Service Providers' Experiences of Interpreter-Assisted Mental Health Care for People with Refugee Backgrounds

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Abstract

Lack of a common language is one of the major barriers to providing mental health services for people with refugee backgrounds. However, while research shows that using interpreters can present some challenges, there is little research that focuses on people with refugee backgrounds, and particularly research that considers the specific challenges and benefits related to interpreter-mediated mental health sessions. As such, this study aimed to investigate the experiences of both interpreters and mental health professionals regarding the potential ways of improving interpreter-assisted mental health care for people with refugee backgrounds. Mental health professionals ($N = 8$) and interpreters ($N = 9$) working with people with refugee backgrounds in Australia were interviewed. Data were analyzed using thematic analysis in a qualitative paradigm. Analysis returned five themes: 'interpreters as cultural advisors', 'importance of briefing and debriefing', 'interpreters as part of the therapeutic relationship', 'interpreter-client interactions', and 'specialized training for both interpreters and mental health professionals'. This study found that interpreters have various roles and are a part of the therapeutic relationship with mental health practitioners and people with refugee backgrounds. Future studies should investigate training for both interpreters and mental health professionals, as well as developing new guidelines specific to interpreter-assisted mental health care for people with Refugee backgrounds.

Keywords: refugees; mental health care; interpreters.

Declaration

This thesis contains no material which has been accepted for the award of any other degree of diploma in any University, and, to the best of my knowledge, this thesis contains no material previously published except where due reference is made. I give permission for the digital version of this thesis to be made available on the web, via the University of Adelaide's digital thesis repository, the Library Search and through web search engines, unless permission has been granted by the School to restrict access for a period of time.

Contribution Statement

For this thesis, I devised the research question, applied for ethics, conducted the interviews for data collection, extracted themes from the data, conducted the analysis, and wrote up all the aspects of the thesis. My supervisor oversaw my work at each step and assisted with the analysis.

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CHAPTER 1: Introduction

1.1 Overview

Providing interpreter-assisted mental health care for people with refugee backgrounds has long been a challenge for mental health professionals and interpreters working in resettlement countries (Bauer & Algeria, 2010; Crezee et al., 2011; Doherty et al., 2010; Fennig & Denov, 2021; Kindermann et al., 2017; Kuay et al., 2015; Pugh & Vetere, 2009; Yakushko, 2010). Recent research in this area has investigated the distinct features of interpreter-assisted mental health care, for instance interpreters' additional roles and the development of a three-way relationship between clients, mental health professionals, and interpreters (Fennig & Denov, 2021; Kuay et al., 2015; Miller et al., 2005; Resara et al., 2014; Mirza et al., 2017), ambiguity of the interpreters' role (Doherty et al., 2010), mental health professionals feeling isolated due to clients bonding with interpreters (Miller et al. 2005; Raval, 1996), and interpreters being negatively affected by refugees' accounts of trauma (Crezee et al., 2011; Fennig & Denov, 2021; Kindermann et al., 2017; Kuay et al., 2015). Research has also explored the critical requirements in order to improve the therapy process and mental health outcomes for clients with refugee backgrounds, such as training for interpreters and mental health professionals (Gartley & Due, 2017; Miller et al., 2005; Mirza et al., 2017; Yakushko, 2010). However, the little research which has been conducted has not resulted in resettlement countries such as Australia recognizing the necessity of implementing specialized training and mandated guidelines specific to interpreter-assisted mental health care for refugees. As such, this study aimed to contribute to the growing literature in this area by analyzing the experiences of mental health practitioners and interpreters working with people with refugee backgrounds in mental health settings.

1.2 Terminology

As a signatory of the 1951 Refugee Convention (Refugee Convention, 1951), Australia uses the same definition for refugees as stated in the convention, article 1A(2), whereby a refugee is "someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion". An asylum seeker, by contrast, is defined as "a person who has fled their own country and applied for protection as a refugee" (Australian Human Rights Commission, n.d.). There were 26.3 million refugees and 4.2 million asylum seekers in the world by mid-2020 (United Nations High Commissioner for Refugees, 2020). Importantly, while most non-refugee migrants have some autonomy and choice about where they relocate to, refugees are often forced to leave their home countries and resettled in another country chosen by an organization such as the UNHCR (Segal & Mayadas, 2005).

For the purpose of brevity in this study the word "refugee" refers to asylum seekers whose refugee claims have not been yet accepted or have been rejected, refugees living in the community on temporary visas, and Australian permanent residents who came to Australia as refugees. The numerous mental health services for survivors of trauma and torture in Australia provide interpreter-assisted mental health care for all people with refugee backgrounds. It is important, however, to acknowledge the differences among these groups primarily based on their visa status, including access to services such as mental health assistance, work and study rights, and ability to reunite with family members (Murray & Skull, 2004). It is also important to acknowledge the potential diversity within each group in terms of their education and literacy levels, including in their first language (AMES Australia, 2021).

1.3 Background and Previous Literature

1.3.1 Refugees' Mental Health

Research has shown that refugees are at significantly greater risk of a range of mental illness as compared to both the general population and other migrant groups in resettlement countries (Heeren et al., 2014; Hollander et al., 2011). For instance, the prevalence of post traumatic disorder (PTSD) in refugees is 31%, which is about 10 times higher than the general population prevalence in high income countries of 3.9% (Blackmore et al., 2020; Fazel et al., 2005). The prevalence of depression among refugees is 31.5%, which is significantly higher than the general population prevalence of 12% (Blackmore et al., 2020). Rates of anxiety and depression have also been shown to be twice as high in refugees than in labour migrants (Lindert et al., 2009). It is also important to note that asylum seekers have significantly higher rates of depression and anxiety than people whose refugee status has been confirmed (Heeren et al., 2014).

In terms of risk factors or predictors of mental illness for refugees, the research has clearly established links between mental ill-health and pre-resettlement experiences (e.g., torture, family separation, exposure to war), the migration journey itself, and post-resettlement challenges (e.g., unemployment, social isolation, language challenges) (Heeren et al., 2012; Heeren et al., 2014; Hengst et al., 2018; Kirmayer et al., 2011; Porter & Haslam, 2005; Steel et al., 2009). For example, exposure to traumatic experiences consistently predicts higher levels of depression, PTSD, and anxiety in refugees fleeing war situations (Bogic et al., 2015; Marshall et al., 2005). The length of the asylum procedure is significantly correlated with the rate of psychiatric and somatoform disorders (Laban et al., 2004). Furthermore, refugees are often uncertain as to the length and outcome of their asylum procedure for extended periods, which contributes to psychological distress (Kirmayer et al., 2011). Post-resettlement socio-ecological and practical factors such as lack of secure

accommodation, social isolation, and limited financial opportunities for refugees in resettlement countries are also strongly associated with psychological distress, particularly depression (Bogic et al., 2015; Steel et al., 2009). In general, refugees face a range of significant cumulative risk factors for mental illness and as a result have significantly worse mental health than other migrant groups and the general population in resettlement countries (Heeren et al., 2014; Hollander et al., 2011).

1.3.2 Barriers to Mental Health Care

Considering the prevalence of mental health issues among refugees as outlined above (Blackmore et al., 2020), it is arguably the responsibility of host countries to provide refugees with mental health care. However, previous research has identified a range of barriers to service access (defined here, following Levesque et al. (2013), as both being able to access a service and subsequently use it) which result in refugees being under-served by mental health services in resettlement countries such as Australia, including limited funding for specialized refugee mental health services, lack of culturally safe services, lack of awareness of the existing services on the part of refugees, cultural differences in understandings of mental health, and stigma surrounding help seeking (Duden & Martins-Borges, 2021; Satinsky et al., 2019). Refugees' views on the importance of mental health, their manners of expressing mental health-related symptoms, and their help-seeking behaviors can be very different from western culture, and these differences often have hindering effects on refugees utilizing mental health services in resettlement countries (Satinsky et al., 2019).

One of the main barriers to accessing and utilizing mental health services in resettlement countries is the low language proficiency of refugees in the primary language of the country of resettlement (Ohtani et al., 2015), and sometimes low levels of literacy even in refugees' first language (AMES Australia, 2021). As such, lack of interpreters within health care systems is recognized as a key barrier to providing care for, and having meaningful

communication with, refugee clients (Duden & Martins-Borges, 2021; Fennig & Denov, 2021; Thomson et al., 2015). Since research shows that refugees in Australia have the lowest English language skill levels among all migrant groups (Chiswick et al., 2006), using interpreters is essential to their ability to receive psychological care.

1.3.3 Interpreter-Assisted Intervention

Most recent studies have found no significant difference in therapeutic gains between interpreter-assisted and non-interpreter assisted interventions for refugee clients, including cognitive behavioural therapy (CBT) (d' Ardenne et al., 2007; Villalobos et al., 2016), trauma-focused therapy (Lambert & Alhassoon, 2015), and cognitive processing therapy (Schulz et al., 2006). In contrast, a retrospective cohort study by Sander et al. (2019) comparing the effectiveness of CBT for refugee clients with and without the use of interpreters reported lower treatment outcomes in improving PTSD for the interpreter-assisted group. However, the authors noted that this difference in outcomes is not necessarily a result of using interpreters per se, but rather other factors such as potential cognitive impairments in the group needing interpreters, or interpreter-assisted treatment proceeding more slowly.

