher, which reflects its direct development from the themes and not the researcher's previous thoughts. With hindsight, the researcher's preconceptions of what she might find more closely reflected the portrayal of refugees in



the media and psychological literature than the people that she met through the research and interviews.

As a methodology, IPA invites/encourages the researcher to gain an insiders perspective of the phenomenon in question, in this case the experience of being a refugee interpreter and working with refugees and PSA in mental health contexts. Throughout the research interviews and later analysis, the researcher observed herself experiencing similar dilemmas to that which the interpreters described. There were times when she would feel drawn in, such that she was privy to what they were describing (ally) and there were occasions when she would feel alienated and rejected by them (adversary). At times, this mirrored the power dynamic the interpreters described with their clients, whereby the researcher was made aware that she was part of the dominant Western culture and as such, part of a system that refugees saw as imposing the rules and casting decisions about whether they would stay or go.

Eleftheriadou (1999) talks about the affect that working with people who have been through difficult circumstances has on those who do this work, he suggests that they often have a desire to make things better and compensate for the negative experiences that clients may have had. Following several of the interviews, the researcher experienced a strong desire to make things better, 'to rescue'. She found herself donating clothes and toys to a refugee charity and reflecting on the profound sense of guilt she experienced in view of the freedom and safety that living in a democracy bestowed and of which she was often complacent.

In contrast, however, as a trainee Clinical psychologist working in an inner city the researcher had course to use interpreters in sessions with clients. There were times when

as relatively naïve and inexperienced in this area she too had experienced feeling de-skilled, overwhelmed, irritated and undermined in the presence of interpreters. This enabled her to reflect on how other professionals might feel in this situation and how these feelings might be further misconstrued or be experienced by interpreters and/or clients as projections of rejection and mistrust.

Grafanaki (1996) states that it is important for the researcher to be aware that having a ‘private view of another person’s life is a privilege’ (p.335). The researcher concurs with this statement. As a white Western woman, she felt privileged that the participants had chosen to share their experiences with her.

#### 4.5 Future research

Few studies to date have sought to investigate interpreters’ experiences of therapy the focus of research had tended to be on therapists’ experiences of therapy with an interpreter (Raval & Smith, 2004). This is a misnomer given the vital role interpreters play in the therapeutic relationship. Further research in this area may help to identify factors that enhance or detract from establishing effective therapeutic relationships with clients when an interpreter is present.

In view of the importance of effective communication in mental health work, trans-cultural meanings and taxonomies for emotions and mental health warrant further research. It would be useful to obtain further understanding from interpreters about how they negotiate cultural differences and provide apt translations for Western concepts of mental distress for which there are often no culturally synonymous translations.

Smith (2004) has tentatively suggested that ‘identity’ has emerged as an organising principle across many IPA studies, in this study, negotiating identity was a recurrent



theme in the interpreter's accounts. Moreover, there is little empirical work documenting the impact of becoming a refugee on identity and sense of self. Work that does exist has tended to focus on immigrant as opposed to refugee populations and is subsumed largely within acculturation theories (Papadopoulos, 2003; Ryder, Alden & Paulhus 2000). Future research, may wish to extend the findings of this research and look in greater depth at the various identities refugee interpreters assume and the impact this has on their understanding of themselves and in relation to their own mental health.

Finally, with specific reference to this study, several of the transcripts provided particularly rich and compelling data. The researcher suggests that these may warrant extension as case studies. Smith (2004) suggests that detailed, nuanced single case data, may be beneficial because 'delving deeper into the particular takes us closer to the universal' that is where material invites extension (p. 42).

#### 4.6 Conclusion

At present, minimal research exists on the experiences of interpreters in mental health contexts which is a misnomer given the vital role they have in assessment and therapy (Tribe & Raval, 2003). Moreover, to the author's knowledge this is the first empirical account of the experience of refugee interpreters. Research suggests that the majority of interpreters who speak refugee languages will be refugees themselves (Papadopoulos, 2003; Green, 2003). Therefore, it is important that we gain an understanding of their needs as people, and of their work, in order that effective working relationships may be established. In addition, the majority of studies that have used IPA as a methodology have been based on semi-structured interviews with adults whose first language is English

(Smith, 2004). As such, this study extended the corpus data for IPA by interviewing participants who were refugees and whose first language was not English.

The researcher's hope is that this study will open up a much broader dialogue of the work of refugee interpreters. In concluding, the researcher encourages other professionals to afford them due compassion for the similarity of their experiences whilst acknowledging their intrinsic strengths as survivors and their capacity for self-healing. It is hoped that this study, and allied research, will foster greater recognition of their value, as people and as professionals for the contribution, they make to mental health work with refugees.



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## Appendix A



### *Letter of Introduction*

**Dear Interpreter**

I am training to become a doctor of clinical psychology at Leicester University and as part of the research for my degree, I would like to talk to interpreters who work with refugees and asylum seekers in the city of X.

I hope to interview people who work as interpreters in the city but who also consider themselves refugees. In particular, interpreters who have experience of mental health work with asylum seekers and refugee clients.

I am interested to find out from the interpreters themselves what it is like to do this work, both good and bad experiences so that health professionals may have a greater understanding of the valuable work that interpreters do.

If you think that you would like to take part, the interviews will last about an hour and will take place in X in the autumn of 2003. I will be able to pay you for your time and refund any travel expenses.

Every interview will remain **confidential** which means that no information will be shared with your employers. You do not have to tell anyone at work that you are taking part in the research if you do not want to.

If you are happy for me to contact you then please complete the tear off slip at the end of this letter. You can return this to me in the stamped addressed envelope provided or if you prefer you can leave the slip with X of X and she will pass your details on to me.

I would be pleased to hear from anyone who feels that they would like to be involved. If you require further information about the study you can contact me on this telephone number X.

Thank you very much for your time. If you have, any further questions then please contact me. I hope to hear from you.



**Information Sheet**

**1. Study title: 'A qualitative analysis of the experiences of refugee interpreters who work with asylum seekers and refugees in mental health settings.'**

This is a study based on interviews with refugee interpreters who work with asylum seekers and refugees who have experienced mental health problems and who are in contact with mental health services.

You are being invited to take part in a research study. Before you decide it is important for you to understand, why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether you wish to take part.

Thank you for reading this.

**2. What is the purpose of the study?**

Individuals who are asylum seekers or refugees often experience psychological difficulties as they adjust to the UK. Sometimes this is due to the experiences they have been through in their own countries, other times because of all the adjustments they have to make as a refugee. For many of these people English is not their first language and as such, the skills of an interpreter are often needed to act as a bridge between the refugee client and mental health services.

Many of these interpreters may be refugees themselves and may share similar experiences to those of the people that they are interpreting for. Interpreting for mental health assessments and therapy is in turn a complex and at times emotionally demanding job and the aim of this research is to enable refugee interpreters whose views to date have not had a voice in the literature to talk about the work that they do.

**3. Why have I been asked to take part?**

The researcher is interested in hearing the views of interpreters who work with refugees and asylum seekers and who are themselves refugees. Staff from organisations for interpreters, asylum seekers and refugees have been asked to discuss this study informally with the interpreters they employ. You have been chosen because you are an interpreter with refugee status, are currently working in X and have expressed an interest in taking part in this study.

**4. Do I have to take part?**

It is up to you to decide whether to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason.

#### **5. What are the possible disadvantages and risks of taking part?**

It is possible that talking about some of the experiences that you have had whilst undertaking mental health assessments and mental health related work with refugees may be upsetting and being asked to talk about these experiences may affect your own feelings. If you are distressed, you can stop the interview. Information about how you may access individual support will be also be given at the interview if you have found the discussion distressing and feel that you would like an opportunity to talk to someone.

#### **6. What if something goes wrong?**

If you are harmed by taking part in this research project, there are no special compensation arrangements. If you are harmed due to someone's negligence, then you may have grounds for a legal action but you may have to pay for it. Regardless of this, if you wish to complain about any aspect of the way you have been approached or treated during the course of this study, the normal National Health Service complaints mechanisms should be available to you

#### **7. What will happen to me if I take part?**

The interviews will take place in X. The researcher will arrange a convenient time and place with you for the interview to take place.

The interview will last between an hour and an hour and a half with a short break about half way through. You will receive payment of £30.00 to cover loss of earnings and travel expenses.

