A DIALOGUE WITH THREE VOICES:

The impact of interpreters on the therapeutic alliance when working with asylum seekers and refugees who have lived through traumatic experiences.

A thesis submitted to The University of Manchester for the degree of Professional Doctorate in Counselling

In the Faculty of Humanities

2015

LYNN LEARMAN

School of Education: education support and inclusion
2.10 Stage Two: one-to-one Interviews ................................................................. 41
2.10.1 Rationale for using semi-structured interviews ........................................... 41
2.10.2 Contact process: finding clients for the interviews ....................................... 42
2.10.3 Sample characteristics ................................................................................. 43
2.10.4 Interview procedures ................................................................................... 43
2.10.5 Insider research ........................................................................................... 43
2.11 Power ................................................................................................................ 45
2.11.1 An ethic of care ........................................................................................... 46
2.11.2 Power within the research interview ............................................................. 47
2.11.3 The role of manager-researcher ................................................................. 49
2.11.4 Research with asylum seekers and refugees ................................................. 50
2.11.5 Working with ex-clients of a service ............................................................. 52
2.11.6 Boundary management ............................................................................... 53
2.12 The development of the research questions ..................................................... 54
2.13 Data analysis ..................................................................................................... 56
2.13.1 IPA using two qualitative methods ............................................................... 56
2.13.2 The ideographic focus of IPA ................................................................... 56
2.13.3 Selection of specific quotations ................................................................... 58
2.14 The audit trail ..................................................................................................... 59
2.15 Reliability, validity and trustworthiness ............................................................ 63
2.15.1 Sensitivity to context ................................................................................... 63
2.15.2 Commitment and rigor ................................................................................. 64
2.15.3 Transparency and coherence ....................................................................... 65
2.15.4 Impact and importance ............................................................................... 66
2.16 Ethics ................................................................................................................ 66
2.16.1 Insider researcher ethical issues ................................................................. 70
2.17 Recording, storing and transcribing of interview data .................................... 71
2.18 The reflexive researcher ................................................................................... 71
2.18.1 The impact of the researcher on the research ............................................................ 73
2.18.2 Participant reactions ..................................................................................................... 75

Chapter 3 Literature Review .................................................................................................. 77

3.1 Trauma ................................................................................................................................ 78
   3.1.1 Cultural constructs of mental health. ............................................................................ 78
   3.1.2 Post-traumatic stress disorder ..................................................................................... 80
      3.1.2.1 Complex post-traumatic stress disorder ................................................................. 82
      3.1.2.2 Cross-cultural factors in post-traumatic stress disorder ......................................... 84
      3.1.2.3 Psychological theories of PTSD .............................................................................. 87
   3.1.3 Neurobiology .............................................................................................................. 90
   3.1.4 Genetics ..................................................................................................................... 90
   3.1.5 Post-traumatic growth .............................................................................................. 91
      3.1.5.1 Post-traumatic growth in cross-cultural contexts .................................................. 92
   3.1.6 Resilience .................................................................................................................. 94
   3.1.7 The impact on practitioners ....................................................................................... 95
   3.1.8 Psychological therapies for trauma work with asylum seekers and refugees .............. 96

3.2 Communication ............................................................................................................... 98
   3.2.1 Cross-cultural and intercultural communication ......................................................... 98
   3.2.2 Verbal communication .............................................................................................. 100
      3.2.2.1 Language ............................................................................................................... 100
      3.2.2.2 Mother tongue ...................................................................................................... 101
      3.2.2.3 Power, status and identity within language ........................................................... 103
   3.2.3 Non-verbal communication ....................................................................................... 106
      3.2.3.1 Universal and culture specific .............................................................................. 106
      3.2.3.2 Therapeutic implications ....................................................................................... 108

3.3 Working with interpreters in mental health settings ...................................................... 108
   3.3.1 Service user voices .................................................................................................... 110
   3.3.2 Working with asylum seekers and refugees .............................................................. 112
      3.3.2.1 Interpersonal skills ............................................................................................... 112
3.3.2.2 Training ........................................................................................................... 113
3.4 The therapeutic relationship .............................................................................. 115
  3.4.1 Interpersonal neurobiology ........................................................................... 115
  3.4.2 A psychotherapeutic perspective .................................................................. 116
    3.4.2.1 Interpersonal attunement ......................................................................... 117
    3.4.2.2 The therapeutic alliance ......................................................................... 118
3.5 Contribution to knowledge ................................................................................ 121

Chapter 4 Research Findings ................................................................................... 123
  4.1 The Therapeutic Alliance .................................................................................. 124
    4.1.1 The triadic relationship .............................................................................. 125
    4.1.2 The dynamics in the room .......................................................................... 128
    4.1.3 Good practice ............................................................................................. 131
      4.1.3.1 What worked? ...................................................................................... 132
      4.1.3.2 What goes wrong? .............................................................................. 133
    4.1.4 Training ....................................................................................................... 137
    4.1.5 Stories behind the findings ......................................................................... 138
  4.2 Interpersonal Attunement ................................................................................. 140
    4.2.1 Working at interpersonal attunement ....................................................... 141
    4.2.2 The interpreter as added value ................................................................... 144
    4.2.3 The impact on the individual ...................................................................... 148
    4.2.4 Stories behind the findings ......................................................................... 152
  4.3 Communication ................................................................................................. 155
    4.3.1 Verbal communication ............................................................................... 156
    4.3.2 Non-verbal communication ........................................................................ 163
  4.4 Culture ................................................................................................................ 168
    4.4.1 Working within differing cultures ............................................................. 169
      4.4.1.1 Diversity and difference ...................................................................... 169
      4.4.1.2 Counselling as a unique culture ......................................................... 172
    4.4.2 A changing perspective ............................................................................. 176
4.4.2.1 Pre-conceptions ................................................................. 176
4.4.2.2 Post-experience ............................................................... 179
Chapter 5 Discussion ................................................................... 184

5.1 What happens to the therapeutic alliance when a third person is involved
and is it possible to work at a deep level of interpersonal attunement? ........ 185

5.1.1 The therapeutic alliance ....................................................... 185
5.1.2 Alliance dynamics ............................................................... 186
5.1.3 The unique role of the interpreter ........................................ 188
5.1.4 Interpersonal attunement ...................................................... 190

5.2 What is the experience like from a personal perspective for each
participant in the room (the client, the counsellor and the interpreter)? .... 192

5.2.1 New cultures .................................................................. 192
5.2.2 Changing perspectives and post-traumatic growth ................. 192
5.2.2.1 The clients’ perspective .................................................. 192
5.2.2.2 The interpreters’ perspective .......................................... 194
5.2.2.3 The counsellors’ perspective .......................................... 195

5.3 What is good practice in this situation? What helps or hinders a ‘dialogue
with three voices’? .................................................................. 196

5.3.1 What is good practice? ....................................................... 196
5.3.1.1 Working as a team ......................................................... 197
5.3.1.2 Matching interpreter to client ...................................... 198
5.3.2 What hinders good practice? ............................................. 199
5.3.3 Added value .................................................................... 201

5.4 Training .................................................................................. 202

5.5 Working across cultures .......................................................... 203

5.5.1 Working inter-culturally ..................................................... 203
5.5.2 Power inside the triad ......................................................... 203
5.5.3 Counselling as a unique culture ........................................... 205

5.6 Communication ...................................................................... 207

5.6.1 Verbal communication ....................................................... 207
5.6.1.1 Language ................................................................. 207
5.6.1.2 Pacing ................................................................. 208
5.6.1.3 The therapeutic experience of speaking in a mother tongue .... 208
5.6.2 Non-verbal communication ........................................ 210
5.6.2.1 Body language ....................................................... 210
5.6.2.2 Trauma beyond words: silence .................................. 211
5.7 Summary ......................................................................... 211
5.8 Critique of the research process ........................................ 213
5.8.1 Methodology ............................................................. 213
5.8.1.1 Interpretative Phenomenological Analysis ...................... 213
5.8.1.2 Using two qualitative methods – IPA and a focus group .... 214
5.8.2 Validity ......................................................................... 215
5.8.3 Strengths of this study .................................................. 216
5.8.4 Limitations of this study ................................................ 217
5.8.5 Reflexivity ..................................................................... 219
5.8.5.1 An IPA researcher ...................................................... 221
5.8.5.2 How reflexivity impacted on my analysis ...................... 221
5.9 Implications for future practice .......................................... 226
5.10 Suggestions for future research .......................................... 226
Chapter 6 Conclusion ............................................................. 228
List of Tables

Table 1: Themes ......................................................................................................................... 123
Table 2: Theme 1 ....................................................................................................................... 124
Table 3: Theme 2 ....................................................................................................................... 140
Table 4: Theme 3 ....................................................................................................................... 155
Table 5: Theme 4 ....................................................................................................................... 168
Abstract

The University of Manchester

Lynn Learman

Professional Doctorate in Counselling

A dialogue with three voices: the impact of interpreters on the therapeutic alliance when working with asylum seekers and refugees who have lived through traumatic experiences.

27th April 2015

This study started to explore the process of working therapeutically through an interpreter and whether it was possible to achieve interpersonal attunement with asylum seekers and refugees who have lived through traumatic experiences. Insider research was conducted by the manager of a third sector, specialist psychological therapies service that employed interpreters on a freelance basis. Three perspectives are offered to examine lived experience of the triadic relationship. Four counsellors, four interpreters and four clients were interviewed through a focus group and semi-structured interviews. Using these two qualitative methods, the data was analysed using interpretative phenomenological analysis (IPA). Transcripts were examined for group patterns and ideographic accounts. Four super-ordinate themes: the therapeutic alliance, interpersonal attunement, communication and culture and a further ten sub-ordinate themes emerged from the analysis. The discussion raises issues about the specific role of the interpreter in this field, the management of emotion, differing cultures of mental health and verbal and non-verbal communication. When good practice guidelines are adhered to the findings indicate that the presence of an additional skilled professional may enhance the work and support both counsellor and client.
Declaration

No portion of the work referred to in this thesis has been submitted in support of an application for other degree or qualification of this or any other university or institute of learning.
Copyright Statement

i. The author of this thesis (including any appendices and/or schedules to this thesis) owns certain copyright or related rights in it (the “Copyright”) and s/he has given The University of Manchester certain rights to use such Copyright, including for administrative purposes.

ii. Copies of this thesis, either in full or in extracts and whether in hard or electronic copy, may be made only in accordance with the Copyright, Designs and Patents Act 1988 (as amended) and regulations issued under it or, where appropriate, in accordance with licensing agreements which the University has from time to time. This page must form part of any such copies made.

iii. The ownership of certain Copyright, patents, designs, trademarks and other intellectual property (the “Intellectual Property”) and any reproductions of copyright works in the thesis, for example graphs and tables (“Reproductions”), which may be described in this thesis, may not be owned by the author and may be owned by third parties. Such Intellectual Property and Reproductions cannot and must not be made available for use without the prior written permission of the owner(s) of the relevant Intellectual Property and/or Reproductions.

iv. Further information on the conditions under which disclosure, publication and commercialisation of this thesis, the Copyright and any Intellectual Property and/or Reproductions described in it may take place is available in the University IP Policy (see http://documents.manchester.ac.uk/DoculInfo.aspx?DocID=487), in any relevant Thesis restriction declarations deposited in the University Library, The University Library’s regulations (see http://www.manchester.ac.uk/library/aboutus/regulations) and in The University’s policy on Presentation of Theses.
Dedication/ Acknowledgments

I would like to thank Dr William West, Dr Clare Lennie and Dr Jenny Peel for being sounding boards and guides; Damian Hart and Steve Miller who picked me up when the findings chapter fell, my children Josh and Poppy and PSS colleagues for being unfailingly supportive. Finally I have to thank each of the participants for their time, honesty, courage and determination. I hope that soon there will be a corresponding bravery on the part of health authorities to address the mental health needs of alienated communities.

This work is dedicated to Esther Gorman my maternal great grandmother and her 3 grandsons Cyril (my father) Jeff and Sidney who were never given the educational opportunity to formalise their considerable intellect.

But ultimately this thesis is dedicated to my late husband, the incomparable Jeff Learman who challenged, supported and stretched me into a new shape. We started this journey together and somehow I have managed to finish it alone.
Chapter 1 Introduction

“THE WORLD CAN COME INTO OUR INTERVIEWING ROOM”

(Lago, 2011, p. 5)

The impact of trauma on the individual has been documented in factual accounts for hundreds of years. When Heroditus chronicled the battle of Thermopylae Pass in 480 B.C he told the story of a Spartan named Aristodemus who was so shaken by battle he was nicknamed ‘The Trembler’ and described how he eventually hung himself in shame (Bentley, 1991).

In 1667, six months after Samuel Pepys survived the Great Fire of London he wrote in his diary:

It is strange to think how to this very day I cannot sleep a night without great terrors of the fire; and this very night could not sleep to almost two in the morning through great terrors……A most horrid, malicious, blood fire... So great was our fear... It was enough to put us out of our wits.

(Saigh and Bremner, 1999)

Picasso said, “Art is a lie that makes us realize the truth” (Cummings, 2007, p. 98). From Shakespeare writing about Lady Macbeth washing her hands while sleepwalking after murdering a king, to the paintings Picasso created after the massacre in Guernica, there have been creative attempts to convey the psychological sequelae of trauma. Many of these were drawn and written centuries before post-traumatic stress disorder was identified by the American Psychiatric Association in their Diagnostic and Statistical Manual of Mental Disorders (DSM -III) in 1980 (3th ed. American Psychiatric Association, 1980)
1.1 Contextualising the research
It is “estimated that one in every thirty-five people in the world is an international migrant” (Christodoulidi and Lago, 2010, p. 231) and that every four seconds someone is forced to flee their homeland (UNHCR, 2015). The number of people who claim asylum in industrialised countries is identified and monitored by the United Nations High Commissioner for Refugees (UNHCR). They report that in 2014 there was a forty five percent increase in claims from the previous year (UNHCR, 2014, p. 2). The largest numbers of people claiming asylum came from the Syrian Arab Republic, followed by Iraq, Afghanistan, Serbia, Kosovo and Eritrea (UNHCR, 2014, p. 3).

In 2014 the number of applications for asylum into the United Kingdom was 24,914. Although there has been a general downward trend in recent years this figure is six percent higher than in 2013 (Refugee Council 2015). In the United Kingdom applications for asylum are made to the Home Office, the government department in charge of immigration, control, order and security. The UK is the eighth largest recipient of asylum claims behind Germany, USA, Turkey, Sweden, Italy, France and Hungary (UNHCR, 2014, p. 9).

Many asylum seekers arrive in this country having experienced global conflict and human rights abuses (Splevins et al., 2010). How one asylum seeker or refugee is affected by these experiences compared to another depends on many factors (Miles and Garcia-Peltoniem, 2012). While every person who witnesses or experiences human rights abuses will be affected by them, some people who have been exposed to traumatic events develop long-standing psychiatric disorders, while others exposed to the same event do not (Jakovljevic, 2012). However, Freedom from Torture (formerly the Medical Foundation for the Care of Victims of Torture), an organization that provides care and treatment for victims of torture has received over 50,000 requests for help since it was founded in 1985. Many of those who need support do not speak English (Freedom from Torture, 2015).

Anti-discrimination legislation (such as the Equalities Act, 2010) and the government’s mental health strategy (Dept of Health 2011) are designed to ensure equal access to the necessary help for all communities. Lack of spoken English
should not “impede or preclude access to psychological services” (Tribe, 2007, p. 156). This has resulted in an increased demand for non-European linguists and a focus on how to incorporate the work of interpreters into counselling, psychotherapy and psychology. “A properly resourced, supervised and utilised interpreter service is the most quickly achievable means of raising the standard of mental health services for this [asylum seekers and refugees] population” (Summerfield, 2001, p. 162).

In the UK interpreters receive formal training by the Chartered Institute of Linguists. There are four levels leading to a Diploma in Public Service Interpreting (DPSI). Interpreters can study for a mental health specialism that is designed to focus on the technical language used within a psychiatric medical model. It has a strong emphasis on psychopathic, neurotic and organic disorders. However the reading list for this module does include some material about working in psychological therapy services with asylum seekers (Chartered Institute of Linguists, 2015).

Although the number of people living in the UK who would need to use an interpreter in order to access mental health services is difficult to estimate, the 2011 Census revealed that nearly 140,000 people living in England and Wales cannot speak English, and around 726,000 said they had a weak grasp of the language. This means that English or Welsh are not the main languages of about four million residents, or 8 per cent of the population. The 2011 Census found that 49 different languages were used as the main form of communication by groups of more than 15,000 people (including sign language). A regional breakdown found 22 per cent of Londoners used a main language other than English (Office for National Statistics, 2011 Census).

1.2 The aim of this study
The aim of this research is to explore if it is possible to work therapeutically through an interpreter and achieve interpersonal attunement with asylum seekers and refugees who have lived through traumatic experiences. Three perspectives are offered to examine the lived experience of the triadic relationship. Four
counsellors, four interpreters and four clients were interviewed through a focus group and semi-structured interviews. The data generated by using two qualitative methods were analysed using Interpretative Phenomenological Analysis (IPA). IPA is concerned with understanding and making sense of significant life experiences for participants from an insider, lived perspective (Larkin et al., 2006). It is concerned with the idiographic; the distinct experiences of particular people and the particular contexts in which those experiences occur (Eatough and Smith, 2008; Smith, Flowers and Larkin, 2009).

There are relatively few empirical, clinical or research studies that explore clinical work with interpreters (Raval and Smith, 2003). Century, Leavey and Payne (2007) state that no previous research had attempted to look at the experiences of counsellors in primary care, working with asylum seekers and interpreters. The literature also contains little research or comment based on service users’ views (Williams, 2005). The data that does exist seems to focus on practitioners and services, which do not always adhere to good practice, (Raval and Smith, 2003; Century et al., 2007).

An agency that purports to good practice was intentionally chosen and all the participants in this research had worked in therapeutic alliances that had lasted for a minimum of three months. This enabled the study to explore if therapeutic relationships could build and a working alliance between the two practitioners could develop in an atmosphere of good practice.

The main research question is:

‘Is it possible to work therapeutically through an interpreter with asylum seekers and refugees who have lived through traumatic experiences?’

A number of issues or sub-questions developed out of this question. These were:

1. What happens to the therapeutic alliance when a third person is involved and is it possible to achieve interpersonal attunement?
2. What is the experience like from a personal perspective for each participant in the room (the client, the counsellor and the interpreter)?

3. What is good practice in this situation? What helps or hinders a 'dialogue with three voices'? (Rielo, 2000).

1.3 Chapter details
In addition to the introduction and conclusion, this research is divided into five further chapters:

Chapter 2: Methodology: describes why a phenomenological methodology and Interpretative Phenomenological Analysis (IPA) were chosen for this research. It outlines the procedures that were used to recruit and interview participants and the rationale for the methodological decisions taken. It also explains the ethical guidelines that were followed.

Chapter 3: Literature Review: examines the current research literature on working with interpreters within mental health. It focuses on communication issues and the therapeutic relationship. It also explores the concept of trauma, the cultural constructs of mental health, post-traumatic stress disorder and the role of post-traumatic growth and resilience in recovery. It aims to be an introduction to the field, with a critique of key contributions.

Chapter 4: Findings: presents the individual experiences of twelve participants. Using data from the focus group and one to one interviews they are grouped into client (n=4), interpreter (n=4) and counsellor (n=4) experiences. Grids of the four super-ordinate and ten sub-ordinate themes are presented. The triadic and focus group experience is acknowledged through stories of specific interactions.

Chapter 5: Discussion: is divided into three sections. The first examines the findings from this study in relation to the research questions and places them in the wider context of existing literature. The second looks at other issues not directly raised by the research questions but pertinent to the findings. This is
followed by a critique of the research process, implications for future practice and suggestions for future research.

1.4 Reflexivity
This study uses insider research with a subjectivist ontology and epistemology (Creswell, 2007), further explored in the methodology section of this thesis. The research was conducted by the service manager in a third sector, specialist psychological therapies service that employed interpreters on a freelance sessional basis. It is understood that the perspective of the researcher will inevitably impact on any research undertaken and accepts the fact that participants will be known to each other. This is seen as advantageous to the development of knowledge into a phenomenon.

As an insider researcher I was aware that it was essential to critique every decision I made throughout this study. Insider research demands high levels of awareness about the role, interactions with others and the researcher’s own preconceptions, assumptions and judgments. For this reason IPA requires reflexivity in every stage of the research process. The first stage of this reflexive process is to identify who I am including my biases and preconceptions, in order for the reader to understand where this places my research. ‘The researcher is his or her primary instrument, and as a result must be aware of the fantasies, expectations and needs that his or her participation introduces to the research process’ (McLeod, 2006, p. 72).

I came to this research as a BACP Senior Accredited Counsellor/ Psychotherapist who has worked as a therapist for 32 years. I had worked with asylum seekers and interpreters for the last 13 years. Before working with trauma and asylum seekers I had worked with substance misuse and addiction for a number of years. A Professional Doctorate aims to integrate professional and academic knowledge in order to develop professional practice by making a contribution to professional knowledge. There are relatively few studies that explore clinical work with interpreters (Raval and Smith, 2003). As a researcher with some experience of the phenomena my research is an attempt to contribute to this important field of work.
At first glance I look like a white, English, middle class woman, which is definitely part of who I am. However I am only second generation British born. My grandparents came to this country at the turn of the twentieth century. I do not know when they arrived but they are all present in the 1911 UK census. Both my maternal and paternal grandparents were brought to London as children (aged between 2 and 13) by their parents. They were fleeing persecution as Jews from the pogroms in what is now Moldavia but was then part of the Russian Empire. They were clearly asylum seekers although that word did not exist. My family brought virtually nothing with them. A desire to obliterate Jews from the landscape and history of Eastern Europe means that all records that existed in their hometown have been destroyed. So my family has no documents to trace back, as celebrities do in programmes about family trees. All I have is the name of the towns they lived in and some hazy family legends about who my ancestors might have been. My father confided the story of his maternal grandmother’s abusive treatment at the hands of the Cossacks to me when I decided to become a therapist but I have no knowledge of the human rights abuses experienced by the rest of the family. No one ever talked about it. I now understand that they were trying to protect future generations from the trauma.

I am aware that I have always lived in two communities; one English, the other Jewish. As a school child in the 1960’s I had to ask for extra time off for Jewish holidays. I remember incredulous teachers who did not believe that I could not do the work at home when I explained that it was a religious holiday and I was prohibited from writing on holy days. The contrast in food between my two worlds illustrates this; one of my memories is the contrasting horrible runny mince of school dinners and the stuffed aubergines of home, but also the sponge pudding and fish and chips in school that I never got at home. I realise that I have grown up and am used to existing in a number of cultures, languages and values simultaneously. My parents spoke English to me and Yiddish to each other when they did not want me to understand. My father also spoke French and Arabic. My Aunt is Dutch so my cousins are bi-lingual and I have family in France, Holland and Israel who I see regularly. I have an extremely vivid memory of my mother’s first cousin sitting down with his small daughter on his knees at my seventh birthday party to translate from English to Hebrew for her while we played pass the
parcel. As the world gets smaller due to travel, e-communication and multi-cultural communities increase, these experiences have probably become less unusual.

Carter (1998) asserts that the psychotherapy and counselling process is always influenced by the participant’s race and culture. I now understand that ever since I trained to be a psychotherapist in 1983, my therapy has by definition been cross-cultural because of who I am. My clients may not have realised this process going on and it certainly was not an issue raised in my training. Yet I have lived my professional life adapting to and understanding the variety of communities I have found myself sitting in a room with, long before I saw my first asylum seeker client. I realise now why this work immediately felt comfortable for me, although I did not connect my background with my professional life for some time. I now understand why it was also one of the reasons I found working with an interpreter relatively easy; I have grown up and am at ease when I don’t understand conversations going on around me.

While researching for this thesis I have come to realise how much feeling and understanding can be picked up by empathic accuracy and interpersonal neurobiology. I have also come to realise that, because of my life history, I learnt to speak that language literally at my mother’s knee.

1.5 Definition of key terms
For the purposes of this thesis, the following terms are defined as:

**Asylum seeker (page 16)**
‘An asylum seeker is someone who has lodged an application for protection on the basis of the Refugee Convention or Article 3 of the ECHR. Article 3 of the European Convention on Human Rights (ECHR) states that:

‘No one shall be subjected to torture or inhuman or degrading treatment or punishment’.
A person can make a claim for protection based directly on Article 3 of ECHR as states are prohibited from returning a person to a country where she/he may suffer a violation of his/her rights under Article 3.’

(Refugee Council, 2015)

**Refugee (page 16)**

‘A refugee is a person who:

‘Owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country…’ (Definition quoted from the 1951 Refugee Convention).

Refugee status is awarded to someone the Home Office recognises as a refugee as described in the Refugee Convention. A person given refugee status is normally granted leave to remain in the UK for 5 years, and at the end of that period can apply for Indefinite Leave to Remain’.

(Refugee Council, 2015)

**The therapeutic alliance (page 17)**

‘The therapeutic alliance can be defined as the ‘quality and the strength of the collaborative relationship between the client and the therapist (Hovarth and Bedi, 2002 p41). Bordin (1979) suggests that it has three aspects:

1. Agreement between therapist and client on the goals of therapy (i.e. what the therapy is trying to do).
2. Agreement on the tasks of therapy (i.e. how therapy is done).
3. The therapist-client bond (i.e. mutual trust, acceptance and confidence).’

Quoted in Knox and Cooper (2015, p23)

The following definition/ process description was presented to the research participants:
'A means of promoting and applying a set of values concerning respect for others, acceptance of difference, the worth of human beings and the importance of connectedness and human relationships'

(McLeod, 2007, p.82) this is further discussed in the Literature Review.

**Interpersonal attunement (page 17)**

Current research suggests that a key determinate of a positive therapeutic outcome is when therapist and client experience a profound connection to each other, (Cooper, 2012). Each theoretical model of psychotherapy now offers a definition of connectivity that relates to its specific orientation. This study intentionally uses a term that is not claimed by any specific theoretical orientation:

Interpersonal attunement is a deep and profound emotional connection that creates a resonance in each participant.

**Post-Traumatic Stress Disorder (PTSD) (page 79)**

‘[a] response to one or more traumatic events such as deliberate acts of interpersonal violence, severe accidents, disasters or military action…’

The ICD–10 definition states that PTSD may develop after ‘a stressful event or situation … of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone’ (World Health Organization, 1992: p. 147). Thus, PTSD would not be diagnosed after other upsetting events that are described as ‘traumatic’ in everyday language, such as divorce, loss of a job or failing an examination.

‘The DSM–IV highlights that a traumatic stressor usually involves a perceived threat to life (either one’s own life or that of another person) or physical integrity, and intense fear, helplessness or horror… PTSD depends on their subjective perception of the traumatic event as well as on the objective facts… those at risk of PTSD [also] include…witnesses, perpetrators and those who help PTSD sufferers (vicarious traumatisation)’

(NICE, 2005, p. 5)
Posttraumatic growth (page 89)
Can be seen as an increase in psychological functioning categorised by changes in self-perception, changes in perspective on life and changes in relationships (Joseph, 2012).

Counsellor (page 24)
The organisation used to access the participants for this research provides a variety of psychological therapies including EMDR, trauma focused CBT and play therapy. However throughout the interviews the participants refer to the counsellor and counselling. In order to create consistency and not alter the participant quotations I use the term counsellor throughout this research as a generic term that refers to a variety of therapeutic interventions.
Chapter 2 Methodology

This chapter explores why a phenomenological methodology and Interpretative Phenomenological Analysis were chosen for this research. It outlines the procedures that were used to recruit and interview participants and the rationale for the methodological decisions taken. It also explains the ethical guidelines that were followed.

A phenomenological methodology was chosen because it provides a richness and depth of experience that more formally structured studies may miss. A focus group was held consisting of four interpreters and four counsellors. This was followed by four individual semi-structured interviews with ex-clients. The aim was to explore the phenomena of an interpreter in the therapeutic relationship from all three participants’ perspectives in the belief that truths about reality are grounded in peoples lived experience (Polit and Beck, 2009).

2.1 Ontological and Epistemological positioning
Ontological issues are concerned with the nature of reality (Creswell, 2007). Subjectivist ontology sees reality as subjective and multiple. Epistemological issues are concerned with the relationship between the researcher and what is being researched (Creswell, 2007). In a subjectivist epistemology the researcher attempts to lessen the distance between themselves and the subject being researched. The philosophical foundations of a subjectivist ontology and epistemology are based on the study of the particular, the role of the researcher is close to the data and there is a hyper reflexivity on the part of the researcher through the analytic process (Creswell, 2007).

2.2 Interpretative Phenomenological Analysis and Grounded theory
Charmaz (2011, p. 359) argues that qualitative research attracts researchers who are concerned with social justice inquiry “studies that attend to inequalities and equality, barriers and access, poverty and privilege, individual rights and the collective good, and their implications for suffering”. However "in many qualitative
studies the role of the researcher is a fairly traditional one” (McLeod, 2003, p.97). I was keen to find a methodology that would be flexible and creative but also provide me with the rigor of academic structure. I analysed my data using IPA because it provided me with a methodology that encompassed a number of separate concepts I had found in differing data collection methods such as subjectivity, co-creation of meaning and reflexivity.

As Grounded Theory has become the most popular qualitative research method (McLeod, 2003) I felt it was important to consider its potential usage. IPA and Grounded Theory (Glaser and Strauss, 1967) are frequently compared and there are so many similarities that Willig (2001) says many struggle to understand the differences. Systems advocated by Grounded Theory such as simultaneous data collection and analysis, inductive coding and memo writing have become ubiquitous to all qualitative research (Strauss and Corbin, 1994).

Grounded Theory and IPA are usually organised around semi-structured interviews with individuals and are transcribed and analysed in terms of emergent themes. They both study processes in a field setting, data collection and analysis form an emergent iterative process, they both reject claims of objectivity, consider both researchers and participants relative positions and standpoints, emphasize reflexivity, are alert to variation and difference and have flexible analytic guidelines (Charmaz, 2011; McLeod, 2011).

Grounded Theory has become an evolving and general qualitative methodology with three distinct branches: the constructivist, the objectivist and the post-positivist perspective, each with distinct epistemological differences (Charmaz, 2011). IPA was developed during the 1990’s specifically to conduct qualitative research in psychology with a theoretical foundation and a detailed procedural guide (Brocki and Wearden, 2006). IPA is a new and developing approach that avoids the debates and controversies associated with Grounded Theory (Willig, 2001). It is increasingly the method of choice within counselling and psychotherapy research, (McLeod, 2011). When considering an analytic tool I was aware that the small scale of this study would limit the implications for its findings.
and its generalizability. The choice had to be based upon the goals of the research.

IPA has an explicit philosophical rationale based on phenomenological and hermeneutic ideologies. IPA tends to use purposive sampling and homogenous small sample sizes with detailed contextualisation (Smith and Osborne, 2003). This is to illuminate a particular research question and interpretation of the data, (Brocki and Wearden, 2006). Grounded Theory uses theoretical sampling and collects data until saturation. While Grounded Theory focuses on the broader population, IPA studies are more concerned with examining divergence and convergence in small samples (Brocki and Wearden, 2006). There is an explicit, idiographic or caseload emphasis, which is focused on nuanced, lived experience in contrast to the development of explanatory models in Grounded Theory (McLeod, 2011). Kay and Kingston (2002, p. 171) identify IPA as “particularly suitable where one is interested in complexity or process or where an issue is personal” and where the aim is to understanding an issue through a personal, deeper individualised analysis.