In terms of the process of interpreter-assisted mental health work, several studies have demonstrated the importance of interpreters' role and their contributions to therapeutic practice (Fennig & Denov, 2021; Gartley & Due, 2017; Kuay et al., 2015). In fact, the relationship between clients, interpreters, and mental health professionals has been indicated as one of the most important factors contributing to successful mental health therapy with refugee clients (Fennig & Denov, 2021; Mirdal et al., 2012; Mirza et al., 2017). Research suggests that interpreters enrich and improve the therapeutic relationship, traditionally between clients and mental health practitioners, by instead making it a three-way relationship

which assists in fostering trust from refugee clients and guiding professionals in providing culturally appropriate mental health care (Fennig & Denov, 2021).

However, there is also consensus among studies about the complex and challenging nature of psychological care with the use of interpreters in general (Bauer & Algeria, 2010; Kuay et al., 2015; Pugh & Vetere, 2009; Yakushko, 2010), and working with refugee clients who are likely to have had traumatic experiences can be an added complication (Tribe & Thompson, 2009). For instance, mental health professionals are sometimes unclear as to the requirements of interpreters' role (Crezee et al., 2011; Gryesten et al., 2021). Some find the presence of a third person uncomfortable or feel excluded when clients form strong bonds with interpreters (Miller et al. 2005; Raval, 1996). Not being able to communicate directly with clients can create challenges regarding therapeutic empathy, both verbally and nonverbally (Pugh & Vetere, 2009). Using interpreters also makes the communication proceed more slowly and presents difficulties in engaging clients in certain techniques of therapy (Raval, 1996). As such, a few studies have indicated the importance of training for mental health practitioners that targets the complications and practicalities of interpreter-assisted therapy (Crezee et al., 2011; Mirza et al., 2017; Yakushko, 2010). However, research around the importance and effectiveness of training mental health professionals to work with interpreters is extremely limited, and such training is lacking in Australia and many other resettlement countries (Brisset et al., 2013; Miletic et al., 2006; Miller et al., 2005; Yakushko, 2009).

Research on the dynamics of interpreter-assisted mental health care has brought into light the many ways in which mental health interpreting is different from interpreting in other settings (Gryesten et al., 2021; Miller et al., 2005; Mirza et al., 2017; Resara et al., 2014). Working in mental health settings with refugee clients often requires an expansion of the interpreters' role to cultural advisors, due to the cultural differences in understandings of

mental health which may affect the therapy process (Fennig & Denov, 2021; Kuay et al., 2015; Miller et al., 2005; Resara et al., 2014; Mirza et al., 2017). This added role, together with the therapeutic relationship between clients and interpreters, makes the conventional role of interpreters as an impartial and detached translation 'machine' not only incompatible but also potentially inappropriate (Miller et al., 2005). In addition, Gryesten at al. (2021) noted that interpreters actively trying to improve clients' mental health outcomes shows that they regard themselves as caring professionals; a factor that is not currently taken into account in much of the practice and guidelines for interpreters.

On the other hand, working in mental health settings can be challenging and stressful for interpreters as well. For example, previous research indicates that interpreters find important requirements of mental health interpreting (e.g., building rapport with clients, showing sensitivity, trying to stay unbiased, and navigating mental health professionals' expectations) to be challenging (Doherty et al., 2010). Furthermore, many interpreters lack adequate knowledge of mental health care, which can create problems for cooperating with mental health professionals (Miller et al., 2005). Interpreting in mental health is also associated with higher levels of secondary traumatic stress (Mehus & Becher, 2016), and interpreting for refugee clients can be even more stressing due to the often highly traumatic nature of refugee clients' experiences and situations (Crezee et al., 2011; Fennig & Denov, 2021; Kindermann et al., 2017; Kuay et al., 2015). These issues and challenges justify the necessity of providing interpreters with briefing and debriefing before and after each individual session (Crezee et al., 2011; Fennig & Denov, 2021; Kuay et al., 2015; Miller et al., 2005) and specialized training in order to work in mental health settings with refugees (Gartley & Due, 2017; Miller et al., 2005; Mirza et al., 2017; Yakushko, 2010). However, despite the (admittedly limited) literature indicating the distinct features of mental health interpreting and the importance of specialized training for interpreters working in mental

health, there is currently no mandated training in this area in Australia. The National Accreditation Authority for Translators and Interpreters (NAATI) only offers two types of training and accreditation for interpreters: Certified Specialist Legal Interpreter (for practising in legal settings) and Certified Specialist Health Interpreter (for practising in general – but not necessarily mental – health settings). Similarly, there is no separate training for interpreters in order to prepare them to work with refugee clients.

1.4 Theoretical Underpinning

While the small body of research outlined in the previous section has addressed the interactions between refugee clients, mental health practitioners, and interpreters, there is a lack of models which help explain these interactions and their effects on refugee clients' mental health outcomes. The theorical model by Street et al. (2009) presents pathways through which communication between clinicians and clients can contribute to positive intervention outcomes, both directly and indirectly. This simple model considers intrinsic contextual factors as well as extrinsic social ones which modify the clinician-client relationship and its effect on health outcomes. According to this model, there are seven pathways which link communication to better health outcomes. These are: 1) Access to care, which includes increasing clients' awareness of availability of care and ability to navigate health systems; 2) Patient knowledge and shared understanding, which reflects clients' views on health, treatment, and their importance, and clinicians' awareness and respect for clients' health-related thoughts and preferences; 3) Enhancing the therapeutic alliance, encompassing the various health professionals, family, and friends who support clients, and the relationship between them; 4) Enhancing patients' ability to manage emotions, which is related to clinicians assisting clients in coping with negative emotions like fear and worry; 5) Improving family and social support, related to clinician-client communication improving client's wellbeing through contributing to social support; 6) Enhancing patient empowerment

and agency, which includes improving clients' skills in managing their health-related activities, coping with their unique circumstances, and accessing various resources; and finally 7) Making higher quality decisions, which relates to improving clients' health through mutual and practical decisions.

The relationship between mental health practitioners and clients has long been considered a key underpinning of mental health work; however, there has been little consideration of how interpreters might affect this relationship. While the above model was created with respect to medical care in general (and not necessarily with the use of interpreters), Fennig and Denov (2021) used it as a foundation in their scoping review to demonstrate the various ways in which interpreters contribute to mental health care for refugees, for instance by enhancing therapeutic alliance through trust and rapport. To the authors' best knowledge this model has never been drawn upon by studies with primary data in interpreter-assisted mental health care context. This study explored to what extent the service providers' experiences around interpreters' role in such settings fit into the Street et al. (2009) model.

1.5 Aims and Research Question

While the limited research in resettlement countries such as Australia has demonstrated the unique sensitivities and demands of interpreter-assisted mental health care for refugees, there are some gaps and contradictions in the findings particularly in regard to interpreters' role which require further exploration. In addition, there are currently no specific regulations or trainings for either mental health professionals or interpreters who work in such settings. This qualitative interview-based research aimed to investigate the process, benefits, and challenges of interpreter-assisted mental health care for refugees as well as potential ways of improving care using interpreters.

CHAPTER 2: Method

2.1 Participants

The participants (total $n = 17$) were eight mental health care professionals and nine interpreters residing in Australia. Mental health care professionals were four men and four women, aged between 29 and 63 ($M = 50$, $SD = 12.9$). In terms of experience working with refugee clients they ranged between three and 27 years ($M = 12.5$, $SD = 10.1$) (see Table 1 for more demographic information). Interpreters were six women and three men, between 33 and 71 years of age ($M = 51.4$, $SD = 13$), with three to 27 years of experience in interpreting for refugees in mental health settings ($M = 14.4$, $SD = 8$) (see Table 2 for more demographic information).

Table 1

Participant Characteristics (Mental Health Professionals)

Name*	Gender	Age	State	Occupation	Years of Experience
Rafael	M	47	SA	Counsellor	4
Jeoffrey	M	46	WA	Psychotherapist	5
Beatrice	F	63	WA	Counsellor	9
Terry	M	61	SA	Clinical Psychologist	27
Noah	M	35	VIC	Psychologist	6
Carry	F	29	VIC	Counsellor	3
Daisy	F	57	SA	Counsellor	26
Milent	F	62	SA	Counsellor	20

*All names are pseudonyms.

Table 2

Participant Characteristics (Interpreters)

Name*	Gender	Age	Nationality	State	Years of Experience
Olivia	F	49	Syria	SA	16
Sue	F	62	Serbia	SA	15
Tom	M	66	Serbia	SA	27
Roy	M	71	Iran	SA	26
Anna	F	41	Serbia	TAZ	15
Suzanna	F	33	Egypt	NSW	3
Vera	F	56	France	VIC	7
Nina	F	46	Iran	SA	13
Mavi	M	39	Bangladesh	QLD	8
Bloss	F	78	Indonesia	VIC	3

*All names are pseudonyms.