The researcher is interested in talking to you about your work and what it is like to interpret for refugees and asylum seekers in X. You will be asked about your experiences of working with asylum seekers and refugees during mental health assessments and therapy and about what it is like to do this work.

The researcher is interested in your views as an interpreter and about the difficulties and problems that you may experience in your work with this group of people. You will be asked to comment on the impact this work has on your life and your own feelings. The researcher is also interested in your views of how mental health workers and clinicians can work better with interpreters so that this information may be used to inform how professionals work with interpreters.

The interview will be audio taped and notes will be made during the discussion. All information will be anonymous and no names will be used. At the beginning of



the interview, you will be asked to sign a form consenting to the discussion being audio taped.

Altogether approximately 10 other refugee interpreters will take part in this study.

#### **8. Who is organising and funding the research?**

The study has been organised by Kirsty Williams a trainee clinical psychologist at the University of Leicester, employed by the Leicestershire and Rutland NHS trust that are funding the research. Clinically relevant research is a requirement of the training for NHS clinical psychologists.

#### **9. Will my taking part in this study be kept confidential?**

All information that is collected about you, your employers or the people that you interpret for will be kept strictly confidential during the course of the research. Any information about you will have your name and address removed so that you cannot be recognised from it.

#### **10. What will happen to the audio tapes and transcripts at the end of the research?**

During the research, the audio tapes and transcripts will be kept securely. The transcripts will be anonymised to the extent that information that may lead to recognition of you or your clients will be deleted. At the end of the research, the audio tapes will be destroyed and the anonymised transcripts will be kept with the research thesis.

#### **11. Who will transcribe the audio tapes?**

To ensure anonymity and confidentiality, the researcher and not a third party will do transcription of the audio tapes.

#### **12. What will happen to the results of the research study?**

The findings of this study will be written up as research document. The researcher will share the findings of this research with service providers and interpreting services in the voluntary sector, social services, the City Primary Care Trust and the X Healthcare Trust. You will not be identified within the report. The final version of the report will be available from the main researcher.

#### **13. Contact for further information**

If you would like to discuss this study further you can contact the principal investigator Kirsty Williams on either X or X

Appendix C



Consent to take part in the research.

**Title of project;** Asking the middleman; ‘A qualitative analysis of the experiences of refugee interpreters who work with asylum seekers and refugees in mental health contexts.’

**Site;**

**Investigator;** Kirsty Williams Trainee Clinical Psychologist

The individual should complete the whole of this sheet himself/herself.

**Please cross out as necessary**

☐ Have you read & understood the patient information sheet **YES/NO**

☐ Have you had opportunity to ask questions & discuss the study **YES/NO**

☐ Have all the questions been answered satisfactorily **YES/NO**

☐ Have you received enough information about the study **YES/NO**

☐ Who have you spoken to **Mrs.....**

☐ Do you understand that you are free to withdraw from the study at any time without having to give a reason **YES/NO**

☐ Do you agree to take part in the study **YES/NO**

**Signature (Interpreter)** **Date**

**Name (In block capitals)**

I have explained the study to the above patient and he/she has indicated his/her willingness to take part.

**Signature (Researcher)** **Date**

**Name (In block capitals)**



## Appendix D

### **SEMI-STRUCTURED INTERVIEW SCHEDULE/GUIDE**

#### Introduction

Introductions background to research, confidentiality, format (including tape recording), consent form, any initial questions from the participant.

#### Background

Age, gender, nationality and current status (immigrant, refugee, etc...), languages spoken, employment status (freelance, employed by agency statutory or private), length of time working as an interpreter, type of work generally undertaken, training history.

#### Introduction

I was wondering if I could start by asking you to tell me a little bit about yourself and how you came to live in this country.

#### Being an interpreter

I understand that you work as an interpreter (with refugees). I wonder if you could tell me about how you came to do this work and what your work involves?

Did you have any formal training for this work?

I am interested in what your work as an interpreter involves, could you describe a typical assignment for me / could you explain what you feel your role should be.

(Prompt) Is this how others see your role?

(Prompt) What are some of the difficulties with this?

How would you describe your role to another person?

Can you tell me about a time when you have been asked to do things that you consider are beyond your role as an interpreter? Can you give me an example? What was this like? How did you manage this?

#### Working with refugees

Can you tell me a bit about your experience of working with refugees?

I understand that you work with refugees and asylum seekers and I am aware that you have been a refugee yourself, what is it like to do this work? Do you feel that this has any impact on your work as an interpreter?

Are there any differences that come up in relation to refugee clients that are different to the interpreting that you might do for other clients?

I am interested in how your clients respond to you as someone who shares the same language as them.

Are there times when it is difficult to remain independent/separate from them?

Have there been any occasions in your work with refugees that have been emotionally difficult for you, I wonder if you could give me an example (prompt do you have any other examples).

I am interested in how it feels for you when clients describe events that have happened to them which may have involved cruelty or torture. – Can you tell me about your experiences of working with refugees who have experienced atrocities in their country of origin, what is your experience of translating in these situations?

How does this leave you feeling? Do you have anyone that you can talk to about how you feel? How do you manage the feelings that this brings up in you?

Do you have any examples of when you have experienced emotions other than X when interpreting for refugee clients – I wonder if you could tell me about this.

What is it like to translate for a client who may have different opinions to you – can you give me an example of this?

What do you feel would be helpful for other interpreters in your situation to help them manage assignments that have been difficult?

## Mental Health

I am interested in what you understand by the term 'mental ill health or mental illness' is there a comparable term in your language?

Please could you tell me what it is like to translate ideas relating to mental illness to refugee clients – how would you go about this? Can you describe an occasion when this happened?

You have had experience of working with health professionals, e.g. doctors and psychiatrists can you tell me what this has been like? Do you think that they understand your role?

How do you think other professionals see interpreters?



Have there been times when you have been asked to tell a client something that you were unprepared for? How did this feel, what did you do?

If you were the G.P, psychiatrist would you have done things differently if you had booked an interpreter

What do think refugee clients understand by the term mental health?

Are there any other issues that you feel that you would like to bring up in relation to working with refugees.

## Ending

Is there anything else that you would like to add?

Feedback and wind down on the experience of being interviewed

Review consent and ask about inclusion of any information that is considered too sensitive to include.

Provide debriefing (thanks, any questions, how to contact me, what happens next, would they be prepared to provide feedback on the initial analysis and interpretation, feedback and dissemination of results).

## General Probes

Can you say a bit more about those feelings you have had?

Could you say a bit more about that?

Is there anything else you want to say about that?

Do you have any other examples of when that has happened?

Do you have ideas about.....?

What did you think of that? What does that mean for you? How did you make sense of that?





Research & Development Office  
Daisy Peake Building  
Towers Hospital  
Gypsy Lane  
Leicester  
Tel: 0116-225-3743  
Fax: 0116-246-3591  
David.Clarke@leicspart.nhs.uk

DC/KVW/0273

13<sup>th</sup> August 2003

Ms. Kirsty Williams  
3 Lancaster Rise  
Belper  
Derbyshire  
DE56 1HF

Dear Kirsty

**Re: Trust Ref SOCP0273**  
**Asking the middle man: A qualitative analysis of the experiences of**  
**refugee interpreters who work with asylum seekers and refugees in**  
**mental health contextx.**

Thank you for supplying comprehensive documentation in connection with the above study. I have also received confirmation that the study has received appropriate ethical committee approval.