The issues of being an insider researcher discussed later in this chapter also required a nuanced, sensitive approach to the participants and the emergent findings. After some consideration, I decided that the most effective way to achieve this was through a variety of reflexive processes emphasised by the IPA double hermeneutic. “Issues surrounding reflexivity affect all qualitative approaches, not just IPA. IPA does in fact go further than many other approaches in addressing these issues” (Brocki and Wearden, 2006, p. 92). However Brocki and Wearden (2006) point to a relative weakness in published IPA research where the interpretive role of the researcher is often not mentioned, and point to the need for researchers to acknowledge their own perspectives, including research interests, theoretical groundings and why they undertook their research. I felt that this would establish the integrity and validity of this research.

IPA does not claim generalisability but uses an inductive process to discuss findings in the context of existing psychological theories, models or approaches
(Brocki and Wearden, 2006). For example, Flowers et al. (1997) use their analysis of sexual decision making in gay men to highlight the inadequacies in psychological theories relating to sexual health and sexual health promotion. This approach seemed particularly relevant to my research as the findings could be seen in the context of accessibility to mental health and psychological services for BME communities in England.

Smith, Flowers and Larkin (2009, p. 3) identify appropriate subject matters for IPA research as examinations of how “someone makes sense of a major transition in their life”. This fitted my research question, as there was a delicate balance between the traumatic reasons that the clients had attended therapy and the research questions about the process and experience of having therapy. It also acknowledged the transitions, if any, that the practitioners’ had made in their professional lives in order to accommodate working in a triad. A detailed IPA analysis can also identify if anything else is leaking out from the interview that was not intended (Smith and Osborne, 2003). It encourages an open-ended dialogue between the researcher and participants and accommodates the possibility of unexpected answers. This was ideally suited to my subject matter as there was always the potential for sensitive and important issues to emerge such as power, race and identity. This, in turn, could lead to a new perspective on the research question. As this is a little researched field I believe this has provided me with some useful flexibility.

In order to understand the methodology and to equip myself with the skills to analyse a focus group as well as one-to-one interviews, in January 2012 I attended an IPA professional development course at Aston University with Dr Rachel Shaw.

2.3 The theoretical base of Interpretative Phenomenological Analysis (IPA)

IPA is an approach to qualitative, experiential and psychological research, which has informed concepts and debates from three
key areas of the philosophy of knowledge: phenomenology, hermeneutics and ideography.

(Smith, Flowers and Larkin, 2009, p.11)

Phenomenology focuses on lived experience. Hermeneutics is the theory and practice of interpretation and focuses on how people interpret those experiences (Polit and Beck, 2009). Ideography focuses on the particular. Developed in the field of social sciences, IPA examines individual cases using in-depth systematic analysis (Polit and Beck, 2009). IPA is a qualitative methodology with a focus on understanding experience using firsthand accounts through collection methods such as individual interviews, diaries and lived experience description. The data analysis focuses on the cares and concerns of the participant and their meaning making processes, what matters to them, and how they make sense of that experience. The data analysis process also places importance on the reflexivity of both participant and researcher. By describing meaning filled reflections on the experience, the researcher gets as close as possible to the phenomena.

The concepts of IPA can be broken down into constituent parts:

I = Interpretative:

Heidegger (1962) asserts that we are all part of the world and that interpretation is at the very heart of humanity. It is impossible not to interpret what we see, hear and read through the filter of our own experience. IPA acknowledges this and sees itself as an interpretative activity based on a hermeneutic cycle. This cycle is created when our pre-conceptions are added to by new experiences that revise what we know. This, in turn, creates new pre-conceptions. This cycle is constantly moving. In IPA the focus is on the unique experience of each participant. It does not look for themes that may emerge from sampling a broader population because no two people will perceive the same experience in exactly the same way. IPA also explicitly acknowledges the researchers role in interpreting the results of the data collected, identifying this as a double hermeneutic. During data analysis the researcher is interpreting what has been recorded. First the participant makes sense of their story by creating a narrative and then the researcher’s role doubles.
the interpretation because they are making sense of the participant making sense of their story (Smith, Flowers and Larkin, 2009). Within IPA this creates an acknowledged double hermeneutic which runs through any analysis.

P = Phenomenology:

Smith, Flowers and Larkin (2009) cite Husserl, Heidegger, Merleau-Ponty and Sartre as leading figures in phenomenological philosophy. This Hermeneutic-Existential movement was an attempt to bring philosophy back to lived experience (Moran, 2000). IPA took these philosophical ideas and adapted them for qualitative research in social research and psychology. IPA is phenomenological in that it wishes to explore an individual’s personal perception of an event, it examines empirical experience as opposed to attempting to produce an objective record of the event or state itself. It is therefore concerned with the idiographic, distinct experiences of particular people and the particular contexts in which those experiences occur (Eatough and Smith, 2008; Smith, Flowers and Larkin, 2009). In IPA the individual perspective is central to the inquiry, it is a detailed examination of the particular case. As they are based on lived experience IPA studies are frequently emancipatory in focus. They use participants’ personal accounts to learn and make a difference, to breakdown power imbalances, to make services user friendly and to change policy (Smith, Flowers and Larkin, 2009).

A = Analysis:

IPA uses in-depth analysis on a case-by-case basis. This means that the first interview is analysed before completing a second and subsequent interview/s. The aim of IPA is to develop an organised, detailed, plausible and transparent account of the meaning of the data. This produces a narrative that tells the participants' stories and also identifies patterns and produces a hierarchy of themes. After familiarization with the data, coding is done twice, first phenomenologically i.e., descriptively and then interpretatively. The participants’ voice is valued above everything. There is a great emphasis on making sure that the research reflects the exact meaning that the participant wanted to communicate. After this there is
identification and clustering of themes. It is only when this is complete that the next interview takes place. Each participant is analysed individually. When all the interviews are complete an integrative analysis (a comparison across cases) then takes place (Smith, Flowers and Larkin, 2009).

2.4 Outline description
The aim of this research was to explore what impact the addition of an interpreter may have on the therapeutic process. By interviewing all the participants in the therapeutic triad (the client, the interpreter and the counsellor), I hoped to gain all three perspectives on the phenomenon.

The main research question was:

‘Is it possible to work therapeutically through an interpreter with asylum seekers and refugees who have lived through traumatic experiences?’

A number of sub-questions developed. These were:

1. What happens to the therapeutic alliance when a third person is involved and is it possible to achieve interpersonal attunement?
2. What is the experience like from a personal perspective for each participant in the room (the client, the counsellor and the interpreter)
3. What is good practice in this situation? What helps or hinders a ‘dialogue with three voices’? (Rielo, 2005)

This study is an attempt to explore a rounded view of the phenomenon. I was influenced in this by the Experts by Experience panel created by Freedom from Torture (2014) (formally the Medical Foundation for the Victims of Torture). This is a panel of ex-service users who have survived torture and trauma and have been asked to advise on improvements to the service. Used in the social care and mental health sectors for the last 10 years, the concept of Experts by Experience aims to involve service users (who have a lived experience of the system) in inspections and feedback to professionals with the aim of improving the quality of
service provision (McLaughlin, 2009). This study saw each person in the therapeutic triad as an expert with a unique experience of this phenomenon.

The research was conducted using two qualitative methods. I began by scoping the questions through a Focus Group. This comprised of 8 participants (4 counsellors and 4 interpreters) who had worked together before. After analysis of these findings a second stage of four individual semi-structured interviews followed. These reflected my concern for a service user perspective and the participants were four ex-clients. They were psychologically well, had received therapy in the past with the use of an interpreter but now spoke fluent English.

2.5 Access
Participants were recruited from a third sector, specialist psychological therapies service in Liverpool. The aim of the service is to improve the mental and emotional wellbeing of migrants and refugees who have experienced human rights abuses and trauma. It uses interpreters for approximately 70% of its work with clients. I was able to access this service because I am employed part-time as the Service Manager. My workplace was chosen for potential participants as I felt it would be impossible to find people willing to participate in a potentially delicate subject area without establishing a long-term relationship.

The first stage of the research was a focus group recorded by audio and video. The individual semi-structured interviews were recorded by audio. As all three small groups (n=4) had previously been involved in the service, the counselling rooms and offices of the therapy service represented a neutral, yet familiar and safe setting in which all the interviews took place.

2.6 Sampling
Participants from all three perspectives of the therapeutic triad were interviewed. The population that the sample was selected from included the 50 interpreters who work on a freelance, sessional basis for the service and who provide over 60 languages and dialects; the 13 counsellors (7 paid staff and 6 associate
counsellors) who regularly work with interpreters in the service and the potential one thousand clients who had been seen during its twelve-year existence.

IPA advocates purposive sampling, a deliberately non-random method of sampling that selects a group of people with a particular characteristic. ‘A non-probability sampling method in which the researcher selects participants based on personal judgment about who will be most representative or informative’ (Polit and Beck, 2009, p. 565). Respondents are selected because they have knowledge that is valuable to the research process. In this case, they had knowledge of working as a therapeutic triad because the client and therapist speak different languages. Although not representative, I did attempt to find a cross section of ages, country of origin, language and professional experience amongst the participants.

2.7 Rationale for using two qualitative methods
My primary concern when conducting research interviews was how to make each participant feel comfortable, and therefore, able to talk about their unique experience. Initially I intended to complete semi-structured interviews with each participant. However, during the process of purposive sampling it became clear that I had an opportunity to explore an interesting phenomenon. As this research was conducted inside one specific agency, interpreters and counsellors where known to each other and came together as effective working partners. Another advantage was the potential for three people who had worked in the same triad to be interviewed. This research does not claim to be positivist in nature. It is a postmodern study with a subjectivist ontology and epistemology. As insider research, it accepts the fact that participants will be known to each other and sees this as a positive advantage in the development of knowledge into the phenomenon (Costley, Elliott and Gibbs, 2013).

Instead of seeing twelve separate participants I began to explore the idea of joining participant groups together. If the interpreter, client and counsellor worked together on the same case would their perceptions of the experience be the same or different? I was faced with the opportunity to link the unique experiences of three separate individuals who had distinct roles and had all encountered the
same phenomenon from different perspectives, sometimes in the same encounter. Firstly, I considered interviewing in triads but quickly realised that this would be unethical as it would break confidentiality and complicate therapeutic relationships that had already terminated. I also considered three homogenous focus groups. When considering the ethical dimensions of this issue, a group for ex-clients would clearly break client confidentiality and expose the clients to the possibility of vicarious trauma when hearing the stories of the other clients. I was also aware that the ex-clients would be communicating in a second language and trying to understand each other, possibly in a new context if they had not experienced a research interview before. On reflection, it became clear that semi-structured interviews would provide confidentiality and sensitivity to the clients’ needs. With reference to Smith, Flowers and Larkin (2009), I then considered whether to run a focus group of mixed composition between the counsellors and the interpreters. Encouraged by research carried out by Tomkins and Eatough (2010), and Palmer et al. (2010) which reflect on the use of focus group data and the use of IPA, I decided to adopt two different qualitative methodological approaches in this study, with the interpreters and counsellors in a focus group and the ex-clients interviewed individually.

2.8 Potential limitations of methodological approaches
There are limitations when collecting rich data about unique experiences for qualitative research, whatever the collection method. The study is dependent on participants’ perceptions and the way they choose to present themselves to the researcher. Their observations are snapshots, the version of events they give may be told differently the day before or after the research interview. There is also the question of what motivates individuals to join or decline to participate in the research. Once part of a study, just observing a participant may change their reactions, known as the Hawthorne effect (Politt and Beck, 2009).

When conducting focus groups there is the danger of a contamination of ideas, (Costly, Elliott and Gibbs, 2013) and some people may be uncomfortable expressing views or experiences in front of others (Politt and Beck, 2009). In choosing to combine the counsellors and interpreters in one focus group there is a
potential increase in group dynamics, inequalities and power issues. There is the potential of a perceived power difference between the counsellors and interpreters that may result in the interpreters wanting to please the counsellors. There are also potential conflicts between people who work nominally at the same level; their place in the hierarchy may influence how they want to present themselves in a group. There are also interpersonal factors across a homogenous group where there may be potential for rivalry.

Some researchers maintain that using focus groups in phenomenological research is an oxymoron (Bradbury-Jones et al., 2009). Others who do acknowledge its potential, stress that as IPA is fundamentally an idiographic approach, it is concerned with the intrapersonal rather than group experiences (Millward, 2012). Combining IPA methods with a focus group and interviews as a methodological approach clearly presents challenges. The Dunne and Quayle (2001) IPA study asserts that negative group dynamics in focus groups can be mitigated by good facilitative processes which are likely to reduce the dominance of interpersonal factors and address the potential problem of group dynamics taking precedence over discussion topic. While Leask, Hawe and Chapman (2001) argue that when focus groups consist of pre-existing groups, the potential for conformity with pre-established group norms and leadership patterns increases. However, Leask et al. (2001) accept that natural groups may be preferable when exploring sensitive topics and when studying narrow target populations.

IPA researchers are expected to analyse participants’ language in an attempt to understand how they make sense of their experience. Smith et al. (2008, p. 194) recognise that IPA is “inevitably always already enmeshed with language and culture”. Individual participants in any research may struggle to express themselves in a way that accurately conveys the subtleties and nuances of their experience (Willig, 2001). In this research this issue is further complicated because six of the twelve participants interviewed were speaking in a second language. There were also layers of cultural difference because the focus group participants were sharing two different professional cultures and bringing a variety of other differing cultural communities into one discussion room. Extra layers was
added by myself as a researcher/manager/practitioner who came from a different culture to any of her participants

2.9 Stage One: the focus group

2.9.1 Finding participants for the focus group

I aimed to find counsellors and interpreters who had worked together. This would create rapport and allow discussion of mutual experience in the focus group. The purposive sampling became a very practical manner. I wanted to interview both volunteers and paid counsellors. I realised that out of six associate counsellors (volunteers) only two had worked with Interpreters (Victoria and Donna). When they agreed to participate I asked them which interpreters they worked with regularly and they came up with the names of Fatima, Majid and Kim. When they agreed to participate I immediately had three of my four interpreter names. When I contacted the three interpreters about participating I asked them which of the paid counselling staff they worked with regularly; two names came up repeatedly, Isara and Rita. When they both agreed to participate I then asked which other interpreters they used and followed up the one name that was on both of their lists, Martin. All the people I approached agreed to join the focus group.

2.9.2 The Interpreters

There were two male and two female interpreters who attended the focus group. They ranged in age from 35 to 54. Together they spoke seven languages other than English. These were Farsi, Dari, French, Spanish, Arabic, Zaghawa and Somali. Two said they had no religion and two said they were Muslim. They identified their ethnicity as Iranian, Anglo-Irish, Sudanese-African and Somali-African. They all had diplomas in Public Service Interpreting with a specialism in health (this includes mental health issues). However, the questionnaire also identified the lives, experience and interests they held outside of their work. One said that they had a teaching degree, another identified themselves as a trainer and lecturer, another wrote their profession as Engineer rather than Interpreter. Between them they had worked for the UK Border Agency, the National Health
Service (NHS) and the International Criminal Court (ICC) as well as in a therapeutic context. Their experience as interpreters ranged from 4 to 11 years, citing between 4 and 10 years’ experience working with trauma and asylum seeker issues. Their experience ranged from having worked therapeutically with three clients to approximately one hundred.

2.9.3 The Counsellors

All four participants were female with an age range from 35 to 65+ years. Two of the therapists were paid employees and two were associates who volunteered their time and expertise to the service. Three identified their religion as Christian and one said they had no religion. Three said their ethnicity was English and one Irish-African. All were professionally qualified with diplomas in counselling. Between them they had training in Cognitive Behavioral Therapy (CBT) and Eye Movement desensitization Reprogramming (EMDR), an M.A, vocational training in social work (CQSW), and a certificate in youth and community work. They worked across a spectrum of therapeutic approaches including EMDR, trauma focused CBT and person centered therapy. Their experience as therapists ranged from 6 to 30 years, citing between 2 and 9 years’ experience working with trauma and asylum seeker issues. They had worked therapeutically with between twenty to one hundred clients.

2.9.4 Focus group characteristics

It was important to explore the issues with both experienced practitioners and those who were newer to this field in order to identify if they had common or different experiences and views. Although not representative, the eight participants of the focus group did present as a cross section of ages, ethnicity, languages spoken and professional experience. The participants had worked with between three and one hundred clients over a period of 2 to 11 years. I felt a range of experience and qualifications was particularly important to this study in order to gain as broad a perspective as possible within the limits of this sample size. Extra data such as demographics and general information about the participants was needed in order to critique the sample and create a picture of each group. I had
not included this in my ethics submission to Manchester University but obtained agreement to submit the same questionnaire to each small group (n=4).

2.9.5 Focus groups: theoretical background
Focus groups can be defined as collective conversations or group interviews Kamberelis and Dimitriadis (2011, p. 545). “Focus groups provide an inter-active environment. Focus groups enable people to ponder, reflect and listen to experiences and opinions of others. This interaction helps participants compare their own personal realities to those of others” (Krueger and Casey, 2009, p. 163). Kamberelis and Dimitriadis (2011) identify three overlapping functions for focus groups. The first is pedagogic and involves collective engagement designed to promote dialogue and to achieve higher levels of understanding of issues’ (ibid, p. 546). The second function is to ‘transform the conditions of existence for particular stakeholders’ (ibid, p. 546). The third, and most obvious, is the function of qualitative inquiry or research to ‘generate rich, complex, nuanced and even contradictory accounts of how people ascribe meaning to and interpret their lived experience with an eye toward how these accounts might be used to affect social policy and social change’ (ibid, p. 546).

2.9.6 Rationale for the use of focus groups
Focus groups are an efficient way of collecting data, and can generate debate, (Politt and Beck, 2009). They can produce different results from interviews because of a cross fertilization of ideas and experiences (Costly, Elliott and Gibbs, 2013). There may be instances where people find it easier to talk openly about their personal perceptions and experiences in a group situation with people who have had similar experiences than in individual interviews (Millward, 2012). This is possible if the facilitator can engage every participant at an experiential level in the discussion process (Bradbury-Jones et al., 2009). A further strength of focus group methods lies in the amount and nature of data produced through participant discussions. Morgan (1997) refers to the chance to share and compare amongst participants and suggests that this provides an opportunity to collect evidence on how participants understand their similarities and differences. The purposive sampling process had produced pairs of working practitioners. Using two separate
homogenous groups would have made analysis simpler but I hoped that joining all the practitioners together would allow them to enter into a lively dialogue and debate. It would develop each practitioner’s ideas and allow space for some cross discipline evaluation. “When group dynamics work well the participants work alongside the researcher, taking the research in new and often unexpected directions” (Kitzinger, 1995, p.299). A precedent for this is the IPA study on genetic counselling (MacLeod, Craufurd and Booth, 2002) which interviewed family units about their experiences. Joining the two practitioner groups together created some specific ethical issues and the need for some clear ground rules, particularly about confidential material that may have been known to a particular working pair of counsellor and interpreter. It was stressed that client confidentiality was paramount and no client name was to be referred to.

2.9.7 The fishbowl focus group procedure
The fishbowl was set up with four participants sitting in a circle who interact with each other around a process-orientated question. The other participants sit outside and observe and reflect in silence. The group then changes seats and roles so that only the inner circle speak and the outer circle reflect. This happens several times so that each participant has time to speak, reflect and share again. This allows the reflections to become deeper and more considered. The structure of the fishbowl protocol allowed each group (n=4) an equal voice with built in time to reflect and question other participants. On a very practical level it was a constructive use of a valuable resource.

2.9.8 Rationale for the fishbowl focus group
By joining the counsellors and interpreters into one focus group I hoped to facilitate discussion, debate and insight. Typically, a focus group has between six and ten participants, although some researchers suggest a maximum of six in a group (Willig, 2008). I wanted to create an environment that would facilitate some rich, in-depth data but had a large group of eight practitioners. An ordinary focus group could have potentially obscured the differences between the counsellor (n=4) and interpreter (n=4) experience because everybody would have spoken together. The practitioners fell naturally into two professional groups of counsellors
and interpreters (n=4). I decided to use a technique generally used for educational and training purposes (Dressler, 2006) called the fishbowl. It is a discussion process often used in the field of communication, particularly in education and business contexts (Dressler, 2006). As there are two distinct groups the fishbowl technique provided a process model to facilitate a shared forum with potential to create interplay of professional minds working together on one issue. If I had run two homogenous focus groups they may have each gone over the same ground. This study was looking at both practitioners’ professional and personal experience. Hearing each other’s ideas proved valuable because it created a platform to develop and deepen those ideas.

Feminist research argues that in a group the power of the researcher becomes decentralised, allowing participants a ‘safe space’ to talk about their own lives (Madriz, 2000, p.843) and within a focus group the views of the researcher are less influential than in one to one interviews (McLeod, 2006). Introducing the structure of the fishbowl protocol into the focus group further diminished the potential for researcher influence and the power dynamic of being a manager inside my own agency. It gave an organisational structure to the focus group that allowed the participants’ space to consider issues in-depth and create a lively debate, in which, patterns of convergence and divergence could emerge.

The structure the fishbowl gave to the group facilitated in-depth reflection but also facilitated analysis. Only four practitioners were heard at any one time focused on a specific research question. The aim of this research was to produce a detailed examination in order to reveal unique experience. However, IPA also explores the similarities and differences between each case through integrative analysis. The format of the fishbowl focus group allowed the two participant voices to be separate and heard as distinct and different because I was hearing either counsellors or interpreters’ reflections in a unified group. During the analysis it was clear to see the similarities and differences between the groups and these are documented in the findings and discussion chapters. The process model also allowed debate and disagreement between the two professional groups to be aired in a safe way because it facilitated a right of reply.
2.9.9 Critique of the fishbowl technique

When researching this topic no academic literature could be found that provided a critique of the fishbowl process. However it is clear that this technique could only be successful when certain criteria were put in place. The participants would need skills in active listening, because this is an essential component of the process. It is also unlikely that the group would be successful unless there was a pre-established level of trust between the participants. That is why the technique is often used amongst students and in family therapy. Boundaries need to be established with clear ground rules. However the group facilitates itself and the facilitator has a minimal role. This creates the potential for problems, arguments could occur and there is the potential for a participant to be marginalised. There could be an argument between 2 participants that gets out of hand and criticisms could go unchallenged.

The exercise is based on the premise that when the group has trust and respect for each other the discussion will be accepted then processed and considered in an open and honest exchange or debate. If the participants feel defensive or are challenged to a point that they feel angry, alienated or unaccepted by the group the discussion will not be an honest exchange of views, the debate will close down and no deeper insights would be achieved. It is also vital to debrief after each session. If this is not followed each participant would not have the opportunity to express what the experience was like for them and process any adverse reactions they may have experienced. This could create the potential for distress and breach ethical responsibility for the wellbeing of the participants.

2.10 Stage Two: one-to-one Interviews

2.10.1 Rationale for using semi-structured interviews

As this was IPA research, the ex-clients were being asked to give a snapshot of their unique experiences. There was real potential for emotional distress. Individual interviews allow the researcher to focus on one participant at a time and to conduct each interview in depth. They are a widely used qualitative data collection technique to explore complex and subtle phenomena (Denscombe,
McLeod (2006, p. 74) says interviews are a “flexible way of gathering research data that is detailed and personal”. Individual interviews have a high response rate, focus on the priorities of the participant and have an inbuilt validity as the data is immediately checked for accuracy and relevance (Denscombe, 2010). Individual interviews were the obvious collection method to research the experience of ex-clients as they ensured confidentiality and respect to the clients' unique perspective. If the ex-clients were part of the mixed focus group they would have faced both their ex-therapist and ex-interpreter. Interviewing them separately meant they had the confidentiality and space to say whatever they wanted to, including talking about negative experiences. It would also be a clear and distinct task without the expectation of further contact or extra therapy. If the ex-clients were part of a homogenous focus group there was the possibility of emotional over-exposure and vicarious trauma. One participant of the client group (n=4), Val, became distressed in the one-to-one interview and this illustrated my concern. It is highly likely that she would have remained silent in a focus group and may have been further traumatised by hearing other participants’ stories.

2.10.2 Contact process: finding clients for the interviews

My initial aim was to interview participants from all three experiences in the triad. However, I hoped to capture more intimate and rich data if I could find participants who had actually worked together in a triad. I continued by purposive sampling as this had proved to be such a positive way of gaining access to the first two groups (n=4). The clients interviewed were selected very carefully because they needed to fit a specific profile. The client had to be over 18 years old at the time of the interview, completed therapy, have refugee status and have an established support system in place. They also had to be clients who had used an interpreter at the time of therapy but now spoke good enough English to be interviewed. I asked the counsellors in the focus group if there were any ex-clients they knew of who fitted my criteria, and had worked with themselves and any of the four interpreters who had attended the focus group. Victoria identified a client she and Fatima had worked with called Val and then Rita and Kim mentioned Mariam. As there were no other obvious triads and many ex-clients were no longer resident in Liverpool, my next search was to find people who fitted the criteria. Isara had
worked with Oluwaseyi and I contacted an ex-client of mine called Nadia. Therefore, I was able to interview two complete sets of triads (Victoria, Fatima and Val and also Rita, Kim and Mariam) as well two other clients, two other counsellors and two other interpreters

2.10.3 Sample characteristics
The client group (n=4) were all female and were aged between 18 and 54 years. Three said they were Muslim and one was Christian. All four identified their ethnicity as African and were born in Algeria, the Ivory Coast, Nigeria and Somalia. Between them they spoke French, Arabic, Yoruba and Somali as well as English. They had worked with an interpreter between five weeks and eighteen months. Three had children and the youngest had been an unaccompanied minor of 16 years old when she had received therapy.

2.10.4 Interview procedures
Having completed the focus group I was made aware that the description of the therapeutic alliance was hard for the interpreters to understand. Once they understood what I was trying to describe, they made it clear that they had experience of the concept but simply did not understand my explanation. With this in mind I simplified the ideas in the individual interviews.

2.10.5 Insider research
Brannick and Coghlan (2007, p. 59) define insider research as “research by complete members of organisational systems and communities in and on their own organisations”. Whilst my research was investigating process and unique experience rather than the organisation itself, the position I found myself in was multi-layered and was indeed, research carried out by an insider. “It is becoming increasingly common for individuals who are participating in academic programs, particularly on a part-time basis in conjunction with full-time employment, to select their own organisational setting as the site for their research” (Brannick and Coghlan, 2007, p. 6).
There is a growing acknowledgement that insider-led research can be of significant benefit, (Raelin, 2008). Insider researchers are usually experienced practitioners who use colleagues as subjects in their research, draw on established literature and look at a wider body of knowledge outside of the immediate context (Costley, Elliott and Gibbs, 2013) This is precisely the approach I took when deciding to access participants from within the service I was part of. I was able to access experienced practitioners who were willing to participate while exploring literature from a variety of disciplines to critique the data. However “…. It may be noted that by and large, this research (insider research) does not get published in refereed journals, has difficulty in being accepted as real research and frequently is referred to as a company project”. (Brannick and Coghlan, 2007,p.61). I was aware that the criticisms of insider researcher needed to be considered, and where possible, mitigated if the research was to have any kind of credibility and validity. Positivist paradigms criticise insider led research because of the subjectivity of researching your own practice. The issues raised include a lack of impartiality and objectivity when analysing the data as well as a vested interest in finding particular results, (Costley, Elliott and Gibbs, 2013). There is a danger that the researcher is too close and familiar to the phenomenon which may result in valuable data getting overlooked because the researcher is so immersed in the culture, (Politt and Beck, 2009). Yet in postmodern qualitative research the objective researcher is believed to be an *epistemological impossibility* (Costley, Elliott and Gibbs, 2013, p. 33). It is understood that the perspective of the researcher will inevitably impact on any research undertaken, whether they work inside an agency or as an external researcher entering into a new community.

Insider research demands that researchers maintain high levels of awareness about their role, their interactions with others and their own preconceptions, assumptions and judgments. As an insider researcher I was aware that it was essential to critique every decision I made throughout this study. In order to do this I used a model advocated by Brannick and Coghlan (2007). They identify two different types of reflexivity that social scientists engaged in insider researcher should use to explore the relationship between the researcher and the object of research. This is based on Bourdieu’s concept of Social Praxeology (Everett, 2002) in which both reflexivity and relational thinking create a double focus. They
suggest using ‘Epistemic Reflexivity’ which addresses the researchers’ belief system and is a process for analysing and challenging conscious and unconscious meta-theoretical assumptions. This is used in tandem with ‘Methodological Reflexivity’ which monitors the behavioural impact carrying out research has on its setting and all participants, including the researcher, within the framework of the chosen research tradition and paradigm, in this case, hermeneutic and postmodernist subjectivism.

2.11 Power
I am aware that the issue of power is pertinent to any research within a subjectivist paradigm. However the more I examined the issue, the more layers of complexity emerged. I was an insider researcher. I managed the service and was interviewing staff from that service. Interviewing ex-clients presented one issue, interviewing participants from diverse backgrounds another, with the potential for the interview itself to unintentionally oppress or victimize. This required transparency and personal honesty, a hyper-vigilance to complex power dynamics and an ongoing reflexive deconstruction of my own practice and power.

Sutherland and Moodley (2011) argue that researchers working with racial and ethnic minority populations should go beyond established research protocols and consider using the Belmont principles (Bowman, 1991, p. 137) which “emphasize personal respect, transparency, justice and a commitment to engage in practices that would benefit the population under investigation rather than simply not cause harm”.

I attempted to create an atmosphere which adopted Foucault’s (1980, p. 98) concept of power as ‘something that circulates, or rather something which only functions in the form of a chain’. He believed that power is not finite, it is not something to possess or achieve but rather moves constantly. In research terms this “places all ‘participants’—refugees, researchers, interpreters, interviewees, and so on—on an equal footing: they are vehicles for the circulation of power, simultaneously undergoing and exercising it” (Dona, 2007, p. 226).
2.11.1 An ethic of care

Costly, Elliott and Gibbs (2010, p. 45) stress that an insider researcher is required to be “respectful, sensitive, and imbuing confidence with openness, democratic sensitivity and a feeling for the micro-politics of a situation, amongst other understandings and nuances of understanding”. They advocate an Ethic of Care. “Caring is more than a superficial clarification of one’s actions by means of a voluntary consent form; it is the reframing of the research project as a mutual activity which has personal consequences other than the research report and which has its own legitimacy” (ibid, p. 43).

An Ethic of Care reframes the concept of power in a traditional research relationship to eliminate any potential for exploitation in work-based projects, Gibbs (2004). I tried to take a sensitive approach to the potential power dynamics throughout this research. I explored whether the research focused on sensitive topics and whether anyone would be made vulnerable by the outcome of my research. I needed to address whether my research would adversely affect any working environment or relationship. Participants were fully informed of the aim of this research and every one independently articulated that they shared a belief in the value of the research to inform best practice. From the outset it was vital that I worked collaboratively with all the participants. I stressed that both positive and negative experiences were equally valuable to this research and that sometimes the greatest learning happens when things go wrong. Costly, Elliott and Gibbs (2010) say an Ethic of Care also contains a moral obligation. I was known to approximately two thirds of the participants and there were strengths and challenges associated with this. “If you accept the offered trust, you are in a privileged and powerful position; you are trusted not to use your authority to manipulate and exploit the trustee” (Costly, Elliott and Gibbs, 2010, p.44). It is also concerned with the pragmatic, the ethics of ‘being in the world’ (ibid, p.45). For this reason I needed to consider which particular approach and methodology would fit with all the participants; including the professionals, their work requirements and the practicalities of researching within a work environment. One consideration was an effective use of time and contributed to my decision to use a focus group to interview the practitioners.
2.11.2 Power within the research interview

All qualitative researchers should acknowledge the potential for exploitation and manipulation in the research interview. “The qualitative research interview entails a hierarchical relationship with an asymmetrical power distribution of interviewer and interviewee. It is a one-way dialogue, an instrumental and indirect conversation, where the interviewer upholds a monopoly of interpretation” (Kvale, 2006, p. 484).