2.2 Procedure

The study was approved by the School of Psychology human research ethics subcommittee on the 31st of March 2021, approval number 21/14.

One inclusion criterion for both mental health care professionals and interpreters was to have worked with refugees in mental health settings for at least three years; this criterion was chosen in order to produce richer data about different aspects of the service providers' experience. Other inclusion criteria for both groups were adequate English language proficiency and being aged 18 years or over.

Research flyers (Appendix A) were emailed to the Australian Institute of Interpreters and Translators, several interpreting companies, and refugee mental health services across Australia. Interested service providers were asked to contact the primary researcher by email or phone, and after answering their questions and checking their eligibility the information sheet and consent form (Appendix B and C) were emailed to them. Interviews were arranged at a time convenient for participants and conducted in person, via Zoom, or on the phone. At the beginning of each interview the participants were informed that they could choose not to answer any questions or withdraw from the study at any point. The demographic information was collected at the end of each interview.

Interviews were conducted between May and June 2021. All interviews were recorded, and their length ranged between 20 and 54 minutes (M = 39, SD = 8.7). Interviews were semi-structured, using open-ended questions to produce rich data for the exploratory study (Braun & Clarke, 2013). An interview guide (Appendix D) was developed based on previous literature and used in the pilot interview, conducted in May 2021 with a Syrian interpreter. This interview did not result in the addition of any new questions, and was included as an interview in the final sample. Interview questions were iteratively reviewed after each interview, but this also did not result in any major changes. Data saturation was

achieved by the eighth interview for mental health practitioners and the ninth interview for interpreters.

Following standards for rigor in qualitative interview-based studies (Tracy, 2010), an audit trail was kept throughout the project, including details of participant recruitment, communications with supervisors and participants, and interviews. Field notes and analytic insights were also recorded after each interview, in order to improve the quality of future interviews and develop a reflexive analysis (Braun & Clarke, 2013).

Interviews were transcribed orthographically, producing a verbatim record of all verbal talk and utterances (Braun & Clarke, 2006; 2013). All participants were given pseudonyms, and necessary changes, such as removing names and locations, were made to the transcriptions to ensure confidentiality. After each interview participants were asked if they would like to receive a copy of their interview transcription and the preliminary themes, so they would have the opportunity to provide feedback. Three participants expressed interest in receiving the transcriptions and preliminary themes, and none of them suggested any changes.

In qualitative research, acknowledging the researcher's potential influence on different aspects of the research process is necessary for personal reflexivity (Braun & Clarke, 2013). The primary researcher in this study is a psychology student with refugee background who has been working as an interpreter for several years. It is important to acknowledge the potential effect of participants' knowledge of the primary researchers' refugee background and interpreting experience on their responses, as well as the effects of the primary researchers' personal experiences and assumptions on shaping the data.

2.3 Data Analysis

The research had an experiential qualitative design and data were analysed using thematic analysis as a realist method whereby analysis takes place with the assumption of a

straightforward relationship between the data and the researchers' perception (Braun & Clarke, 2013). Themes were identified with an inductive approach (Braun & Clarke, 2006) in order to grasp the full scope of participants' experiences without imposing a theoretical lens over the data at the initial data analysis stages.

The analysis process was guided by Braun and Clarke's (2006) six phases of conducting thematic analysis. Familiarity with the data was reached through conducting, listening to, and transcribing interviews. The transcripts were coded according to the research questions, and patterns which were noticed in the coded data were used to shape relevant themes, as in relation to the research questions. The themes were reviewed, reflected upon, and modified by the primary researcher, with cross-checking provided by the academic supervisor. Analysis was conducted and written up by the primary researcher.

CHAPTER 3: Results

Analysis of the data led to identification of five major themes: ‘interpreters as cultural advisors’, ‘importance of briefing and debriefing’, ‘interpreters as part of the therapeutic relationship’, ‘interpreter-client interactions’, and ‘specialised training for both interpreters and mental health professionals’. The theme ‘interpreters as part of the therapeutic relationship’ had two subthemes: ‘trust’ and ‘choosing the same interpreter’. These themes and subthemes are presented below.

3.1 Interpreters as Cultural Advisors

Most mental health professional and interpreter participants noted that they found the interpreters’ role in mental health sessions with refugees to be much more than just translating from one language to another. In particular, interpreters were frequently seen as acting as cultural advisors, with interpreter participants indicating that when working with refugees in mental health settings they often found themselves explaining various concepts both to mental health practitioners and to clients. For example, Roy, a Farsi interpreter, said:

> The first issue is that to really make both sides to understand each other, because I tell you for them – especially if refugees coming from Iran or Afghanistan and all that, it’s very hard to go and understand the psychologist. And then to explain to the psychologist what, really, they are coming from. So then they understand each other and go ahead. (Roy, interpreter, 124-128)

The most common example of assisting mental health practitioners and clients in understanding one another was the translation or explanation of mental health-related words and concepts. Apart from asking the professional for clarification, many of the more experienced interpreters reported explaining new or ambiguous concepts to the client

themselves. They did, however, emphasize the importance of informing the professional if they did so, as Sue, a Serbian interpreter, pointed out:

> For example, say, oh, schizophrenia, they won't understand what that is, so you can say that word, but then maybe explain, or if you don't know how to explain you always ask the professional 'what does that mean?' … you don't understand something, you clarify it with the professional first and then you explain to the client. If you do need to explain to the client I think the interpreter also needs to tell the professional that they will be explaining to the client because that does not exist or the client doesn't understand what that is. (Sue, interpreter, 180-187)

Mental health professionals similarly discussed the role that interpreters often play as cultural advisors, pointing out the necessity of some cultural guidance when working with refugees from different countries in order to ensure that they were interacting in culturally safe ways. Here, mental health practitioners expressed a lot of trust in interpreters' judgement as cultural advisors. For example, Beatrice, who has worked as a refugee counsellor for nine years, indicated that this was particularly important for cultural norms such as those related to gender:

> So they know and they are as well advisers, and they say, 'Beatrice, this is not a topic that the client will be confident to talk in front of me, I'm a male,' or 'Beatrice, these questions are not appropriate. Maybe you can formulate the question another way.' The interpreter is an adviser as well, because they know the culture, and I follow what they said, and you need to be respectful. (Beatrice, counsellor, 270-275)

In addition to verbal communication, mental health practitioners also acknowledged that different cultures have different nonverbal ways of expressing their feelings and emotions, and that without the guidance of interpreters it would be impossible for them to perceive these nonverbal cues. Daisy, who has worked with refugee clients for twenty-six years and was one of the most experienced mental health practitioners in the study, said:

> An interpreter is not just a language medium, it is also a cultural bridge. There are many subtle cultural communications that are not verbal, they're nonverbal, that we miss because we don't belong to that culture. (Daisy, counsellor, 151-154)

Later in the interview, Daisy noted that these cues are critically important, as missing them could lead to misdiagnosis:

> Or they might even say to me – I can't say that because it is disrespectful. So that means that it alerts me that I need to find a different way to talk about a topic that is really important. So, apart from language, it is that cultural bridge that is, if not as equal, sometimes a bit more important. Because if you miss those cultural cues, you misdiagnose. (Daisy, counsellor, 162-166)

Participants also acknowledged that people from culturally diverse backgrounds often also have different needs, some of which mental health professionals might not be aware of. For example, Terry, a clinical psychologist who has been working with refugee clients and interpreters for decades, revealed that he even encourages interpreters to talk to him about crucial information that clients with refugee backgrounds share with them outside sessions.

Terry indicated that making use of information that's only known by interpreters can potentially save lives:

> But you know, the information that the interpreter gathers even outside is very helpful. Without that information, well, lives have been lost because we've not made use of that information. People have been discharged to home with nobody there. The interpreters knew, but nobody else. And the interpreters thought, 'well, it's not my position to tell the doctors.' Well, I think it is your position, because you know and you can say to the doctors, 'are you aware that this person is being discharged to the home that they live alone and they have none of this and they have none of that and they have no idea support, you know? Within our culture, you need support.' They've got to share that. They've got to be advocates and cultural consultants. (Terry, clinical psychologist, 484-494)

In general, both mental health practitioners and interpreters pointed out the necessity of some cultural guidance when working with refugees from different countries, not only to avoid improprieties but also to assure utmost levels of understanding and communication. Participants noted that, since their cultural backgrounds are often the same as the refugee clients', interpreters may have information about clients that mental health practitioners do not have, and as a result they can act as cultural advisors.