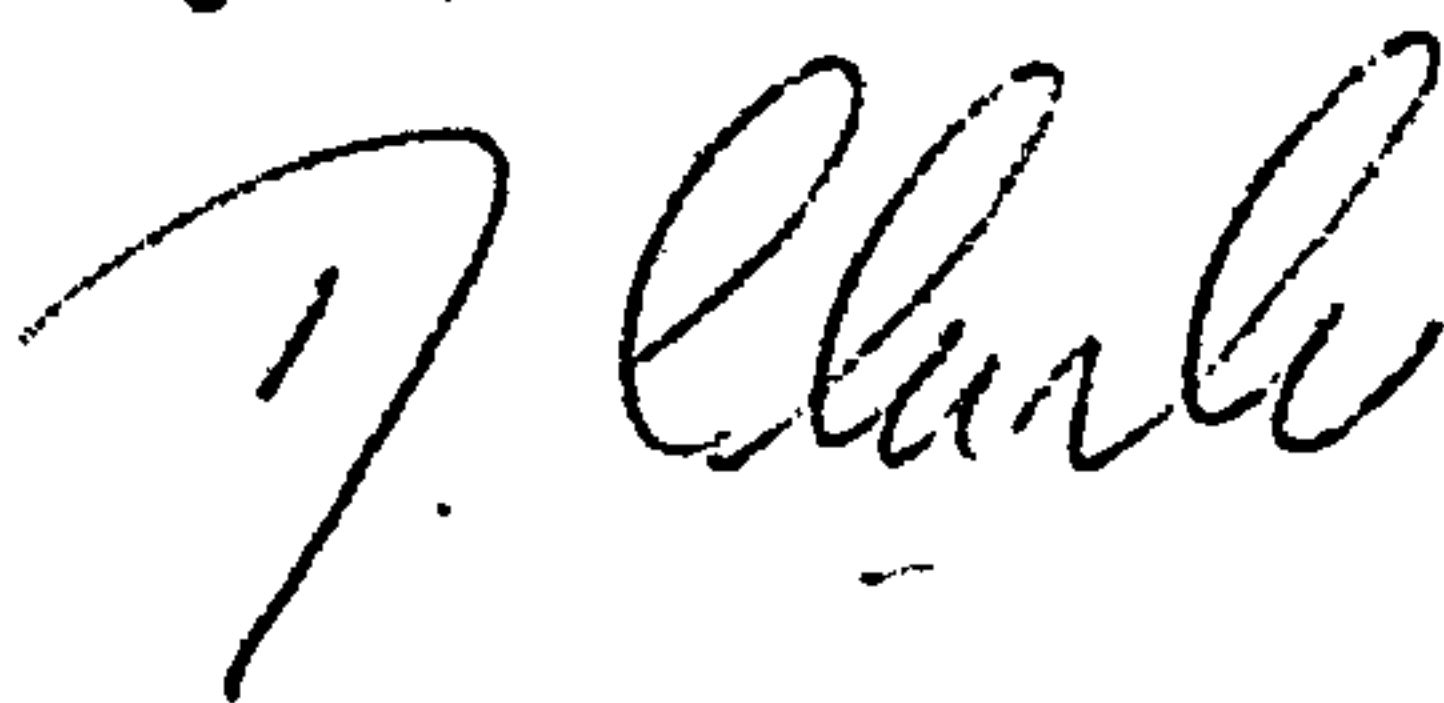
As requested therefore, I am happy to confirm that Leicestershire Partnership NHS Trust accepts the role as an employing organisation to provide indemnity for this research. This letter also serves as confirmation of formal Trust Approval for the project. This is contingent upon compliance with the following conditions:

- The agreed protocol is adhered to.
- Any changes in the protocol, timescale etc are notified to the R&D Office
- At the conclusion of the study, a final report form is completed and a summary of the main findings submitted to the Trust.
- A copy of any subsequent publication is lodged with the Trust.
- That paperwork related to the study may be subject to audit at any time.

Please use the reference code SOCP0273 for all correspondence related to this study.

With best wishes on the success of your study.

Regards,



Dr. Dave Clarke  
[R&D Manager]



1<sup>st</sup> Floor Vickers Corridor

Direct Line: 0114 271 4894 or 271 4011  
Fax: 0114 256 2469  
Email: Sue.Rose@sth.nhs.uk

rieries Road  
S5 7AU

SRB/SR/3/11/03  
Williams/NS203 11 1787  
(Please quote reference on all correspondence)

30 September 2003

Mrs K V Williams  
Trainee Clinical Psychologist  
School of Psychology  
Clinical Section  
University of Leicester  
Asrley Clarke Building  
University Road  
Leicester  
LE1 7RH

Dear Mrs Williams

Re A qualitative analysis of the experiences of refugee interpreters who work with asylum seekers and refugees in mental health contexts  
Ref: NS203 11 1787

Thank you for letting me have sight of the above project which, I note, has received approval from both  
and RECs.

On behalf of the Research Ethics Committee, I am prepared to grant Chairman's approval in order for you to proceed with the project. This approval will be ratified at the next available meeting but it will not be necessary for you to attend. I will only contact you again if there are further comments arising from the meeting.

Please ensure that any patient information sheets, consent forms etc are produced on letterhead and are localised accordingly e.g. local contact name and number.

Yours sincerely

S R Brennan  
CHAIRMAN - RESEARCH ETHICS COMMITTEE  
Consultant Physician

Cc Dr P Newton - R & D Consortium



Please ask for:  
Linda Ellis, Administrative Assistant  
Ext: 49435. E-mail [linda.ellis@rushcliffe-pct.nhs.uk](mailto:linda.ellis@rushcliffe-pct.nhs.uk)

Research Ethics Committee 1  
1 Standard Court  
Park Row

Tel: 0115 912 3344  
Fax: 0115 912 3300

REC M1030301  
(please quote this number on all correspondence)

14 May 2003

Mrs KV Williams  
Trainee clinical psychologist  
School of Psychology  
Clinical Section  
University of Leicester  
Asrley Clarke Building  
University Road  
LE1 7RH

Dear Mrs Williams

Re: A qualitative analysis of the experience of refugee interpreters who work with asylum seekers and refugees in mental health contexts

The Chair of the Research Ethics Committee 1 has considered the amendments submitted in response to the Committee's earlier review of your application on 15 April 2003 as set out in our letter dated 29 April 2003. The documents considered were as follows:

- . Application form
- . Protocol dated 2003
- . Patient Information Sheet
- . Consent to be audiotaped
- . Consent to take part in the research
- . Letter of Introduction
- . Tear off Slip

The members of the Committee present agreed that there is no objection on ethical grounds to the proposed study. On behalf of the Committee I am, therefore, happy, to give full approval for this study on the understanding that you will follow the conditions set out below:

1. The Project must be started within three years of the date on which REC approval is given.

You must not start your project in any institution until you have received written approval from their R&D department. You should have submitted your original application to the R&D office and parallel reviews will have been taking place. Approval should therefore be imminent.

If your study is to take place in any of the following units then you do not need further ethical approval but you do need R&D approval.

If your study is to take place in units outside of                      but still within the boundaries of the Strategic Health Authority, then you do not need further full ethical approval. You will however need your study approved by the R&D unit of the institution concerned and an assessment of 'locality issues.' These 'locality issues' (such as appropriate status of research aspects of local research subjects, information sheets) are usually addressed and reviewed by the local ethical committee and you should clarify this point with the administrator of your local REC. These reviews should take place quickly.

3. You must not deviate from, or make changes to, the protocol without prior written approval of the REC, except where this is necessary to eliminate immediate hazards to research participants or when change involves only logistical or administrative aspects of the research. In such cases the REC should be informed within seven days of the implementation of the change.
4. You complete and return the standard progress report form to the REC one-year from the date on this letter and thereafter on an annual basis. This form should also be used to notify the REC when your research is completed and in this case should be sent to this REC within three months of completion.
5. If you decide to terminate this research prematurely you send a report to this REC within 15 days, indicating the reason for the early termination.
6. You advise the REC of any unusual or unsuspected results that raise questions about the safety of the research.

Yours sincerely



Dr D Pearson/Mrs L Ellis  
Chair/Administrator  
Research Ethics Committee 1

cc Research and Development



## Appendix F

### Demonstrating the Analytic Process using interview F1

IPA is strongly idiographic (Smith, 2004) and starts with the detailed examination of one case until some degree of closure or gestalt has been achieved, the researcher then moves on to consider other transcripts in the data set. When all of the transcripts have been examined individually, the researcher starts to cross-analyse the tables of themes from each individual to check for convergence and divergence (Smith, 2004 p.41).

Interview 1 has been used as an example to illustrate the process of analysis. A brief pen portrait of Vezire has been provided to contextualise the excerpts. Vezire was exiled from Kosovo Albania during the war. Prior to the humanitarian evacuation, she had been living rough with her family in the mountains to escape capture by the Serbian soldiers. Vezire had trained as a nurse and was about to qualify before they fled. Her personal experiences of the war involved the observed rape of her mother and the death of her uncle, her brother remained in Kosovo when they were evacuated because he was fighting in the war. Prior to coming to the UK, Vezire spoke no English and in her words could only say 'hi' and 'bye'. After a period in the UK, she resumed her nurse training and learnt English. She now works part time as an interpreter, works as a nurse at a hospital in the East Midlands, and has refugee status. In terms of training, she took the Metropolitan examination for interpreters and is now on the National register. After the war, the rest of Vezire's family returned to Kosovo.