The accepted paradigm for qualitative research interviews is that the interview gives power to the interviewee. There is reciprocity between the researcher and those being researched, so that they become co-researchers. Social and health science interviews are seen as warm personal dialogues (Kvale, 2006). However there is the potential for confusion between an intimate and personal research interview and a therapeutic interview (Kvale, 2003). Participants are asked to provide elaborated accounts about particular experiences. The power dynamics of empathic interviews may in fact be disingenuous when the interviewer encourages the participant into revealing more than they had intended. My interviews were not “private conversations for public use” (Kvale, 2006, p. 497). Each participant was clearly informed that the interviews were for research purposes and were not extra therapy for ex-clients or supervision for practitioners. As the interviewer, I inevitably own the interview. It is my research project and interest, so I set the agenda and the questions. As the research analyst, I also have a monopoly of interpretation.

I attempted to be as transparent as possible, however, and acknowledged the power discrepancy inherent in this research. It was important that the participants gave informed consent with full disclosure. I acknowledge that ultimately cultural values, religion and different social norms may make it difficult to obtain truly informed consent (Thomas and Byford, 2003). There was a clear statement of purpose in all correspondence and at the beginning of each meeting whether in the focus group or one-to-one interviews extensive member checks were carried out.
Kvale (2006, p. 484) sees the research purpose as one sided, a means for the researcher to gain “descriptions, narratives and texts”, which is undoubtedly true, however he goes on to assert that within the context of a research interview: “a good conversation is no longer a goal in itself, or a joint search for the truth” (p. 484). I dispute this, and believe that all the participants I interviewed genuinely wanted a dialogue with a shared motivation and a mutually agreed aim to improve the experience of others. The researcher statement below comes from the transcript of Val (one of the ex-clients interviewed). I hope it displays the spirit in which this research was approached:

Lynn: I think I sent you a statement and really all its about is saying that I am interested in what it’s like from your point of view….coming into a room with two people and having to use an interpreter. So it’s what you felt like in that room, seeing two people. I am interested in whatever you have got to tell me. So bad things as well as good, you know things you think will help us make our work better. So I am not just expecting you to say, oh it was lovely, oh it was good. You know bad things are good as well or just suggestions of things that would have helped you, are really, really useful. So there isn’t a right and a wrong. All I want to do is hear it from people’s perspectives, people’s story, what it was like for you. Yeah?

Val: Yeah

Lynn: Ok, we have got about an hour, I have got some questions but you can say whatever you want to say. It’s just a way to help us get started really

Val: Right
2.11.3 The role of manager-researcher

Undertaking a research project in one’s own organisation is political and might even be considered subversive…. The key to this is assessing the power and interest of relevant stakeholders.

(Brannick and Coghlan, 2007, p. 71)

I carefully considered the issue of my duality of roles. Inevitably an invitation to an egalitarian dialogue was coming from someone higher in the chain of command (Kvale, 2006). Although a challenge, I made the decision that the practical and substantive advantages of being an insider researcher outweighed the disadvantages of being a manager inside the agency I was accessing for participants. However my role as service manager inevitably impacted on this research and the findings need to be evaluated against the backdrop of this methodological problem.

In addressing this issue, Jensen (1997) explores the appropriate role of researchers from a dominant group in conducting research about a subordinated group. He concludes that researchers can work with integrity but that it takes self-reflection and commitment to accountability. His analysis requires one to question the motivation for carrying out the research and what contribution it will make (p. 25). As an insider researcher I was in a position to contribute to good practice that was informed by a depth of both experience and knowledge of the phenomenon. I believe that the key issue was to present as a credible and trustworthy person. The confidentiality offered to a colleague had to be a deep and longstanding personal commitment because of the long-term relationship between us. This relationship would continue after the research was completed. Participants knew me to be part of the agency. This presented a different but I believe equally valid way to interview ex-clients.

There was an ease of entry into the culture being researched that research in another agency would not have provided. I was trying to access difficult to reach participants some of whom had been oppressed and abused. As a long-term presence in the agency I believe that I was ideally placed to carry out this research
because I had access to a depth of information. I occupied “a unique place in the continuum of personal relationships between researchers and participants” (Costley, Elliott and Gibbs, 2010, p. 57). I would not be a researcher who parachuted in, took a snapshot and withdrew. I continue to have an on-going sense of involvement and commitment to the issue and the people involved.

As a service manager interviewing staff, I was acutely aware that there were issues of role, power and economic disparity. I had concerns about how staff would react to me in this different role. Although I saw the research role as facilitative, dependent on them and their participation, I was their manager, and as such, they may have felt obligated to participate. There was the potential for employees to be concerned about how their professional competence was perceived, or unwilling to be honest because of concerns about confidentiality when speaking to the researcher who was also a manager. Colleagues may have felt obliged to co-operate with the research. Were interpreters concerned about future employment? Would they only tell me things they thought I would want to hear? I am aware that these are relevant issues for all researchers but my role as manager inevitably increased these concerns and required “rigorous introspection, integration and reflection on experience to expose underlying assumptions” (Brannick and Coghlan, 2007, p. 69). Working within this duality of roles added a complex dimension to my analysis. I attempted to mitigate any potential problems that I could anticipate or became aware of during the research, however I acknowledge that the hierarchical role of service manager inevitably presents a weakness in this study.

2.11.4 Research with asylum seekers and refugees

There are specific ethical issues that need to be considered when working with migrants and refugees. Participants may have unrealistic expectations of the benefits of the research, believing that researchers may have the power to influence their claim for asylum (Mackenzie, McDowell and Pittaway, 2007). The ex-clients selected all had asylum status which meant that this was not an issue. After long and exhausting interviews with the Home Office, research interviews may be viewed with suspicion and even when the participants speak English,
understanding the subtleties of research questions may affect accurate responses (Mackenzie, McDowell and Pittaway, 2007). As researcher, I was vigilant to convey that I saw the ex-clients as experts by experience and empowered to play an active and equal role. I was also aware that a parallel process to therapy could potentially develop. Clients could see me as the expert, that there may be “issues of ascribed power and racist or dominant beliefs, which may need consideration and attention” (Tribe and Sanders, 2003, p. 57).

Honesty and integrity were paramount in all my decisions as a researcher. As recommended by Collet (2008) participants needed to see me as someone they could trust and who is investing in their long-term wellbeing. A vital part of building and maintaining trust was to feed back the research results to all participants. It was also important to acknowledge the impact that the research process may have on the people who are the participants in it. Steel and Silove (2004, p. 93) argue from a socio-political perspective that there is “a legitimate moral imperative in such situations for clinical researchers to breach the walls of enforced silence and give a voice to these who are afflicted”. They stress the importance of weighing up the risks of undertaking such research against the potential harm to participants, as well as the risks in not undertaking such research and the potential benefits the research may create.

In studies of how migrants and refugees respond to participation in research, Dyregrov, Dyregrov and Raundalen (2000) show that using participants from traumatized and bereaved populations can have beneficial effects. Newman and Kaloupek (2004) say that the limited research done suggests that most migrant and refugee participants make favorable cost-benefit appraisals regarding their experience. Their research identified a subset of participants who reported strong negative emotions or unanticipated distress, however even these said that they did not regret or negatively evaluate the overall experience. Refugee women in particular, are multiply marginalized, and their voices are not typically incorporated in research (Goodkind and Deacon, 2004). "Interviews are a sensitive and powerful method; they are, in themselves, neither ethical nor unethical, neither emancipating nor oppressing. In a critical social science, interviews may contribute to the empowerment of the oppressed" (Kvale, 2006, p. 497).
I was mindful that migrants find themselves in powerless situations; they are unable to exercise political or socio-economic power and are in many respects at the mercy of others, (Mackenzie, McDowell and Pittaway, 2007). Aware that any questioning had the potential to lead to traumatization or re-traumatization, (Thomas and Byford, 2003), it was vital to build some ethical safeguards into the design of this research. The Royal College of Paediatrics and Child Health (British Medical Journal (BMJ), 2003) recommend that provision for continuing emotional support should be built into all research with asylum seeking children. I was aware that the client-participants interviewed for this study had past experiences of trauma and experiences of oppression and I used this recommendation as a model of good practice. A procedure was put in place to introduce the process immediately before the interview and to debrief immediately after the interview, allowing the client-participants to ask questions about the research or discuss the interview. They were also told that if they felt at all upset post interview, a therapist not connected with the research would be happy to support them. I was aware that despite procedures to support ex-clients “the power imbalance may result in the participant not feeling able to ask questions or express feelings and ideas” (Tribe and Sanders, 2003, p. 33). However several of the clients did ask questions in the debrief and one, Val, asked to see her ex-therapist when the session was over.

Each small group (n = 4) were experts by experience. In this role the participants knew more than I did. The clients all agreed to be participants and seemed pleased to be asked. I believe this was an empowering experience for them as they returned able to speak in their own voice. “The ability to use one’s voice in speaking out can be seen as personal power. The opportunity to speak and to use one’s voice can be seen as political power” (Patel, 2003, p. 219).

2.11.5 Working with ex-clients of a service

The question of when a client becomes a former client used to be answered by the BACP code of ethics that stated that no relationships should develop until two years after therapy. The new code has no time frame but discusses ‘keeping trust’ and states “practitioners must not abuse their client's trust in order to gain sexual,
emotional, financial or any other kind of personal advantage” (BACP, 2013). Pipes (1997) observes that before involving any client in research a reasonable timeframe should lapse: “some clients have very strong feelings about their former therapists...however, it seems in keeping with the idea of doing good and preventing harm that there be some period of time during which the client’s feelings are given time to diminish” (Pipes, 1997, p. 34). The ex-clients interviewed had not been seen in the agency for between two and six years.

2.11.6 Boundary management
As an insider researcher maintaining boundaries were complicated. I was researcher-manager to the counsellors and interpreters and researcher-therapist to the ex-clients. It was important to make a clear and explicit contract. The written contract sent out to all participants and signed in front of a witness was followed by an oral contract at the beginning of the focus group in respect of the professionals and the interviews in respect of the ex-clients; both explained what would be involved. Setting clear boundaries was vital and my role needed to be unambiguous. I was aware that when interviewing clients it might be difficult to maintain the boundary between research and therapy (McLeod, 2006). Three of the ex-clients saw me as a colleague of their ex-counsellor. It was emphasised to all the ex-clients that their participation or lack of it would never exclude them from accessing therapy in the future and I made it clear that if at any time the ex-clients needed to return to therapy it would not be with me.

One of the ex-clients presented yet more complications because she had been a past client of mine. When counselling practitioners carry out research with their own clients, it raises some specific ethical dilemmas. McLeod (2006) identifies the main issue as the potential conflict for the ex-client between the researcher role and the past therapeutic role. We had not met for five years and in all correspondence I made it clear that this meeting was a one off intervention, it was not therapy or a meeting in a social context. However the before and after briefing did allow Nadia to tell me about her life post-therapy, something I would not have known about if I had not contacted her for this research. Another issue was raised by the fact that as a researcher I specifically ask her about her experiences of
therapy with her counsellor and interpreter. However, many benefits I believe there were to interviewing Nadia, I need to acknowledge that this was not an ideal situation and is an area of weakness in the research.

2.12 The development of the research questions

In order to address the original research question ‘Is it possible to work therapeutically through an interpreter?’ I was influenced by the three questions used by Lago (2006).

1. “To what extent can the client dare to reveal or be more of their ‘real selves’ to trust the counsellor and interpreter more?” (Lago, 2006, p.76)
2. “To what extent can the interpreter understand the work of the counsellor and become an ally to the therapeutic process?” (ibid, p.76).
3. “To what extent can the counsellor skilfully incorporate all these additional facets within the counselling encounter without becoming sabotaged by the demands of the situation?” (ibid, p.76).

These three questions formed the basis for my research sub-questions and subsequently developed into the semi-structured questions used in both the focus group and the individual interviews.

From the question “to what extent can the client dare to reveal or be more of their ‘real selves’ to trust the counsellor and interpreter more?” (Lago, 2006, p.76) I realised the need to focus on the unique experience of each participant. This developed into a wider perspective in which I wanted to explore:

*What is the experience like from a personal perspective for each participant in the room (Client/Counsellor/Interpreter?)*

This sub-question led to developing questions on personal experience used in the interviews (see appendix 6 & 9). An example of which is:
'How did you feel before your very first session in a therapeutic triad?'
(asked in the focus group)

and

'Did you expect to see two people in the room when you first came for therapy?'
(asked in the one-to-one interviews)

"To what extent can the interpreter understand the work of the counsellor and become an ally to the therapeutic process?" (Lago, 2006, p. 76) evolved into the sub-question:

**What happens to the therapeutic alliance when a third person is involved?**

This sub-question led to developing some questions about the therapeutic alliance for the interviews (see appendix 6 & 9). An example of which is:

‘To what extent are you able to create a therapeutic alliance?’
(asked in the focus group)

and

‘To what extent were you able to relax, trust the people in the room and talk in detail about your experiences?’
(asked in the one-to-one interviews)

"To what extent can the counsellor skilfully incorporate all these additional facets within the counselling encounter without becoming sabotaged by the demands of the situation?" (Lago, 2006, p. 76) developed into the sub-question:

**What is good practice in this situation? What helps and hinders the ‘dialogue with three voices’?**
This sub-question led to developing some questions on good practice for the interviews (see appendix 6 & 9). An example of which is:

‘Who do you feel is in charge of the session?’
(asked in the focus group)

and

‘Who did you feel was in charge of the sessions?’
(asked in the one-to-one interviews)

The questions asked in the focus group (appendix 6) and the one-to-one interviews (appendix 9) were therefore structured around the concepts of personal experience, good practice and the therapeutic alliance. Every effort was made to make each question open ended in order to allow participants to discuss these and any other important issues to them, in whatever way they wanted.

2.13 Data analysis
2.13.1 IPA using two qualitative methods

Semi-structured interviews are described by Smith and Osborn (2003) as an exemplary method for IPA. However Brocki and Wearden’s (2010) analysis of IPA studies identify a number of focus group studies as well as telephone interviews, e-mail interviews and written narratives that have all used IPA. Smith (2004) suggests a number of ways in which IPA research might develop in the future, specifically citing different participant groups and data collection. There have been a number of IPA studies using focus group data, (Flowers, Duncan and Frankis, 2000; Flowers, Knussen and Duncan, 2001; Dunne and Quayle, 2001; Flowers, Duncan and Knussen, 2003; Tomkins and Eatough, 2010; Palmer et al., 2010). In all the above quoted studies participants were already known to each other.

2.13.2 The ideographic focus of IPA

If focus groups are to become established as a serious option in IPA research, we think that the theoretical and epistemological
issues and tensions do need to be tackled more explicitly. At the very least researchers should try to demonstrate their awareness that such tensions exist.

(Tompkins and Eatough, 2010, p. 260)

IPA is concerned with the idiographic, distinct experiences of particular people and the particular contexts in which those experiences occur (Eatough and Smith, 2008; Smith, Flowers and Larkin, 2009). The individual perspective is central to the inquiry; the researcher attempts to understand as much as they can about the participants unique perspective before moving on to the next participant. Finally a cross-case analysis is conducted. At this final stage however, the analysis attempts to remain faithful to the individual whilst also illustrating more general themes (Smith and Eatough, 2006). In this way a picture is built up of the general, as well as the particular, experiences of individuals (Smith and Osborn, 2008).

Focus groups make it more difficult to develop the ideographic aspects of IPA because of the multiple voices that can be heard and the presence of group dynamics which may inhibit experiential narratives (Smith, Flowers and Larkin, 2009). The dilemma of using IPA as an analytic tool with a focus group is how to balance the individual and group level data. Tomkins and Eatough (2010) analysed focus group IPA studies and cite Dunne and Quale (2001), O’Toole et al. (2004) and Vandravala et al. (2006) as examples where there is a tendency to develop general group level themes which eclipse the individual voice. This challenges the explicit idiographic commitment of IPA. Yet they also point out that in some studies the verbatim extracts tend to showcase the individual at the expense of the group dynamic, therefore losing sight of the interaction within the group, potentially a rich source of experiential data. Acutely aware of this issue, I decided to use the practical, procedural adjustments suggested by Tomkins and Eatough (2010) to analyse and present focus group data. These adjustments attempt to achieve a balance in analysing and representing data at both a group and an individual level.
My advice to someone committed to conducting focus groups within an IPA perspective is to ‘parse’ transcripts at least twice, once for group patterns and dynamics and subsequently, for idiographic accounts. If the researcher is convinced that participants are able to discuss their own personal experiences in sufficient detail and intimacy, despite the presence of the group, then the data may be suitable for IPA.

(Smith, 2004, pp. 50-51)

In order to answer the research questions, my analysis focused on the ideographic nature of the group rather than the group dynamics however, the group discussion did enhance the personal accounts. For example, the laughter from the group when discussing what can go wrong between counsellor and interpreter allowed the development of the discussion, created a collective permission to admit mistakes and encourage participants to add their own experiences. The Rita and Kim dialogue between counsellor and interpreter would not have happened in isolated semi-structured interviews or homogenous focus groups.

2.13.3 Selection of specific quotations

During analysis the theme table emerged. When each participant had discussed the theme, the line numbers were noted. This allowed me to cluster the quotations together in subordinate themes. Each participant then had a list of possible quotations under theme headings. When these were later merged into the superordinate themes and the analysis was written up, I made decisions that I believed represented the findings. I selected quotations that summed up the feelings of the whole group, for example, when Isara as counsellor said: “its opened up my world”, or the feelings of one specific group, such as when Majid, one of the interpreters said: “this is another world of interpreting”. I also selected specific quotations that expressed the unique experience of the participant, for example when Mariam (one of the clients) said: “I was scared, [why did she] want to know about my life? Maybe she will kill me”. Every attempt was made to check that each participant had been quoted in equal measure throughout the research.
2.14 The audit trail

The transcription process is the first stage of IPA. I paid a professional court transcriber to create a first draft. I was aware that this had the potential to distance me from the initial transcript. This was not ideal, but purely pragmatic; my lack of IT skills meant that this process would take a considerable amount of time. The person concerned was a professional, used to creating transcripts with a variety of voices and accents. The transcriber was asked to include absolutely every audible sound including repetitions, part words, pauses, laughter and background noises and events. Punctuation was kept to a minimum so that the transcriber did not accidentally alter meanings as a result of the transcription process itself. Commas were not used, question marks were added when it was clear that a question was being asked and emphasised words were underlined. In the focus group transcript the transcriber was able to identify the participants’ distinct voices and called them voice 1 to 8 so confidentiality was maintained.

This was then returned to me for a second transcription process. This allowed me to immerse myself in the data. Having listened to the audio recording a number of times I added the pseudonyms chosen by each participant, made changes and found that in some cases, there were omissions. Although the transcriber was extremely competent and professional, it became clear that the accent of one of the participants had been misunderstood in some instances. I produced a second version that I felt was a more accurate reflection of the discussion. I also added the absolute minimum of punctuation, mindful of the potential for punctuation to subtly alter intended meanings. The interpretations that the transcriber had clearly added had created a third hermeneutic cycle to the process that I had not anticipated. By producing a second transcript I attempted to reduce this influence and immerse myself in each transcript. (Appendix A shows notes and alterations into a second transcript)

Although the second transcription was changed, no attempt was made to correct grammatical errors, primarily because the transcript was intended to accurately represent the spoken word, not merely a grammatically correct version. It was also important to use the verbatim language chosen as six of the twelve participants were speaking in a second language. On completion, the second transcript was
sent to the participants for validation. It is interesting to note that my concern for breach of confidentiality inside the focus group was unfounded as participants commented that apart from their own opinions they could not remember enough to identify other participants.

The transcripts were returned with some minor adjustments. Once these were made, I altered the layout of the validated text to meet IPA requirements and numbered each line. I began this process on my first interview transcript which was the focus group and approached the document as a single interview. This process was repeated with all subsequent transcripts.

IPA has been described as a dynamic process (Smith, 1996). No single method is advocated, although the practical training I received from Dr Shaw shaped my analysis. The use of IPA with data produced from focus groups also required some procedural adjustments in order to balance both group and individual data. “My advice to someone committed to conducting focus groups within an IPA perspective is to ‘parse’ transcripts at least twice, once for group patterns and dynamics and subsequently, for idiographic accounts” (Smith, 2004, pp.50-51). Tompkins and Eatough (2010, p. 250), suggest that this extra iterative loop in the analytic process enables individual accounts to be ‘reclaimed’ within the group data. I used their suggestions when approaching the focus group data. The transcript was read in detail several times in order to look specifically at the interactions between participants, including the influence of these in prompting responses and contributions. When this first parsing was complete, the focus group data was then analysed in exactly the same way as the other transcripts, for idiographic content.

The IPA cycle required three stages of analysis. The first, complete, hermeneutic cycle started with the iterative process of reading and re-reading each transcript to become immersed in the data and obtain an overview. That resulted in some Initial Reflections. I wrote a brief summary of the transcript at the bottom of each page together with immediate and brief reflections.
The second analysis was *Phenomenological Coding* in which I paraphrased the words of the participants, written in the first person in the left hand margin. The third analysis looked for *Interpretative Coding*; patterns of recurring and significant topics and issues, contradictions or conflicts and identifying words, metaphors and images. I wrote these in the right hand margin. This study had a postmodern research perspective with a subjectivist ontology and epistemology (Creswell, 2007). As such it accepted reality as subjective and multiple (Heidegger, 1962). For this reason the answers to my research questions, for example about a therapeutic alliance or any other experience, were not measured in a clinical way but were noted as the unique opinion and experience of the individual participant.

I then used post-it notes to write down each interpretative coding. I was careful to mark each with the name of the participant and which group (n=4) they belonged to. These were then amalgamated to group together themes and issues as proto-themes that were directly grounded in the transcript. This process was repeated after each individual interview. Appendix B provides an example from the focus group transcript. It was representative of the vast majority of text and illustrates the processes in the development of the data analysis.

As I had read and reread the focus group transcript to analyse data for group level themes I became aware of the individual narratives emerging from the transcript. Following the guidelines of Tompkins and Eatough (2010), once the initial table of themes was created I returned to each individual focus group member to assess the relevance of each theme. This involved revisiting the focus group transcript from the perspective of each individual, highlighting their contributions, and the three stages of analysis. This enabled the account of each individual to be read as a whole text. It was then possible to assess which themes were emphasised in individual accounts and which did not fully represent the individual (an example of this is in Appendix 12).

Once the data analysis was complete, the next stage was to compare themes across all twelve participants. Smith and Osborn (2003, p. 74), suggest a method of comparison using the superordinate list of themes from the first transcript “to
inform the analysis of other transcripts”. The list of themes was first placed in sequential order relating to the first participant and then, to facilitate between-transcript comparisons, clustered according to theme. New themes arose or disappeared whilst others were amalgamated, wording of themes changed where a collection of ‘proto-themes’ was better described by a different theme. During this stage it became clear that the same themes emerged from all three groups (n=4) which led to the decision to produce a single overarching collection of superordinate themes to encompass and reflect all twelve participant experiences. Once the analysis was complete I used post-it notes to gather all the information together to create sub-ordinate and then super-ordinate themes (Appendix 13).

An example of this audit trail is a set of themes that were eventually put together from the post-it notes across all the interviews. They had the initial working titles:

- Emotional issues- Interpreters/unique to therapy
- Added value in the room
- Deep relationships between triads
- Holding the moment/ process issues
- The professional dyad- what does good work look like?
- Life changing/ enhancing experiences
- Emotional impact on Interpreters
- Personal qualities needed from a practitioner

These were put together and developed into the sub-ordinate themes of:

- The Triadic Relationship
- Changing Dynamics
- Good Practice

These were later grouped together under the super-ordinate theme of The Therapeutic Alliance.

The final stage of analysis involved the production of a summary table of superordinate themes, the sub-ordinate themes underlying them, and quotes from participants to illustrate each theme. Once the sub-ordinate and super-ordinate themes were established, I identified these into participant clusters of counsellor, interpreter and ex-clients. This was to explore similarities and differences inside each group but also between the groups. I wanted to identify the three distinct and different voices in the study. As I had analysed all the transcripts for idiographic
data, I decided to present this in one unified table with twelve participants which would illustrate the shared sub, and super-ordinate, themes but which also highlighted the three distinct clusters (n=4) in order to consider convergence and divergence within their accounts.

2.15 Reliability, validity and trustworthiness
Traditionally qualitative researchers have used four criteria identified by Lincoln and Guba (1985) to establishing the trustworthiness of qualitative data. These are: Credibility, Transferability, Dependability and Neutrality. More recently qualitative researchers who wish to focus on the validation of subjective experiences have challenged this. Feminist researchers such as Oakley (1981, p. 41) developed the concept of ‘reciprocity’ achieved when the relationship between the interviewer and interviewee is non-hierarchical and when the interviewer “is prepared to invest his or her own personal identity in the relationship”. The interviewer becomes more than an instrument of data collection.

Interpretative Phenomenological Analysis puts an emphasis on validity and quality. It aims to develop an organised, detailed, plausible and transparent account of the meaning of the data. Smith, Flowers and Larkin (2009) advocate the use of Yardley’s (2000) criteria to evaluating qualitative data, which are relevant to this study:

2.15.1 Sensitivity to context
Yardley says that sensitivity to the context of the research should run through the whole of the study. She breaks this down into:

- Theoretical methodology – The appropriate choice of a research method; in this case IPA to examine individual cases using in-depth systematic analysis, with a double hermeneutic.

- Relevant literature – To orientate the topic under investigation and to ensure that the findings relate to the relevant literature in the discussion section of the research.
Empirical data – Sensitivity should start with the collection of data. This incorporates good interview skills such as empathy, an ability to put participants at ease and cope with any unexpected issues that arise during the interviews. This did happen when one of the ex-clients became upset. She said that she was being interviewed in the room she had received therapy in and it brought back sad memories. We stopped the interview for a time and took a break. She was then happy to resume the interview. I decided to hold the further three interviews in an office setting rather than a therapy room in order to distance the clients from their previous experiences in therapy.

Participants' perspective – through the analytic process the researcher must be sensitive to the meaning making of the participant. Flowers et al. (2009) point out that a good IPA study should include a considerable number of verbatim extracts and any general claims made about the findings should be offered cautiously. I have carefully re-read and checked this study several times with this aim in mind.

Sociocultural setting – Both the focus group and the individual interviews took place at the service offices. This represents a neutral, yet familiar and safe setting for all three participant groups as they have all used the office in the past. In IPA, the setting also includes an awareness of the contextual issues of place and time. In this study, understanding each participant’s sociological and ethno-cultural perspectives was an important dynamic in the analysis.

Ethical issues - Through purposive sampling I was able to find difficult to access groups who shared a particular lived experience, some of whom had experienced trauma in their past. It was therefore essential to be sensitive to their needs and make this an ethically and psychologically safe experience for participants.

2.15.2 Commitment and rigor

In-depth engagement with the topic – this can be assessed by my attention to detail during data collection, including adding a questionnaire to the design, care
with the detail of the analysis, and the use of verbatim statements from participants in order to give them an authentic voice. This included member checks for all quotations used in the completed study.

- Methodological competence and skill through data collection – this can be measured by the appropriateness of the sample, the completeness of the analysis and skills when interviewing. This included such things as finding a balance between closeness and separateness during interviews and picking up important cues. The reflexivity section of this research about my interview with Nadia illustrates this dilemma and the processes I completed to ensure transparency and validity.

- Depth and breadth of analysis – this should be thorough and systematic. Flowers et al. (2009, p. 181) say that good IPA analysis should include “something important about the particular individual participants as well as something important about the themes they share”. Each theme should be illustrated by quotes from a number of participants’ and accounts would evenly represent each participant. This study has been carefully checked several times with this aim in mind.

2.15.3 Transparency and coherence

- Clarity and the power of description and argument – the study should present a coherent argument with any ambiguities or contradictions dealt with clearly in the analysis.

- Transparent methods and data presentation – My study should describe the stages of the research process in a clear and understandable way.

- Fit between theory and method – This means that my research should fit well with the principles of IPA and phenomenological methodology. This research explored if it was possible to work therapeutically through an interpreter. A focus group and four individual interviews were used to make sense of the participants’ stories and experiences in a meaningful way. This is a good fit with phenomenological methodology in which truths about reality are grounded in
peoples lived experience (Polit and Beck, 2009).

Reflexivity – The qualitative researcher has a responsibility to reflect on how their own experience and feelings may impact on data gathering, analysis and findings. As a practitioner, I have been part of many therapeutic triads but I am in the role of researcher for this study. The recognition of this dual role within IPA accommodated reflexivity and reflectivity during my analysis of the transcripts. Instead of editing myself out of my data, IPA acknowledges my unique place in this research in a transparent way.

2.15.4 Impact and importance

However well a piece of research has been conducted, Yardley’s (2000) principle is that it is only valid if it tells the reader something important, interesting or useful. She has broken this down into three identifiable criteria:

- Theoretical – enriching understanding. There has been little research done in the field of the therapeutic triad (Century, Leavey and Payne, 2007) and even less with interpreters working in therapeutic settings (Miller et al., 2005).

- Practical – I hope this study will contribute to knowledge about best professional practice.

- Socio-cultural - The aim of my work is to bring greater understanding of this issue, more interest and encourage practitioners to enter the field of inter-cultural therapy.

2.16 Ethics

This research was submitted to the School of Education Review Panel of Manchester University in November 2010 and then to the Ethics Committee of Manchester University in April 2011. Ethical approval was given before any data was collected. During the course of this study, I also adhered to the British Association for Counselling and Psychotherapy (BACP) Ethical Guidelines for Research (Bond, 2004). Ethical approval was also granted by the Head of Service
at the psychological therapy service were the research took place. The head of
service agreed that if the Ethics Committee at Manchester University passed the
study he would allow the research to be undertaken within the service.

It became clear that some extra demographics and general information about the
participants were needed. As I had not included this in my ethics submission to the
University I re-contacted the relevant authorities who gave me permission to
create a basic questionnaire. I referred to the new legislation (Equality Act 2010)
and its identification of protected characteristics and devised a questionnaire. An
information pack was sent out to all participants. This included an explanation of
the research, a consent form, details about the focus group or interview, the
questionnaire and a copy of the questions that would be used. Although everyone
acknowledged receipt verbally, two participants of the focus group did not return
their consent forms. However I was able to provide extra copies on the morning of
the focus group and they signed before we started the session.