3.2 Importance of Briefing and Debriefing

As touched on in the previous theme, one of the most strongly emphasised points by both interpreters and mental health practitioners was the importance of briefing and debriefing interpreters. Interpreters reported having a much less challenging job interpreting for clients in mental health settings when they had been briefed by the mental health

professional before the session, for instance about the likely clinical presentation of the client and the therapeutic approach the professional might take. They also mentioned the lack of an allocated time for briefing and debriefing to be problematic. For example, Bloss, an Indonesian interpreter, emphasised the importance of briefing while also acknowledging that this could be a "burden":

> (How the session goes) depends on whether I have been given a good briefing beforehand, and I tend to ask for it, although I am very aware that everyone is so busy rushing around, like it's an added burden for the professional if I ask for a briefing beforehand. (Bloss, interpreter, 57-59)

Here, Bloss indicated that often people were "rushing" before appointments. Later in the interview she built on this by saying that she thought more time should be allocated specifically for briefing prior to, and debriefing after mental health appointments with refugee clients:

> Time management is a big thing. I think they should be allowing for more time, particularly in a mental health setting. If you're interpreting and people sitting for driving test, you finish and it's straight forward, but in the mental health you really need briefing and debriefing. I think there should be added time for that kind of job. (Bloss, interpreter, 162-166)

Mental health practitioners who participated in the study also found briefing the interpreter and discussing what is going to happen during the therapy process prior to the session highly beneficial. Many participants said that they also valued the interpreters'

opinion on the clients' ability to understand and follow certain methods of therapy. For instance, Beatrice said:

> Ideally, I ask the interpreters to arrive minutes early to say, 'I need to do this today' or 'this is the activity, and I want to get to this point if possible'. But you're letting me know as well if a client is able to understand what it is we do. The interpreters need to know your way, they go with you. It is a mutual collaboration. (Beatrice, counsellor, 209-213)

Here, Beatrice again stresses the importance of interpreters' insight, echoing the first theme about interpreters as cultural advisors. Relatedly, most professionals were also very interested in getting feedback from the interpreters after the session, acknowledging the interpreters' insights and considering them as a valuable source of information about refugee clients. Some also reported depending on interpreters to inform them about things they might have missed in the session, for instance the significance of certain remarks, or the need to choose a different angle to work with clients. For example. Rafael, a counsellor, said that he does debrief with interpreters about refugee clients following their sessions, which can lead to important information:

> They help sometimes in emphasising things, emphasising words or emphasising the importance of something that I haven't been able to pick up. They've done that to me in the past definitely. When I debrief with an interpreter, I generally get exposed to what their impression is, I guess, sometimes of the person they're working with. They can really give me insights into some of the ways they're thinking, where their expressions have come from, insights into their formal education, they could give me

> insights into language used. … Some of them have really told me that I'm barking up the wrong tree in regard to my questions. 'You're going down a path that is not landing, your questions are not landing, and there isn't a way to interpret what you're saying that lands with them, that's understood.' So there, they do a little bit of guidance for me and they're incredibly helpful. (Rafael, counsellor, 314-322)

Additionally, mental health professionals also indicated the importance of briefing and debriefing for interpreters' own mental health and wellbeing, expressing concern for interpreters listening to refugees' accounts of trauma. As such, some participants indicated that they felt the need to speak to interpreters about their feelings after difficult sessions. Carry, a younger counsellor who works at a centre for survivors of trauma and torture, indicated:

> I don't know what support interpreters have, but obviously interpreters can have really, really challenging conversations that are just as difficult for the clients and clinicians and I would be worried that they don't always get that support or would be able to debrief about, … as a clinician you get supervision or you can debrief with colleagues about things, but interpreters are also hearing all of that. (Carry, counsellor, 102-107)

The lack of systematic arrangements for briefing and debriefing for interpreters working with refugees in mental health settings was considered worrying by many mental health professionals in the study. Participants indicated that listening to refugees' accounts of trauma and torture could lead to the resurfacing of personal memories of traumatic experiences. As such, debriefing could give the mental health professional the chance to

make sure interpreters talk about their feelings before they leave. Psychologist Noah criticised the current system in which interpreters work:

> And so the interpreter walks in, they've just done another job, they do an intense hour and a half talking about horrific things that might bring up their own painful experience, and then they jump in their car and drive to whatever it is, a hospital or something. That doesn't sustain the interpreters. (Noah, psychologist, 369-373)

Interpreter participants said that they also appreciated being given the chance to speak to the professional after mental health sessions, especially when interpreting for refugees:

> Working in a complex setting with client's complex needs, there needs to be a lot more of debriefing, offered, as well. ... A lot more emotions come up, you know … if we're talking refugee trauma and mental health issues, that brings with that a lot more sensitivity. (Anna, interpreter, 328-333)

Overall, implementing briefing and debriefing into the time allocated for interpreter-assisted mental health sessions for refugees was agreed upon by participants, irrespective of their role, background, and experience. Briefing interpreters beforehand makes proceeding with sessions easier for both interpreters and mental health professionals, and debriefing provides the opportunity for feedbacks and further cultural advice from interpreters, as well as giving interpreters a chance to talk about their own feelings especially after intense sessions.

3.3 Interpreters as Part of the Therapeutic Relationship

Mental health professionals acknowledged interpreters as human beings with thoughts, beliefs, and feelings, whose presence has an impact on the therapy process. In this way, many mental health professional participants said that they considered interpreter-assisted therapy for refugees to be a three-person relationship. They argued that dismissing interpreters as merely translating devices, while possibly practical in other settings, would contradict the nature and aims of mental health therapy:

> I've argued against that, you know, many times in training interpreters, for mental health. … It's not a box. You're not a black box. You have feelings and thoughts and, I mean, that's okay, if you're interpreting in courts or if you're interpreting at Centrelink, you know? I mean, mental health, no, it's not like that. Can't be like that. And if it was like that that, then it would be useless having an interpreter in the room, you know? You'd lose the whole point of a therapy session is that you have a relationship with someone and with an interpreter, there's three people in this relationship and we all have to get on. We all have to understand each other, and we all have to share a little bit in some way, for it to be authentic. You couldn't do it if there was a person who was like a neutral box. Not in mental health. (Terry, clinical psychologist, 436-447)

Given that interpreters were seen as part of the relationship and not a "black box", it follows that mental health professionals emphasised the importance of interpreters, including their welfare and their various contributions to the therapeutic relationship with refugee clients. Mental health professionals' focus in such settings is not only on clients' points of view and feelings, but also those of the interpreters. However, this was not described as an

added burden by mental health professionals, rather as a natural and essential element of collaboration. For example, Rafael, a counsellor working with refugees in rural areas, used dance as a metaphor to explain how the relationship and interactions could work:

> It's something like a dance, but there's three of us on the dance floor. It's not just two of us, and the interpreter must be part of the dance. They have to be with us and amongst us in the dialogue and because the trust and the faith and the importance of the interpreter is a lot, so they cannot be kept at an arm's distance from myself or the people I'm working with. They must be amongst it and within it and their thoughts and their ideas and their well-being must be considered in the counselling at times. (Rafael, counsellor, 108-114)

The importance of this three-person relationship was also reflected in the interpreters' interviews. They also considered themselves as part of the therapy process, rather than just an outside facilitator of the relationship between the mental health practitioners and refugee clients. Vera, a French interpreter who mostly works with refugees from African countries, stated that she saw herself as part of a "team" and a "process":

> Really, the counsellor wants you to be a team, you know, the three of us are a team. So you can't just not be part of a team. And what we did, when they let the client go, once they feel that's it, … we have a little party or something, the three of us and we'll bring some food. And that would be ridiculous not to be part of that, because you're part of a process. (Vera, interpreter, 348-353)

While these examples portray how most participants described working with interpreters, Jeoffrey, who has been a psychotherapist for refugees for five years, had different views:

> We don't learn, through interpreters, cultural differences. They interpret. They are busy interpreting. I really want to, just, kind of words, to be conveyed in a meaningful manner so I can do my work, which is psychotherapy. You see it's different. I don't like having extra person in a room, doesn't help basically. (Jeoffrey, psychotherapist, 262-266)

Here, Jeoffrey clearly centres his role as psychotherapist in the relationship. It is noteworthy, however, that his negative feelings are not only directed to interpreters providing cultural guidance, but to their very presence in the therapy session, something which he says he doesn't like. Other mental health professional participants, like Daisy, believed the interpreters' presence to be reassuring to refugee clients, and considered it natural for the clients to connect with interpreters:

> If someone speaks your language, looks like you, smells like you, understands you, understands your cultural cues, of course they're going to connect to the interpreter. And that's fine. And that action in itself speaks volumes about where the client is at. … So, I don't see a problem with that, at all, but some professionals do … Yeah, 'they should look at me, they should talk to me.' Well, actually, no, I talk to the person that I'm talking to first, because I can connect with that person. I feel heard, I feel understood, I feel safe for once in a very long time. (Daisy, counsellor, 236-245)

Nevertheless, the majority of participants considered including the interpreter in the relationship between mental health practitioners and refugee clients not only inevitable but highly beneficial. Gaining refugees' trust was stated as one of the most important benefits of this inclusion, leading to the following subtheme.