#### Stage 1 – Pre-transcription analysis

The researcher's initial thoughts and reflections following each interview were recorded in her field diary. This extract reflects first thoughts, notes would typically incorporate the researcher's feelings about the interview, feelings brought up by the interview or revisions/ ideas for subsequent interviews as well as comments on particular things that had been said and or quotes that stood out.

#### □ Extract from field diary 1.7.2003.

1.7.2003 (evening).

Interview with (x) listened to tape on way home, feeling quite excited but guilty because no experience of war like that, quite emotional to hear someone describing that, wonder if we get it right with refugees? Being VALUED, STRONG, sense of being valued as a person, refugees worthy of status as people and for (x) as a professional. Identities, nurse, interpreter, woman, Muslim, professional all of these. Professional versus personal/cultural loyalties - 'I've been there', obligation to help, doing over and above job to help people out 'sorting out all their hearts', Serbian feelings still strong - but making sense? E.g. told Dad - living with pain but making it fit into her new life. Maybe integrating? Loss, distance from others - fell into work, advocacy?



## Stage 2 – Micro level analysis

This stage involved a line by line analysis of the transcript. Preliminary ideas, thoughts and reflections were noted on the left hand side of the transcript, the aim was to capture summaries of the content and ideas and to offer tentative ideas about the underlying meaning of what she was saying. At this stage emergent sub themes or clusters of ideas were tentatively noted in the right hand margin.

□ Page of transcript depicting initial ideas and tentative themes.

Interview 1 with Female B Kosovo Albanian – Duration 52 mins - Interview code 1F

Mechanistic  
IMPACT OF WORK

COMMODITY

618 B: Yes I was called emergency for A&E department at the hospital  
619 here and they said oh we need an Albanian interpreter and when I  
620 went there he was a Serbian-Croatian and I was in very difficult  
621 position because I was still (...) I still have anger and hated  
622 towards Serbian people for what they have done, but going there I  
623 think that that was the worst time of my interpreting experience  
624 because I felt very sorry to leave a poor old man who was going to  
625 go in theatre soon and he had no way of understanding the doctors  
626 about his illness.  
627 R: Mmm  
628  
629  
630 B: On the other hand, well I was well, very angry doing translation  
631 for him because, it might be his son, nephew or maybe his family  
632 who live in Serbia and who has killed my uncle, so I was in the  
633 middle of feeling what should I do. And I I had to talk to the  
634 doctors and tell them you have booked the wrong person which  
635 this shouldn't be happen again (...) and then I was thinking again  
636 he is the same human being as everybody else and war is war it is  
637 in the past so I decided to carry on the session and I stayed in the  
638 theatre because he was having Hickman line and was fully awake  
639 and I held his hand for two hours and we were talked and we cried  
640 (...) (He was just so grateful that I was there for him.)  
641  
642 R: He was aware of the difference?  
643  
644 B: Yes, he was apologising to me. I told him there is no need to  
645 apologise because I do not think you are one of them if you have  
646 been living in this country for a long time.  
647 R: Umm  
648  
649 B: His English was very good, but it is very important for  
650 everybody to know that if something happens to you personally  
651 your first language will come up there is no way you can speak  
652 English.  
653 R: Umm  
654  
655 B: If you are going to the hospital because all the feelings come  
656 from in your own language so that person who lived here for forty  
657 years couldn't speak any English because he was so depressed at  
658 being in the hospital, just anxious about what was going to  
659 happen. I did the session and they were all so thankful. When I  
660 came out they were saying to me we need to pay you double  
661 (laughs). So I said no no I don't think that I need to be paid double  
662 as long as you don't call me again.  
663  
664  
665

helping profession  
dilemma & personal feelings  
Stock not being  
prepared for this.  
Anger being in a  
difficult position.  
Feelings remain.  
Empathy  
despite everything  
LOSS  
What if I &  
consequences.  
Concern  
what do I  
Confusion  
Conversations asking  
others  
Human  
need rising  
about culture & respect  
for people.  
Sharing & him  
We talked he  
cried  
empathic  
marriage  
Knowledge  
an experience of  
being a second lang  
speaker -  
sharing information  
others gratitude  
plugging gap  
scarce resources  
session difficult.  
Then & there  
Here & Now  
War is war it is in the past  
I was very angry -  
interpreting (past) personal (present)

Wide picture  
Colloquial discourse  
Sympathy - no one else to  
provide service.  
Validation sharing  
self-esteem  
attribution.  
Resolution  
war is war it is in  
the past  
Empathy & how  
he felt.  
Interpreters as  
important.  
Valued by profs?  
Bigger picture  
did they  
really know what  
it was like for  
her?  
Impact of work  
difficult job.  
Obligations to people & others.  
Doing the right thing - humanity  
as paramount?

IMPACT OF CONFLICT  
DILEMMAS  
CONFLICT  
IDENTITY.  
COMMODITY  
interpreting  
all the same.  
IMPACT.  
Reflection.  
Obligations to  
others  
IDENTITIES  
Medical? from being  
nurse professionally?  
Plugging the  
gap.



**Stage 3 - Macro level analysis of the transcript.**

It is at Stage 3 that the researcher is encouraged to stand back from the fine line by line detail and to consider the themes that emerge from the transcript as a whole. Stages 2 and 3 respectively involve asking questions of the data.

□ Questions to ask of your data as you code and develop themes (Larkin, 2003).

*At the 'interpretative' stage (2) -*

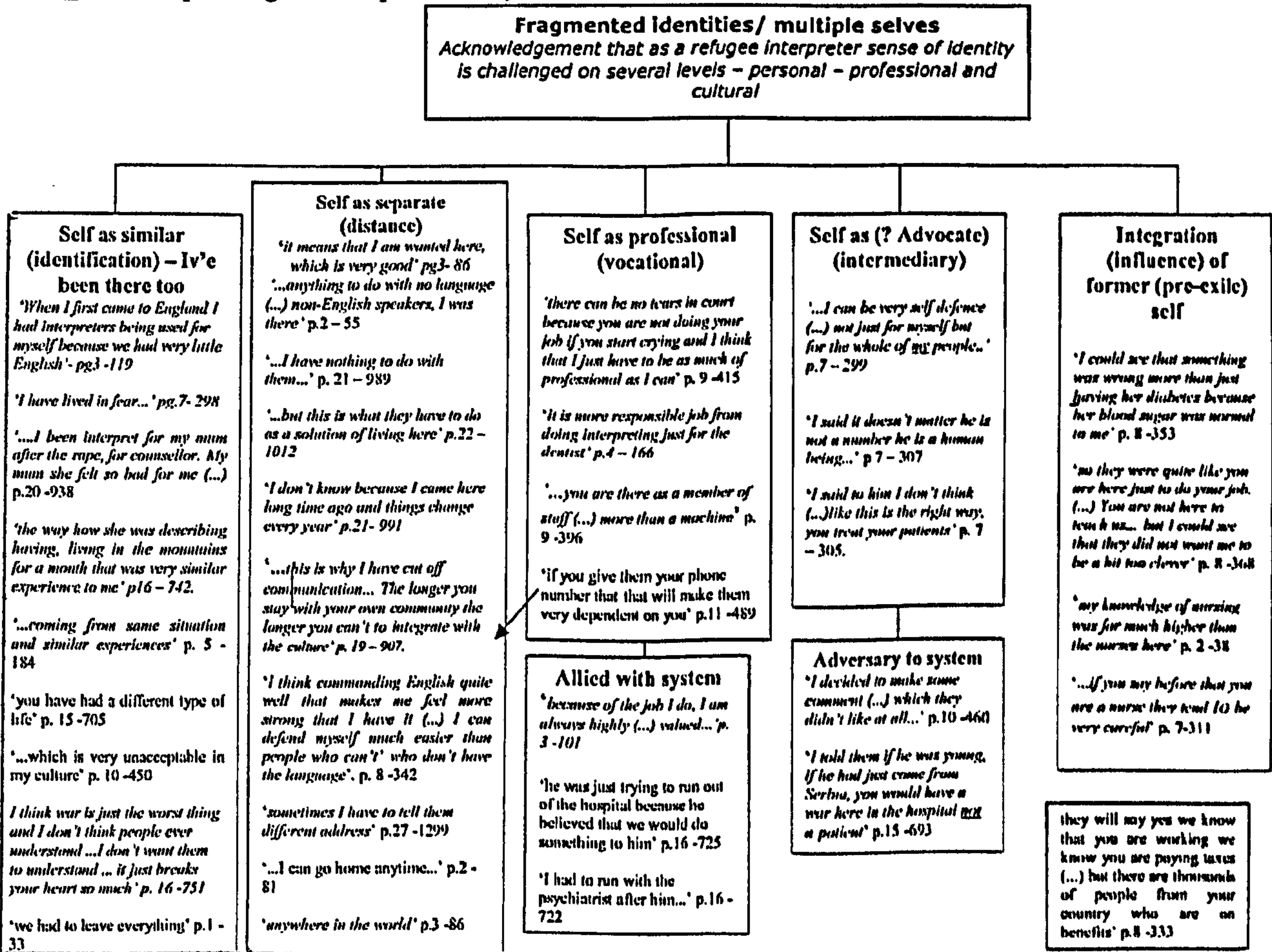
- What other meanings might such experiences have? How else could they be understood?
- What are the contextual constraints within which the participant's understanding of the experience can be seen to make sense?
- What other factors might shape the participant's experience in this setting?
- What does the participant achieve through offering this particular understanding of their experience?
- What narrative and discursive strategies can you identify which assist them in this?
- What have you contributed to this understanding?