During the course of this study I was able to interview three separate groups (n=4)
who had experience of all aspects of the therapeutic triad. Although this added
depth and insight to my data it also raised some specific ethical issues. Smith,
Flowers and Larkin (2009) see ethical research practice as a dynamic process that
should be monitored throughout data collection and analysis. With this in mind I
tried to remain aware of four key ethical questions that have been identified as

*What harm might possibly occur to the participants?*

The primary issue was the emotional safety of the participants. Selection was by
personal choice and professional assessment. All the participants were both
emotionally and physically safe and were in a position to reflect on their past
experiences. Due to the subject matter and the underlying trauma issues in this
research, all participants faced the potential of touching some distressing personal
material. So it was important to put procedures in place to protect personally
sensitive information in accordance with the BACP ethical guidelines on risk point
3.2 (Bond, 2004, p.7). All participants were made aware of the subject of the research and volunteered to take part. They were all aware of the interview questions beforehand, the interviews were semi-structured and focused on process issues. Every effort was made to allow the participants control over the level of emotional depth they wished to reveal. The participants were also aware that they could withdraw at any stage of the research. I was, however, aware that there was still the potential for participants to be triggered into feeling distressed. This happened with the youngest client who was interviewed; she said that sitting in the therapy room and thinking back made her feel sad. I halted the interview to give her time to rest, have a drink and something to eat. She said she was then happy to continue with the interview but asked if her counsellor (Victoria) could stay in the room with us, which she did. Victoria contacted her after several days to check she was alright and the client re-assured her she felt well.

**What procedures can be established to minimise harm and respond appropriately to distress?**

I focused my concerns on the ex-clients who would be interviewed. I realised that if I put procedures in place that were appropriate for them it would also cover the needs of the practitioners involved. The clients were selected very carefully. The inclusion criteria was that the client had to be over 18 years old, have completed therapy, defined themselves as a survivor of their experience, needed an interpreter at the time of therapy but now spoke good English, have refugee status and an established support system in place. The data collected was focused on their experiences of the process of counselling and not the issues that brought them to therapy. The individual interviews were conducted sensitively with time and space to acknowledge any distress that arose.

Although it is not possible to measure the strength of the support system put in place for participants, BACP ethical guidelines were followed. Psychologically robust participants were chosen, with the proviso that they all had family support systems in place. They were informed that they could access support from an independent counsellor, uninvolved in the research, within twenty - four hours of a request. Should participants need further support debriefing sessions have been
offered with another therapist working at the specialist psychological therapies service. These procedures are in harmony with the guidelines on researching areas of vulnerability in people’s lives, BACP ethical guidelines point 3.3 (Bond, 2004, p. 8).

*How can confidentiality be safeguarded and respected?*

I disconnected the questionnaires and any other information about participant identity from the transcripts. I employed an experienced court stenographer to transcribe the focus group and an experienced transcriber employed by Liverpool University for the individual interviews. Each participant was identified by a number during transcribing. I then checked and amended the transcript to include the pseudonyms the participants had chosen for themselves. Only the researcher was aware of their real identity; this is in line with BACP ethical guidelines (Bond, 2004, p. 9) point 4.1.1 and 4.1.2.

To respect research integrity, participants were asked to check and agree to their transcript. This raised the issue of sharing the focus group transcript but as all participants had signed-up to this and been present at the discussion I realised this did not break any confidentiality. The same transcript was sent to all eight participants with the pseudonyms attached. It was interesting to note that many members of the focus group said they could not identify the other participants while checking it. It was important to use verbatim statements from participants in order to give the study an authentic voice. This included member checks for all quotations used in the completed study.

*What are the broader moral implications of the study, in terms of the ways data can be used?*

Data is always open to interpretation. This research had the potential to reveal sensitive issues such as race and feelings of discrimination. I strived to ensure that no data was collected that the participant was unhappy with. The inclusion of verbatim extracts was double checked with each participant (Smith, Flowers, and
Larkin, 2009). I kept all data confidential and did not share it with any other researcher. My intention was to protect the raw data from any unintended or damaging re-interpretation. I have tried my best to honour the intentions of the participants and comprehensive member checks have ensured that participants are happy with their contributions. This complies with the BACP ethical guidelines, Research Governance section 5 (Bond, 2004, p. 12).

2.16.1 Insider researcher ethical issues

It is reasonable to conclude that any research design will generate ethical dilemmas. The implication is not that research should be abandoned, but that every effort should be made to examine the effect that a study will have on all of the people who participate in it.

(McLeod, 2006, p. 170)

As well as the ethical considerations discussed above, insider-research raises some specific issues and unique challenges. Adopting a vigilant and reflexive approach, a literature search was undertaken, exploring current good practice in insider-led research from both professional and academic spheres. I was particularly concerned about the potential to unintentionally oppress or further victimise the participants who came from other backgrounds or communities.

I carefully considered a number of documents and articles including the University Research Ethics Committee on working with vulnerable adults, the ethical guidelines for conducting research with minority ethnic communities written by NHS Greater Glasgow, and some key journals and published books quoted in the following section. I was mindful that “the use of power in interviews to produce knowledge is a valuable and legitimate way of conducting research with interview knowledge jointly constructed by interviewer and interviewee. Overlooking the complex power dynamics of the social construction process may, however, seriously impair the validity of the knowledge constructed” (Kvale, 2006, p. 486).
2.17 Recording, storing and transcribing of interview data

Interviews were recorded digitally and transcribed professionally for data analysis. All participants were asked to choose their own pseudonyms. Participant checks were carried out by sending transcripts by post. They were returned by post and by hand. Participant checks allowed individuals to feel that they had control of the raw data and access to all material used in the final research. Chosen quotations were double checked for accuracy and consent. Pseudonyms are used throughout this research to protect participants' confidentiality. Both the original audio and visual recordings were stored in a safe, lockable filing cabinet and the electronic version of the transcript was held on a personal computer with a coded password while work was carried out on this research. No-one else could access the files. It is intended that the hard copies of the transcripts will be shredded and electronic versions deleted from the PC and other equipment when this is possible. All participants will receive a copy of the research.

2.18 The reflexive researcher

This research was motivated by my experience as a practitioner. I wanted to explore if others who had experienced the phenomena replicated my experience. However during the process of completing this study I was able to reflect on my role as a researcher and the impact it had on myself, and on the participants. My developing understanding of both content and method (Etherington, 2004) meant that in the process of completing this study I learnt how to become a researcher. Decisions made during analysis are inevitably influenced by the researchers interests and orientation (Willig, 2008). At some level I was still interested in whether my own experience would be confirmed. However this soon changed into a desire to document the participants' unique stories and experiences whatever the outcome.

My initial focus was to hear the three distinct voices of counsellor, interpreter and client talking as experts by experience. The interpersonal skills I had acquired as a psychotherapist made connecting with participants and the interviewing aspect of the research relatively easy. As a practitioner/researcher I had also hoped to find some generalisability that may have resulted in a model of good practice. The large number of participants reflected this initial plan. As the research progressed and I began to understand the difference between a practitioner and a researcher
as well as the intricacies of IPA, it became clear that this was not appropriate or necessary. In hindsight, the number of participants was larger than may have been necessary to complete this study.

Language and communication are at the heart of this thesis. IPA pays great attention to the words chosen by participants and searches for nuance and subtlety. I had not anticipated the extra hermeneutic cycle that employing a professional transcriber would create. It also became clear that the ex-clients had varying levels of spoken English. This presented me with a dilemma. In both these situations my interpretations became even more vital but required circumspect judgements, which slowed down my analysis as I searched for meaning in each statement.

As documented elsewhere in this chapter, I learnt that using IPA with the two differing qualitative methods of focus group and semi-structured interviews was complicated. Running the focus group was a relatively easy task but analysing it proved far more complex than I had anticipated. I attempted to parse the group data in a number of ways in order to explore every aspect. The focus group generated a great volume of data that took over a year to analyse. I initially felt lost in the detail. Although the group proved difficult and time consuming to analyse, in hindsight I would still have run a focus group. However, I would have invited the ex-clients to a homogenous group as well. They may have accepted or refused but would have been given the choice instead of my decision about what was best for them. If I had infinite time and resources to complete this research I would have also conducted semi-structured interviews with all the practitioners. I will never know if semi-structured interviews would have captured any different data but using both would have enabled me to have the best of both data gathering methods.

At the beginning of this process I expected the findings to be the most prominent part of my research. Although they still remain at the heart of this study, I now know that being as transparent as possible by documenting the process and decisions taken throughout the process of conducting this study contribute to the
credibility and rigor of those findings and document my own journey as a researcher.

2.18.1 The impact of the researcher on the research

Heidegger (1962) claimed that our experiences of knowing shape our world. IPA recognises that access to the participants’ experience is dependent upon and complicated by the researchers own conceptions (Smith, 1996). The aim of an IPA researcher is to gain a credible interpretation of the participant’s experiences. The researcher uses a reflective and reflexive approach to data collection and analysis in an attempt to bracket out and withholding preconceptions, assumptions and judgments:

The aim of the IPA researcher may be to reveal a phenomenon as itself but we will always fall short of this as the researcher is also part of the world and we can never fully escape the preconceptions our world brings with us. Therefore to be wholly inductive is an impossible task. (Larkin et al., 2006,p.107).

The participant’s story is heard, analysed and interpreted by the interviewer. In IPA this is called the double hermeneutic. It “illustrates the dual role of the researcher as both like and unlike the participant” (Smith, Flowers and Larkin, 2009, p.35). As I was a practitioner-researcher who had experienced the phenomenon I was researching, my own preconceptions, assumptions and judgments were a major concern to this study. I was also in a potentially complicated power dynamic as Service Manager. It was essential to use a methodological and analytical tool that acknowledged my own unique role in the research but also gave a systematic structure to my findings, as there was the potential to threaten the validity and trustworthiness of the research. Throughout the research I have kept a reflexive journal in order to explore how I feel my role has impacted on the study. “Reflective methodologies seem to be close to the hearts and minds of practitioners who value using themselves in all areas of their practices (including
research) and who also value transparency in relationships” (Etherington, 2004, p. 16).

I was acutely aware that my experiences of working in this field could easily distort the research findings and this became a major concern in the design of the research methodology. In order to manage any distortions, I acknowledged my own beliefs about this issue and then designed a study that reframed my experience into a research question that asked if my experience was the same or different for other practitioners. I also took some practical steps in order to be vigilant about personal influence. My focus group questions were developed from those raised by Lago in his book Race, Culture and Counselling (2006). My questions were then discussed and re-written several times with two academics: my clinical supervisor, who is also a doctoral supervisor at another university and my academic supervisor at Manchester University, in order to ensure that the questions were as open and non-directive as possible. In the participation information sheet sent to all participants (Appendix 1) it clearly says:

*The aim of this research is to explore the good and bad experiences of all three people in the therapy room (the Client, the Interpreter and the Counsellor).*

In the letter sent to all participants (Practitioners letter Appendix 4, Clients’ letter, Appendix 7) it says:

*There are no right and wrong answers and each of you has been asked because your experience will be different to other peoples...As well as my questions I am really interested in whatever you want to tell me about the experience and there should be plenty of space for an open conversation about your experiences.*

I reiterated that I was interested in both good and bad experiences at the beginning of each interview and this is in the recorded transcripts.
During the focus group I was careful to leave the participants to self-manage in order to minimise my influence on the discussion. I used both epistemic and methodological reflexivity as a way to be vigilant about any personal bias. I have to accept that however hard I try the world will always be viewed through my perspective and my findings are inevitably subjective. However, I believe that I put in place as many checks and balances as I could reasonably achieve.

2.18.2 Participant reactions

The reactions of research participants to the process of being researched can impact in different ways on the findings. McLeod (2006) says participants may think that they are special and have been chosen in some way. They may be performance compliant and strive to produce the right or wrong material for the researcher because they wish to please. This is known as the Acquiescence Response (Polit and Beck, 2009). Even when this is not true the research relationship may result in the feeling that the participant is in some way being studied by the researcher and this awareness may affect their behaviour. I was also concerned about a Social Responsibility Bias (Polit and Beck, 2009), where participants give answers that they think are consistent with the prevailing social views.

I considered how these behaviours could potentially impact on the validity of my research. There has been growing dissatisfaction within qualitative research and IPA in particular, about using the same evaluation criteria as quantitative research. This has focused particularly on the criteria for validity and reliability, (Smith, Flowers and Larkin, 2009). Yardley (2000) advocates that instead of validity, IPA should be evaluated by quality which Smith, Flowers and Larkin (2009) also call rigour. This includes thoroughness, the quality of the interview and the completeness of the analysis undertaken. Above all, the research should “ensure that the account produced is a credible one, not that it is the only credible one” (Smith, Flowers and Larkin, 2009, p. 183).

I ensured that I used sensitively worded open questions so that participants could answer positively and negatively. I made it clear that this would be a research
interview, not extra therapy for clients or supervision for practitioners. I tried to create a non-judgmental atmosphere and guaranteed the confidentiality of all responses, which I hoped would give participants freedom to say what they thought. Above all, I stressed that this research was process driven. Good and bad experiences led to learning about the phenomenon and were equally valued contributions.
Chapter 3 Literature Review

The aim of this study is to explore the impact that introducing interpreters may have on the therapeutic process when working with asylum seekers and refugees who have lived through traumatic experiences. This review will examine current literature on working with interpreters within mental health. It will focus on communication issues and the therapeutic relationship. It also explores the concept of trauma, the cultural constructs of mental health, post-traumatic stress disorder and the role of post-traumatic growth and resilience in recovery.

An IPA literature review

In IPA research there is a stress on “open-mindedness ” (Smith, Flowers and Larkin, 2009, p. 42). There is no such concept as “too much or too little previous knowledge when collecting data” (ibid, p. 42) It is beyond the scope of this review to provide a complete analysis of a complex field that incorporates a variety of disciplines. Instead, an IPA study should contain a short literature review to introduce the reader to the field, with a critique of key contributions (Smith, Flowers and Larkin, 2009). The literature review should also offer an argument that illustrates why the study is making a useful contribution to knowledge in this area (Smith, Flowers and Larkin, 2009).

As I had limited experience of doing a literature search, I attended a database and literature search training session at Manchester University library. I was briefed on the techniques needed for a successful literature search and then given time to practice whilst being supervised. I also booked a one-to-one session where a librarian helped me refine my specific searches.

A search was conducted on a variety of online databases including PubMed, Cinahl, MedLine, British Medical Journal, and PsychINFO, as well as Google Scholar. I used a Boolean search to create more precise searches for literature from 2000 to 2014. I also did manual searches looking at journals and published books.
As this area of research is not a distinct field but draws together research from a variety of different disciplines, I began using key terms and combination operators to identify English language publications in relevant selection criteria. For example, I started by searching ‘trauma and post-traumatic stress disorder (PTSD)’, then refined the search to identify literature that examined trauma and PTSD cross-culturally and then further by linking it specifically to the mental health issues of asylum seekers and refugees. Other broad topics explored in the early stages of the research were ‘the therapeutic alliance’ and ‘working with interpreters’. Areas of exploration developed as the data was analysed such as cross-cultural communication, separated into verbal and non-verbal communication. This review also developed post viva when ‘post-traumatic growth’ and the ‘impact of therapy in a mother tongue’ were added. At all stages potentially relevant peer reviewed papers were identified. A decision to reject or include a specific academic or research paper was made by critically appraising them against the original research questions and the emergent findings.

The result is a literature review that draws upon a variety of different disciplines to explore working with asylum seekers and refugees who have lived through traumatic experiences using an interpreter. The first section, Trauma, explores the literature relating to cultural constructs of mental health and post-traumatic stress disorder including neurobiology, post-traumatic growth and resilience and vicarious trauma. The second section, Communication, examines language, the use of the mother tongue and power issues related to the spoken word and non-verbal communication and its therapeutic implications. The third section looks at the current research into Working with interpreters, with special reference to asylum seekers and refugees. The fourth section focuses on the Therapeutic relationship, the therapeutic alliance, interpersonal attunement, interpersonal neurobiology and current theories of connectivity.

3.1 Trauma

3.1.1 Cultural constructs of mental health.

The World Health Organization (WHO) states, “Mental health is crucial to the overall well-being of individuals, societies and countries” (WHO, 2008, p.6). Mental
health is not restricted to aspects of an individual’s behaviour and experience, but is also dependent on the functioning of the whole individual, family groups and communities (Fernando, 2010).

Culture plays a significant part in how mental health is understood across the world. Culture applied to an individual refers to a mixture of behaviour and cognition from “shared patterns of belief, feeling and adaptation which people carry in their minds” (Leighton and Hughes, 1961, p. 447).

The latest edition of the ‘Diagnostic and Statistical Manual of Mental Disorders’, (DCM-V) (2013), produced by the American Psychiatric Association (APA), describes the symptoms of a vast range of mental illnesses. It is a universal tool used in psychiatry and psychology as a guide to diagnosis. There is a clear inconsistency in professional practice. The United States National Institute for Mental Health (NIMH) argues that laboratory tests for biomarkers are the only rational way to diagnose mental illness (NIMH, 2013). By contrast, a growing number of psychiatrists suspect mental conditions are culture-bound syndromes rather than exclusively biological or symptom-based universal certainties (Burns, 2013).

Culture-bound syndromes are a combination of psychiatric and somatic symptoms considered to be a recognisable illness only by other members of that person’s cultural group. The ‘dhat syndrome’ observed in parts of India, characterised by fatigue, anxiety and guilt, usually experienced by men, is a well-documented example of a psychological culture-bound syndrome, as is the ‘susto’, or fright sickness, of Latin America (Ember and Ember, 2004). It has been argued that in western communities depression could be seen as a culture-bound syndrome, rather than a universal disorder. "In western anglophone societies we have developed an ethic of happiness, in which aberrations…are assumed to indicate illness" (Dowrick, 2013, p. 229).

Western psychology and psychiatry are rooted in values and beliefs that remain “ethnocentric disciplines with a limited perspective”(Fernando, 2010, p. 2). An
awareness of this bias has resulted in cross-cultural or comparative psychiatry, cultural psychiatry and transcultural psychiatry yet these have mainly explored issues of racism and service provision for minorities in mental health provision within western communities (Fernando, 2014).

Western psychology and psychiatry focuses on the concept of the individual. Many cultures have a collectivist and interdependent society and define ‘the self’ in relation to their community and social context (Markus and Kitayami, 1991). As well as conventional patterns of responding, culture shapes various psychological aspects of a response to traumatic events (Marsella, 2010). This can include meaning making narratives and the implications of phenomena such as the difference between nightmares and visions. The role of an individual or collective belief system may address whether an event is perceived as destiny, fate, or a curse, and may affect the perception of personal responsibility for the event. In many cultures there is a strong stigma attached to problems with mental health precluding families and individuals from seeking help. They may not admit that there is a problem because they believe this will bring shame on the family or be perceived as weak (Amri and Bemak, 2013). There are other variables that can impact on the perception of trauma including genetic make-up, social networks, status, cultural and social patterns of coping, including diversity in the expression of emotion and religious or other belief systems (Marsella, 2010).

3.1.2 Post-traumatic stress disorder

Post-traumatic stress disorder had become one of the most controversial diagnosis in psychiatry (Stein, Friedman and Blanco, 2011). It emerged as a new psychiatric disorder identified after the Vietnam War when veterans returned experiencing a number of symptoms which were identified by the American Psychiatric Association in their ‘Diagnostic and Statistical Manual of Mental Disorders’ DSM -III in 1980 (3rd ed. American Psychiatric Association, 1980). This had developed from the recognition that differently labeled syndromes experienced by survivors of war, rape, trauma, child abuse and concentration camp survivors were all characterised by similar patterns of symptom clusters. These were specifically; the trauma re-experiencing or creating intrusive
memories, emotional numbing or the avoidance of stimuli associated with the trauma and increased autonomic arousal (Friedman, 2011).

The psychological sequelae of PTSD involve intense fear, helplessness and horror (Bisson, 2007). Symptoms can include persistent re-experiencing of the trauma (such as thoughts, images, flashbacks and nightmares evoking extreme feelings of distress and fear), persistent avoidance of stimuli associated with the trauma (such as talking or thinking about what happened) and numbing of general responsiveness. There may also be persistent symptoms of increased arousal such as concentration and memory problems, irritability, being easily startled and hyper-vigilance to threat (Bisson, 2007). People with PTSD commonly experience vivid and intrusive parts of the trauma memory in their mind, which come back involuntarily, often when they are reminded of what happened (in either an obvious or innocuous way). Intrusive traumatic memories are typically visual images but can also include sounds, smells, tastes and physical sensations that were present during the traumatic event (Bisson, 2007).

Since 1980 the criteria for DSM has been refined. The latest version DSM-V (5th ed. American Psychiatric Association, 2013) identifies PTSD when a person has experienced, witnessed or has been confronted with an event that involves actual or threatened death or serious injury, or a threat to physical integrity of self or others. DSM has become the universal tool used to assess trauma. However, the gap between the publication of DSM-IV and DSM-V was 23 years, a timeframe in which knowledge about trauma has advanced considerably. Any revisions have to be supported by strong empirical evidence. This process means that the American Psychiatric Association’s ‘Diagnostic and Statistical Manual’ is by nature conservative and often lags behind whatever current developments are emerging in the field of PTSD (Friedman, 2014). DSM-V (2013) has a new category of ‘Trauma and Stressor Related Disorders’ to encompass PTSD, trauma and stress related conditions originally classified under anxiety disorders. The other major changes in DSM-V are re-conceptualising PTSD to include post-traumatic anhedonic/dysphoric, externalizing and dissociative clinical presentations along with the original fear-based anxiety disorder and the establishment of preschool and dissociative subtypes (Friedman 2014).
In contrast, the World Health Organization has been developing the eleventh edition of its 'International Classification of Diseases' (ICD-11) as yet unpublished but due later in 2015. Review articles and position papers already published indicate that ICD-11 will focus exclusively on PTSD as a stress-induced fear-based anxiety disorder and will include Complex PTSD as a separate diagnosis (Friedman, 2014) with the proviso that individuals must first meet PTSD diagnostic criteria (Maerker et al., 2013). However, the new fifth edition DSM does not include Complex PTSD in its classification system.

3.1.2.1 Complex post-traumatic stress disorder
Herman (1992, p.377) outlined the concept of complex post-traumatic stress disorder (CPTSD) as “prolonged, repeated trauma can occur only where the victim is in a state of captivity, unable to flee, and under the control of the perpetrator”. Examples of such conditions include prisons, concentration camps and slave labor camps. Such conditions also exist in some religious cults, in brothels and other institutions of organised sexual exploitation, and in some families (Herman, 1992). Herman (1992, p. 125) argued that instead of using separate diagnostic categories such as somatization or dissociation they should be combined and seen as one complex syndrome or "spectrum of conditions.

The International society for traumatic stress studies (ISTSS) has developed guidelines for the treatment of CPTSD (Cloitre et al., 2011) in contrast to the APA who have not addressed this issue. The debate is still live, even though it has continued for decades (Friedman, 2014). Cloitre et al., (2013) conclude that there is a valid distinction between PTSD and CPTSD but Wolf et al., (2015) disagree. Knefel and Lueger-Schuster (2013) reported PTSD prevalence among 229 Austrian adult survivors of childhood abuse with regard to ICD-10 (the current definition) (53%) and ICD-11 (17%). When individuals with complex PTSD are included, ICD-11 prevalence is increased to 38%. They claim this indicates that using a measure of CPTSD is highly relevant for individuals with a complex trauma history.
Since 2013 research papers are emerging that compare PTSD prevalence according to DSM-IV, DSM-V, ICD-10 and ICD-11 criteria (O'Donnell et al., 2014; Stein et al., 2014). “All four definitions [of PTSD] are providing information on unique clinically significant cases that are omitted from the other systems. Any one diagnostic system will overlook many individuals who suffer from clinically significant symptoms including distress and impairment” (Stein et al., 2014, p. 502).

There has been criticism that DSM-V has broadened its co-morbidity range so widely that there are infinite ways to have PTSD (Galatzer-Levy and Bryant, 2013; Young, 2014). There is concern that a diagnosis of PTSD can be used primarily for litigation and financial purposes rather than for psychological support (Scott, 2006). For refugees and asylum seekers, the legal profession may use a diagnosis of PTSD as a currency by which their clients asylum claim will be seen as reliable and credible (Gojer and Ellis, 2014). Increased financial incentives may inflate the number of military veterans claiming to experience PTSD; “After the wars in former Yugoslavia, PTSD from the Cinderella diagnosis became the most popular and beneficial diagnosis in Croatia” (Jakovljevic, 2012, p. 238).

The establishment of a specific psychiatric disorder for trauma and its inclusion in DCM-III in 1980 has enriched knowledge of psycho-traumatology and the ability to offer appropriate care to traumatised individuals (Brewin, 2011). It is now recognised as a psychologically and neurobiologically distinct disorder (Brewin, 2003). The official recognition of PTSD has also resulted in reliable ways to evaluate and measure symptoms and provide effective treatments (Jakovljevic, 2012).

The debate between DSM-V and ICD-11 will continue. “We have just begun to investigate the scientific and clinical implications of these very different sets of diagnostic criteria which are based on very different conceptualizations of PTSD. These controversies will definitely result in important new research that will advance our scientific understanding of PTSD in order to develop the best treatments for PTSD” (Friedman, 2014, p. 3).
3.1.2.2 Cross-cultural factors in post-traumatic stress disorder

PTSD is discussed within this review because it has become the universal tool to assess traumatised individuals. It was also the measure by which the client/participants in this study were evaluated by health practitioners and social care for trauma. However, it is a controversial concept within work with asylum seekers and refugees (Tribe and Keefe, 2007). Many clinicians believe it is a useful framework to understand and treat survivors of trauma (Brewin, 2011), others believe it is a western, medical construct that ignores socio-political and cultural difference (Summerfield, 2004).

The first widely published studies in refugee mental health were conducted after the Second World War, (Krupinski, Stoller and Wallace, 1973). The addition of cultural and language difference may complicate a diagnosis of PTSD. In the West, talking about feelings after a traumatic event is encouraged, but individuals from other cultures may feel uncomfortable doing so. A focus on unique personal experience, change and identity is incongruent with the cultural expectations of an interdependent self and social role within a collectivist culture (Berntsen and Rubin, 2007; Jobson and O’Kearney, 2008). If PTSD is a diagnostic category defined by westernised concepts and symptoms it may be less applicable to refugees and asylum seekers from non-western origins (Marsella 2010; Jobson 2009; and Wilson 2007).

Different cultures may demonstrate the psychiatric sequelae of post-traumatic stress disorder in diverse ways (Goji and Ellis, 2014). A concept of the mind and body as two distinct and different entities, the Cartesian duality, is a western perspective (Tribe, 2011). In communities who do not adopt this concept, the link between somatic symptoms and psychological distress may be greater (Bhugra and Gupta, 2011). So an individual with a history of complex traumatisation might not report the diagnosis-relevant PTSD symptoms, and therefore would not meet the criteria for CPTSD. This in turn, could put them at risk of not receiving a trauma-specific treatment (Knefel and Lueger-Schuster, 2013). This may explain the findings of the ‘World Mental Health Survey’ reported by Stein et al. (2014). From 23,936 respondents in thirteen countries, only one-third of broadly defined
cases met criteria in all four classifications of DSM-IV/V and ICD-10/11 and another third met PTSD criteria in only one of the four systems.

The DSM-V categorises trauma using a framework designed originally for combat veterans. Both DSM-V and ICD-11 display a more Euro-American cultural bias of single incident trauma rather than chronic ongoing traumatic stress in countries such as Iraq, Israel/Palestine and Afghanistan “where exposure to terror is persistent, constant and of national proportions” (Bensimon et al., 2013, p. 81). This risks over simplifying the impact of trauma. It generalises between different trauma populations, the duration of the critical incident and the impact of social and cultural implications on specific communities (Patel and Mahtani, 2004).

In *DSM-IV* cross-cultural symptoms were relegated to an appendix. Hinton and Lewis- Fernandez (2011) reviewed the cross-cultural applicability and validity of PTSD within the new DSM-V and acknowledged that the Euro-American bias of past criteria has now been replaced by a genuine effort to incorporate cross-cultural symptom expression within all DSM-V diagnostic categories. High prevalence rates of PTSD have been reported in non-western nations as diverse as Algeria, Cambodia, Lebanon, Israel/Palestine, Nepal and the former Yugoslavia (De Jong et al., 2001; Thapa and Hauff, 2005; Hinton et al., 2006). However, research that uses direct comparisons of people from different cultures is rare. One study compared PTSD prevalence among Russian and American adolescents, assessing symptom frequency and levels of comorbid psychopathology. Their results suggest that post-traumatic symptoms are not culture bound and that the psychological consequences of trauma follow similar dynamics cross-culturally (Ruchkin et al., 2005). Another study of the psychiatric morbidity among Kenyan survivors of a bombing at the American embassy in Nairobi was compared with American survivors of the bombing of a Federal Building in Oklahoma City. Kenyans and Americans exposed to these events exhibited remarkably similar impacts and the study concludes that the prevalence of PTSD amongst both communities exposed to the events were similar (North et al., 2005).
Miles and Garcia-Peltoniem (2012) argue that how one refugee is affected by trauma compared to another depends on many factors, some of which may be dependent on their cultural constructs but may also include personal coping skills, types of torture endured, whether they have support available, and their living conditions after surviving torture. They conclude that PTSD may not be the most appropriate construct for traumatised refugees. However, this debate goes wider and raises the issue of whether a diagnosis is appropriate for anyone. How one individual (whether a refugee or a survivor of the Herald of Free Enterprise) is affected by trauma compared to another individual depends on many factors including those cited above by Miles and Garcia-Peltoniem (2012). Personal resilience, support and living conditions will impact on how anyone can cope with trauma. There may also be significant socio-political and cultural differences within any community, including one within a western framework.

PTSD has been criticised as “a narrowly defined socially constructed psychiatric category that fails to capture a holistic view of people’s trauma and should not be utilized as a tool to measure the credibility of refugee trauma” (Gojer and Ellis, 2014, p. 6). It is clear that a focus on the individual, emotive experiences and single incidents of trauma may not be applicable for people from non-western backgrounds. However, studies appear to show that the impact of trauma may be similar; it may be the ways in which it is expressed that are different for asylum seekers and refugees who have lived through traumatic experiences. This may sometimes be culture bound and raises concerns about the implications of the diagnosis of PTSD amongst different populations. Yet these differing findings are not mutually exclusive.

The recognition of PTSD as a specific disorder has given trauma credibility, resulting in reliable ways to evaluate and measure symptoms and provide effective treatments for traumatised individuals (Jakovljevic, 2012). It has encouraged an increase in knowledge of psycho-traumatology (Brewin, 2011) and been recognised as a psychologically and neuro-biologically distinct disorder (Brewin, 2003). However, Summerfield (2004, p. 233) warns of the “medicalisation of human suffering”. There is danger of seeing symptoms rather than a unique human being and raises the danger of a homogenous, universal diagnosis. Any
individual brings with them their own belief and value systems, some of which are personal and some community influenced, and a variety of symptoms, some of which may be interpreted through their own unique perspective. These are cross-cultural factors to be considered whatever community the individual comes from.

3.1.2.3 Psychological theories of PTSD

Traumatology has evolved significantly over the last 50 years. It is impossible to examine the complexity of these theories in this small literature review, however, I will present a brief overview. In order to critique theories of PTSD, Gillihan, Cahill and Foa (2014, p. 166) suggest that the model should address three areas; the “psychopathology of the disorder” that is natural recovery versus the development of chronic PTSD; the “phenomenology of PTSD” specific symptoms and features such as trauma related cognitions; and demonstrate the “effectiveness of therapeutic interventions” linked to the model that will reduce the severity of PTSD symptoms.