3.3.1 Trust

Considering that refugees' often traumatic experiences can lead to a general lack of trust in authorities and organisations, mental health professionals placed a lot of value in the trust that can form between refugees and interpreters in mental health sessions. Noah, a psychologist working in a mental health service for survivors of trauma, spoke of his experience:

> I've got some really great examples of the importance of the relationship with the interpreter where a client might not feel trust in institutions, they might not feel trust in very much else, but they do feel trust in their relationship with the interpreter across really extremely challenging times." (Noah, psychologist, 35-39)

He also mentioned how this trust, while unusual, can be important, particularly in some specific cases such as sexual assault:

> … because especially when we're talking about pre-arrival torture and trauma, maybe sexual trauma, maybe torture, it can be very, very intense in the room. And I can imagine that the interpreter and the client can sometimes bond in a way that's a bit strange, it's very unusual. And often the clients might be very lonely and isolated, and having that connection might feel really meaningful."
> (Noah, psychologist, 325-330)

Interpreters were also aware of the role they could have in reassuring refugees about the mental health professionals and the effectiveness of mental health interventions. Roy reflected on his many years of interpreting for refugee clients in mental health settings:

> I think the way that we made the relationship with them to advise them sometimes when they come out of the counselling room and all that, to make them to calm down and look at the positive stuff of their life as it was advised by the counsellor. So to make it more elaborate for them, that really if they focus on that they will have a much better life. They will have an easier life. (Roy, interpreter, 243-248)

Viewing interpreters as potentially able to assist the development of therapeutic relationships with mental health practitioners by gaining refugee clients' trust was closely related to another aspect of participants' accounts, namely the importance of using the same interpreter for clients throughout the therapy sessions.

3.3.2 Choosing the Same Interpreter

Mental health practitioners discussed several reasons for the importance of using the same interpreter throughout mental health therapy with refugees. This included both re-using the same interpreters within their practice with different refugee clients, as well as trying to ensure that across their therapy refugees only interacted with one interpreter rather than changing each session. Mental health practitioners found that when interpreters were familiar with their work process, they could communicate better with clients, as explained by mental health practitioner Beatrice:

> … to be able to convey the message to the client in the best way possible, and the clients to convey to me in the best way possible. That's why I don't change too many interpreters. I work more or less with the same battery of interpreters, … very helpful, because the interpreter gets to know your way of working and adapt easily, because it's a training process. At the same time you are working with the client, getting to know the client better. But as well, the interpreter needs to know how you work, and they need to know as well how the interpreter manages the information. (Beatrice, counsellor, 193-206)

Refugee clients having the same interpreter across different settings and appointments was also considered highly advantageous by both groups of participants. Mental health practitioners observed how interpreters develop a strong sense of responsibility towards refugee clients for whom they regularly interpret. Noah pointed out how important this was, particularly for refugee clients with more severe mental illnesses:

> I've had it before with people, especially people who are highly psychotic or really depressed. They might have the same interpreter across the hospital and here, they might have the same interpreter for important appointments with their caseworker or their lawyer. That's just immeasurably valuable generally, because there's so much that gets lost through all those appointments. The clients often don't understand much of what's going on. The interpreter generally just feels so much for the client and wants to be able to communicate the best for them, so that's another benefit. I know it's a huge burden for the interpreter, but it's a great benefit. (Noah, psychologist, 272-281)

Another important reason for using the same interpreter was the sensitive nature of the experiences which refugees often share in mental health sessions, which might be unpleasant or difficult to disclose in front of strangers. Additionally, although maintaining confidentiality is one of the most important requirements of interpreters' work, participants mentioned incidents of interpreters breaking confidentiality in small communities, which again pointed to the need for building and maintaining a relationship with a specific interpreter that both the mental health practitioner and refugee client could trust. Olivia, an experienced Arabic interpreter who has also been working as a social worker for survivors of torture and trauma for many years, said:

> But also their choice to choose female or male, the choice to request specific interpreters, because they know someone that they spoke before in other agencies and they know their story and they don't want to repeat the same story again because to repeat the same story in front of another person that could, they don't know, maybe they will judge them maybe they go and speak behind their back, and also because we come from a small community that's another thing, people are afraid of their secrets to go out into the community, which sometimes does happen. (Olivia, interpreter, 359-370)

In general, both mental health practitioners and interpreters shared a preference for using the same interpreter for refugee clients in mental health contexts – including across different settings if possible.

3.4 Interpreter-Client Interactions

Given the aforementioned importance of trust and using the same interpreter, it is unsurprising that many participants saw interactions between refugee clients and interpreters

as positive. Senior mental health practitioners found interpreters communicating and forming a positive relationship with refugee clients healthy, and also helpful to enhancing refugee clients' faith in mental health care, as explained by Terry:

> Mental health is one of those interpreting tasks where the work that the mental health worker does needs to be sold and marketed to the client, you know? And the interpreter plays a very big part in that. … The patient is going to need reassuring and so that time in the waiting room can be a perfect use of time to reassure the client about what's happening, you know? And about the person that they're going to see and what they can expect. (Terry, 460-467)

As discussed further in the next Chapter, it is notable that in suggesting that interpreters interact with clients in waiting areas and so on, Terry is suggesting that interpreters breech the Australian Institute of Interpreters and Translators (AUSIT) Code of Ethics (Australian Institute of Interpreters and Translators Inc, 2012), which contains requirements of impartiality and clarity of role boundaries. Many interpreter participants also considered these aspects of the AUSIT code of ethics too rigid, and were explicit in saying so. For example, some interpreter participants believed having friendly chats in the waiting room to be harmless and a good way of avoiding refugee clients having negative feelings or worrying about the upcoming session. Although being concerned with the outcome of refugees' mental health or the success of interventions is not a part of their formal role, interpreters mentioned reasons such as "humanity" and "discreetness" for engaging in this manner of contact with refugee clients:

> I mean, I'm looking at some people, I will be following them for four, five years. I mean, there is a point where if you just pretend you don't know them, unless you're a complete asshole, it doesn't fit in with the aim of the counselling, you know. You can't just, sort of, you have to talk to them. You don't have to become their best friend – far from it – but you can't, you know, if you're both in the same waiting room and you've been interpreting for a year and this person knows that you have heard them, you can't just pretend, you know what I mean? It just doesn't make sense to be honest. So, I think, I agree with the ethics and I think it's very important but you have to use some, what you can call, some human discretion. (Vera, interpreter, 325-334)

Tom, the most experienced participant of the study who has been interpreting for Iranian refugees for almost 30 years, agreed:

> "Strict adherence to some principals is not always the best practice believe it or not because if you I mean of course I'm not kissing or hugging or dancing with the clients, but bit of addition maybe, maybe just a bit of softer approach just to break the barrier."
> (Tom, interpreter, 156-160)

Other interpreter participants noted that due to their unique situation, refugees in general - and particularly those who were newly arrived - have a lot more difficulty managing a variety of issues including housing and health. As such, participants indicated that this group require high levels of support and assistance. Several interpreters reported helping refugees outside work to be an inevitable part of their role. Interpreter participants with

longer experience spoke about supporting refugees with their day-to-day problems as an inevitable part of their work, and considered "humanitarian" considerations more important than rules and regulations:

> They come out, they have hundreds of questions from you. They want lots of help from you, to take him to here and there and you feel that if you don't do it you feel very bad because you feel that this guy here, as an example going to Housing Trust and filling a form. So he doesn't know where is Housing trust. He doesn't know how to do or where we go. You have to take him then. Or sometimes they want to find medication. They don't know where to go. It's a 'come with me. There's a shop here. Chemist.' Stay with him because he has to pay the correct amount and get the medication and cover. So these are the extras, we did a lot, not only me. I know there's lots of other interpreters that did. That's based on humanitarian grounds. (Roy, interpreter, 196-205)

There were, however, some interpreters who preferred to limit their contact with all clients to only during interpreting sessions. Mavi, who has been interpreting for eight years, explained that his reason for not getting involved with clients was not being comfortable with the responsibility that came with it:

> A few of my colleagues, I've had a conversation about this, that 'you are not doing the right thing. You might need to involve more', and my opinion was I have to make a decision so that I don't get involved with it, because that will come on my shoulder, and then I have to make a decision. (Mavi, interpreter, 353-357)

Other interpreter participants only mentioned the rules and regulations as their reason for refusing to be in contact with clients outside work sessions and didn't differentiate between different settings in this regard. Suzanna, an Arabic interpreter with three years' experience, talked about the importance of maintaining boundaries, particularly when it came to mental health:

> Of course, talking to the patients outside their encounter, not only in mental health, but in different encounters, is not accepted. Sometimes, it happens with me that one of the patients after they finish their encounter, because they knew I was one of the, I had a mental issue, they asked me about what I had, and if I have the similar medication or not, and the side-effect of the medication, so I told them, to tell you the truth, I told them that it's up to the doctor and I have nothing to say about it, I am not a psychiatrist, I am an interpreter, and I can't tell or comment on this. So I was so neutral. (Suzanna, interpreter, 351-358)