*At the 'integrative' stage of theme generation (3) -*

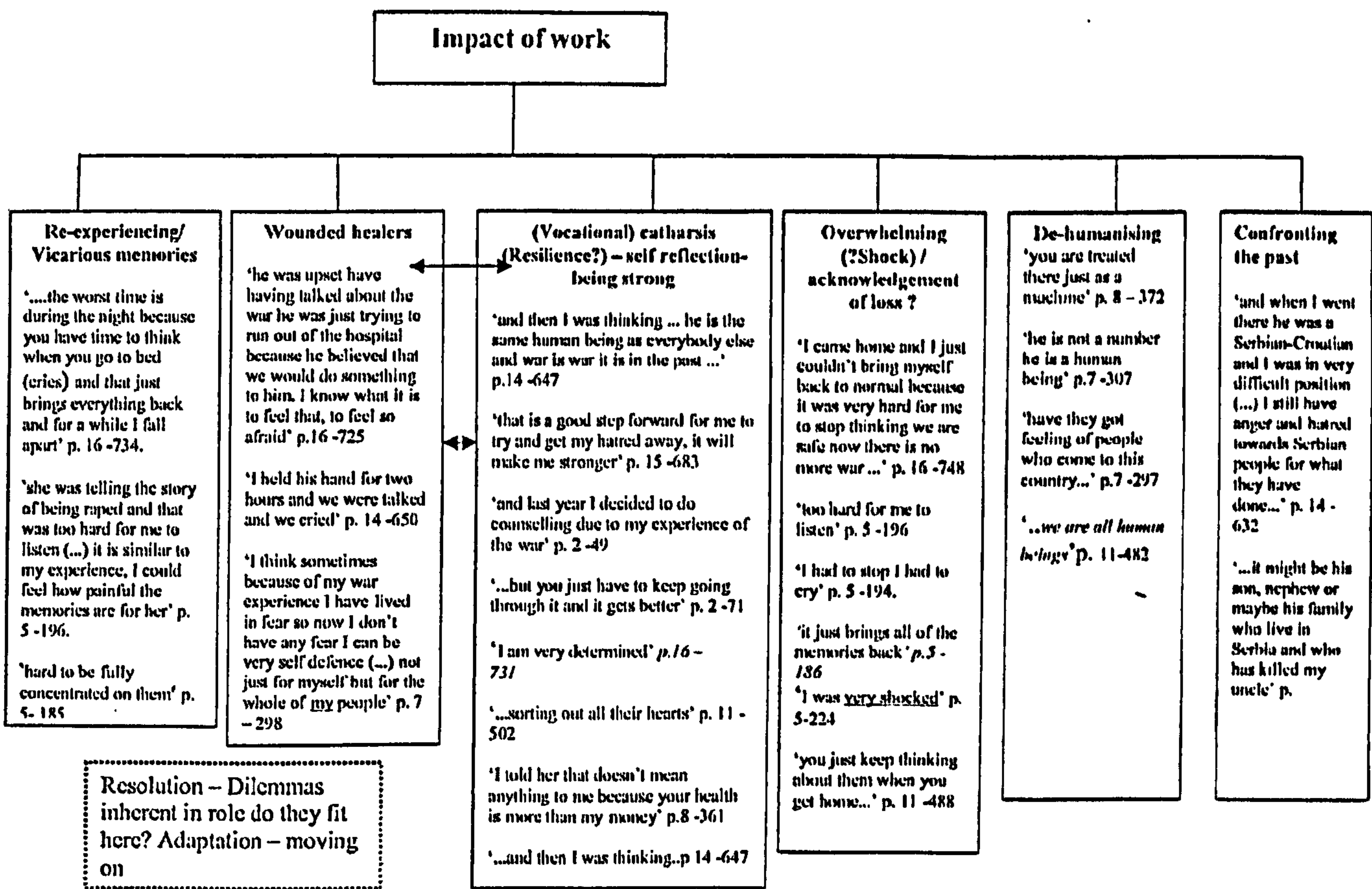
- What features are common across the accounts?
- What features are distinct?
- How might you most plausibly explain this?

The sub themes from interview 1 were studied, revised and then organised to form consistent and meaningful statements. Preliminary diagrams of the superordinate and sub themes were then drawn. Example diagrams from this stage have been reproduced below. These are not however, a definitive analysis of the themes that emerged from the transcript, rather they represent an initial attempt to group the researcher's interpretations of one participant's experiences in a congruent and coherent manner.

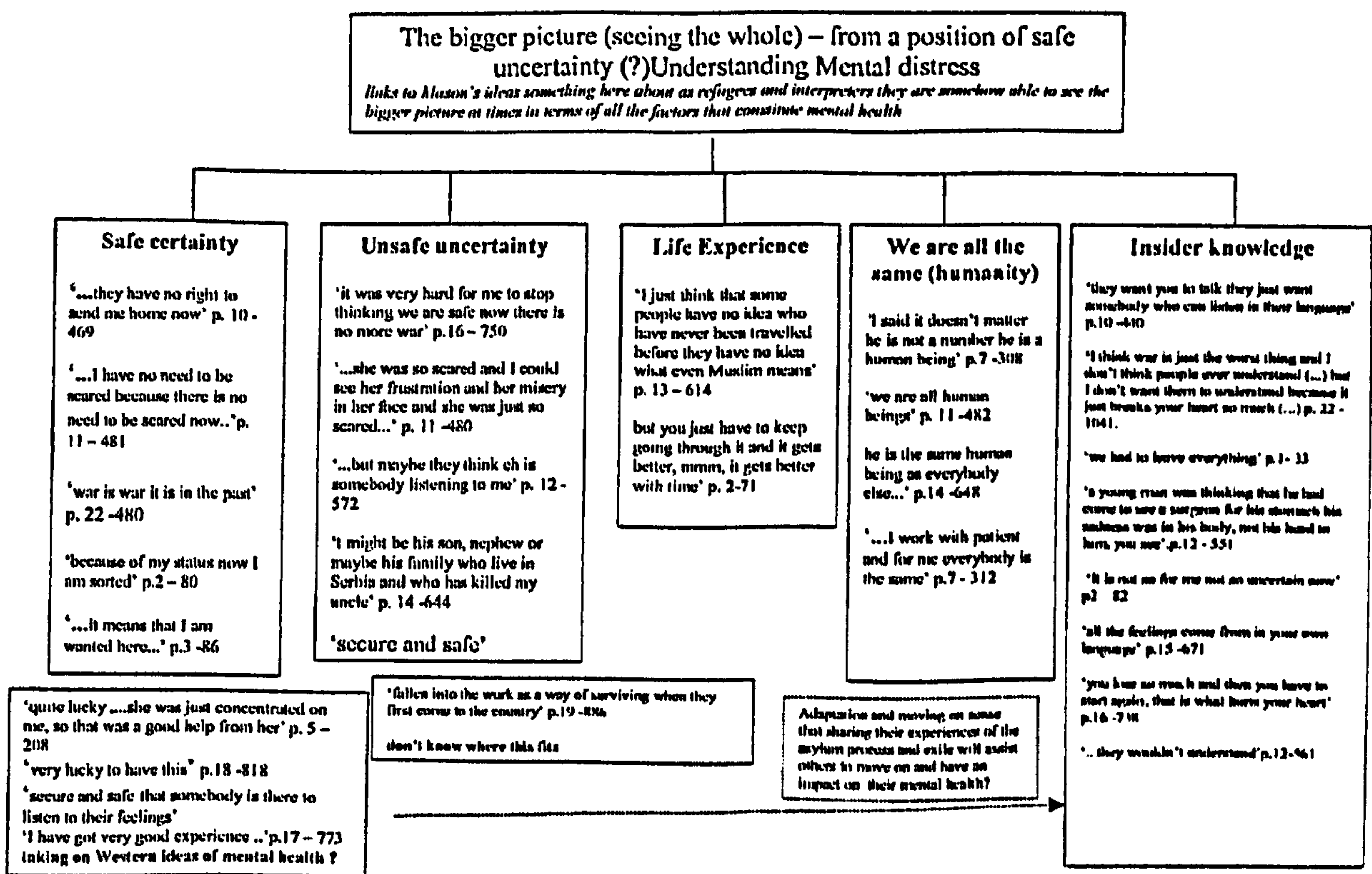
□ Example diagrams of preliminary themes extracted from interview 1 –