Mowrer’s two-factor theory or ‘The Conditioning Model’ (Mower, 1960) represents one of the first attempts to provide a behavioral explanation for the fear associated with PTSD (Hembree and Foa, 2004; Cahill et al., 2009). It suggested that emotions are learned through a two-part process that includes both classical and operant conditioning. This model is a framework for understanding emergent symptoms, their persistence and a way of creating change. It highlights the negative re-inforcement of avoidance strategies and asserts that symptoms should disappear with repeated exposure. It does not address why specific symptoms appear or identify which cognitions may help therapeutic change (Richard and Auterbach, 2011). These theories have been criticised for not addressing the full spectrum of PTSD symptoms (Foa et al., 1989; Hembree and Foa, 2004).

The ‘Schema Theories of Horowitz’ (1976) and Janoff-Bulman (1992) are theories from personality and social psychology. Based on Piagets (1971) model of cognitive development, schemas are core assumptions and beliefs that influence the perception and interpretation of information (Gillihan, Cahill and Foa, 2014). Horowitz (1976) adapted psychoanalytic and information-processing concepts
saying that avoidance strategies restrict the natural processing that occurs between existing inner models and new trauma related information. Janoff-Bulman (1992) identified specific schema that were relevant to post-trauma reactions saying that most people see the world as benevolent and meaningful. These schemas are challenged by a traumatic event and require revision in light of the new trauma related experience. Traumatic experiences change individuals’ views of themselves, others and the world around them. This model does not acknowledge post-traumatic reactions when an individual has experienced a traumatic event but does not develop PTSD. It also fails to address how a new trauma would change the schema of someone who had experienced multiple prior traumas such as systematic torture.

The ‘Emotional Process Model’ (Foa et al., 1986; 1989), has emerged as the most influential model in the PTSD literature (Richard and Lauterbach, 2011). It addresses mechanisms of change and advocates the use of prolonged exposure as an effective treatment. This theory combines learning, cognitive, and behavioral theories of PTSD, based on the concept that emotional experiences continue to affect behaviours long after a critical incident. Emotional re-experiencing can create a pattern of avoiding the trauma memory, which, in turn, sustains PTSD (Foa et al., 1989; Foa and Jaycox, 1999). This model provides a framework for understanding the emergence and maintenance of core symptoms. It is based on the belief that recovery results from emotional processing. In order to achieve this, exposure therapy is used to activate the trauma memory creating opportunities to re-frame negative cognitions and stimulate emotional processing, (Gillham, Cahill and Foa 2014).

The ‘Cognitive Model’ (Ehlers and Clark, 2000) was first developed for the treatment of depression (Beck et al., 1979) and then extended to anxiety disorders. This theory is based on the assumption that it is the individual’s interpretation and appraisal of the trauma and the ensuing memory that contribute to persistent PTSD, rather than the event itself. It is the perception of present threat based on a past event and its sequelae that contribute to the intense negative emotions and behavioral reactions (Ehlers and Clark, 2000; Hembree and Foa, 2004). Cognitive therapy for PTSD focuses on teaching clients how to
identify, evaluate, and reframe the dysfunctional cognitions related to the specific trauma. The cognitive model has amassed considerable support from research studies (Gilliham, Cahill and Foa, 2014).

The ‘Dual Representation Model’ (Brewin, Dalgleish and Joseph, 1996; Brewin, et al., 2010) uses findings from contemporary cognitive neuroscience in their theory that two memory systems operate simultaneously in a traumatised individual. The verbally accessible memory (VAM) is communicated verbally and allows trauma survivors to provide a narrative of the event. This includes primary emotions that happen at the time such as fear and helplessness and secondary emotions such as anger, shame and guilt generated afterwards in cognitive appraisals of those events. VAM memories exist within a personal context in which the individual makes sense of their past, present, and future. These memories are transferred to a long-term memory store in a form that can later be deliberately retrieved. At the neural level this involves activity in the hippocampus, which is integral to creating a unique context for each individual (Gilliham, Cahill and Foa, 2014).

In contrast Situationally Accessible Memory (SAMS) are triggered involuntarily by external and internal reminders of the trauma and so present as symptoms such as flashbacks. The SAM system stores information about the individual’s bodily response to the trauma, such as changes in heart rate, flushing, temperature changes, and pain. This explains why flashbacks are more detailed and emotion-laden than ordinary memories. SAMS cannot be retrieved intentionally, are difficult to communicate to others and to integrate with other memories. At the neural level SAMS involve parietal areas, the amygdala and the insula (Gilliham, Cahill and Foa, 2014). The extreme stress of a traumatic event can lead to an imbalance between these two memories. Typically SAMS increase because of amygdala functioning and VAMS reduce as a result of a dampened hyper-campal activity (Gilliham, Cahill and Foa, 2014). Dual representation theory asserts that PTSD is a hybrid disorder that may incorporate two different pathological processes. One requires the resolution of negative beliefs and emotions; the other requires the management of flashbacks. This model advocates exposure therapy that puts the SAMS into a context, which can then be integrated into existing autobiographical
material. It is too early to know if research will prove significant and testable hypotheses (Gillham, Cahill and Foa, 2014).

3.1.3 Neurobiology

Developments in neurophysiological assessment, done through the new technology of Magnetic Resonance Imaging (MRI) scans mean that a universal understanding of trauma is evolving as scientists begin to understand the complex workings of the brain (Gillham, Cahill and Foa, 2014). The constructs of new models of traumatology can now be based on research in cognitive neuroscience, which has the potential to advance knowledge about psychopathology and its treatment (Gillham, Cahill and Foa, 2014). In trauma and PTSD the areas of the brain affected are the hippocampus and the amygdala. Studies have revealed changes when emotional healing takes place in the autonomic nervous system (ANS) within the brain, particularly in the hippocampal functioning of the limbic system (Rutherford, 2007). This is linked to research on the biological impact of trauma in the body and the changes in production of noradrenalin, serotonin and cortisol levels (Solomon and Heide, 2005). We now understand that anxiety and fear is a genetically ingrained function of the nervous system. Emotions arise from our neural processes and can create reactions such as tonic immobility, especially when faced with direct physical contact with an aggressor such as a rapist or torturer (Moskowitz, 2004). This has implications for more focused and effective psychological interventions “in order for the amygdala to respond to fear reactions, the prefrontal region has to be shut down...(treatment of traumatic memory) may require that the patient learn to increase activity in the prefrontal region so that the amygdala is less free to express fear” (LeDoux, 2003, p. 217).

3.1.4 Genetics

There is also the possibility of an epi-genetic role that is the modification of DNA in response to environmental influences that may lead to inter-generational transmission of PTSD (Yehuda and Bierer, 2009). It is already known that trauma is contagious. The children of parents who have PTSD also have higher rates of PTSD in adulthood (Yehuda, Halligan and Bierer, 2001). In a study of refugee families where one or both of the parents had a history of torture and suffered from
post-traumatic stress disorder, it was found that 41% of the boys and 63% of the girls showed post-traumatic stress symptoms although they themselves had not experienced the trauma (Daud, Skoglund and Rydelius, 2005).

3.1.5 Post-traumatic growth
Since the first world-war psychiatry has examined responses to traumatic circumstances. The primary focus of this work has been to examine when traumatic events are precursors to psychological and physical problems. If the majority of the twentieth century was characterised by an examination of the negative consequences of trauma, in the twenty-first century there is a growing interest in exploring the resilience of the human spirit (Weiss and Berger, 2010). The key question in contemporary psycho-traumatology is why some people exposed to traumatic events develop long-standing psychiatric disorders while others exposed to the same event do not (Jakovljevic, 2012). Researchers have begun to make a distinction between resistance (survivors who did not develop psychopathology) and recovery (survivors who had developed PTSD or other symptoms but who no longer had those symptoms) (Yehuda et al., 2010; Yehuda and Flory, 2007; Yehuda et al., 2013).

Interest in how trauma can be a catalyst for positive change (Caplan, 1964; Frankl, 1963; Maslow, 1970; Yalom and Lieberman, 1991) has resulted in the concept of ‘Post-Traumatic Growth’ (Tedeschi and Calhoun, 1996; 2004) and has developed into a new area of inquiry (Calhoun and Tedeschi, 2006; Joseph and Linley, 2008; Weiss and Berger, 2010). Traumatic growth has become a major theme in ‘Positive Psychology’ (Seligman, 2011). “The aim of positive psychology is to begin to catalyse a change in focus of psychology from preoccupation only with repairing the worst things in life but also building positive qualities” (Seligman and Csikszentmihalyi, 2000, p. 5).

Post-traumatic growth is situated within a humanistic framework and has been identified as an increase in psychological functioning categorised by changes in self-perception, changes in perspective on life and changes in relationships (Joseph, 2012). This is illustrated by a three year survey of survivors of the ‘Herald
of Free Enterprise’ which found that 46% of those who survived the disaster felt that their view of life had changed for the worse, while 43% percent felt that their view of life had changed for the better (Dalgleish, Joseph and Yule, 2000).

“In the developing literature on posttraumatic growth, reports of growth experiences in the aftermath of traumatic events far outnumber reports of psychiatric disorders” (Tedeschi and Calhoun, 2004, p. 2). Calhoun and Tedesci’s model (1999) is a series of stages that gradually lead to what they term ‘initial growth’ and then ‘further growth’. Trauma is dealt with emotionally, cognitively and behaviorally at each stage. However, the model is designed for a single traumatic event and it is unclear how it applies to chronic traumatic experiences such as surviving war and genocide (Hollander-Goldfein, Isserman and Goldberg, 2012). The model only addresses positive changes using terms like ‘serenity’ and ‘wisdom’. It ignores any negative changes that might occur raising a question about its applicability within a wider trauma field, “it is perhaps naïve to assume a state of serenity in trauma survivors” (Hollander-Goldfein, Isserman and Goldberg, 2012 p. 23).

Current research is developing a new understanding of psychological trauma that integrates post-traumatic stress and post-traumatic growth within a single conceptual framework (Peterson and Seligman, 2003; Butler et al., 2005; Helgeson et al., 2006; Kunst, 2010; Dekel et al., 2012). However, the widespread assumption that trauma will often result in disorder should not be replaced with expectations that growth is an inevitable result. Instead, continuing personal distress and growth often coexist (Cadell et al., 2003).

3.1.5.1 Post-traumatic growth in cross-cultural contexts

Within the literature relating to post-traumatic growth there is acknowledgement that a multicultural perspective needs to address both the universal (etic) and culture specific (emic) of traumatic exposure and its aftermath (Maddi and Harvey, 2006; Wong and Wong, 2006). Ideas of gaining psychological benefits following traumatic events are incorporated in Buddhism, Hinduism, Islam. Judaism and Christianity and are rooted in the history of diverse cultures, (Splevins, Cohen, Bowley and Joseph, 2010). However, over the last twenty years the construct of
post-traumatic growth and the positive psychology movement have been established within a Western cultural framework. If post-traumatic growth is a representation of the societal values of a culture and the meaning making narratives they create (Weiss and Berger, 2010), then some of the criticisms leveled at the diagnosis of PTSD are also true of post-traumatic growth. “Even when context is taken into consideration, cross cultural comparisons are typically based on concepts and instruments rooted in Euro-American psychology” (Wong and Wong, 2006, p. 5). In order that the construct of post-traumatic growth is culturally relevant there is a need to value differing perceptions and interpretations of what constitutes adversity. In a meta-analysis of cancer survivors from the United States of America it was found that benefit finding and health outcomes were clearly associated with race (Helgeson, Reynolds and Tomich, 2006).

This poses theoretical, methodological and practice challenges (Weiss and Berger, 2010). It is clear that reliable, statistically valid and culturally relevant instruments are needed to measure and predict post-traumatic growth, which address socio-cultural and contextual orientations (Calhoun, Cann and Tedeschi, 2010). There is acknowledgement that any psychometric tests and routine outcome measures need to be in the participant’s own language. However, there is often a reliance on insensitive translations. Even when interpreters are used to support research or outcome measures there is the potential for miscommunication, an inability to express concepts across cultures and interpreters adding their own perspectives or withholding information (Tribe and Raval, 2003). Measurable outcomes for post-traumatic growth such as the post-traumatic growth inventory (PTGI) (Tedeschi and Calhoun, 1996) rely on tools validated in one culture being applied to another. There is a danger that western constructs may inadvertently assume a universal framework, precisely the criticism directed towards the American Psychiatric Association and the DSM (Splevins et al., 2010). Western models that focus on individual wellbeing may not adequately acknowledge the importance of resilience, cultural or socio-political meaning in the life of an asylum seeker or refugee (Tribe and Keefe, 2007). There is a need for tools to be designed by practitioners familiar with that culture and its nuances, who understand how to express the construct of posttraumatic growth in the context and value systems of that community. (Splevins et al., 2010).
3.1.6 Resilience

The theoretical and empirical literature on trauma survivors has moved from a focus on pathology to cognitive models of recovery and post-traumatic growth. There has also been a growing literature on resilience. Resilience is the ability to bounce back after distressing experiences, with an emphasis on cognitive processes; “the individual’s capacity to process traumatic experiences” (Brom and Kleber, 2009, p. 133). Resilience is a two-dimensional construct that focuses on exposure to adversity and the positive adaptations after trauma (Luthar and Cicchetti, 2000), such as developing new strengths or insights that improve functioning (Meyer and Mueser, 2011).

Most of the early literature has focused on children who survive adverse conditions (Anthony and Cohler, 1987; Garmezy, 1993; Kaplan, 1999), some in longitudinally studies such as Werner and Smith (1977, 1982, 1992, 2001) with children from birth to mid-life in Honolulu. These examine the protective factors that enhance adaptation to adverse conditions, such as good parenting, supportive communities and specific personality attributes. The focus in research has moved from protective factors to understanding protective processes examining how different factors are involved in promoting wellbeing and protecting against risk (Ungar, 2004a, 2008; Masten, 2001; Rutter, 1987, 2008).

The research into resilience has been criticised for its varying conceptualisations and measurements. It has been focused on quantitative studies designed from the top-down (Ungar, 2004b). Despite years of research there is no clear, agreed definition of resilience (Goldberg and Hollander-Goldfein, 2012). However several concepts of resilience are pertinent in the functioning of asylum seekers and refugees who have lived through traumatic experiences. Resilience is now seen as an adaptive, complex process that continues throughout the lifespan (Kaplan, 1999). It is now believed that trauma survivors who develop PTSD may be just as resilient as trauma survivors who don’t develop PTSD (Yehuda and Flory, 2007). Cumulative risk (Fraser, Richman and Galinsky, 1999) is the concept that there is a tipping point that any individual will be unable to withstand and risk chains have
been identified as a number of distinct risk factors which all link together over a life history, (Fraser, Kirby and Smokowski, 2004).

The ‘Differential Resiliency Model’ (DRM), (Palmer, 1997) defines resilience on a continuum of coping. This is a process model that acknowledges that a survivor can oscillate between different states for the rest of their life. This is a non-staged model that is purely descriptive. Unlike post-traumatic growth, there is no pinnacle of growth that should be reached. A survivor moves around the levels of resilience throughout their lifespan in response to different stressful events.

At the 2013 conference held by the International Society for Traumatic Stress Studies (ISTSS) definitions of resilience were debated but all included a concept of; “healthy, adaptive or integrated positive functioning over the passage of time in the aftermath of adversity. Resilience was seen as a complex construct…defined differently in the context of individuals, families, organisations, societies and cultures” (Southwich et al., 2014, p. 1). There was a consensus that the empirical study of the determinants of resilience should be approached from “…genetic, epigenetic, developmental, demographic, cultural, economic and social variables” (Southwich et al., 2014, p. 1).

3.1.7 The impact on practitioners

Until we have sat with someone who knows the capacity of human beings to inflict pain, who knows the depth of physical, emotional and mental pain that can arise in situations of war, we cannot be totally sure just how we will react.

(Bryant-Jefferies, 2005, p. 15)

Witnessing the despair and emotional pain of an asylum seeker or refugee can impact on anyone who is present in the therapy room, “trauma is contagious” (Herman, 1992, p. 140). Limited attention has been given to practitioners who work in the mental health field and therapeutically support survivors of trauma (Barrington and Shakespeare-Finch, 2014). If a practitioner experiences vicarious
trauma they may, by extension exhibit the same symptoms as the client. Belief systems can become increasingly negative in five key areas, trust, safety, esteem, control and intimacy (Pearlman and Saakvitne, 1995). A study of therapists (Century et al., 2007) and two with interpreters (Miller et al., 2005, Doherty et al., 2010) all noted that the practitioners reported experiences of vicarious trauma but also positive outcomes in enhanced relationships, increased appreciation for human resilience, learning opportunities and job satisfaction (Barrington and Shakespeare-Finch, 2014). Three studies have been designed to explore vicarious post-traumatic growth in trauma practitioners (Arnold et al., 2005; Splivens et al., 2010; Barrington and Shakespeare-Finch, 2014). All studies reported that participants had negative responses yet simultaneously experienced positive outcomes such as greater appreciation of life, tolerance and empathy (Arnold et al., 2005) and a sense of joy and inspiration (Splivens et al., 2010) and personal growth (Barrington and Shakespeare-Finch, 2014).

3.1.8 Psychological therapies for trauma work with asylum seekers and refugees

The current paradigm in traumatology is the incorporation of therapies built upon recent findings in neurobiology, resilience and posttraumatic growth. There is increasing clinical evidence that ‘Trauma Focused Cognitive Behavioural Therapy’ is effective for PTSD (Dalgleish et al., 2005; Cohen, 2009) while evidence for ‘Eye Movement Desensitisation Reprograming’ (EMDR) is growing (Stallard, 2006; Seidler and Wagner, 2006). The National Collaborating Centre for Mental Health (NCCMH), formerly the National Institute of Clinical Excellence (NICE) published guidelines in 2005 for trauma-focused psychological treatment based on these findings:

All people with PTSD should be offered a course of trauma-focused psychological treatment (trauma-focused cognitive behavioural therapy [CBT] or eye movement desensitisation and reprocessing [EMDR]). These treatments should normally be provided on an individual outpatient basis. (NCCMH, 2005 p. 4)

These guidelines focus specifically on trauma focused cognitive behavioural therapy with little acknowledgement of its cultural limitations or appropriateness.
with complex trauma. NICE advocate CBT for work with asylum seekers when desensitisation, that includes the re-exposure to the details of a traumatic event are inappropriate for victims of torture and rape, (Summerfield, 2005). In a letter to the BMJ, Gersons and Oiff (2005) say, “we cannot delete the memory of trauma”.

It is clear that exposure to the violence and destruction of armed conflict impacts on people’s mental health (Joseph, Williams and Yale, 1997). There are additional factors that impact on an asylum seeker’s capacity to disclose and engage in a therapeutic relationship. For example, they may feel shame or unwillingness to disclose sensitive information in interviews conducted by therapists or interpreters of the opposite sex (Burnett and Peel, 2001). This is often compounded by fear that information discussed may be passed back by the interpreter to their country of origin to inflict more harm on the asylum seekers family (Tribe, 2002). Women may also find the interview difficult if they come from cultures where the man is traditionally the spokesperson (Burnett and Peel, 2001). Thus, therapy may be conducted in inappropriate ways to the cultural, religious or emotional needs of the client. That is why best practice referral procedures which can identify not only language spoken, but tribe, religion and preference for the kind of interpreter wanted (such as age and gender) should be followed to ensure that these issues are dealt with before the client meets with the therapist and interpreter.

[Migrants and refugees] are frequently subjected to multiple traumatic events and severe loss, as well as ongoing stressors within the country of exile. Although...resilient, many experience mental health difficulties, including PTSD, depression, anxiety and grief. An awareness of relevant risk and protective factors is important. A phased model of intervention is often useful and the need for a holistic approach crucial......... Knowledge of the particular needs of working with interpreters, cross-cultural differences and the importance of clinician self-care is also necessary. (Ehntholt and Yule, 2006, p. 1197)
3.2 Communication
Although communication is an interactive process, for research purposes verbal and non-verbal communication are distinctive areas of study. Verbal communication, what is being said or written, has traditionally been the focus of linguistics. Non-verbal communication, how something is being said is the focus of communication science. There are infinite definitions for communication many of which are abstract and long in order to incorporate as many fields of communication as possible, (Samovar, Porter and McDaniel, 2012). The aim is “intentionality and interaction” (Samovar, Porter and McDaniel, 2012, p. 9); we intend to communicate and achieve this objective by interacting with someone else.

3.2.1 Cross-cultural and inter cultural communication
Cross-cultural and inter-cultural communication research spans a number of interdisciplinary academic fields, including anthropology, linguistics and communication, international relations, psychology, sociology and cultural studies. This is because it is carried out across a wide range of perspectives; “You live in an era where intercultural communication skills are not just an asset; they are a requirement”(Samovar, Porter and McDaniel, 2012, p. 4). These range from mass media communication, a field that encompasses electronic technology to international freedom of expression; diplomacy and economics as well as the communication needed to conduct business on a global stage including negotiation styles and conflict resolution (Samovar, Porter and McDaniel, 2012).

The words ‘cross-cultural’ and ‘inter-cultural’ are often used interchangeably. However, cross-cultural communication focuses on an etic view of other cultures, that is factors that are universal across cultures (Brislin, Lonner and Thorndike, 1973). Studies aim to understand similarities and differences across cultures, and the comparability of cross-cultural categories (Tanaka-Matsumi, 2001). The act of comparing needs a benchmark, so ‘cross-cultural’ refers to the understanding of another culture from an outsider’s point of view.
By contrast, inter-cultural communication involves an emic view of other cultures from an insider’s perspective or the things which are unique to a given culture (Aegisdottir, Gerstein and Canel, 2008, p. 190). These approaches are in-depth studies of the local context and the meaning of constructs without imposing a priori definitions on the constructs themselves (Tanaka-Matsumi, 2001).

Researchers in this field usually reject claims that the theories they work with are universal. Inter-cultural communication is generally defined as “face-to-face communication between people from different national cultures, but the term also is used frequently to include all aspects of the study of culture and communication” (Gudykunst, 2003, p. 7).

The focus of this review relates to the more personal aspects of inter-cultural communication; what happens when people from different cultures interact on a face-to-face level. Something as simple as an awareness of cultural variations in eye contact can help a psychotherapist achieve greater communication with their client.

Inter-cultural communication is generally perceived as a scientific field that examines interaction between individuals and groups from different cultures. It looks at the influence of culture on who people are, how they act, feel, think, speak and listen (Dodd, 1991).

Communication researchers have approached competence from an interactional point of view, psychologists from an individual internal processes perspective. Most models contain lists of personal attributes, psychological adaptation, communication skills and cultural awareness (Chen and Starosta, 1996). Samovar, Porter and McDaniel (2012, p. 13) identify these as “perception, patterns of cognition, verbal behaviours, non-verbal behaviours and the influence of context”, stressing that “culture can often produce different ways of knowing and doing” (ibid, p. 15). The United States Army Research Institute is currently engaged in research into cross-cultural competence. They define it as a set of cognitive, behavioral and affective/ motivational components that enable individuals to adapt effectively in inter-cultural environments (Abbe, Gulick and
Herman, 2007). Samovar and Porter’s (2004) work identifies possible barriers in inter-cultural communication as seeking similarities; uncertainty reduction; withdrawal; stereotyping; prejudice; racism; and ethnocentrism (p. 284-300).

The tensions between the emic, the culturally specific and the etic, the generalised and universal perspective are a challenge in any qualitative research; they present an even greater one in the area of cross-cultural communication (Aneas and Sandin, 2009). In studying inter, and cross-cultural, communication there is a danger of gross generalisation. Even when the findings are from an emic perspective there is a danger of losing the individual, their unique traits, different identities and opinions.

The fallacy of the monolithic identity, (Stanfield, 1993, p. 21). Not all of the members of a given cultural group adopt, live or reflect their common culture in an identical way in every moment and life circumstance, nor do all members of the same group demonstrate the same feeling of identification. Viewing cultures in this way would rapidly lead us to adopt the most simplistic of cultural stereotypes (Aneas and Sandin, 2009, p. 4).

I suggest that nearly all communication is to some degree cross-cultural in the sense that no two people have exactly the same background and, consequently precisely the same expectations about interaction. Expectations, however, are more strikingly different when backgrounds diverge more drastically.

(Tannen, 1980, p. 327)

3.2.2 Verbal communication

3.2.2.1 Language

Language could be defined as “a set of symbols shared by a community to communicate meaning and experience” (Jandt, 2001, p. 126). Language is shared
by a group of people to express their thoughts and experiences and so language reflects culture (Samovar, Porter and McDaniel, 2007).

Language is not merely a more or less systematic inventory of the various items of experience which seem relevant to the individual, as is so often naively assumed, but is also a self-contained, creative symbolic organization, which not only refers to experience largely acquired without its help but actually defines experience for us by reason of its formal completeness and because of our unconscious projection of its implicit expectations into the field of experience.

(Davies 2003, p. 100)

The primary form of communication that psychotherapists and their clients’ use are; vocal expressions of thoughts, behaviours and emotions. It is only relatively recently that the psychotherapeutic world has engaged with issues of race and cultural diversity with the result that there is very little research into the impact of using a variety of languages in the therapy room (Burck, 2004).

3.2.2.2 Mother tongue
A first language, native language or mother tongue is the language(s) a person has learned from birth or their early years. In some countries, the terms native language or mother tongue refer to the language of one’s ethnic group rather than one’s first language, (Davies, 2003). In the twenty-first century it would seem more appropriate to use the term first language rather than mother tongue, which has some connotations of sexual stereotyping, however, most of the emerging literature uses the term mother tongue and so this term will be used in this literature review.

The importance of speaking in a mother tongue is slowly emerging in the research literature (Burck, 2004; Harris, 2006; Costa and Dewaele, 2012; Pavlenko, 2012).
These clinical studies are beginning to be supported by research literature in psycholinguistics (Matsumoto, 2000) and neurology (Perez-Foster, 1998). A comprehensive review paper undertaken by Pavlenko (2012) has documented that native languages have an advantageous emotionality. This is because intense emotions developed in early years will have been encoded in the native language (Harris, 2006). In a study of twenty-four bilingual speakers, participants felt they expressed emotion, intimacy and closeness more effectively in their first language, “the prosodic elements of a first language, its sounds, rhythms, ebbs and flows, its music, were drawn attention to, in its absence”(Burck, 2004, p. 320). First languages were seen to have specific qualities including creativity and humour. They allowed the speaker to feel a sense of belonging and authenticity, creating a strong sense of self and identity. They also carried a connectedness to national and political identity. For an asylum seeker or refugee speaking a first language can connect to a past which represents people, place and identity (Burck, 2004).

Clients can feel free to express themselves:

He mostly talked about his pleasure in feeling understood when using his dialect, with its emotionally dense, concise and precise meanings, which he felt unable to convey in any other language. It was important to him to know that he and his partner shared the same dialect and the humour in it, so they understood each other without too many words.

(Antinucci, 2004, p. 1161)

The way in which experiences and emotional reactions are encoded becomes more complex when more than one language is spoken (Costa and Dewaele, 2012). In Burck’s (2004) research participants said their second or subsequent language was used in a more formal way and introduced distance. Some of those interviewed had used this new language to construct a different identity. Each language encoded a different concept, allowing a participant born in China to be assertive or angry in English, something she felt impossible to do in Mandarin. Dewaele (2010) similarly reported that several Arab and Asian participants
consciously spoke English to escape the social taboo in their native languages and cultures. This distancing was used in both positive and negative ways. As a therapist this distance can facilitate a connection to difficult issues:

Languages, dialects and personal lexicon that the patient employs can enrich the analytic dialogue in all its nuances. Pluralistic internal landscapes, meanings, a variety of possibilities of ways of signification: all of this undoubtedly enhances the analytic encounter.

(Antinucci, 2004, p. 1158)

However many asylum seekers speak a number of languages. Their mother tongue may be a patois or minority dialect. These are extremely difficult to find spoken by a professional interpreter, which precludes many clients from accessing their mother tongue in therapy. Language reflects social constructs and emotion will be expressed differently in different languages. “Languages differ, then, in what they enable us, or even in what they require us to say or not to say. Different languages speak us differently” (Burck, 2004, p. 323). Languages are not directly interchangeable. Some words and concepts are unique to a specific language making direct translations impossible and the need to encode very different meanings, the “in-between’ of languages” (Burck, 2004, p. 334). Meanings may be emotionally and conceptually encoded. They may be so internalised in one language that they may not be accessible in another (Keefe, 2007).

3.2.2.3 Power, status and identity within language
Minority communities do not exist as homogenous groups and there is a danger of services accessing the easiest language to find rather than the best language for the client (Edwards, 1995). For example, Kurdish people may speak Kurdish, Iraqi, Turkish or Arabic, as well as other languages and dialects; Chinese people may speak Mandarin or Cantonese and/or a variety of dialects; while Bangladeshi people may speak Sylheti, Bengali and various dialects (Alexander, Temple and Edwards, 2004).
Power and status can be expressed in the socio-political implications of language. Tribe and Keefe (2009), present a case study of a Kurdish woman from Iraq who chose to have psychodynamic counselling in Arabic with an interpreter, even though her mother tongue was Sorani. They raise the question “if she was interrogated in Arabic, what does it mean to have therapy in that language?” (p. 418). In Burck’s study (2004) the participants who spoke the most languages were those with the least status. She cites a black Rhodesia/ Zimbabwean who spoke five languages and a white South African who spoke one language until late adolescence. The white South African had to come to terms with the fact that his native language, Afrikaans, in which he felt emotional expressiveness was seen by others as oppressive and evil.

Asylum seekers and refugees have experienced multiple losses. If they cannot speak the host language, they have also lost the ability to communicate on a daily basis with the people around them through a shared language (Tribe and Keefe, 2009). Speaking minority languages can emphasise difference, ‘otherness’ in ethical and cultural identity; “a particularly poignant construct of neither/nor identity, rather than a both/and identity” (Burck, 2004, p. 330). Individuals who speak little or no English are “doubly disadvantaged” (Edwards, 1995, p. 57) because they are subject to the same racism as English speaking minorities such as the indigenous black and Afro-Caribbean community but their lack of English increases their vulnerability to institutional racism (Edwards, 1995).

Interpretation becomes a separate component of the therapeutic relationship when the clients native language is not the same as the counsellors (Antinucci-Mark, 1990). “Certain experiences can best, and possibly only be, elicited in a first language. This is why it is so important to work with an interpreter”(Burck, 2004, p. 334). There are definite challenges to negotiating extra language provision inside a therapy room (Burck, 2004; Antinucci, 2004; Tribe and Keefe, 2009; Costa and Dewaele, 2012). Therapists need to find ways of exploring both their own and their clients cultural patterning of meanings in order to explore what is not being said, the implicit (Krause, 2002). The languages used in the therapy room are not neutral mediums but have the potential to impact in positive or negative ways on the client, particularly in the context of discrimination and racism.
As well as past experiences there is the potential for issues of power, domination and subjugation within the context of the therapy room (Burck, 2004). Power relationships in interpreting can be complex with the potential for any of the three participants to exert power over the other two (Williams, 2005). There may be perceived power differences between the two practitioners in the host society (Green, 2004) especially because the interpreter is the only person in the room who understands everything that is being said (Tribe and Keefe, 2009). The client may perceive the psychotherapist or the interpreter as having more power and authority because of the language(s) they speak. The client may put the therapist on a pedestal, “a locus of omniscience” (Antinucci, 2004 p. 1158) simply because they speak English and represent the country with the power to give them legal status. There may also be unresolved issues of cultural imperialism from all participants in the triad. Mental health care provision in the UK is usually provided by staff from the dominant, white indigenous population, drawing from their own reference points of western cultural values (Ravel, 2003). The differential between client, clinician and interpreter can increase when there are differences in language and culture (Ravel, 2003).