Mental health professionals also discussed the rules for interpreters in relation to speaking with clients outside mental health settings, with some noting that it was a "difficult" situation because it was so different to what would be expected within normal interactions. For example, several mental health professionals drew on the cultural inappropriateness of interpreters avoiding contact with clients, and its potential negative effects on refugee clients in particular, as noted by Noah below who highlighted that this sort of interaction could cause "hurt":

> It's difficult. I know that culturally it must be very strange for people to have left a country where that's not the case. And then they come here and they finally meet

> someone who can speak their language and maybe is even a cousin of a cousin or something. And then they walk out the front of the room and they never, they just part. And I think there's a hurt there for the clients, because that just doesn't make sense to them, and I don't know that they really get used to it. (Noah, psychologist, 309-315)

Mental health practitioners also noticed that real life situations are usually more complicated than what the code of ethics for interpreters assumes, and that being part of the community, interpreters often feel responsible to support refugee clients outside sessions. Milent, who has been providing counselling for refugee clients for 20 years, observed:

> But some interpreters are part of the community, they feel it's their duty to do so, so they find themselves in a very difficult position to be in. … interpreters give their number, we know that, and sometimes other interpreters go a bit further in the sense of supporting the person, we know that happens, yeah. So that rule again is very difficult to, it's a complex situation because the interpreter is part of a community and even if the interpreter is being told not to give the number, this and that, they could be in a situation where they really feel the need to support this other person as a member of the community. (Milent, counsellor, 383-391)

Overall, participants' experiences regarding contact between interpreters and clients were varied. While there was a general agreement about refugee clients benefiting from interpreters' emotional and practical support outside therapy sessions, interpreters were divided in the way they viewed this aspect of their work, particularly with regard to whether or not it was suitable for them to assist clients outside of the mental health sessions.

3.5 Specialized Training for Both Interpreters and Mental Health Professionals

Both mental health professionals and interpreters discussed the importance of training for the other group of participants. As such, training for both groups was identified as a key theme. The necessity of specialised training for interpreters who work in mental health settings was emphasised by almost all mental health professionals. They expected interpreters who work in mental health settings to have some understanding of commonly used psychological words and expressions. Furthermore, training was considered important for interpreters in order to prepare them for emotionally intense or challenging situations:

> Well for me it is essential that the interpreter receive training in mental health, because bad communication with the interpreter will be another level than with the client. I would talk to the interpreter, 'Well I – I need to measure if the client is suffering from anxiety and depression.' Then I expect the interpreter to have knowledge about what is anxiety and depression, or at least to know the terminology. As well, to know a little bit about certain concepts in mental health like hallucination, manic behaviour. … The interpreter must have a little bit of knowledge on, be prepared to confront mental health at stake, be able to control themselves when the clients have a panic attack or a desperate, a moment of fear and the interpreter needs to have the maturity to be able to react accordingly, … be able to manage itself when the counsellor is trying to work on the panic attack on the client. But if the interpreter runs away, it's not going to be for me useful, it's going to be a problem. (Beatrice, counsellor, 427-446)

Here, Beatrice highlights the importance of training to ensure that interpreters have both knowledge of terminology and training to work in mental health settings where

significant illness might be discussed or witnessed. Relatedly, Rafael, a counsellor who has been exclusively working with refugees for four years, mentioned a potential side effect of interpreters' self-gained familiarity with mental health concepts. Interpreters, according to Rafael, sometimes replace clients' words with what they consider to be the equivalent mental health expressions:

> Sometimes an interpreter may bring into the room knowledge and understanding of mental health as from a Western perspective, and therefore they may use very traditional Western mental health words like, 'I'm suffering from mental health,' like, 'I'm disassociating,' or, 'I am psychologically damaged.' And I know that those are not the words of the person I'm speaking to but what the interpreter, with the best interests of me and the person I'm working with at heart, will bring that language into the interpreting because of their experience of working with other psychologists and doctors, and mental health. … but that's not what I want. I want to know what the person's talking about. (Rafael, counsellor, 153-162)

In addition, mental health professionals also noted that interpreters needed training to value the work being done in the session. For example, interpreters might have different views on the benefits of mental health care based on their personal experience and education. Correspondingly, mental health professionals were of the view that interpreters' beliefs and feelings affect clients and the therapy process, and so an important reason for proposing specialised training for interpreters to work in mental health was to ensure they have a positive attitude towards mental health care:

> You need to sort of train interpreters to make sure that they value what we're doing, you know? … (if) They don't value it, it's not going to work. So your real client is your interpreter for a while. And hope that they act as a good sort of mediator between you. So, over the years, I've found it really challenging to use or break in a new interpreter, because sometimes the interpreter will say 'oh yeah, I've had this problem too, but I mean, it's not such a big problem'. (Terry, clinical psychologist, 206-211)

Several interpreter participants also pointed out the unique sensitive nature of working in mental health settings, and many considered interpreting for refugees in mental health settings to be particularly complicated. Anna, an experienced Serbian interpreter, reflected:

> In general, mental health setting is a lot more specific - a lot more specific issues, a lot more subtleties, a lot more sensitivities, being a medical study. Then you add another layer of being a refugee to the add, and then you've got even more sensitivities, and specific issues, and underlying – it's like layers of complexities. (Anna, interpreter, 319-323)

Anna went on to note that as such, training was essential for interpreters in order for them to have the awareness and skills to deal with mental health-related issues in general, but more specifically to be able to sensitively communicate with refugee clients:

> Probably more of that training, mental health specific or interpreting in mental health in general, but then interpreting in mental health with the clients with refugee background, so making it even more specific. And talking about all this issue you know communication, sensitive communication, trauma talking, interpreting to people

> with trauma background. There must be some specific issues and subtleties to be aware of that are different to when just interpreting for someone who's going to have an X-ray. (Anna, interpreter, 581-588)

While mental health professionals (and many interpreters) stressed the importance of training for interpreters working in mental health settings with refugee clients, interpreter participants also thought it essential for mental health professionals to have some knowledge and experience in working with interpreters. They reported that mental health professionals who work with interpreters need training in various areas including using simple terminology, effective briefing and debriefing, and time management. Nina, a Farsi interpreter with 13 years' experience, talked about the challenges of working with some mental health professionals:

> So in the therapy, I found that sometimes the professional, they don't have that knowledge and they don't know about briefing and debriefing the interpreter. They assume that interpreters should know about every terminology, that they have spent four or five years for their Bachelor and Honours to learn those kinds of things, and they're thinking that this interpreter is a simultaneous converting machine, to change everything to another language. Sometimes they don't understand that some of the terminology is not there, it can't translate in the same amount of words, sometimes the meaning is non-existing, or you need to clarify that based on the level of the literacy of the party to explain to them that they can pass the message … It's about they need some education to understand how to work effectively with the interpreter. (Nina, interpreter, 71-86)

Interpreters also found the diversity in professionals' expectations of interpreters' role quite challenging. As seen in previous themes in this thesis, while many mental health professionals encourage interpreters to provide them with clarifications and feedback, others consider it unacceptable conduct. Interpreters therefore reported having difficulty deciding whether and to what extent they should offer clarifications:

> Some people they will accept, expect or accept you saying 'ah um look I'm really sorry but may I just interfere here a little bit? This is how it works', some people they say 'you are here just to say what I say and nothing else' or 'you're breaking boundaries', so interpreter's in a position where it's very difficult for them. (Olivia, interpreter, 221-225)

Daisy, one of the more experienced mental health professionals also recommended training for mental health practitioners in order to improve interpreter-assisted work with refugees. She also noted the disparities in mental health professionals' views on interpreters' role in mental health settings:

> So, it's about training professionals of all sectors, particularly in mental health, hospitals in particular, to use an interpreter - how to use an interpreter - why you use an interpreter. Because sometimes professionals have a different idea of what interpreters should be doing. (Daisy, counsellor, 227-231)

In general, the unanimous opinion was that specialised training would give interpreters a better understanding of the benefits of mental health care, teach them the general mental health care processes and jargon, and provide familiarity with mental health

professionals' general expectations. Many interpreters also recommended training for mental health professionals in order to prepare them for the subtleties of working with interpreters and providing interpreter-assisted mental health care.

CHAPTER 4: Discussion

4.1 Overview

This qualitative study investigated the process, challenges, and potential ways of improving interpreter-assisted mental health care for refugees as reported by mental health practitioners and interpreters. The findings support previous literature concerning the various ways in which using interpreters in mental health settings for refugees is unique and complex (Bauer & Algeria, 2010; Kuay et al., 2015; Pugh & Vetere, 2009; Tribe & Thompson, 2009; Yakushko, 2010). Interpreter-assisted mental health care for refugees was differentiated from normal mental health care due to the therapeutic relationship shaping between all three participants. Likewise, interpreting in mental health settings for refugee clients was depicted as different form interpreting in other settings, both as a result of the additional roles undertaken by interpreters and the often traumatic nature of the conversations. There was unanimous emphasis on the importance of training interpreters, as well as providing them with briefing and debriefing. Other aspects of the findings including training for mental health practitioners and the extent of interpreters' duties and responsibilities were complex and the subject of some disagreement amongst participants.