□ Example diagrams of preliminary themes extracted from interview 1

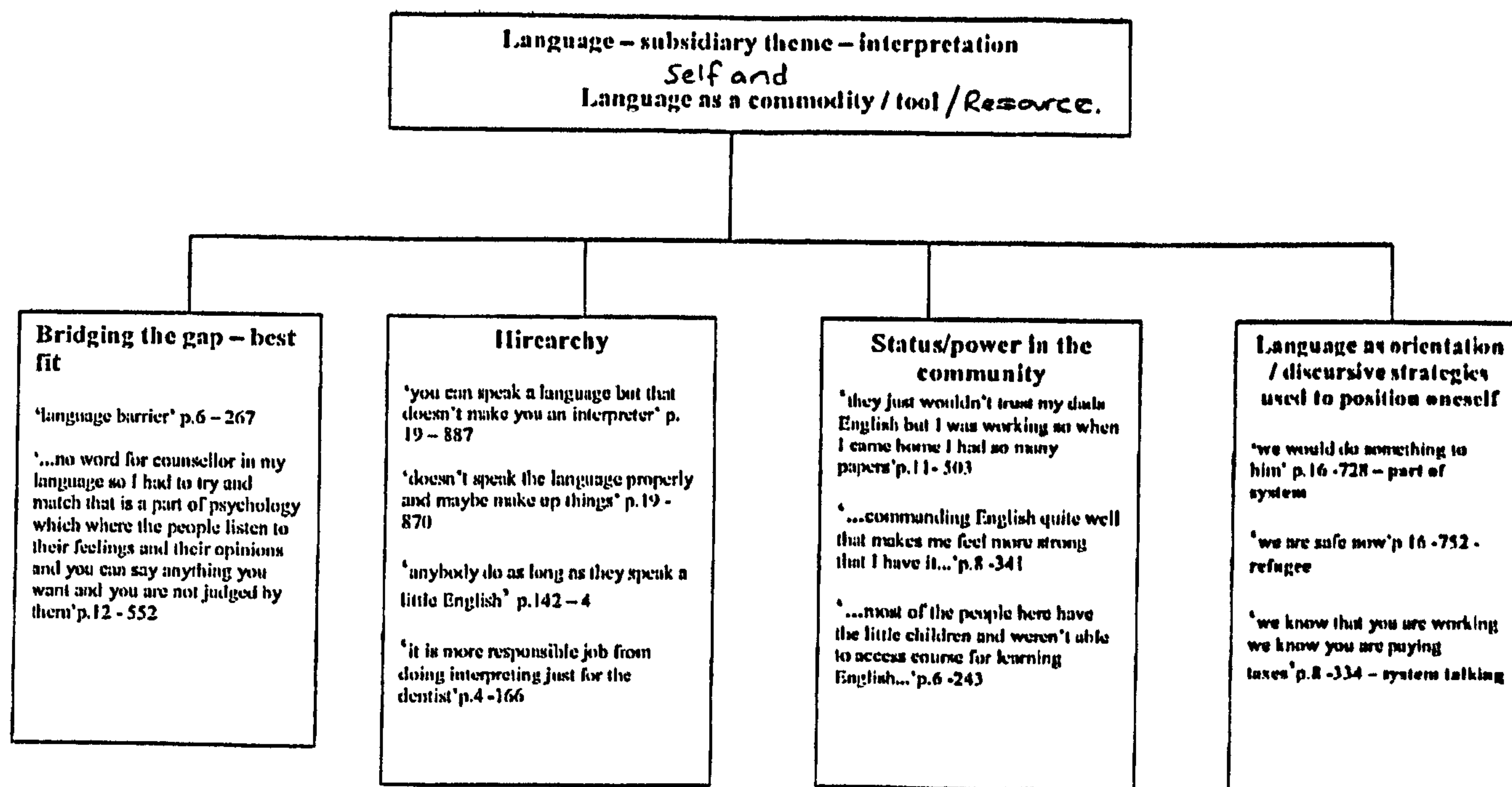


□ Example diagrams of preliminary themes extracted from interview 1

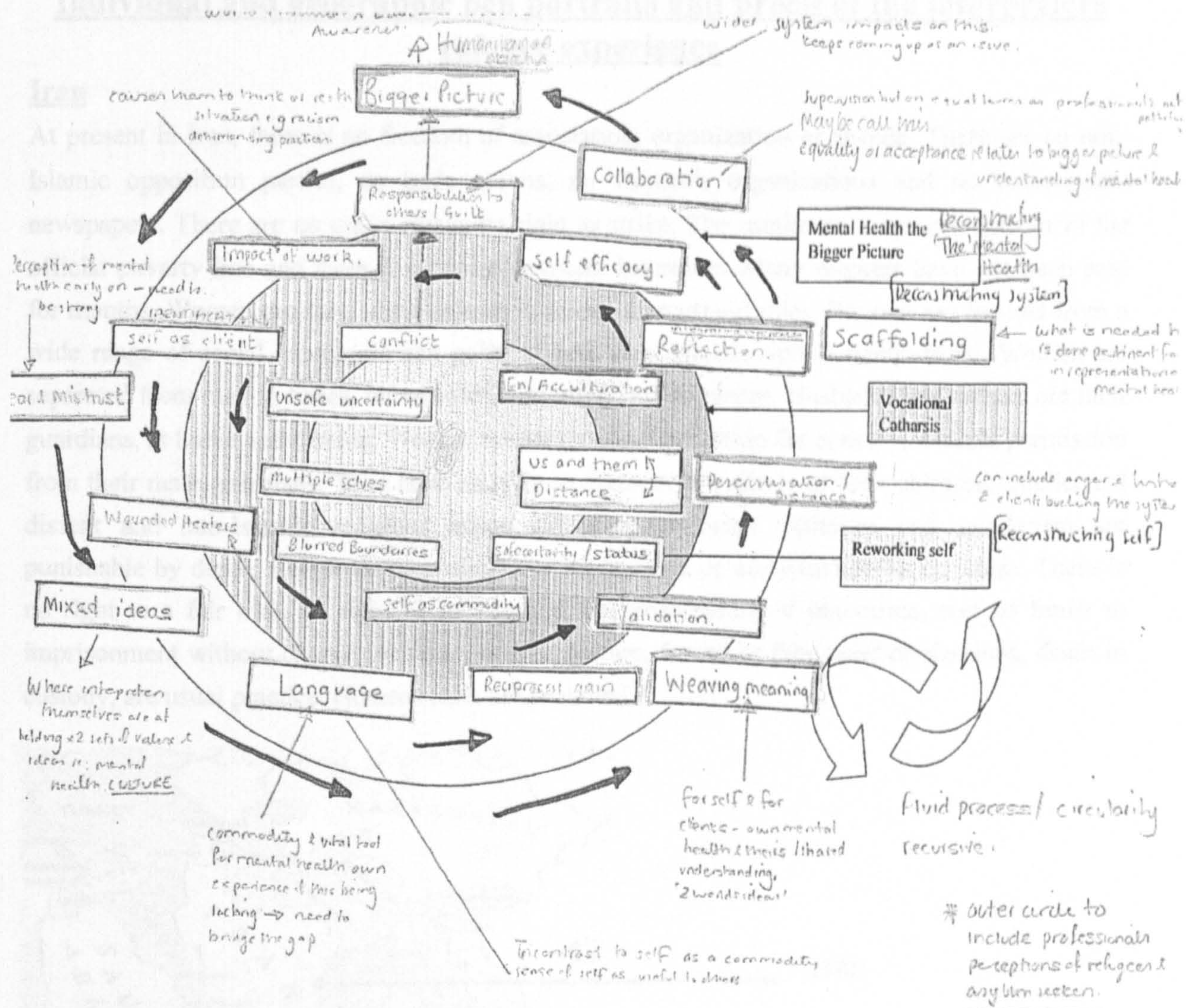




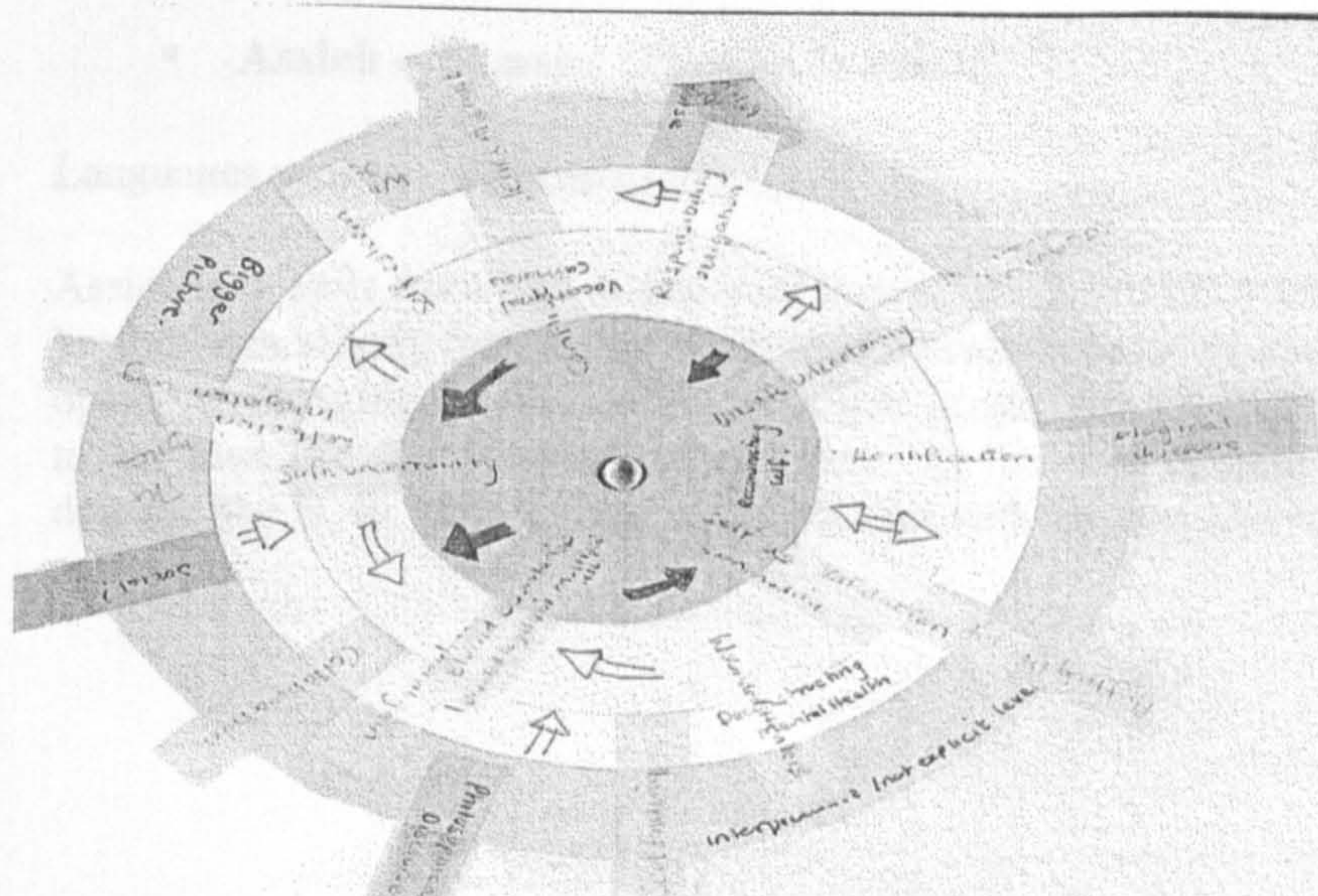
□ Example diagrams of preliminary themes extracted from interview 1







□ Examples of early models attempting to illustrate and develop relationships between super-ordinate themes





## Appendix: G

### Individual and geographic pen portraits and précis of the interpreters refugee experience

#### Iran

At present in Iran, there is no freedom of association, organization or speech. There are no non-Islamic opposition parties, no trade unions, no women's organizations and no independent newspapers. There are no union rights, no right to strike. The minimum wage is a quarter of the official poverty line and there is no unemployment insurance. Many workers have not been paid for months. Women are third class citizens and sexual apartheid rules. Women are banned from a wide range of social, economic and political activities; Islamic veil is compulsory. Women are separated from men in buses, universities, and many public places. Husbands and fathers are their guardians, at home and outside. Women cannot travel, even within the country, without permission from their male guardians. They have no right to divorce, or custody of their children. Intellectual dissent and non-Islamic religious expression are suppressed. Atheism and secularism are punishable by death. Religious 'cleansing' and suppression of non-Muslims is the norm. There is no right to a fair trial, no right to an attorney, no presumption of innocence, and no limits to imprisonment without charge. Arbitrary arrests, torture, forced or fabricated confessions, death in custody, are usual practice. Homosexuals are executed.