If the practitioner is unaware or finds it difficult to raise issues about power inside the therapy room there is further potential to subject the client to issues of disempowerment and racism by their unconscious actions (Ravel, 2003). It has been shown therapy has more successful outcomes when the client and therapist feel able to openly discuss the client’s ethnic identity. Carter (1995) shows that European American therapists consistently felt unable and uncomfortable to discuss these issues in comparison with their African American colleagues. This is consistent with the UK study carried out by Century, Leavvy and Payne (2007). “Whiteness as a set of normative cultural practices is visible most clearly to those it definitively excludes and to those to whom it does violence. Those who are housed securely within its borders usually do not examine it” (Frankenberg, 1993, p. 228).
3.2.3 Non-verbal communication

3.2.3.1 Universal and culture specific
Non-verbal communication is defined as “communication effected by means other than words” (Knapp and Hall, 2006, p. 5). The first scientific study of non-verbal communication was in ‘Expression of emotion in Man and Animals’ (Darwin, 1872). The pioneering research carried out in behavioural science occurred between the 1950’s and early 1970’s (Argyle, 2007). This work identified a number of different types of non-verbal communications including facial expressions; eye contact; paralinguistics: tone of voice, loudness, inflection, and pitch; kinesics: gestures, body language and postures; proxemics: the physical space in communication; haptics: communicating through touch; appearance; and chronemics: the use of time and speed of speech. Some of these non-verbal communications have different and sometimes opposite meanings in different cultures (Knapp and Hall, 2006, p. 10).

However Mehrabian’s (1972) work on non-verbal communication found some universality. Mehrabian’s findings were that 55% of human communication is through body language, 38% is through tonality (the speed, sound and pitch of the speakers voice), and only 7% rests in the words themselves. There are questions about his methodology (Lapakko, 1997) and ongoing disputes about the proportions of his formula (Morton and Trehub, 2001) but the principle has been established that human beings believe non-verbal signals more than verbal ones when faced with conflicting messages (Stiff et al., 1990).

MRI scans have resulted in advances in neurobiology and neuro-anatomy adding to knowledge about the links between the brain and the universality of some responses (Trimble, 2012). Crying has now been recognised as a universal emotional response, especially to sadness, feelings of loss and the death of a loved one. “Emotional weeping is not only uniquely human, but universal” (Trimble, 2012, p. 19). Crying is not only associated with an alteration of facial expression accompanying tears but involves the respiratory muscles, with brief cycles of expiration and inspiration, changes in the tension of the vocal cords and an outplay of the autonomic nervous system (Trimble, 2012).
It is also possible to identify emotional expressions such as sadness, happiness, anger and surprise regardless of the culture of the person displaying the emotion (Ekman, 2007) through involuntary expressions that can occur in as fast as 1/25th of a second (Haggard and Isaacs, 1966). However, within a universality of emotional expression each group adds their own culturally specific overtones “Thus we can recognise basic universality while moving beyond it. Just as emotional expression may be a universal ‘language’ different ‘accents’ or ‘dialects’ may vary in subtle ways across cultures” (Elfenbein and Ambady, 2003, p. 21).

Non-verbal communication does vary across cultures. It is thought to be shaped by cultural context and the society that an individual grows up in (Lago and Thompson, 1996). Some non-verbal facial and bodily expressions form a coding system for constructing and expressing meaning and these expressions are culture bound. In inter-cultural communication inappropriate or misused non-verbal behaviours can lead to misunderstanding and insults (Samovar, Porter and McDaniel, 2012). In the field of mental health a client’s affect and demeanour are important indications of how well a client is (Cushing, 2003). This will combine the content and the form in which the client speaks as well as their facial expressions and bodily movements. As non-verbal communication may contain cultural variants, it is easy to misunderstand these communications (Cushing, 2003). This can be complicated still further because of the delay between auditory and visual stimulus when using an interpreter (Farooq and Fear, 2003).

Non-verbal communication is a complex area made more so by considering the implications of cross-cultural issues. However, most research has been carried out in the United States of America with western subjects. Many of the cross cultural studies (excluding Ekman’s) are in fact with foreign students studying in the West who have been assimilated into the host culture (Knapp and Hall, 2006). However, there does seem to be consensus that where incongruity and ambiguity is being communicated on an emotional level adults rely on what they see and feel rather than what they are told (Mehrabian, 2007) and that “some researchers believe the primary function of the face is to communicate, not to express emotion” (Knapp and Hall, 2006, p. 10).
3.2.3.2 Therapeutic implications

Although counselling and psychotherapy are often characterised as ‘talking therapies’, silences and non-verbal communication form a significant part of any therapeutic interaction. “Moments of intimacy and relational depth often occur without words” (Mearns and Cooper, 2005, p. 47). Clinicians working in the field of psycho-traumatology write about how silence communicates more than words; “The fragility of language and the limitations of what can be tolerated in our conceptual thinking tend to render the words to describe these horrific memories void and redundant” (Hassan, 2009, p. 11). In ‘Speech and Silence’ (Ross, 2001), an account of the public hearings of the South African truth and reconciliation commission women who had experienced brutal treatment of rape and violence during apartheid did not speak openly about their experience. Yet it was present in their testimonies “witnessing needs to take into account that which is left unsaid in testimonies” (Ross, 2001, p. 272). “Silence marks particular kinds of knowing” (ibid, p. 272). “Women’s silence can be recognised as language, and we need carefully to probe the cadences of silences, the gaps between fragile words, in order to hear what it is that women say” (ibid, p. 273).

In order to achieve successful interactions in a therapeutic setting participants must have particular communication skills, some of which may be at an unconscious level. These may include a set of cognitive, behavioural and affective/motivational components that they are able to adapt effectively in inter-cultural environments (Abbe, Gulick and Herman, 2007). If non-verbal communication is a mixture of the universal and the culturally specific, then natural communicators will be comfortable with an out-of-conscious level of information exchange (Hall, 1959) in which some of our non-verbal communication is innate and physiological.

3.3 Working with interpreters in mental health settings

Working in the field of mental health is a relatively new phenomenon for interpreters (Tribe and Ravel, 2003) with a relatively small amount of emerging literature. A systematic review of the literature into clinical care for patients with limited English proficiency found that:
Professional interpreters are associated with an overall improvement of care for limited English proficiency patients. They appear to decrease communication errors, increase patient comprehension, equalise health care utilisation, improve clinical outcomes and increase satisfaction with communication and clinical services for limited English proficient patients.

(Karliner et al., 2007, p. 15)

The fact that three people are engaged in the communication instead of two complicates the dynamic process in the room (Blackwell, 2005; Miller et al., 2005; Lago, 2009; Tribe and Thompson, 2009). The existing research seems to indicate that interpreters are concerned about the technical issues in their work while clinicians worry about the therapeutic relationship (Tribe and Keefe, 2009). The research also shows that many asylum seekers and refugees report using an interpreter as an empowering experience that allows them to communicate effectively with the clinician (Tribe and Keefe, 2009).

The literature appears to have an emphasis on the challenges working with an interpreter brings rather than the advantages (Farooq et al., 1997; Farooq and Fear, 2003; Odhiambo-Abuya, 2004; Century, Leavey and Payne, 2007; Lago, 2009). “The literature in this area of work is restricted and largely limited to descriptive reports about how difficult the work is” (Ravel, 2003, p. 25).

There is agreement that the task is complex. Interpreters need an array of sophisticated and nuanced skills (Nijad, 2003). They navigate discourse and cultures, which may entail three communities if the client speaks a common language but comes from another country than their own (Angelilli, 2008), and act as “brokers” between two worlds (Razban, 2003, p. 93). “It must be remembered that interpretation is a very much more complex process than is word-for-word translation…it calls for the deciphering of two linguistic codes, each with its own geographical, cultural, historical and linguistic traditions” (Farooq and Fear2003, p. 105).
Mudarikiri, (2003, p. 185) identifies four levels of interpretation; Linguistic interpretation’, words and their meanings; ‘Metaphorical interpretation’ contextual knowledge of a community which pass on the essence within the meaning; ‘Digital interpretation’ or non-verbal communication identifying meaning, taboos and permissible behaviour and ‘Cultural interpretation’, belief systems, socio-political contexts or practices about age, gender or acceptable norms within a specific culture. Interpreters have to process and accommodate all four levels simultaneously. Often clinicians only focus on the linguistic level of communication and ignore the metaphorical, digital and cultural aspects of the interaction (Mudarikiri, 2003).

There is no consensus about how an interpreter should work in the mental health field within the existing literature, (Williams, 2005). Instead, a variety of different models and approaches are discussed which reflect the variation in work, ranging from an objective neutral role as a language machine to a fully engaged co-facilitator (Freed, 1988; Sanders, 2000; Warfa and Bhui, 2003; Angelelli, 2004; Hwa-Froelich and Westby, 2003; Tribe, 2005; Raval, 2005). This is because interpreting in a long-term therapeutic intervention requires a different approach to interpreting in a medical emergency (Williams, 2005) and there is no specific model for interpreters working with asylum seekers and refugees (Tribe and Keefe, 2009). Hwa-Froelich and Westby, (2003), propose a model that acknowledges the variety of situations that require an interpreter by advocating a continuum that ranges from neutrality to active participant.

3.3.1 Service user voices

The existing literature contains little research on the views of clients who use interpreting services (Williams, 2005). The research that has been conducted shows that a lack of trust was the main barrier cited when using interpreters in primary care (Gerrish, 2001; Alexander et al., 2004; Robb and Greenhalgh, 2006, Barron et al., 2010). Barron et al. (2010) found that participants expected accuracy, independence and confidentiality from the interpreter and preferred someone of their own gender and culture.
The research carried out by Alexander, Temple and Edwards (2004) on behalf of the Rowntree trust interviewed people from five different minority ethnic groups: Polish, Chinese, Gujerati Indian, Bangladeshi and Kurdish, who had all accessed interpreters. They found that the participants preferred to use their family and friends as interpreters rather than professionals. The research distinguishes two types of trust. The concept of ‘personal trust’, which participants identified with familial qualities such as emotional commitment and loyalty, someone who will advocate in their best interests and ‘abstract trust’, which they associated with professionalism such as confidentiality and expert knowledge. It is clear that the participants did not want impartial language machines:

The interpreter’s character and attitude are important. An interpreter needs empathy, and this is enhanced where interpreter and user know something about each other. In addition, people often want an interpreter to be proactive, pleading the user’s case and giving advice about systems and procedures.

(Alexander, Temple and Edwards, 2004, p. 32)

Participant research shows that many asylum seekers and refugees prefer members of their family or at least their community as interpreters because of issues of trust and credibility. The research also found that these were established with professional interpreters when a relationship was able to build over a period of time. (Alexander, Temple and Edwards, 2004)

Personal and abstract trusts need to be combined, rather than be separate. The embodiment of trust in an interpreter is either a family member or friend who has professional skills and expertise, and adheres to professional codes of good practice, or a professional interpreter who fulfills the obligations inherent in their role and is a familiar person. (Alexander, Temple and Edwards, 2004, p. 57)
3.3.2 Working with asylum seekers and refugees

Working with asylum seekers and refugees is recognised as subtly different from other interpreting work in the literature, (Blackwell 2005; Williams, 2005; Boyles, 2010; Tribe, 2011). An asylum seeker or refugee will have a traumatic migration narrative and have engaged in immigration issues in the present or in the past. This may create vulnerabilities that can impact on how they experience and engage with mental health services (Williams, 2005). The combination of long-term involvement in therapy and emotionally intense material distinguish this work from more conventional interpreting roles (Miller et al., 2005; Doherty et al., 2010). Interpreters can find themselves caught between experiences of trauma, both their own if they are survivors of conflict and the client’s present traumatic experiences (Tribe and Keefe, 2009; Boyles, 2010).

3.3.2.1 Interpersonal skills

The dynamics within a triad have been described as a series of alliances (Lago (2006; Tribe and Thompson 2009). “The work is as much about understanding the relationships that develop between them as it is about the process of language translation” (Mudarikiri, 2003, p182). It has been suggested that when working with asylum seekers, practitioners, whether clinicians or interpreters need to understand about the context they are working in and have a “capacity to adjust their practice accordingly” (Williams, 2005, p. 37). The clinician and the interpreter may take on a different role as human rights practitioners, actively supporting the client rather than taking a politically neutral stance. There may be greater need to demystify therapy within the cultural framework of the client and slowly build a trusting relationship from a starting point in which the client anticipates betrayal. Ending therapy may be particularly difficult with its implications of loss and bereavement, especially for clients who have engaged with therapy but have no other place of safety, who face an uncertain future and may be at risk of return to a hostile homeland and possible death (Boyles, 2010).

Those engaged in this field need excellent interpersonal skills and emotional maturity. Miller’s research (2005) found that interpreters may have the appropriate language skills but may not be temperamentally suited to this kind of work. When
asked what made a good interpreter, participants from a variety of different ethnic minority backgrounds focused on personal qualities rather than skills. They wanted an interpreter to show empathy and be pro-active in attitude (Alexander et al., 2004). The BACP guidance on good practice in counseling and psychotherapy (2013, p. 3) says: “Personal qualities to which counsellors and psychotherapists are strongly encouraged to aspire include: empathy, sincerity, integrity, resilience, respect, humility, competence, fairness, wisdom, and courage”. However, no equivalent guidance on personal qualities for interpreters is issued by the ‘Institute of Linguists’, which has an emphasis on neutrality and impartiality. This reflects a code of practice that has not caught up with the changes and demands in this new area of work.

There is some evidence that the interpreter is more vulnerable to vicarious trauma than the therapist (Satkunanayagam et al., 2010). A lack of clinical training can add to this risk (Becker and Bowles, 2001; Tribe, 2011). “Interpreters need containment too. It can be frightening for an interpreter to interpret for a client in the midst of a flashback” (Boyles, 2010, p. 111). For some interpreters, there is the possibility of a shared culture, history, experience of trauma and shared refugee status which can increase their credibility and sensitivity to the work (Splivens et al., 2010). However, this may also increase the emotional impact (Miller et al., year). Splivens et al., (2010) found their participants were ‘shocked’ that clients who were ‘completely broken’ could recover which “filled interpreters with hope, admiration and inspiration…and a sense of growth which mirrored that expressed by their clients” (p. 1712). These findings illustrate the importance for consistency in personnel. If the same interpreter is present throughout therapy they are protected from the negative impact of witnessing atrocity without understanding the post-traumatic growth that may occur.

3.3.2.2 Training
There is clear agreement about the need for training in the literature (Freed, 1988; Farooq and Fear, 2003; Tribe and Ravel, 2003; Tribe, 2011). “The need for training and support for all clinicians when working with interpreters has been noted by the British Psychological Society (BPS), the Royal College of
Psychiatrists (RCP) and the British Association for Counselling and Psychotherapy (BACP)” (Tribe, 2011, p. 89). Yet there is a lack of clarity about what constitutes effective professional training (Williams, 2005) and little evaluation of training courses in the research literature (Miller et al., 2005).

An empirical study of professional interpreters by Granger (1996) found that only thirty percent of the participants had professional qualifications while Miller et al. (2005) identified that only three out of fifteen interpreters interviewed had received training in mental health interpreting. Most professional clinical training has limited teaching on race and cultural issues (Ravel, 2003). This lack of training and awareness can impact on the assumptions and attitudes of clinicians who may believe that it is not possible to undertake psychological work with an interpreter (Tribe, 2007). “Some counsellors reported feeling that the counselling was ‘inferior’ and that the work felt ‘compromised’” (Century, Leavey and Payne, 2007, p. 30).

Yet working through interpreters in specialist psychiatric services has been established for deaf children since 1991, (Beresford, 2008). Trained practitioners can enhance understanding (Tribe and Morrissey, 2004) and allow greater reflectivity in clinical work (Raval and Smith, 2003). Doherty, MacIntyre and Wyne’s research (2010) suggests that interpreters would benefit from the same supervision structure as therapists: “opportunities to reflect on work with clients in the context of a supportive relationship with an experienced colleague” (McLeod, 2003, p. 652).

Emotionally intense material and length of contact make working with asylum seekers and refugees subtly different from other interpreting roles (Boyles, 2010) and require excellent interpersonal skills and emotional maturity. There is an ongoing debate between health care professionals and interpreters about the most useful interpreting model when working in this field. In reality, interpreters often fulfil multiple roles including Mudarikiri’s (2003) four levels of interpretation whilst being cultural consultant, advocate and bilingual worker (Raval, 2003). “The therapist remains the main driver with the interpreter as co-driver who is sometimes allowed to drive, using their own expertise and knowledge” (Patel, 2003, p. 228). The current literature on working in mental health with interpreters provides a range of models and approaches but no clear consensus, reflecting this
debate (Williams, 2005). However research that reflects the views of service users (Alexander et al., 2004; Robb and Greelhalgh, 2006; Barron et al., 2010) is converging with some practitioners who identify the role of interpreter as an active participant (Davidson, 2000; Patel, 2002; Angelelli, 2004; Raval, 2005; Tribe and Thompson, 2009) and acknowledge the interpreter as a “co-constructor of the interaction” (Williams, 2005, p. 39). “Embracing the personal qualities of the interpreter into the work can have an enhancing effect, rather than becoming a problem to be overcome” (Mudarikiri, 2003 p. 190).

It is hoped that research into the needs of clinicians and interpreters who work therapeutically together will result in a nationally recognised qualification. This would acknowledge the emotional demands and personal qualities required of any practitioner working in this field. It would also contain provision for clinical supervision and training in self-care in order to help protect against vicarious trauma. Clinicians and interpreters would also be trained together to understand how to work in a clinical triad. This training would incorporate cultural constructs of mental health (Tribe and Sanders, 2003). Miller et al. (2005, p. 38) say the development of empirically based training programmes is “likely to enhance the triadic therapy experience for each of its members”.

3.4 The therapeutic relationship
3.4.1 Interpersonal neurobiology

During the last twenty years neuroscientists have begun to link physiology and psychology with the result that an understanding of the human brain and our behaviours has grown significantly (Cozolino, 2006). Interpersonal neurobiology’ (Siegel, 1999) identifies how the brain is wired for connection, emotion and relationships. “Human connections create neuronal connections” (Siegel, 1999, p. 85). “When two people feel rapport…their very physiology attunes” (Goleman, 2006, p. 28). Research has emerged that primal empathy, the quick reactive feeling which includes nonverbal synchrony, is a subcortical, limbic emotional resonance between people. ‘Empathic accuracy’ is an activation of the prefrontal cortex when feelings and thoughts join to understand another individual (Goleman, 2006). The mirror neuron system is a sophisticated and complex neurological
process that creates moments of connectedness and empathy, to “know another from the inside out” (Cozolino, 2006, p. 202). This has been termed ‘feeling felt’ (Siegel and Hartzell, 2003).

When there is emotional attunement it has been discovered that the whole body synchronises information. Person centered therapists have described this as “specific moments of encounter” (Knox et al., 2012, p. 3). The vagus nerve sends up ‘gut feelings’ from the stomach to the brain, the insula reads body states and combines with the amygdala at a nonverbal level to interpret feelings. This emotional part of the brain constantly monitors faces and other stimuli for positive or negative affirmation (Fishbane, 2007). It has been found that the integration of the prefrontal cortex with the limbic system is necessary for emotional and relational wellbeing (Fishbane, 2007). The orbitofrontal cortex (OFC), serves as the brain’s emotion regulation system (Siegeland Hartzell, 2003). The OFC is active in processes of self-awareness, regulation of emotion, and empathy or "mindsight" (Siegel and Hartzell, 2003). The OFC continues to develop throughout an individuals’ life, characterized by neuroplasticity, or the ability to change at the neural level (Fishbane, 2007), an important factor when considering posttraumatic growth.

3.4.2 A psychotherapeutic perspective
The findings of neurobiology have influenced current thinking in psychotherapy. There is acknowledgement of connectivity and how vital it is to a positive outcome in therapeutic relationships. Each theoretical orientation now offers a definition. From a person centred perspective it is described as ‘Relational depth’; “A sense of connectedness and flow with another person that is so powerful that it can feel quite magical. “At these times, the person feels alive, immersed in the encounter, and truly themselves; while experiencing the other as open, genuine and valuing of who they are” (Cooper, 2012, p. 71). From a transactional analysis perspective it is defined as ‘emotional attunement’, “a kinesthetic and emotional sensing of others, knowing their rhythm, affect and experience by metaphorically being in their skin, and going beyond empathy to create a two-person experience of unbroken feeling connectedness by providing a reciprocal affect and/or resonating
response” (Erksine, 1998, p. 236). While interpersonal neurobiology has generated a number of different orientations the most significant being ‘The Compassionate Mind’ (Gilbert, 2009); ‘Mindsight’ (Siegel, 2007) and the ‘Social Synapse’ (Cozolino, 2006). This study intentionally uses a term that is not claimed by any specific theoretical orientation, interpersonal attunement, defined for the purposes of this research as a deep and profound emotional connection that creates a resonance in each participant.

3.4.2.1 Interpersonal attunement

As soon as you try to define the emotional engagement that can happen in the therapy room, it becomes elusive. At its heart it’s a simple yet profound emotional alliance, a connection felt and shared between people. From the perspective of interpersonal neurobiology, successful psychotherapy creates a ‘limbic revision’ (Lewis et al., 2000, p. 144) a change within the emotional brain. This process requires trustworthiness and attunement on the part of the therapist (Fishbane, 2007, p. 406). For the client to ‘feel felt,’ the therapist must be present emotionally and able to resonate empathically with the client, integrating thoughts with emotions. Good therapy entails “attunement of right-to-right hemisphere between therapist and client” (Siegel, 2003, p. 32). In therapeutic interventions where people can feel vulnerable and emotional, interpersonal attunement can occur in a subtle and nuanced way: “Indeed many of the therapists we spoke to said that their most in-depth moments of relating occurred in silence: a second of eye contact, a touch on the shoulder, a laugh shared between themselves and their clients” (Mearns and Cooper, 2005, p. 47).

Current research evidence suggests that a key determinate of a positive therapeutic outcome is when therapist and client experience a profound connection to each other (Cooper, 2012). There are also indications in the research that the greater the experience of the practitioner the more likely it is that the client will experience these connections (Cooper, 2012). If interpersonal attunement is neurobiological, it would imply that this connection can also happen across differences in culture and language. If a therapeutic alliance and interpersonal attunement between therapist and client can be created an “enduring
relationship is established, the client is offered a truly huge therapeutic space characterised by a strong sense of safety and reliability within the relationship” (Mearns and Cooper, 2005, p. 53).

3.4.2.2 The therapeutic alliance
The research literature shows that the therapeutic relationship is one of the key determinants of a positive outcome to psychotherapy (Asay and Lambert, 1999; Lambert and Barley, 2002; Orlinsky et al., 2004, Norcross, Beutler and Levant, 2005). This raises the question of what creates a healing relationship “Counselling represents at its core, a means of promoting and applying a set of values concerning respect for others, acceptance of difference, the worth of human beings and the importance of connectedness and human relationships” (McLeod, 2007, p. 82). The relationship that develops between client and therapist is referred to as the ‘Therapeutic Alliance’. A strong therapeutic alliance is generally accepted as essential to effective psychotherapy, regardless of the theoretical orientation of the clinician (Wampold, 2001). “Who provides the treatment is a much more important determinant of success than what treatment is provided” (Miller, Hubble and Duncan, 2007, p. 15). A therapeutic alliance can be seen as a collaboration of shared goals and objectives, a working partnership. “It connotes a positive, collaborative relationship based on trust and a shared commitment to the clients growth and healing” (Miller et al., 2005, p. 29). It is the strength of the therapeutic alliance, together with rapport and trust that creates a working relationship between client and therapist and is key to an effective therapeutic outcome.

Different theoretical orientations of psychotherapy contest precisely what constitutes a therapeutic alliance. Psychodynamic, person centred and cognitive behavioural therapy all emphasise different aspects of the alliance. There is also the addition of therapeutic alignment as an associated concept. This is an approach which emphasises collaborative enquiry so that both participants align together in order to explore the client’s issue. Gelso and Fretz (1992) define the establishment of a working alliance as ‘the alignment of the client’s reasonable and observing side with the counsellor’s working, or therapising, side for the
purpose of facilitating the work of counselling’ p152. Therapeutic alignment is an adult -to - adult agreement to work on the client’s issues that requires negotiation of goals, tasks and the establishment of trust (Knox and Cooper, 2015).

A therapeutic alliance has traditionally referred to the relationship between client and therapist. When an interpreter becomes part of that relationship it raises the issue of whether the crucial alliance should still be the dyadic one between client and therapist or does it become a three-way relationship. One study identified the interpreter as a “therapy conduit” (Miller et al., 2005, p. 31) and concluded that the interpreter’s role was to explain psychotherapy in a relevant and positive way to the client in order to bridge the cultural gap between therapist and client. Although this is an ideal solution, interpreters receive little training or support for this. It creates an over reliance on the skills of the interpreter who may not come from the same community or culture as the client and may not understand what psychotherapy is themselves. Interpreters often do not have access to the on-going peer support, clinical supervision or mental health training that other mental health professionals have (Tribe and Sanders, 2003; Miller et al., 2005; Splivens et al., 2010). The interpreter as therapeutic conduit also places the responsibility and power for the therapeutic alliance on the practitioner who has less training in understanding what a therapeutic relationship is or how to create it.

The dynamics within a triad has been described as a series of alliances (Lago 2006; Tribe and Thompson, 2009). However Lago asserts that all the identified alliances are mutually exclusive to two out of the three participants. Tribe and Thompson by contrast (2009, p. 17) say any configuration of a two-way alliance “spells trouble for good three-way work” Ravel and Smith (2003) interviewed nine clinicians and found that there was implicit tension in the triadic working alliance. The clinicians’ perception was that the client was allaying themselves with the interpreter, which created tensions in the three-way relationship. However, the study states clearly that the practitioners did not always work with the same interpreter when seeing a specific client and did not appear to work on a regular weekly basis with their clients, which may have contributed to this problem. Their study illustrates the need to follow good practice protocols advocated by professional bodies such as BACP and BPS. Continuity and trust are more likely
to be established by regular sessions using the same interpreter. Miller’s study (2005) of fifteen interpreters and fifteen therapists found that when the interpreter was actively engaged in the relationship the outcome was more successful. It is interesting to note that this research highlights a pattern of developing relationships over time in which the client allied first with the interpreter and gradually formed a relationship with the therapist. The change in trust could be seen by how frequently the client made eye contact with the therapist rather than the interpreter. The client/therapist relationship clearly took longer to develop but this study demonstrates that it did establish itself in time, creating a three-way relationship. This study illustrates the need for a nuanced, professional relationship between the therapist and interpreter in which they work as a team in order for the triadic relationship to emerge.

Most of the research cited here has been concerned with a two-way therapeutic relationship between client and therapist. The presence of an interpreter challenges researchers to look differently at a relationship raised by a dialogue with three voices (Rielo, 2000). The fact that three people are engaged in the communication instead of two complicates the dynamic process in the room, (Blackwell, 2005; Miller et al., 2005; Tribe and Thompson, 2009; Lago, 2009). There is an extra person to incorporate into the therapeutic alliance and it is inevitable that the introduction of a third person may impact on the potential to create interpersonal attunement. Post-trauma, a client may feel a profound disconnection to their own emotion (Mearns and Cooper, 2005). The challenge this presents for the therapist is increased when a client feels a profound disconnect to their country or identity as well as to their own feelings and does not speak the same language as the clinician.

There is little in the research literature that indicates if the therapeutic alliance, interpersonal attunement and specific moments of encounter are possible with an interpreter in the room; however, the research literature shows that the therapeutic relationship is one of the key determinants of a positive outcome to psychotherapy. Is it possible to experience an intense interpersonal attunement between three people or can the therapist and client achieve a one to one connection with the interpreter in the room. “We still have a limited understanding
of how the use of interpreters may affect either the process or the outcome of therapy with refugee clients” (Miller et al., 2005, p. 28).

3.5 Contribution to knowledge
The aim of this study is to explore the impact that interpreters may have on the therapeutic process when working with asylum seekers and refugees who have lived through traumatic experiences. There has been literature about the challenges of working with asylum seekers and trauma within the counselling community (Rutherford, 2007; Wilson and Drozdek, 2004) yet accompanying literature about how to achieve this through an interpreter is scarce (Tribe and Ravel, 2003). “The addition of an interpreter into the counselling room represents a significant alteration to the traditional dyadic therapy relationship” (Miller et al., 2005, p. 27).

There seems to be a consensus about basic good practice such as using only qualified interpreters, using same gender interpreters from a relevant cultural background, meeting a new interpreter before working with them and debriefing after every session (Blackwell, 2005; Tribe and Raval, 2003; Tribe and Thompson, 2009). The literature consists of a number of clinical and anecdotal discussions (Miller et al., 2005) and a small amount of research which rarely find any advantages and opportunities when working in a triad, instead there is “a literature that can appear somewhat negative about the challenges and possibilities involved” (Tribe and Thompson, 2009, p. 4).

There are relatively few empirical, clinical or research studies that explore clinical work with interpreters (Raval and Smith, 2003). Century, Leavey and Payne (2007) state that no previous research had attempted to look at the experiences of counsellors in primary care working with asylum seekers and interpreters. The literature also contains little research or comment based on service users’ views (Williams, 2005) yet Bot and Wadensjo (2004, p. 375) state that their patients “…liked the fact that two people heard their stories”. “Much further research is needed in this area of work to understand the issues from the interpreters and families perspective” (Raval and Smith, 2003, p. 27).
Moodley (2003) says research into diversity issues is often underfunded and not taken seriously by the counselling and psychotherapy community: “The lack of substantial research has ultimately resulted in a dearth of knowledge on many of the critical experiences of black and ethnic minority clients. At best, the consequences are misdiagnoses, poor treatment planning and high rates of premature termination” (Sutherland and Moodley, 2011, p. 130).

This study has arisen from a perceived need for empirical research by practitioners in the field. I will focus on the unique experience of each participant in the therapeutic triad and ask the counsellor, the interpreter and the client, what impact the addition of an interpreter had on their experience of the therapeutic process.
Chapter 4 Research Findings

The individual experiences of twelve participants are presented. They had all been part of a therapeutic triad using two languages. Using the focus group findings and the one to one interviews they are grouped into clients, interpreters and counsellors for clarity. Grids of the super-ordinate themes and sub-ordinate themes are presented. The triadic and focus group experience are also acknowledged through stories of specific interactions.