The findings of this study support the importance of the several roles interpreters play when working in mental health care for refugees. In particular, a key finding of this study was that in addition to not speaking the same language, cultural differences between refugee clients and western mental health practitioners can seriously hinder communication and therefore treatment, which highlights the potential dual role for interpreters: both translating language and acting as cultural advisors. Previous literature has also suggested that interpreters' role could expand to cultural advising when working in mental health settings with refugee clients (Fennig & Denov, 2021; Kuay et al., 2015; Miller et al., 2005; Resara et al., 2014; Mirza et al., 2017). The results also indicated interpreters' role extending to outside

therapy sessions, where refugee clients' cultural and practical needs are often met by interpreters' compassion and support, as also reported in previous research (Fennig & Denov, 2021; Mirdal et al., 2012). However, interpreters undertaking these additional roles also gives rise to the question of doing what is best for refugee clients while also maintaining ethical boundaries of confidentiality and clarity of roles for interpreters, a paradox which is also reflected in the results of this thesis. While some mental health practitioners participating in this study considered refugee clients' wellbeing more important than western ethical values such as confidentiality, future research should explore the points of view of refugees regarding the relative importance of such matters, as well as how to manage interpreters' wellbeing and the boundaries of their role, should it extend to more general support for refugee clients.

In line with existing literature (Fennig & Denov, 2021; Mirdal et al., 2012; Mirza et al., 2017), the results indicated that mental health care with refugee clients required interpreters to be involved in the therapeutic relationship rather than ignored or dismissed as a translating device. Interpreters' main roles in this relationship seem to be ones which mental health practitioners cannot always succeed in doing themselves, due to refugee clients' special needs and characteristics. For example, it is important for mental health practitioners to gain their clients' trust; however, since interpreters often have more in common with refugee clients in terms of culture, language, and background, interpreters' presence and reassurance may be more effective in gaining trust for this group. Importantly, and also in line with previous literature (Fennig & Denov, 2021; Resara et al., 2014), the development of trust and a three-way therapeutic relationship requires the continued presence of the same interpreter through the therapy process.

This study also found widely varying levels of mental health professionals' reliance on and expectation from interpreters, ranging from limiting interpreters' role to simply

translating word by word to encouraging interpreters to share the information they gather from clients outside the session to assist with the therapy process. This ambiguity in interpreters' role has been pointed out in previous studies in Australia (Kuay et al., 2015) and other countries (Gryesten et al., 2021), and could to some extent explain the preference of the mental health professionals in this study for working with the same group of interpreters, who would be more familiar with their work. The findings also suggest a difference in priorities and practice between the more experienced interpreters and less experienced ones. While interpreters with the longest experience often expressed feelings of responsibility towards refugee clients for social and humanitarian reasons, younger and less experienced interpreters tended to give more importance to adhering to codes of ethics and conduct. Nevertheless, the lack of a standardly used procedure for interpreter-assisted mental health therapy is apparent, which is reflected in participants' opinions about the inefficiency and impracticality of the existing guidelines and regulations.

This study also found further support for the importance of providing interpreters with briefings in order to prepare them for mental health sessions with refugee clients, and debriefings in order to assist them with processing any traumatic content (Crezee et al., 2011; Fennig & Denov, 2021; Kuay et al., 2015; Miller et al., 2005). However, participants in this study also emphasised the importance of allocating time for briefing and debriefing in order for mental health professionals to receive insight and feedback from interpreters. This aspect of the benefits of briefing and debriefing is for the most part missing in the existing literature (see Crezee et al. (2011) for one exception to this) and is well-worth further exploration. Findings about the necessity of training interpreters in areas such as working with refugee clients as well as knowledge and appropriate use of mental health language were also in line with previous literature (Gartley & Due, 2017; Miller et al., 2005; Mirza et al., 2017; Yakushko, 2010). However, the results regarding training for interpreters in order to avoid

their potential negative attitudes towards mental health care affecting the therapy process extend the existing literature in this area. Another interesting and somewhat concerning aspect of the findings of this study is that while interpreters emphasised the importance of mental health professionals being trained in working with interpreters, the majority of mental health partitioners failed to mention any such need for themselves. While a few studies have reported mental health professionals recognising the need for training in order to carry out interpreter-assisted therapy (Gartley & Due, 2017; Yakushko, 2010), there is a gap in the literature in this area since previous studies have mostly been concerned with training interpreters.

4.2 Theoretical Implications

The findings of this study provide scope to extend the model of clinician-patient communication proposed by Street et al. (2009), especially the second pathway concerning patient knowledge and shared understanding, the third pathway concerning therapeutic alliance, and the seventh pathway concerning higher quality decisions. For example, many refugee clients have limited knowledge of, and a potential aversion to, western mental health-related concepts and treatments (Thomson et al., 2015). Additionally, cultural differences between refugee clients and mental health practitioners are a major barrier to having a shared understanding of mental health (Pugh & Vetere, 2009; Thomson et al., 2015). By taking on the role of cultural advisor interpreters help both parties understand each other's points of view, which according to Street et al.'s model results in patients' higher satisfaction and commitment to treatment. Thus, interpreters' additional role as cultural advisors enhances healing communication through the second pathway, increasing patient knowledge and shared understanding. Furthermore, as cultural advisors interpreters inform mental health professionals about refugee clients' beliefs and values, limitations and capabilities, and

nonverbally communicated feelings. In doing so, interpreters facilitate mutual decision making about treatment, the seventh pathway of Street et al.'s model.

The third pathway to healing communication in Street et al.'s (2009) model is enhancing the therapeutic alliance. Using the same interpreter for refugee clients in mental health and across other settings is an ideal way to ensure optimal communication between various health and support resources. This in turn will result in refugee clients feeling cared for and understood (Street et al., 2009). Interpreters also enhance the therapeutic alliance with mental health professionals through the trust they foster in refugee clients. By vouching for the mental health treatments and encouraging cooperation interpreters build trust, and the satisfaction with and commitment to treatment which results can enhance healing outcomes (Street et al., 2009). This is in line with previous research supporting the importance of therapeutic relationship in mental health interventions for refugees, and interpreters' contributions to this relationship (Duden & Martin-Borges, 2021; Fennig & Denov, 2021; Gartley & Due, 2017; Mirza et al., 2017).

4.3 Practical Implications

The AUSIT Code of Ethics (Australian Institute of Interpreters and Translators Inc, 2012) is the standard for regulating interpreters' conduct in Australia and New Zealand. All principles of the AUSIT code of ethics are to be complied with by interpreters in all settings and with all clients. This research highlights the potential inappropriateness and impractical nature of some of these principles for interpreting for refugee clients in mental health settings, which is the reason for them not being practised by many mental health practitioners and interpreters. For example, according to the principle of Clarity of Role Boundaries of the AUSIT Code of Ethics, interpreters "do not, in the course of their interpreting or translation duties, engage in other tasks such as advocacy, guidance or advice" (Australian Institute of Interpreters and Translators Inc, 2012, p. 6). In addition, according to the principle of

Impartiality, interpreters "do not voice or write an opinion, solicited or unsolicited, on any matter or person during an assignment" (Australian Institute of Interpreters and Translators Inc, 2012, p. 9). Moreover, it is also the responsibility of interpreters to "draw attention to any situation where other parties misunderstand the interpreter or translator role or have inappropriate expectations" (Australian Institute of Interpreters and Translators Inc, 2012, p. 10). Complying with these requirements would not be compatible with interpreters providing cultural advice or being a part of the therapeutic relationship. Similarly, previous research has indicated such issues in interpreter codes of conduct or expectations in several other resettlement countries (Fennig & Denov, 2021; Kuay, 2015; Miller et al., 2005; Mirdal et al., 2012; Mirza et al., 2017). This discrepancy between regulations and practice results in lack of homogeneity in interpreter-assisted mental health care. As such, this thesis highlights the need for key changes to be made to codes of ethics for interpreters, in order to take into account the nuances of working in mental health settings as well as the wealth of knowledge which interpreters bring with them, which is currently under-utilised.

Importantly, the fact that the AUSIT Code of Ethics does not recognise any differentiated requirements or standards for interpreting in mental health care or for refugee clients contributes to the lack of systematic briefing, debriefing, and specialised training for interpreters working in such settings. For instance, the AUSIT Code of Ethics assumes that interpreters are always capable of maintaining professional conduct and impartiality or recognising the situations in which they are unable to do so. This assumption results in not recognising the different attitudes and biases interpreters might have towards different mental health problems, mental health care, and refugees, and the way these attitudes and biases can affect the therapy process. Consequently, the need for briefing, debriefing, and training interpreters working in mental health settings with refugees is overlooked. With no specialised training, the extent to which mental health professionals depend on interpreters

for cultural guidance and constructive feedback in order to form diagnosis and make decisions about treatment options, as well as forming a therapeutic relationship with clients, might not be proportionate to interpreters' knowledge and understanding of mental health, refugee clients' specific needs, and their own feelings, biases, and misconceptions. Moreover, the results from this study as well as previous research indicate that sometimes interpreters provide refugee clients with psychological information and/or support (Resara et al., 2014), which can be problematic considering their lack of mental health-related training.