#### ▪ Assieh – Female (Persian/Iranian)

Languages spoken : Persian/Arabic /Farsi

Assieh is in exile from Iran due to combination of the war between Iran and Iraq (during which her brother was killed), her mother committed suicide because of this. She became politically active, openly challenging the war and human rights issues, she felt forced to leave Iran following threats to her own life and those of her children. At the time of exile, she had just completed a law degree. She is 40 years of age and a Muslim and has two children. She is now training to be a counsellor.



## ▪ Farrokh – Male (Iranian)

Languages spoken: Arabic, Farsi

Farrokh was forced to leave Iran because of his involvement in political activities. He was involved with political party called the 'worker communist party of Iran'. He was beaten by the police and imprisoned for his views and for campaigning against human rights abuses for e.g stoning women for infidelity. He was studying law and had passed his exams to become a lawyer. Farrokh is 30 years of age and now works as an interpreter as well volunteering with various refugee groups.

## Iraq

The twentieth-century history of Iraq has been a troubled one. Since its establishment by the British in the 1920s, the country has witnessed the rise and fall of successive regimes, culminating in the rise of the Ba'th party and the ascendancy and dictatorship of Saddam Hussein. The history of Iraq is one of social conflict, power struggles between rival clans, the ebb and flow of government relations with Kurds and Shiites, of hostility and wars with neighbouring states, as well as of their aftermath, and Iraq's deteriorating relations with the West.