Table 1: Themes

<table>
<thead>
<tr>
<th>Super-ordinate themes</th>
<th>Contributors</th>
<th>Sub-ordinate themes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>THE THERAPEUTIC ALLIANCE</strong></td>
<td>ALL</td>
<td>• The triadic relationship</td>
</tr>
<tr>
<td><strong>Who’s the boss?</strong></td>
<td>Donna (counsellor)</td>
<td>• Changing dynamics</td>
</tr>
<tr>
<td><strong>Who’s the boss?</strong></td>
<td></td>
<td>• Good practice –theory, practice and pragmatism</td>
</tr>
<tr>
<td><strong>INTERPERSONAL ATTUNEMENT</strong></td>
<td>ALL</td>
<td>• Working with interpersonal attunement</td>
</tr>
<tr>
<td><strong>This is another world of interpreting.</strong></td>
<td>Majid (interpreter)</td>
<td>• The added value of the interpreter</td>
</tr>
<tr>
<td><strong>COMMUNICATION</strong></td>
<td>ALL</td>
<td>• Verbal</td>
</tr>
<tr>
<td><strong>Sometimes, when you see a person you feel comfortable at the beginning.</strong></td>
<td>Nadia (client)</td>
<td>• Non-verbal</td>
</tr>
<tr>
<td><strong>CULTURE</strong></td>
<td>ALL</td>
<td>• Working within different cultures</td>
</tr>
<tr>
<td><strong>I was scared... (why did she) want to know about my life? Maybe she will kill me!</strong></td>
<td>Mariam (client)</td>
<td>• A changing perspective</td>
</tr>
</tbody>
</table>
4.1 The Therapeutic Alliance

"Who's the boss?"

**Donna**

Table 2: Theme 1

<table>
<thead>
<tr>
<th>Subordinate theme</th>
<th>Contributors</th>
<th>COUNSELLORS</th>
<th>INTERPRETERS</th>
<th>CLIENTS</th>
</tr>
</thead>
</table>
The first stage of this research was to explore if a therapeutic alliance could be formed with an interpreter in the room. The definition used was:

A means of promoting and applying a set of values concerning respect for others, acceptance of difference, the worth of human beings and the importance of connectedness and human relationships.

(McLeod 2007, p. 82)

All twelve participants said they had experienced successful, effective therapeutic alliances. The counsellors (n=4, Donna, Isara, Rita and Victoria) talked passionately about working with interpreters. The interpreters (n=4, Kim, Fatima, Majid and Martin) had also experienced a connectedness to the two other people in the room. In the client interviews (n=4, Val, Nadia, Oluwaseyi and Mariam) all the participants said the therapeutic alliance was key to their recovery whether in a triad or a dyad. These findings reveal a need for flexible practitioners who can act and react in order to create fluid, dynamic relationships that meet the unique needs of each client.

4.1.1 The triadic relationship

*If you get that kind of bond, that kind of trust developing very early on, you really see how a therapeutic relationships working and can work.*

Victoria (Counsellor)

The clients identified that, whether they were in a dyad or a triad, the key relationship was with their counsellor. This matched the priorities of the counsellor group, who said they wanted to create a direct emotional connection with their client, and the interpreters’ aim to facilitate a dyadic relationship between the counsellor and the client.
The Clients
All four clients said they had experienced successful therapeutic alliances while working in the presence of an interpreter. Being able to develop trust was a vital component for them:

*I felt safe here. She [the counsellor] used to always listen to me, she used to let me out all my emotionally and sadness and [I was] free to talk. To tell everything at her. She was good listener and she knew how to calm me.*

Val (Client)

*In your mind you have to accept there is a third party can help you achieve what you want to achieve…..she was very kind by listening to each word I was saying and translate it to the counsellor…..One day by day, session by session, the counsellor and the interpreter were close to me, they felt like my sisters….they are part of my life.*

Nadia (Client)

The Interpreters
Kim saw creating a therapeutic alliance as the counsellors’ responsibility:

*They [the counsellors] should be able to work as they should if I wasn’t there….I don’t want to interfere in that….*

Kim (Interpreter)

Fatima and Majid said the frequency and length of sessions created an unexpected continuity. Kim and Fatima were pleasantly surprised that the client saw them as part of the alliance:

*…sometimes...the client might be offered a different interpreter and say they’d rather not, or once I had to leave and there was a*
bit of an upset; the client was quite sad. So you think it must be working out well….. yes I do feel part of it after a while and it feels very good, very positive.

Kim (Interpreter)

The Counsellors

All four counsellors had worked in an effective therapeutic alliance with an interpreter. They measured the success of the triadic relationship in terms of their ability to make a connection with the client. They agreed that having a third person in the room made the relationship different. However, this did not mean that their relationship with the client was diluted:

……sometimes I feel like I really know the person, and that I’m known.

Rita (Counsellor)

I’ve had the situation with a client and interpreter where the warmth and the affection in the room between the three of us is quite clear, you know, it’s worked, it’s been wonderful.

Donna (Counsellor)

They did not perceive establishing a therapeutic alliance in a three way encounter as any more or less of a problem than trying to establish a two-way intervention:

I don’t see it as any different to any other therapeutic relationship and sometimes it works and sometimes it doesn’t and it depends on the three people in the room, ….. it depends on the client, where the client’s come from and how they respond to therapy, it depends on the interpreter and, you know, where you are as a therapist that day (laughs).

Isara (Counsellor)
.... I think for me it’s a case of having to... trust the interpreter particularly an experienced interpreter. They know why we’re there, they know what I’m trying to do and so it’s a case of having to trust them to keep the pace that we’re working at.

Donna (Counsellor)

4.1.2 The dynamics in the room

...there’s all sorts of dynamics going on........

Victoria (Counsellor)

When asked ‘who do you think was in charge of the session?’ eleven participants said ‘the counsellor’ and one of the clients said ‘God’. These interviews show flexible practitioners who can act and react in order to meet the unique needs of each client interviewed.

The Clients

The clients’ priority was the issue they had brought to counselling. The clients accepted any changing dynamics as a matter of cause. Oluwaseyi and Mariam described starting counselling in such distressed states that all they could remember was that they felt better afterwards. Oluwaseyi said that she felt an immediate connection with her counsellor. Her trauma was so severe at the time of the therapy that she engaged immediately. Mariam said that she felt confident in both counsellor and interpreter and like Oluwaseyi was pre-occupied with the subject matter of her trauma. Val and Nadia felt scared and it took time to feel comfortable and trust the practitioners in the therapy room. They both said that their focus was on the interpreter when they came to their first session but that this shifted very quickly. Val felt that she had made a connection with her counsellor by the end of the first session.

Three of the clients had experience of both a triad and a dyad but did not identify any problems when the interpreter left. The therapeutic alliance had built up with
the counsellor and the relationship could evolve and change without disrupting any therapeutic intervention. Whatever the dynamics in the room the clients were clear about the distinct roles of the counsellor and interpreter. Mariam’s response is typical:

*It's what the counsellor asked me… that make me cry and the answer the interpreter gave to the counselling to understand that….(the) relation is with counsellor and with client.*

Mariam (Client)

**The Interpreters**
The interpreters agreed that the counsellor should control the process of the session and the client should determine the content. Kim was very clear about the interpreters’ role:

*…for us the professional is the person responsible for the outcome of the session and for meeting the needs of the client, whichever service we’re in…*

Kim (Interpreter)

Both Majid and Martin emphasised the client’s role in the dynamic.

*I think in counselling, actually the client …actually is in charge or he or she decides what to talk, but of course the counsellor is managing and listening…. but definitely the interpreter is just an interpreter and shouldn’t intervene…. *

Martin (Interpreter)

Majid recognised how the interpreter could take control over the session:

*…..like somebody doing a television interview it’s about the control, and the interviewer [the counsellor] getting what he wants or what she wants. If the counsellor lost control, then that would mean the*
session would not be running as it’s supposed to……. but I think if the interpreter realises that, they will give the charge back to the counsellor….the counsellor should be in charge most of the time, if not all of the time.

Majid (Interpreter)

The Counsellors
All of the counsellors agreed on the necessity of a fluid, organic approach to the developing triadic relationship.

It depends what the clients come with, it depends where they are …that sets up the dynamics…. If a client’s come in and they’re distressed,(if) it’s a bit overwhelming, it’s their space…. if it’s more about trying to explain to the client what the process is then it’s more mine, ….and then the interpreter is like…..how they get that understanding over to the client.

Isara (Counsellor)

It can change within the dynamics as well.

Victoria (Counsellor)

Donna, Rita and Isara were aware that because they could not understand what the interpreter was saying to the client they had to relinquish some control and trust in the therapeutic process:

It feels a big responsibility that I’m handing over.

Donna (Counsellor)

……the interpreter has the authority, or the power because of the language don’t they, so, there’s a potential for them to take over… I think that’s a diplomatic way of saying it (laughs)

Rita (Counsellor)
Isara felt that the length and depth of experience that both practitioners had were contributing factors in the success of the alliance:

*I think it depends on how professional the interpreter is, as well as the confidence of the therapist as to who’s in charge.*

Isara (Counsellor)

There was an agreement that having three people in the therapy room inevitably increased the dynamic possibilities. Isara identified that as well as linguistic competence, the interpreter needed to understand the concept of therapy in order to explain this to the client, which in turn impacted on the outcome of the therapy.

4.1.3 Good practice

*I think this, three people in a room, this affects the counsellor more than the interpreter…*

Martin (Interpreter)

All the groups (n=12) discussed their positive and negative experiences of the therapeutic triad. All eight participants of the focus group had negative experiences and discussed the issue of quality assurance. Implicit in the discussion was the assumption that a therapeutic alliance could only be achieved if both practitioners were skilled in their own field. Only one of the four clients had experienced a negative outcome (in another agency); implying that the specific practitioners interviewed in this study had been able to mitigate any problems they encountered and delivered a good service. The practitioners (n=8) discussed working collaboratively and the necessary practice of reflecting after sessions in order to improve.
4.1.3.1 What worked?

The Clients
The clients, as experts by experience, were able to reflect on good practice. The group were clear that their preferences for language or gender had been respected. It was Mariam who spoke extensively about issues of good practice; she was the only participant who said that having the same interpreter and therapist for each session was vital. Mariam had had experience of previous therapy where this had not happened, unlike the other clients. She said that when she began she did not understand what counselling was. Contracting, especially confidentiality and setting the scene were particularly important to her. She was also the only client to have returned to therapy for a second time. She said the ability to be re-referred, request the same counsellor and interpreter, and see someone for an open ended period, saved her life:

_I want to kill myself again because the problem no finish. [The agency] give me another chance to come in again to speak. I know that cost a lot of money and I asked for the same person again and they give me the same person again. That was very important….. I think [the agency] give me the chance to have…. a second life._

Mariam (Client)

The Interpreters
Majid and Martin emphasised the importance of contracting and all four interpreters wanted the counsellor to explain the aims and concepts of counselling to the client in simple language. There was a long discussion about debriefing after each session.

_I think that's another very positive thing for us that counsellors will offer that debrief… all professionals should do that but its very rare that we get offered it… I was offered it once when I worked with Macmillan staff at the hospital and someone was dying but it tends to be exceptional rather than routine in what we do….It’s another_
really positive thing that I know that if there’s something I have been stressing about or that there is an issue we can usually manage to take a few minutes to sort it out.

Kim (Interpreter)

The Counsellors
All four counsellors agreed that they should meet with the interpreter before any therapeutic work had been started, to induct the interpreter. When this did not happen there was more likelihood of problems later. Rita highlighted the necessity for detailed referral procedures to identify linguistic and cultural preferences. Sometimes there was a problem even before the three participants sat down if the dialect, tribe, gender or age of the match between the client and interpreter were wrong.

All four counsellors said that a good working relationship with the interpreter was vital in creating rapport and working with strong emotions. Re-employing a skilled interpreter and re-convening an effective team meant that both practitioners returned to previously established roles that enhanced the new triad.

4.1.3.2 What goes wrong?

The Clients

Mariam was the only client who said that she had a negative experience. She talked about her confusion and distress. Her doctor had referred her to an unknown medical setting and she did not understand where she had been sent. The visits were infrequent, there was a male practitioner, and he was never introduced to her so she did not know who he was or what he did. He wrote down everything she said, made no eye contact with her and prescribed medication.

But he no talk to me, no understand me, don’t want to know exactly what I am feeling scared (about).

Mariam (Client)
The Interpreters

Martin highlighted that working with counsellors could be problematic:

……. it definitely… puts pressure on counsellors, particularly if they don’t feel confident or if they get embarrassed or if they mind actually that they are talking in front of somebody else……..

Martin (Interpreter)

Martin discussed how some aspects of the counselling culture may be alien and difficult for interpreters from other communities:

One important thing that working in these sessions gives is being non-judgemental and that’s usually harder for myself and my cultural background….. It took me years to understand, to get used to the impartial role, because you always want, one way or another to impose your own idea.

Martin (Interpreter)

Three of the interpreters (Majid, Martin and Fatima) openly admitted how difficult it was to cope with the parallel processes of creating a therapeutic alliance with the client when having expert knowledge of the subject being discussed.

…. you are a human being and you are getting that information and passing it, you analyse it too, you know. Unconsciously or consciously…..you picture the situations for yourself and sometimes you see contradictions there, yeah of course, as interpreter I can’t mention, I don’t mention. Particularly in counselling you have to trust the person, you have to accept the person, empathy with the person, but you have your own conclusion.

Martin (Interpreter)
Majid said that he coped by trusting the professional he was working with and that his role was not to take responsibility for the outcome:

*I worked with International Criminal Court…..it seemed to me what the witness said was completely from another world (he lied), but they take it as a very serious thing [the accusation]. I think they do a professional job in a very highly sophisticated way. Highly trained people……. the Judges as well. [From the witnesses testimony] they accepted the person gets tried. Sometimes when you think it is completely wrong, [they say]….it is right….. what you think is right is wrong, So in my opinion just leave the process out of your head.……because, as you said, we are not expert in that field…. Just pass it and sometimes when I go out the door I forget what I heard.

Majid (Interpreter)

The non-judgemental role they were encouraged to take in counselling was in contrast to other settings. Majid confided that other agencies such as the Home Office did not want him to remain in a neutral role, but tried to use him as an expert witness to judge the validity of the people he was interpreting for. It is interesting to note that Kim, the only white, British born interpreter in the focus group, did not have these experiences. Her question to Majid clearly illustrates that this had never happened to her:

…… and sometimes in solicitors or Home Office, they shouldn’t do, but if they know you are from the area they try to make a little bit sure, in clever ways, they push you in order to say yes or no, [is the client telling the truth] something like that.

Majid (Interpreter)

*So the Home Office is asking you “Are they telling the truth?”*

Kim (Interpreter)
The Counsellors

The counsellors’ recounted stories of when triads had not worked because the particular interpreter did not understanding the subtlety of the therapeutic alliance. All four counsellors said that the interpreter’s attitude was crucial. The discussion identified the need to respect and value the client:

You can tell if the interpreter hasn’t got the respect, you know, it’s obvious and it is a very important part of building that on-going relationship with the client.

Isara (Counsellor)

It also identified the need to understand the different roles of the interpreter and therapist:

I had a very bad experience, where the client said, (which obviously I didn’t know….), ‘I wish I was dead’, and before I could say anything the interpreter spoke to him. I said, ‘what did you just say?’ and she said, ‘I said, don’t be saying that, that’s awful’….. (laughs) so I suddenly felt totally excluded from this situation.

Donna (Counsellor)

The discussion also identified the need to understand what the therapist was trying to achieve; the subtle nuances of the therapeutic alliance:

I had an interpreter who was [linguistically] excellent but wanted to mother the client and it was just very, very difficult…..she couldn’t make that jump at all and yet wanted so much to do (this kind of) interpreting.

Victoria (Counsellor)
4.1.4 Training

In light of these differences the interpreter group discussed the need for training. The interpreters had all experienced some specific training from the agency.¹ Martin and Kim said that training for interpreters was essential and that the course was ‘a great thing’. Fatima wanted training jointly with counsellors.

Majid talked specifically about the course he had been on. He said that the training he had received from the agency facilitated the therapeutic alliance and working to achieve interpersonal attunement. It taught him to respect silences, manage emotions, and feel confident in the role:

…..unless the training had been done it would be quite difficult as an interpreter just to come and just work. The training really outlined everything for us …..what the interpreter’s role in counselling is … people that came from my background, they don’t know what counselling is……and in the training I realised that counselling is completely different to any other job that we do as interpreting. I learnt how to respect silence and respect the client in this situation and learn how to manage my emotions as well. Just to cope because it’s a very different thing to listen to someone’s situation, to just walk out the door and forget about it. So after the training I felt more confident doing the job ……unless the training had been done it would be quite difficult as an interpreter just to come and just work. . No one will do it perfectly and complete but I think after the training you would be confident to come and do the job.

Majid (Interpreter)

Fatima and Martin said that the skills they had learnt to work in counselling settings were transferable to every other context they worked in and Fatima said they had enhanced her life skills generally.

¹ The interpreters were trained by the agency on a 30 hour course accredited by the Open College Network and funded for 3 years by the Princess Diana fund from 2001 – 2004. Subsequent one day courses had been held annually.
4.1.5 Stories behind the findings

Rita and Kim
A Counsellor/ Interpreter dialogue

During the focus group all of the practitioners joined together for the final section on personal experience. Something unexpected happened; one of the counsellors, Rita, started a dialogue with Kim, an interpreter she had worked with. Rita took a great risk and talked openly about her feelings of vulnerability and insecurity when working with an interpreter in the room and Kim responded openly and honestly. Rita revealed conflicting feelings. First she told the group that because Kim was such an experienced and proficient interpreter it made her feel insecure as a therapist. Rita put her on a “pedestal” and this made working together difficult.

\[\text{I feel more anxious with Kim, (laughs) and it’s nothing to do with you, Kim, it’s all to do with me, but you know because of your experience....}\]

Then Rita acknowledged her real dilemma:

\[\text{….you know I would always choose what’s right for the client so I want the best interpreter I can get but there might be part of me that thinks someone who doesn’t really know what they’re doing, then the pressure isn’t so much on really…..}\]

She finished her statement by clearly acknowledged ownership of her feelings, reassuring Kim that she had not contributed to the problem in any way:

\[\text{…..I’ve said that (laughs) and now I want to pull it back (addresses Kim) ‘cos of course you are extremely supportive as well, it’s not coming from you, it’s coming from my insecurity.}\]
Kim responded immediately and reassured Rita. She said that she did not deny that she observed the counsellors’ work but explained that she saw things from another perspective; Kim was there to do a job and actually saw the counsellor as an asset in helping her to fulfil her role. Implicit in her statement is the fact that her focus is on interpreting not on the quality of the therapy:

I mean it’s obviously interesting for us too in the sense we do observe your practice, don’t we? I mean, I can’t fail to really from working with you, but it’s in a fascinating way, sort of helping us with what we’re doing…..

She then directly addressed Rita’s fears, reassuring her that she was not judging Rita’s ability. She was clear about her facilitative role and explained that the intensity of emotion and concentration are the things that were different for her as the interpreter. This established that both practitioners were equal in taking risks in unknown areas of work:

I don’t think we make any judgements or anything like that, you know, we’re number three in a room with two people talking to us, that’s what we do. I am not aware that there’s anything unusual in that for us ‘cos we always have to interpret between people. It’s more intense isn’t it? [directed towards the other interpreters]

Their interaction happened in full view of the rest of the focus group and showed both participants’ honesty and insight. It demonstrated their ability to be in the moment, the emotional maturity, bravery to take risks, and the relationship and communication skills needed if two people are to work effectively together. Rita needed to acknowledge her feelings and check out her pre-conceptions. Kim was able to clarify her position and openly talking about it allowed them to move on. Above all they were actively mirroring an intuitive understanding of the pre-requisites for a therapeutic alliance.
4.2 Interpersonal Attunement

‘This is another world of interpreting’.
Majid (interpreter)

Table 3: Theme 2

<table>
<thead>
<tr>
<th>Subordinate theme</th>
<th>Contributors</th>
<th>COUNSELLORS</th>
<th>INTERPRETERS</th>
<th>CLIENTS</th>
</tr>
</thead>
</table>
Having established that a therapeutic alliance was possible with an interpreter in the room, I wanted to explore if the relationship could be developed to a deeper level of emotional connectivity; was it possible to achieve an interpersonal attunement between the client and the counsellor, or even between all three members of the therapeutic triad?

4.2.1 Working at interpersonal attunement

All twelve participants said that they had experienced interpersonal attunement within a triad. The four clients described experiences that can be seen as a feeling of connectedness to their counsellor. The clients understood that they had been working at interpersonal attunement, with their counsellor and interpreter, on complex issues with intense emotions. The interpreters stressed that the emotional intensity of therapy was unique in their professional experience and that working at the depth of interpersonal attunement raised some specific professional dilemmas because of the intensity of the interactions. All four counsellors had experienced ‘specific moments of encounter’ (Knox et al, 2012 p.3) and sustained deep relationships with an interpreter in the room. They described the extra work involved in the triad to sustain this. Working at interpersonal attunement was clearly possible and desirable but put extra demands on both practitioners.

The Clients

The four clients described experiencing a sense of connectivity and interpersonal attunement in therapy. They had all been referred with complex trauma and had experienced human rights abuses in countries around the world. Understandably some found it difficult to share such degrading and emotional subjects with strangers. Nadia was able to remember her first session and her first ‘specific moment of encounter’, (Knox et al, 2012 p.3) and the impact this had on her future therapy:

[Before I walked in I was thinking] Can I talk to her about everything? And I start talking…I wasn’t expecting to do that straight away….She understand me, its like she lived what I had in [country of origin], yes she helped me by listening, giving me some advice, yes, how to deal with everyday life, yes, I was very, very,
stressed, I needed to talk to someone, not my husband, not my sisters, not my family at all. I needed stranger, but time by time she was not stranger. No, she was a very important person in my life, because I come here with my heart full of things, when I go back home, to my house, I feel relaxed because, it’s like I emptied bit by bit.

Nadia (Client)

Oluwaseyi said that when she came for her first session she was so distressed she immediately began to work at the deep emotional level of interpersonal attunement:

Because by that time I have a lot of things in mind that is really bugging me. So I have just put everything in my head and it is really heavy for me. I can’t carry it. So I just feel so bad and each time I think of it I will just be weeping I feel so bad…..the counseling cleared to my brain and let me know that…… …I am not the only one who has this problem.

Oluwaseyi (Client)

(It) was helpful, once I talk to her…(it felt like) you put something (a big pot) on your head, you want somebody to help you because its too heavy for you to carry.

Mariam (Client)

The Interpreters

The topic of interpersonal attunement was particularly important to the interpreters. All four discussed how the emotional intensity of therapy distinguished it from every other place they had worked in.

…its more intense, isn’t it?
Kim (Interpreter)

*It’s not easy when the client tells you that they are going to end up killing themselves.*

Fatima (Interpreter)

Fatima liked the therapeutic hour because there was space and time to allow the client to explore things, in contrast to her experience in the NHS.

*The client takes long ‘cos they express their feelings and how they feel inside and what makes them happy and unhappy…..When you come here its silent and emotional and the person can go from one mood to another.*

Fatima (Interpreter)

They also talked about how to convey emotion in their interpretation while maintaining a professional demeanour, rather like an actor playing a variety of parts at the same time:

*In counselling you have to convey emotion and feeling. The counsellor knows that everything should match the feeling of the client…..*  

Majid (Interpreter)

*You have to empathise without going over the top.*

Kim (Interpreter)

**The Counsellors**

All four counsellors said they had experienced working with interpersonal attunement when there was an interpreter present in the room. This was acknowledged as an intense, taxing and delicate process and that adding another practitioner into the room increased the workload of the counsellor:
It’s a lot to hold…if the clients engaging….its quite intense.

Isara (Counsellor)

It’s all about building up relationships and building up the understanding and when it works really well, it flows…

Rita (Counsellor)

Victoria was concerned about holding ‘specific moments of encounter, (Knox et al, 2012 p.3

One of the things I found different right from the start is … keeping the moment……because there’s a third person the moment’s longer. Whatever’s being talked about or whatever comes up…You have to hold the moment longer because there’s three, from the interpreter’s translating to the client……..I found that that was a new experience for me……. I don’t mean takes longer in the wrong sense of the word but that can be a good or a hard thing depending on the depth or what’s happening for the client.

Victoria (Counsellor)

4.2.2 The interpreter as added value

They’re part of the support for the client and it is a key element.

Isara (Counsellor)

There was some discussion about whether the presence of a third party could enhance the therapeutic relationship; that two practitioners may be better than one. The interpreters said that the role they had in therapy was unique as they built up a relationship with the client in their own right. The counsellors felt that the presence of the interpreter provided extra support. It validated the work and an extra person in the room could share the shock waves of the trauma. Two of the
client group and all four counsellors identified that a good interpreter was a positive element to bearing witness within the therapeutic alliance.

The Clients
Val, Nadia, Oluwaseyi and Mariam all commented that their interpreter did an excellent job. Val and Nadia used the term they indicating that the empathic alliance they felt with their counsellor was shared with their interpreter.

They have done a wonderful job and I was so grateful what they have done for me.

Val (Client)

I felt like they are my sisters. We don’t have the same blood, we don’t, but we are sisters this is for me. S (the interpreter) too, yes. Part of my life, I can’t forget her like that no.

Nadia (Client)

Mariam had worked in a triad with Rita as counsellor and Kim as interpreter and emphasised that the two practitioners had doubled her support:

...because my experience was so emotional I saw both of them one day.... I was crying... they start to cry as well.... The interpreter and the counsellor, they are crying......people.....sharing their experience like your experience......It was very, very amazing for me, strange for me ... another person crying because you cry, feel your place on their place, know exactly what was so hard for you like hard for them as well. I never see people like that....That was very, very special.

Mariam (Client)
The Interpreters

Fatima, Kim and Majid discussed the importance of establishing a relationship of trust with the client in their own right. The interpreters noted that there was a more relaxed atmosphere than in other settings and that continuity allowed the development of relationships. Kim said that she found it useful to be given some time at the beginning of the relationship to explain her role:

…… how we’re all helping each other as well….. it’s important that we’re given the opportunity to express our take on it ‘cos the client obviously has to trust in our confidentiality as well.

Kim (Interpreter)

Majid focused on building a relationship:

I think the interpreter plays an important role because the client talks to the interpreter rather than the counsellor,… if the client feels happy, relaxed and confident (with the interpreter)…the more the client talks in depth, the more the counsellor….can do. So I think the interpreter isn’t just sitting there transferring the words.

Majid (Interpreter)

Fatima talked in depth about a sophisticated relationship with a sense of three equals all working together and the connectedness she felt when she was working within interpersonal attunement. She too used the collective us to indicate the two practitioners working as one unit:

I feel that, the connection….you feel a part of it and you’re more connected to them because you get to know each other…..So you feel closer. Whatever situation that person is going through, they can come back and talk to us about it.

Fatima (Interpreter)
Kim and Martin talked about the qualities an interpreter needed to work in a therapeutic triad:

It’s very specialised and it may not suit everyone…. some interpreters try it and don’t like it for whatever reason….It is specialised.

Kim (Interpreter)

If you yourself have gone through some hardships and understand what it would be like, it makes a big difference….

Martin (Interpreter)

The Counsellors

All four counsellors talked eloquently about what a second practitioner can bring to the atmosphere in the room. The counsellors emphasised how important they thought the personal qualities of the interpreter were in creating the alliance. As well as the obvious linguistic skills Rita and Victoria felt that they had to be emotionally literate, mature and self-aware:

The interpreters talked about getting upset and the ways that they managed that and that takes a certain amount of maturity and you know gumption…..you’ve got to choose to do this work.

Rita (Counsellor)

Rita, who had worked as a triad with Kim as interpreter and Mariam as client, echoed Mariam’s observations and described how two practitioners can create a stronger therapeutic alliance than one and create extra validation for the client:

I often feel that the other person is helping that relationship, enabling that relationship. I really like it when interpreters use the same tone of voice as me and it feels like we’re one person a bit, for a little bit, or when they look like they’re really trying to find the
right word or they’re really engaged. They search around and maybe sometimes they apologise but…. I think that’s really good, it’s like two people are saying to the client, ‘you are worth this, we’re giving our time, we’re being there for you.’ We are working together. It’s giving even more respect to a client than one sometimes.

Rita (Counsellor)

Isara stressed that the interpreter’s empathic presence can add to the support in the room:

What Majid said earlier and Fatima that even though the interpreter might seem sort of in the background….. I can feel that they are feeling, and the client can feel that, so even though you’re not actually saying it, you can pick that up in the room.

Isara (Counsellor)

Rita felt that the presence of the interpreter validated the work and an extra person in the room could share the shock waves of the trauma:

Having someone there is company in the situation. You’re not alone (with the trauma)…… just to feel that understanding, that’s something you can’t get when its just you and the client.

Rita (Counsellor)

4.2.3 The impact on the individual

It became a completely new job.

Majid (Interpreter)

Working within a sense of interpersonal attunement was a completely new experience for two of the three groups interviewed (the clients and the interpreters). Three of the interpreters and all four clients talked at length about the
impact working at such an emotional depth had on them as individuals. None of the counsellors had raised this as an issue.

The Clients
The experience of interpersonal attunement had a significant impact on the clients interviewed. The purpose of the intervention was to change their lives in meaningful and positive ways and it was clear from all four interviews that this is exactly what happened. They were all full of praise for their counsellors and the interpreters they had used.

Mariam believed that working at such a deep emotional level with an interpreter literally saved her from suicide:

I feel maybe if it wasn’t coming to (name of agency) maybe on that day I will kill myself, because I tried to kill myself a lot of time…… it was very, very amazing for me… I never see people like that…. that was very, very, special. I could say that they big supported me.

Mariam (Client)

For Nadia, the shadow of her trauma remained but she had learnt to cope with it on a day-to-day basis:

….I was low, very low but thank God and thank (name of counsellor) I am much better, I can’t forget what happened to me no. It’s there, it’s there but….I am getting a little bit emotional when I remember… I am so grateful what these woman done for me.

Nadia (Client)

Oluwaseyi had brought some notes to help her:
The counsellor let me know that I can live my own life, without taking medication and she let me know that I can empower my future, that I will become somebody in future.....I have number one, confidence, confidence in yourself. Number two, know who you are, number three stability, number four encouragement, number five success, number six emotion, seven persistence and number eight make sure you fulfill your goals.

Oluwaseyi (Client)

The Interpreters
The Interpreters who took part in this research were extremely experienced, yet all four made it clear that working in a therapeutic setting was different to any other context they had ever worked in. Majid summed up the feelings of the whole group when he said:

…..when I came here I realised that it is different, what was expected, in the way of the environment, the situation, in the way of the topic, too many differences. So I realised, this is another world of interpreting than the way we usually do.

Majid (Interpreter)

Three (Fatima, Kim, and Majid) discussed how they had struggled to stay professional when confronted with working at such a profound and deep emotional level. The spontaneity of therapy meant that the interpreter was tested personally and professionally in specific moments of encounter. There was an acknowledgement that as well as capturing, processing and delivering the right words, tone and pace they had to maintain a dignified and professional demeanour:

……..sometimes it’s hard to keep control of emotions, you know, ‘cos you don’t wanna show shock, particularly shock….. or you try not to look too upset. That does tend to happen more in counselling, but its also happened to me in other contexts as well
with other clients, even medical ones. People are given bad news it does happen quite a lot.

Kim (Interpreter)

You have to show that you can get emotional too, to show your humanity, but mainly you have to control, to not affect the situation.