One practical implication of this study would therefore be the need for amendments to the AUSIT Code of Ethics such that it recognises the distinct features and requirements of interpreting in mental health settings for refugee clients. Developing separate standards for interpreting in mental health settings for refugee clients was also recommended by Miller et al. (2005). Developing standardised and research-based guidelines for working with interpreters for mental health practitioners would also be highly beneficial. Additionally, systematic changes are required in the practical aspects of interpreter-assisted mental health care process, such as allocating extra (paid) time for briefing and debriefing, as well as prioritising and facilitating booking the same interpreters for refugee clients. For such changes to occur, future research should explore areas such as refugees' experiences of interpreter-assisted mental health care in resettlement countries such as Australia, the potential positive effects of implementing debriefing time into mental health sessions for refugees on interpreters' emotional and psychological wellbeing, and the significance of using the same interpreter in refugees' long-term mental health outcomes.

The most important practical implication of this study, however, is the critical need for developing and implementing mandated training not only for interpreters but also for mental health practitioners. In their guideline for working with interpreters, Searight and Searight (2009) recommended introducing material on working with interpreters to

psychology students' courses. However, much further research is required in order to develop relevant and practical training for both groups, and to assess the effectiveness of such training on the experiences of all involved parties as well as improving refugees clients' mental health outcomes.

4.4 Strengths and Limitations

The present study achieved saturation in the samples of both interpreters and mental health practitioners, including a diversity of work experience and background, with participants coming from across Australia. This together with the fact that the study was conducted following best-practice guidelines for qualitative research (Braun & Clarke, 2013; Tracy, 2010) means that the study findings and implications are of relevance and importance for Australia and other similar resettlement countries. However, this study was limited in only exploring the experience of interpreters and mental health practitioners and not including refugee clients. Future studies should be conducted with refugee participants, possibly also looking into differences regarding refugee status. In addition, not differentiating between different mental health practitioners (e.g., psychologists, counsellors) and mental health care methods, public and private mental health settings, and interpreters from different backgrounds could be a potential limitation of this study. While the findings of this study did not indicate any patterns in relation to these factors, conducting research designed around these differences might reveal important results with regard to practical applications.

4.5 Conclusion

This study further demonstrated the necessity and importance of interpreters' various roles in facilitating and contributing to communication and therefore better mental health outcomes for refugee clients. It also highlighted the resultant need for implementing changes in order to reduce the discrepancies between practice and relevant regulations as well as developing more standardised procedures. Educating interpreters and mental health

practitioners both in the skills required for their respective roles and ways of overcoming the inherent challenges of interpreter-assisted mental health care for refugees is also of critical importance.

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Appendix A

Research Flyer

Researchers from the University of Adelaide are conducting a study called:

Service providers' perception of using interpreters in mental health practice for people with refugee background in Australia

We would like to interview you if you:

- Are a mental health care professional (e.g.,psychologist or counsellor) or an interpreter
- Are over the age of 18
- Can speak enough English to do the interview in English
- Have worked with people with refugee backgrounds in the past three years

We will ask you about your understandings of the way the therapy sessions work, the challenges of using interpreters for these sessions, the possible reasons for those challenges, and the best ways to overcome those challenges.

Interviews will take approximately 1 hour. Interviews will be conducted at a time and place convenient for you.

If you would like further information or would like to take part in the project, please contact:

Dr Clemence Due
University of Adelaide School of Psychology E-mail:
clemence.due@adelaide.edu.au

Appendix B

Participant Information Sheet

PARTICIPANT INFORMATION SHEET

PROJECT TITLE: Service Providers' Experiences of Interpreter-Assisted Mental Health Care for People with Refugee Backgrounds

HUMAN RESEARCH ETHICS COMMITTEE APPROVAL NUMBER: 21/14
PRINCIPAL INVESTIGATOR: Dr Clemence Due

STUDENT RESEARCHER: Elaheh Ghaemi Mahdavi

STUDENT'S DEGREE: Honours of Psychological Science

You are invited to participate in the research project explained below.

What is the project about?

This project focuses on interpreter-assisted mental health therapy for people with refugee background. We are interested in asking you about your understandings of the way the therapy sessions work, the challenges of using interpreters for these sessions (or interpreting such sessions), the possible reasons for those challenges, and the best ways to overcome them.

Who is undertaking the project?

The researchers, Dr Clemence Due and her student, are undertaking this project and will be conducting the interviews. For the student, this project composes a large component of the research area for the degree of Psychology of Honours at the University of Adelaide.

Who is being invited to participate?

You are being invited to participate if you:

- Are a mental healthcare professional (e.g., psychologist or counsellor) or an interpreter
- Are over the age of 18
- Can speak enough English to do the interview in English
- Have worked with people with refugee background in the past three years

What will I be asked to do?

You will be asked to take part in an interview lasting about one hour. The interview can be done face to face, over the phone or via zoom – it is up to you. If you decide on a face to face interview, we can organize a convenient location for you, or we could do the interview in an office at the University of Adelaide.

Participation is voluntary and you do not have to answer questions if you chose not to.

Are there any risks associated with participating in this project?

The project is unlikely to present any risks to you apart from the time to do an interview. There is a small possibility that discussing your experiences with people with refugee backgrounds may be upsetting. If that is the case we can follow up with you to make sure you are ok, and there are a range of options to contact including Lifeline and Beyond Blue.e

What are the benefits of the research project?

We hope that the project will improve understandings of the challenges of interpreter- assisted mental health therapy, and investigate ways to overcome them.

If your workplace allows, you can receive a $50 vouchers as a thank you for your time.

Can I withdraw from the project?

It is completely up to you if you would like to be a part of this project. If you would like to participate, you can still withdraw from the project at any time. We can remove your data if you choose up until the due date of the thesis (September 2021).

What will happen to my information?

Your interview will be audio recorded and we will transcribe this into a written interview. You will have an opportunity to review this transcript.

We will make sure we do not disclose your name or any other identifying information in the written interview or any publications. Only the researchers will be able to access the data from this project. This data will be kept for 7 years on a password protected computer then erased. We can send you a copy of the results of the project if you would like. The final results might be included in a journal.

What if I have a complaint or any concerns?

The study has been approved by the Human Research Ethics Committee at the University of Adelaide (approval number H-2021-xxx). If you have any questions or concerns in regard to your participation in the project or would like to voice a concern or complaint, please contact the Principal Investigator. Contact the Human Research Ethics Committee's Secretariat on phone +61 8 8313 6028 or email to hrec@adelaide.edu.au if you would like to discuss any concerns or complaints, or enquire about the University's policy on research with human participants or your rights as a participant. Any concern or complaint will be confidential and investigated completely. You will be informed of the result.

If I have questions or want to participate, what do I do?

If you are interested in participating, please contact Elaheh

Yours sincerely,
Dr Clemence Due
Clemence.due@adelaide.edu.au

Appendix C

Consent Form

CONSENT FORM

1. I have read the attached Information Sheet and agree to take part in the following research project:

Title: Service Providers' Perception of Using Interpreters in Mental Health Practice for People with Refugee Background in Australia

Ethics Approval 21/14 **Number:**

2. I have had the project fully explained to my satisfaction by the research worker. My consent is given freely.
3. I have been given the opportunity to have a member of my family or a friend present while the project was explained to me.
4. Although I understand the purpose of the research project, it has also been explained that involvement may not be of any benefit to me.
5. I have been informed that, while information gained during the study may be published, I will not be identified and my personal results will not be divulged, unless I specifically request otherwise. I understand I have the opportunity to read over the transcript of my interview and delete any text which may identify me, and this will not be used in any publications.
6. I understand that I am free to withdraw from the project at any time.
7. I agree to the interview being audio recorded: Yes No
8. Iwouldlikeasummaryofthestudy'sresultsemailedtomeuponitscompletion: Yes No
9. I am aware that I should keep a copy of this Consent Form, when completed, and the attached Information Sheet.

Participant to complete:

Name: _____Signature: _____Date: _____

Researcher/Witness to complete:

I have described the nature of the research to _____

(Print name of participant)

and in my opinion she/he understood the explanation.

Signature: ..... Position: ----------
Date: .....

Appendix D

Interview Guide

Questions:

1. **Tell me about your experience working with refugee clients (in mental health settings)?** How long have you been doing it for? Why did you choose to do it?
2. **Is working with refugee clients (in mental health settings) in any ways different from working with other clients with interpreters?** If yes, in what ways? What do you think the reasons might be?
3. **How does working with refugee clients who can speak English differ from working with the ones who need interpreters?**
4. **What are some of the factors which contribute to having a successful and easy interpreter-assisted meetings with refugee clients?**
5. **What are some of the challenges you have experienced working with refugee clients (in mental health settings)?** How often? What do you do in those situations? What systematic changes would help?
6. **Is there anything you would like to add, or expand on?**