## ▪ Mahmood – Male (Kurdish Iraqi) Muslim

Languages spoken: Arabic and Farsi

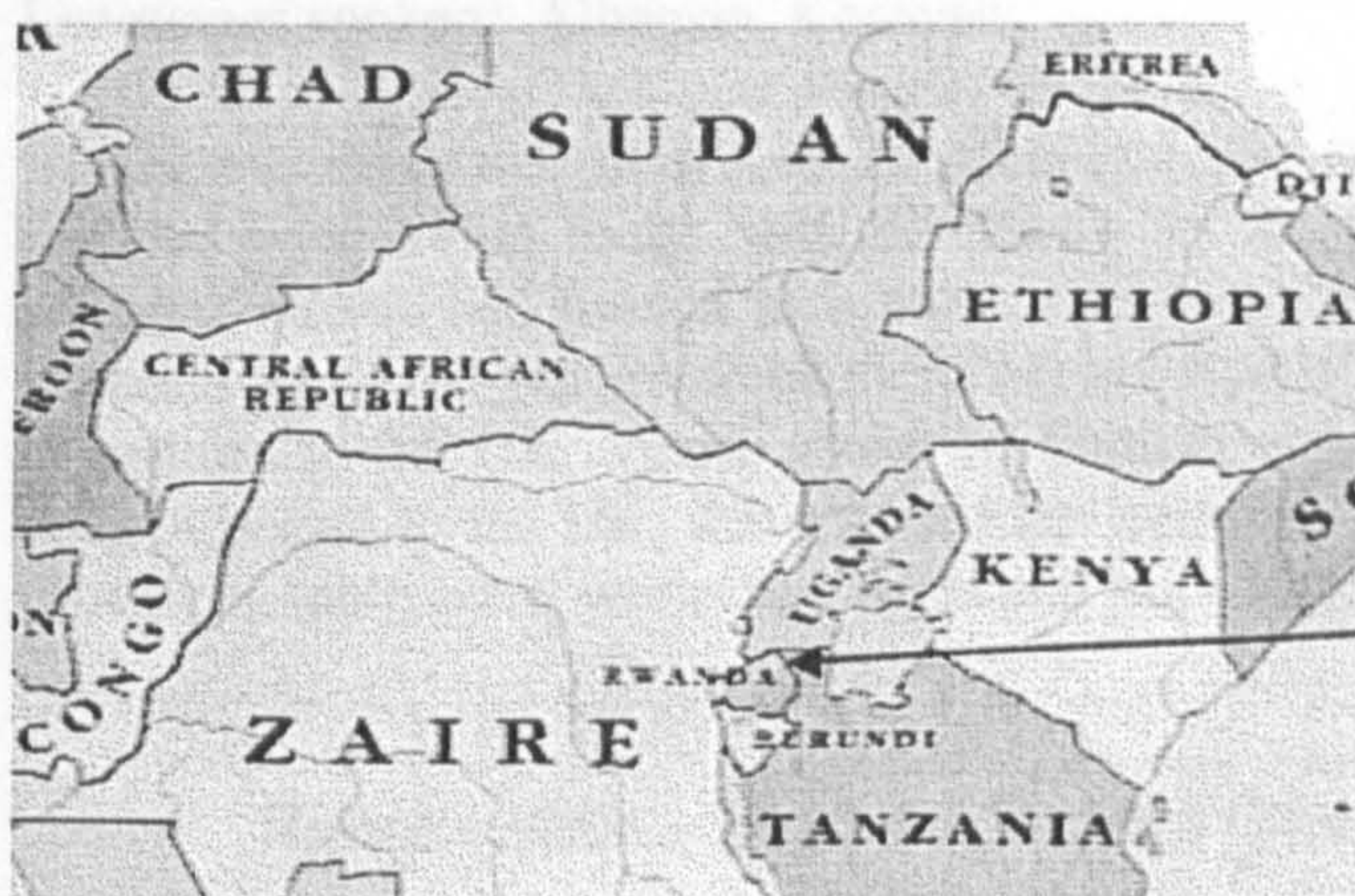
Mahmood is exiled from Iraq where he was working as a doctor. He did not wish to be a part of the 'punishment' operations that were routinely conducted on young men who objected to military service. He refused to participate and as a result was subject to a month of solitary confinement, physical torture and threats to his life if he did not consent to doing these operations in the future. Mahmood decided to flee Iraq. He now lives in the UK and has been granted refugee status. He works as an interpreter and as a volunteer for Refugee Action and is studying for his General Medical council registration so that he might work as a doctor in the UK. Prior to coming to the UK, he spoke a little English, and has had no formal training as an interpreter. Mahmood is 27 years of age.



## Rwanda

Struggles for political and economic power between the rival Hutu and Tutsi tribes have existed since the 1960s. Pervasive mistrust exists between the two ethnic groups and this has led to human rights abuses on both sides ranging from ethnic discrimination to massacres. However, in the spring of 1994 the tiny African nation of Rwanda exploded onto the international media stage, as internal strife reached genocidal proportions. Hutu extremists launched genocide against the Tutsi population and politically moderate Hutu leaders. Between a half-million and 1 million persons, overwhelmingly Tutsi, were massacred. The scale and intensity of the killing was "unprecedented in the history of the...entire African continent," a UN report concluded. Approximately 1 million ethnic Hutu Rwandans fled the country in 1994 and repatriated in huge numbers a few years later, although more than 50,000 have not yet returned.

## Rwanda



Rwanda

- **George – Male –Christian Orthodox**

Languages spoken: Congolese, Lingala, French.

George was forced to flee Rwanda because of the genocide. He lost several family members and friends in the conflict. He now lives in the UK, works as a volunteer for several refugee organisations, and has set up a community support group for African refugees. George is 38 years of age.

## Kosovo (Albania)

The province of Kosovo has been involved in the Balkan crisis for the last decade. By 1998, the conflict turned into a guerrilla war resulting in over one million displaced civilians. About 20,000 left their homes before the beginning of NATO bombings in March 1999 AND 800,000 migrated thereafter. These people became refugees, either in neighbouring countries or in secondary countries of asylum.





- **Vezire – Female – Kosovan Albanian (Muslim)**

Languages spoken: Albanian, Kosovan

Vezire was evacuated from Kosovo Albania during the war. Prior to the humanitarian evacuation, she had been living rough with her family in the mountains to escape capture by the Serbian soldiers. Vezire had trained as a nurse and was about to qualify before they fled. Her personal experiences of the war involved the observed rape of her mother and the death of her uncle. Prior to coming to the UK, Vezire spoke no English and in her words could only say 'hi' and 'bye'. After a period in the UK, she resumed her nurse training and learnt English. She now works part time as an interpreter, works as a nurse and has refugee status. She is 26 years old.

- **Rabet – Male – Kosovo Albanian (Muslim)**

Languages spoken: Greek, Albanian, Italian.

When Rabet was 18 years old he went home to find his house had been burned and that his parents who had been politically active in Albania had disappeared. He went into hiding for several months in the mountains fearful that the people who had taken his parents would try to find him. After several months of living rough, he made his way to the UK where he sought political asylum in the UK and now works for social services as well as working as an interpreter. He is 29 years of age and is married.

- **Zahra – Female - Kosovo Albanian (Muslim)**

Languages spoken: Albanian

Zahra was formerly a schoolteacher in Albania, but was forced to leave Albania because of political and religious persecution and for fear of being exported by gangs as a prostitute. She is now married to an English man and has a young son, she is 29 years of age.

- **Esmê – Female – Yugoslavian (Kosovan)**

Languages spoken: Albanian, Kosovan, Greek.



Esmê's brother was a Kosovan soldier in the war against Serbia. In an attempt to trace her brother, Esmê was arrested and held in a cell. Here she was gang raped by five Serbian soldiers. She was forced to flee following threats to her life. In fear of being culturally ostracised, she told no one of her rape until she came to the UK. She now works full-time as an interpreter and has been reunited with her brother who has sought political asylum in the UK. Esmê is 30.

### **Turkey and Kurdish refugees**

Kurds are the fourth largest ethnic group in the Middle East the Kurdish country is a land of high mountains and great rivers and the Kurds are today the most important ethnic group without a State of their own. The Kurds live in a region called Kurdistan, appeared on maps before World War I. The original 230,000 square miles that made up Kurdistan is now part of Turkey, Iraq, Iran, and Syria. Kurdish people are overwhelmingly Sunni Muslim. In each of the new post-war countries, the Kurds found they were the minority. In these newly founded states, the main ethnic groups treated the Kurdish people with suspicion. They forced the Kurds to abandon their Kurdish identity take the identity of the each state. This meant that the Kurds old independence and traditional pastoral way of life had to change. Kurds were expected to learn the main language of the new state in which they found themselves, Turkish, Persian, or Arabic, and to accept Turkish, Persian or Arab nationalism. As a tribal and traditionally minded society, the Kurds wanted to follow their own customs and traditions. Kurds have fought to regain control over their ancestral territories they want to be a respected nation among nations. As in every conflict the world over, the Kurdish civilians suffer most from the Kurdish struggle for self-determination. Until recently, Kurds in Turkey were prevented from speaking their own language in public or practice their customs by law.



#### ▪ **Azad – Male – Kurdish.**

Languages spoken: Turkish, Kurdish and Farsi

Azad left Turkey because of political persecution. He was being arrested regularly and tortured by the police because he was Kurdish. He left Turkey when he was 19 years old, he is now 24 years old. Prior to exile, he had been employed as a professional footballer. Azad is single and now works full time as an interpreter