Majid (Interpreter)

The interpreters were concerned about the levels of distress they saw and the possibility of vicarious trauma; how this new area of work could impact on them as individuals. Majid said that his training had taught him to manage emotions (both the client’s and his own). Fatima said that particular issues and subject matters affected her, especially suicidal ideation. She admitted that when she started this area of work it was unnerving and uncomfortable:

It was very hard for me to take at first, but a few sessions later I felt comfortable.....there was a case where I would just cry...I couldn't take it, I just couldn't take it.....you have to control your feelings.....it was really hard. Fatima (Interpreter)

The interpreters were also concerned about the on-going welfare of their clients. Kim said she coped better working in a counselling setting because there was a continuity of care:

...when someone’s in dire trouble, you know that when they leave the session (in another agency e.g solicitors) there’s no one going to help them sometimes, and you think what’s going to happen to them next?....But if you know someone’s having counselling, you know that they’re having some kind of help and making progress and they feel cared for in a kind of way.

Kim (Interpreter)
4.2.4 Stories behind the findings

Fatima, Victoria and Val

Interviews with three sides of a complete triad.

Although Victoria (a counsellor) and Fatima (an interpreter) sat in the two separate discussion groups within the focus group, during the analysis it became clear that they were both referring to their joint work with Val.

When asked ‘to what extent are you able to work with interpersonal attunement?’ Fatima said:

*I have. It does affect you because basically you’re taking in (emotion). Even though you know when you’re passing information to the counsellor you try to control your emotional feelings ….so the client doesn’t feel you’re not with it but at the same time you are with them because they’re telling you all their information. There was a case where I would just cry… I couldn’t take it, I just couldn’t take it.*

The story of this specific therapeutic alliance illustrates how important it is to remember that there are three separate individuals in the room, all of whom bring their whole self and experience. The interpreter had to manage the emotional intensity of the material being presented by the client and the impact of these on her personal identity as well as her professional role. The issues are precisely the same as they were for the counsellor involved but the interpreter has not had the supervised practise of a student counsellor or on-going clinical supervision to discuss these issues.

Val, as the client, was talking about the death of a parent and this clearly had a personal resonance with Fatima.
You get more emotional with what the client is saying.... there was a time when I was working with a counsellor when I just couldn’t stop crying because of what the client was saying.

Victoria, as the counsellor, was able to hold the situation and saw it as not only cathartic but also fundamental to the successful therapeutic alliance that developed between the triad:

It was about, suddenly, the client bringing something that was so traumatic but it was also so traumatic for the interpreter and having to hold it, and we all did hold it,........ And I think if you get that kind of bond or that kind of trust developing very early on, you really see how a therapeutic relationship’s working and can work. But it’s quite awesome in a way.......it’s the vulnerability of the client, the counsellor and the interpreter which we all bring into that room, because no one knows at any time when something just comes up........ I think it’s holding on to that moment, the three of you, sometimes maybe in an unconscious way, that it’s indefinable the therapeutic alliance sometimes.

Clearly their story reveals skilled practitioners and a counsellor, who was able to maintain the emotional connectivity and depth of interpersonal attunement, contain the dynamics and hold the moment, while keeping both client and interpreter safe.

It can change within the dynamics as well....The interpreter can be confronted with something that’s quite hard for them early on ..... something that they might have some difficulty with so it’s fluid who’s in charge..... it can change depending on what’s happening in the moment.

The therapeutic alliance was clearly felt by all three participants. Val saw this emotional intensity as a positive experience:
I was kind of nervous; I didn’t know what its going to be like working with Victoria and having interpreter at the time….But after the first appointment I think it was just all good and I started (to feel) more calm and I got to know both of them and it was really good you know.........they have done a wonderful job and I was so grateful what they have done for me (pause) working with both Victoria and Fatima was a good experience.
4.3 Communication

“I like working with counsellors...I feel counsellors are so much more aware of communication than most of the people that we work with...I always feel that helps us.”

Kim (Interpreter)

Table 4: Theme 3

<table>
<thead>
<tr>
<th>Subordinate themes</th>
<th>Contributors</th>
<th>COUNSELLORS</th>
<th>INTERPRETERS</th>
<th>CLIENTS</th>
</tr>
</thead>
</table>
All three groups (n=4) saw communication as the obvious issue to consider when working in a triad. They discussed both verbal and non-verbal communication on a variety of levels to express content, emotion and the developing relationship in the triad. There was an assumption from all participants that the interpreters would be linguistically competent in at least two languages. All four counsellors said that their communicative practice had changed over the time they had been working with interpreters. The interpreters saw themselves as part of a team trying to communicate intimacy and immediacy.

4.3.1 Verbal communication

*The person is talking about their feelings and their emotions.*

*Stopping them (to interpret) is stopping this and changing the atmosphere in one moment.*

Martin (Interpreter)

Seven out of eight participants in the focus group talked about the problem of pacing in therapeutic interventions because of vocal delay. What is seen and heard does not fit together, rather like watching a foreign film that has been badly dubbed. The counsellors discussed the advantages of working with continuous interpretation because it created a slower pace which they felt appropriate to work with complex trauma. The depth of feeling was often enhanced by repetition. There was also some discussion about the use of simultaneous interpretation which could create a sense of immediacy.

The Clients

All four clients said that they had not experienced any communication barriers. They perceived the interpreter as doing a practical job well. The interpretation had been detailed and accurate which in turn had led to a feeling of being listened to, respected and valued by the interpreter.
She helped me a lot and she interpreted whatever I want to say to Victoria.
Val (Client)

I feel relaxed…I have someone that will explain what I want……she is the one between us, between me and Isara. She really did a great job.
Oluwaseyi (Client)

All four clients remembered in detail how the work had been contracted and explained. It was clear that Val and Nadia felt withdrawn and frightened when they first came for counselling. Both talked about scrutinising the specific words used when they met their counsellor. Oluwaseyi and Mariam said that they were unable to function and displayed great distress when they started their sessions. Their therapeutic needs were met by allowing them the space to talk and express their deep distress and both had clearly experienced an emotional catharsis.

Two clients, Oluwaseyi and Mariam, discussed accents and idioms. Mariam was relieved that the interpreter she saw spoke standard French and that her accent could be understood. She said that she was worried that if the interpreter had come from another colonised country, or spoken with a heavy accent or patois, they may not have been able to communicate: Oluwaseyi spoke some English and could understand the interpreter:

I understood everything she is saying to Isara.
Oluwayesi (Client)

However, it was the counsellor that Oluwaseyi could not understand:

At times Isara speaks fast and she speaks Scouse and I don’t hear Scouse because I am new to Liverpool…I don’t understand her. Oluwayesi (Client)
The interpreter was able to understand Isara’s Liverpudlian accent and translate it into the Nigerian language of Yoruba. This illustrates the need for interpreters who have bi-cultural skills, that may extend to the counsellor as much as the client, as well as bi-lingual skills.

Three out of the four clients had continued therapy in a dyad once they were able to speak English. All four clients spoke about acquiring English and how that made them feel. They all saw this as a significant achievement in their lives. Val saw the change from triad to dyad not as an emotional or relationship leap, but purely a linguistic one, as she perceived her interpreter as the counsellor’s voice. She felt a strong connection with her counsellor whether the interpreter was there or not.

_I couldn’t believe that I am talking to Victoria, when at the beginning I didn’t even know anything._

Val (Client)

Oluwaseyi’s interpreter facilitated her linguistic transition. After a few weeks she was not needed:

_She gave me confidence [to speak in English]…. I can explain myself without somebody help me to explain my feelings. [changing from three to two] that doesn’t make a difference but I just feel better. That I can explain myself that I have confidence to explain myself._

Oluwaseyi (Client)

Only Nadia felt a change in her relationship with her counsellor and saw the interpreter as a barrier:

_When I started talking one to one it was much better…It’s like you are in a cage……just me and my counsellor, ok. I was comfortable with S (the interpreter) but now I can fly by my own_
wings… I wanted my counsellor just for myself. You can’t express yourself. I did ok but it’s not like when you can say what you want yourself.

Nadia (Client)

The Interpreters
All four Interpreters agreed that there were some unique linguistic features to working in a therapeutic setting:

As the time goes it makes it easier for you because you understand the person and the way they talk.

Majid (Interpreter)

Kim highlighted the difficulty of translating idioms and the specific language of therapy:

(the) language is sometimes quite vague, there’s a certain type of language used sometimes which isn’t used in other contexts, (laughs) and it’s not always easy to translate is it?….. talking about things like being in a safe place… If you translate that, it means a safe place, literally, doesn’t it? (laughs) it doesn’t mean your state of mind at all.

Kim (Interpreter)

The interpreters identified that the difference between interpreting in other situations and in a therapeutic context was spontaneity; the questions asked were open and that there was no ultimate goal except self-awareness. There was a clear understanding amongst them that they were part of a team trying to achieve intimacy and immediacy:

…in other situations the interpreter may anticipate answers but in counselling they should wait without any anticipation and translate
word by word and with the emotion as well. In other places you don’t have to convey emotion or feeling……. The counsellor [needs to trust]. that everything should match the feeling of the client …

Majid (Interpreter)

The interpreters discussed the complicated issue of capturing emotion and content. They worried about when it was appropriate to stop a client if they were in an emotional catharsis and talking for some length of time. It became clear through the interpreter and the counsellor discussion that both practitioners looked to the other for guidance and that each session, with each client, was unique.

Martin was concerned about the delay in the communication of emotion because of the basic mechanics of translation. He acknowledged the interpreter’s role in creating a communication flow that allowed for emotional intensity and therapeutic interventions:

If three people take more time [consecutive translation], the counsellor is not in actual normal, natural face to face relationship with the client and the interpreter may sometimes have to stop the client. In many situations that is not important, but I think in counselling it is very important because the person is talking about their feelings and their emotions. Stopping them is stopping this and changing the atmosphere in one moment.

Martin (Interpreter)

Kim talked about the difference between working in a counselling setting and other official agencies such as the Home Office. In such settings the aim of the interview is information gathering, whatever emotional state the client is left in. She recalled an incident working in therapy that she had never experienced before when the counsellor made a clinical decision that emotional catharsis should override the need for detail:
Somebody [a counsellor] said to me once, it doesn’t matter if you leave things out, let them talk…. Again, that is a bit different… ideally we’re not allowed to miss things out are we?

Kim (Interpreter)

However, the interpreters were unenthusiastic about simultaneous translation. Martin agreed that it might increase spontaneity and accuracy, however Majid was concerned about pacing and the stress on the interpreter:

I think interpreting in counselling is far more difficult than doing other things because in others they can just stop the client and ask them to repeat in order to just get the sentence. But in counselling I experience that whenever you are speaking with the counsellor, the client may jump in and speak. So you have to listen and speak at the same time and that makes the process in the head quite difficult and sometimes you might miss some and you cannot just say please wait. It makes it difficult sometimes.

Majid (Interpreter)

The Counsellors

All four counsellors discussed the communication differences between a therapeutic dyad and a therapeutic triad. There was an acknowledgement that the work was inevitably harder and requires more concentration than one to one counselling:

…when you work with an interpreter it’s quite intense isn’t it? And it’s quite tiring (voices agree) and you know, obviously it takes twice the amount of time really so sometimes it’s frustrating ‘cos I don’t feel I’ve done as much as I wanted to do in that session.

Donna (Counsellor)
All four counsellors said that their practice had changed over the time they had been working with interpreters. They all agreed that working with – non-English speakers had enhanced their communication skills; their language and phrasing had become simpler, shorter and more effective. They all agreed that this had impacted on their work with English speakers as well. They observed that they had become more sensitive to the linguistic and cultural difference within English speaking communities.

*I’m engaging with the client quicker.*

Donna (Counsellor)

Rita said that she was frustrated by the verbal and emotional delay of consecutive interpretation and that she had experimented with simultaneous translation. Rita made it clear that this required even greater co-operative working with more reliance on the involvement and professional judgement of the interpreter.

*…trying to get the pacing better ….., I enjoy that immediacy, that it starts to flow a bit more and there’s more eye contact and shorter interactions, well slightly shorter.*

Rita (Counsellor)

Isara and Victoria talked of the cultural interpretation of idioms. They discussed how they relied on the interpreter to translate their *little scouse sayings*. Rita felt that was why the interpreter had power over the whole interaction. Isara observed that an effective interpreter in a therapeutic setting had to convey both meaning and intent:

*With the nuances of language that we use to explain what we do…..I depend quite a lot on the Interpreter to get what I’m trying to explain in a way that the clients gonna understand.*

Isara (Counsellor)
All of the counsellors said that they intuitively focused on body language because of the verbal delay. Rita and Isara agreed that the delay caused by the interpretation gave them time to think and listen more intently. They also talked of subtle verbal shifts and nuances. Often the counsellors described working in unchartered territory in which there were no obvious verbal or non-verbal cues to let them know how well the therapeutic alliance was developing:

I sometimes feel I might miss the moment..... I’m not absolutely sure which part of the response is to what particular part I’m saying......... if a client sort of gets to talk, really really talking and there’s something I was going to respond to and then it’s been way left behind because they’re so far ahead with what they’re saying and I think, well, I can’t go back to that now ‘cos they’re talking about something else that’s very emotional and very important to them. So I think there’s something in having to have trust in the experience of knowing, Donna (Counsellor)

Rita particularly focused on her experience of a different kind of therapeutic communication in which the counsellor may not hear every word or detail:

It’s more subtle….there’s certain areas where I really don’t know if I understand what that story was about….I do accept limitations and on balance I find that I’m...helping the person....(but) I want to know that I’m making a difference and its like I have to let go of that.

Rita (Counsellor)

4.3.2 Non-verbal communication

When she listen it feel like you are going to heaven.

Nadia (Client)
Eleven of the participants agreed that non-verbal communication was a significant factor when engaging with clients who do not speak English. There was a collective focus on the positive merits of non-verbal communication. However the practitioners stressed that this could be subject to cultural interpretation and should be approached as a unique expression by each individual that could be learnt over time.

The Clients

Three of the four clients (Val, Nadia and Mariam) discussed non-verbal communication. Nadia said that because she could not understand the words of the counsellor she relied on observation, gut feelings and body language:

*In the waiting room and when we went to the counseling room, just the three of us, believe me I looked at [my counsellor] carefully. Can I trust her?.......It’s [what is] in your heart. When you stay in one room you sit with a person, maybe we talk the same language but if you don’t feel comfortable in here (points to her heart).....It’s your faces....sometimes, when you see a person you feel comfortable at the beginning....The counsellor talk in soft voice to me. In her face I felt I am 100% she understand me. Better than anyone else……The body language helped me a lot and (the interpreter) was very kind by listening to every word I am saying and translating....and we start to communicate.*

Nadia (Client)

Although Nadia emphasised that non-verbal communication was vital to creating trust and a therapeutic alliance, she went on to explain that even though she could not understand the meaning of the words, the very sound, the tone and pace of the counsellor’s words added to the therapeutic atmosphere in the room.

*It’s especially her voice; believe me it’s very, very soft . And anyone’s just depressed, when you listen it feel like you are going*
to heaven believe me……. When I listen to her I forgot everything outside. Yes I am just with her. I have to listen to her, I know she is here to help me to advise me yes, and when she asked me questions, the way of asking its really important. Its not harsh, no its just she gave me time to start talking about what happened to me, yes, and how I felt and how I feel now, it's the body language. Everything, she made everything easy.

Nadia (Client)

The Interpreters

All four interpreters were clear that non-verbal communication was part of their professional responsibility. Fatima particularly talked about pace:

I think it’s more relaxing for both the client and the interpreter because the counsellor always lets the client take their time and…. if they don’t feel like saying something they don’t have to say it…..

Fatima (Interpreter)

Majid identified a non-verbal communication flow, that the interpreter and the counsellor were a team working together:

The interpreter should show the client, or show the counsellor that they are a good listener…. ‘cos some people get very emotional and look in your face, and if you are not just reflecting their emotion, [if you were] smiling or something like that, well they won’t be confident or would not trust you.

Majid (Interpreter)

Fatima and Kim said that in their experience the use of silence was unique to therapeutic work:
……… the silences, which we may quite like because it gives you time to think. I’ve sat for a long time looking at the spots on that green carpet you know, thinking (laughs) what happens next? And you don’t tend to get those silences do you so much? It’s more a case of getting information quickly and you’ve got no time to lose (voices agree).

Kim (Interpreter)

The Counsellors

All of the counsellors discussed non-verbal communication. They agreed that with vocal delay they relied on their client’s eyes to interpret what the client was feeling:

Sometimes I get lost in what the clients saying, even though I don’t understand because I’m picking up their body language and emotions so I can get lost in that…..so I might respond more to the body language rather than what’s said, which is not ideal but it just depends how emotional the dialogue is…..

Isara (Counsellor)

They highlighted that this can result in misunderstandings. Donna, Rita and Victoria all related stories in which their normal professional judgement had been called into question because they had read the body language and intonation of the client in the wrong way:

I’ve felt as though I haven’t connected with the client to the extent I’ve wanted to when I’ve had the interpreter with me, but I’ve completely misread the situation and then when it’s come to an end, I’ve had this huge rush of affection from the client which has bowled me over …… I don’t know if its because I didn’t hear the tone or I didn’t read the body language because the person has been so reserved because of their culture or whatever…..As I say
at times it's been very apparent, but other times I've just missed the depth of the relationship.

Donna (Counsellor)

Victoria related an instance in which she thought the client was angry when they were relating a funny story:

Afterwards I processed that and I thought I was concentrating too much on the tone and I’d obviously missed something, completely missed it ….I couldn't have been more wrong. …..we’d got enough relationship built up ‘cos we’d been working together a while with the client that (getting it wrong) was ok….

Victoria (Counsellor)

Victoria considered that non-verbal communication was a more fluid process than language, with each participant watching and listening to the other two people in the room simultaneously. This increases the possibility of mis-communication and requires honesty and trust by everyone in the triad so that any problems can be explained and rectified immediately:

The fluidity and the trust builds up….It’s like a radio going on to different programmes sometimes. When it’s translated back you’ve got what the client’s listening to [and they are watching you] when the interpreter’s giving back ….it’s like a process isn’t it, …..you’ve got to then respond maybe in a different way and it’s quite hard sometimes, …it’s a big melting pot.

Victoria (Counsellor)
4.4 Culture

“I was scared... why did she want to know all my life? Maybe she will kill me!”

Mariam

Table 5: Theme 4

<table>
<thead>
<tr>
<th>Subordinate themes</th>
<th>Contributors</th>
<th>COUNSELLORS</th>
<th>INTERPRETERS</th>
<th>CLIENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Donna (857-862)</td>
<td>Kim (408-412, 442-448, 475-477)</td>
<td>Oluwaseyi (377-381, 667-694, 735-742)</td>
</tr>
<tr>
<td>A CHANGING PERSPECTIVE</td>
<td>ALL</td>
<td>Isara (916-925, 982-999)</td>
<td>Fatima (936-943)</td>
<td>Val (60-91, 101, 192-193, 332-335)</td>
</tr>
</tbody>
</table>
In the focus group discussions the participants identified two cultures that had to be negotiated simultaneously in the therapy room. One was the obvious diversity and understanding between the three people who formed the triad. The other was the concept of mental health and the professional system of support surrounding it. The alien culture of therapy itself had to be understood by both the interpreter and the client if any intervention was to succeed.

This research demonstrates that a therapeutic alliance and working within interpersonal attunement can both be achieved with an interpreter.

My third research question explored the personal impact on each participant in the triad. All twelve participants had faced new challenges when working in a triad. Having risen to the challenge of working in this new and different way, all the participants felt extremely positive about the experience. It had enhanced the practitioners’ professional skills and enabled the clients’ recovery. It had also changed the personal perspectives of every member of this research.

4.4.1 Working within differing cultures

4.4.1.1 Diversity and difference

*Every triad is absolutely unique, a unique cocktail and a unique situation.*

Rita (Counsellor)

The Clients

The client group (n=4) discussed issues of diversity. Each client focused on different and specific cultural needs echoing the counsellors’ observation that each triad has to be approached as a unique cocktail. It was unclear if these cultural requirements related to the values and culture the client was from, the maltreatment they had experienced in other regimes, personal preferences or all of these. However, the clients were able to feedback on whether their diverse needs had been met. They all said that their preferences had been respected. Having female practitioners was voiced as essential for two clients (Nadia and
Mariam). Oluwaseyi was pleased to see two black women while Mariam was pleased to see two Europeans. She perceived her lack of cultural links with either of the practitioners as an asset. She believed that an interpreter from her community would have judged her by cultural standards in which she was seen as disgraced. The European interpreter represented a set of neutral values and she felt safe to talk and be accepted. Mariam spent some time discussing contracting, emphasising its importance especially if the interpreter came from the same community as the client:

*It wasn’t easy (to talk) because…. if the person (comes from) Africa, all people gossip. There is a lot of things like the confidentiality it’s very, very helpful and make people confident…..If you are confident you can.. (say) everything you want…*

Mariam (Client)

Oluwaseyi saw her counsellor’s African heritage, but not her dual Irish ancestry, or her Liverpool roots:

*I don’t know that I would meet (a counsellor and interpreter who were) black, …..but when she is black I am so happy with it. Yeah so I feel good, I feel relaxed…I felt so because they are both from Africa so I felt at home.*

Oluwaseyi (Client)

The therapeutic alliance has to accommodate the deepening relationship between all three participants. This can create new cultural challenges. As a practicing Muslim, Nadia faced a shift in her perceptions when her counsellor revealed that she was Jewish:

*[My counsellor] was Jewish, I am Muslim and what’s going on in Palestine…..we are human before religion, and she was here for me, this is the most important thing.* Nadia (Client)
The Interpreters

The interpreters did not speak in any detail about the diversity in the room. However, Fatima pointed out the need to understand the customs and specific nuances of the community the counsellor was working in. She explained that in her community looking someone directly in the eye is seen as rude. She stressed that it was important that the counsellor understood and accommodated this into the interaction between the triad. She saw her role as a cultural as well as linguistic interpreter and that as long as the counsellor understood and adapted to the cultural difference in the room it became a lot easier for the client to talk.

The Counsellors

All four counsellors discussed issues around diversity and difference and how the cultural diversity in the room could impact on the therapeutic alliance. All four counsellors agreed that there was a new configuration every time a new triad started. They identified that there may be layers of cultural dynamics working simultaneously:

......it depends if the interpreter is from the same culture or place as the client....when I work with Kim who’s a Scouser like myself, but we’re working with someone from the Congo, there’s a different dynamic. And because I’m a black woman working with an African woman.... it’s different than, say, I was working with a French interpreter from the same place as the client. I don’t know if I’d work differently but I think the alliance would be different because....the client would relate more to the interpreter than they do when I’m working with Kim ......all these different nuances make a difference in how that relationship evolves. So it’s always different, every time it’s different. And you have to work with that.

Isara (Counsellor)

The counsellors described a variety of configurations of diversity that they had encountered. These included working with two Africans from different countries, which meant that ethnicity but not culture was shared. When there was varying
ages between the three people it created a different dynamic about respect for elders. Some clients and interpreters had a linguistic link but not a cultural one because they lived in very different communities. Rules and behaviours relating to gender could also enhance or hinder the therapeutic alliance. In some instances the client made assumptions and projections about the interpreter. For example, assuming that they were born in the same war torn country and had similar experiences when they were British born. All four counsellors agreed that they saw it as their responsibility to negotiate layers of difference or similarity into a safe and comfortable configuration that would result in a therapeutic alliance.

4.4.1.2 Counselling as a unique culture

.....the counsellor told me something very interesting. She say talk with someone, this (will) divide your problem!

Mariam (Client)

The Clients

All of the clients discussed their initial confusion about what the agency did and what was expected of them. Mariam said that the doctor had referred her but she did not know why or what she had come to. She explained that she had no understanding of therapy or concepts of mental health before she came to the agency. Asking her to talk about her feelings was a completely alien concept:

I was scared and everything was in my head. I just ask myself [why did the counsellor]… want to know all my life?....Maybe she want me, she will kill me, what she wanna do me! I was scared. Who is that woman, what does she want?

Mariam (Client)

Soon she began to understand:

She just explained what counselling mean. For lot of time I say maybe it's like in my country. If you not feel well you go to the
hospital and you need to pay money to feel well. She giving me the same experience but we don’t pay the money! “I want you to feel well.”…..Why was she being so kind?…..the counsellor told me something very interesting. She say talk with someone this (will) divide your problem

Mariam (Client)

Nadia raised some boundary issues. She wanted to see her counsellor outside of the counselling room but was told that this was not possible, yet her interpreter had visited her at home and given her some gifts when she had her baby. Her counsellor and interpreter behaved differently so she was confused about what was acceptable. She said she wanted to meet her counsellor in a different setting like a café and that the counsellor was part of her life and she felt like a friend at a time when she had none. She also wanted to keep in touch once therapy was over:

I wanted to keep the contact with her but I thought myself it’s not like home. Maybe in here (England) it’s professional……

Nadia (Client)

The Interpreters

Like Nadia, Fatima struggled with the complex boundary and confidentiality issues. Fatima is a member of a specific community and her private and professional worlds frequently overlap. She interprets for the same person in a variety of settings and then meets them in social and religious settings as part of the Muslim community. This is further complicated when a triad creates a therapeutic alliance and interpersonal attunement:

Even when the sessions finish, and say for example, you met that client somewhere else, you feel like that person’s closer to you than anyone else [I’ve worked with] even though you’ve respected the confidential side of things.

Fatima (Interpreter)
Majid stressed that counsellors should not make assumptions about how mental health was understood by the client sitting in front of them. The laughter his statement provoked confirmed the problems the practitioners shared but implicit in this statement is the need to simplify not just language but also concepts of mental health for people from other communities:

*Some people, back home, they don’t know, or don’t have counselling that much so understanding what counselling is, is sometimes a problem for the client (everybody laughs) so that sometimes makes it a little bit difficult for the interpreter to interpret.*

Majid (Interpreter)

Majid identified the cultural gap that he felt existed between a client’s expectation of medical treatment and the reality of psychological therapies. He echoed Mariam’s description of the culture clash he often witnessed when a new client came for the first time:

*Because for some they think that being referred by the doctor it is like an extension of their medical treatment and when they (the counsellor) ask what happened to you they think, ‘what the hell am I [doing] in here, I came here for treatment, and then they remind me [about the trauma]… you can read their faces.*

Majid (Interpreter)

All four interpreters said that it was vital to induct the client into the concepts and process of counselling by setting the scene for the client at the first session, as for most clients from non-western communities it was a very strange experience. Kim pointed out that counselling was an unfamiliar concept to many of the general public living in the UK, let alone traumatised people from other countries. This was further complicated by the myriad of different practitioners involved in mental health in this country:
Usually it’s such an unfamiliar concept…. It is for a lot of English people I think, isn’t it? An interpreter… the other day referred to you as psychologists……that was someone saying out of experience as well. Only recently there was a client that kept referring to the psychologist…

Kim (Interpreter)

She emphasised that counselling is an experiential process:

…there again most clients do get used to the idea I suppose quite quickly and understand through the relationship.

Kim (Client)

The Counsellors

Isara stressed the importance of introducing not just clients but also new interpreters into the concepts of counselling:

….cos there can be a tendency to work as they might do if they work in a GP’s surgery, or a hospital. It’s very different isn’t it to the way we work.

Isara (Counsellor)

The counsellors discussed the elusiveness of explaining what they were trying to achieve to a new interpreter, deciding, like Kim that you have to experience it before you can fully understand it:

…meeting with them isn’t enough, they’ve got to see the process before they really understand what’s going on.

Rita (Counsellor)
4.4.2 A changing perspective

“It’s opened up my world.”
Isara (Counsellor)

All twelve participants had faced new challenges when working in a triad. All had stepped into new cultures. For the counsellors, this was into the world of the professional interpreter, seeing clients from diverse cultures and communities and working with barriers to communication. For the interpreters it was into the field of psychological therapies, brokering issues of mental health between at least two cultures and facing distressing and disturbing material. The client group had all entered counselling with complex trauma. They were emotionally and culturally challenged in the triad on every level possible.

4.4.2.1 Pre-conceptions
All four clients said that they were informed before the first session that they would see an interpreter as well as a counsellor. Three were informed by a letter in their own language and the fourth was told by her social worker, as she was an unaccompanied minor (under 18) when she received therapy from the service.

Before the practitioners worked together, seven out of eight said that they had pre-conceptions about the experience. Only one (Martin) said it was so long ago he could not remember. Six (all of the counsellors and two of the interpreters) anticipated that it would be different from their usual role. Majid said he assumed his first counselling job would be exactly the same as any other so he came with a very different pre-conception to the other participants.

The Clients
All four participants viewed the interpreter’s presence with pragmatism. Their attitude was summed up by Nadia, who said that she really wanted to see someone in a dyad:
Yes it’s not comfortable 100% but if you need an interpreter you have to deal with it.

Nadia (Client)

Nadia and Mariam talked in detail about their fear of sharing their trauma and whether to trust the two practitioners in the therapy room. Mariam specifically requested someone outside of her culture but was still intimidated by the prospect of talking to two strangers:

I seen two person sitting. I wasn’t know the two persons, two strangers…. It wasn’t easy.

Mariam (Client)

The Interpreters
The interpreters had to step into the world of psychological therapies. They described their first experience of a counselling triad as very different to other work because of the content of the interaction and the level of emotional intensity. Kim described feeling worried and very nervous prior to her first counselling session even though she was an experienced interpreter who taught interpreting to diploma level and had been specifically trained in this field. Fatima said that the experience was very unnerving.

As well as acting as a cultural bridge between two different worlds, working in a therapeutic setting meant that the interpreters were engaging in an unknown third culture, a therapeutic one. Fatima was concerned that she might not be able to cope:

Because it was a situation for people going though trauma and they were expressing their feelings, it was very hard for me to take at first….

Fatima (Interpreter)
Two interpreters said that their concerns were with the therapeutic process. They too felt de-skilled; Kim said that even though the course run by the agency was fantastic that:

*I was trying to brush up on my course notes knowing that the expectations were so high....*

Kim (Interpreter)

The Counsellors

Both Rita and Isara said they had started this work from opposite perspectives. Rita was a newly qualified counsellor and Isara had worked with asylum seekers and refugees who have lived through traumatic experiences before at Freedom from Torture. However, all four counsellors echoed the concerns of the interpreters. Despite different levels of experience Rita, Isara and Donna all use the word de-skilled to explain how they felt before working with an interpreter. Their main concern was competency:

*I felt like the new girl again, I just felt like I was starting from scratch.*

Donna (Counsellor)

Working with an interpreter not only made the counsellors question their therapeutic skills but also raised the possibility of comparisons with their colleagues. Isara voiced the concerns of all the counsellors:

*It was scary......thinking that all the other therapists the interpreter had worked with were much better than I am so it took a little while to settle down.*

Isara (Counsellor)
Rita in particular realised that she had imbued the interpreter with *quite a lot of power*; she felt *a bit intimidated* about professional comparisons but was also intrigued by the idea of being a ‘fly on the wall’:

……*I would quite like being able to go and see that, I’d like to see, you know, what’s it like working with Lynn or working with Isara.*

Rita (Counsellor)

Donna and Victoria said that they volunteered for a single morning or afternoon a week. They described having a phased introduction to the work; working with English speaking asylum seekers before working in a triad. Victoria said this was *helpful*, but also used the word *terrified* to describe her feelings when faced with an Interpreter. Like Fatima she too was concerned about her ability to cope with someone from another community:

*I was very daunted by the prospect because I’m older and come from a completely different background.*

Victoria (Counsellor)

Donna said the phased introduction made things worse:

*Well I was really anxious when I had my first session with a client…. when I had an interpreter it was the same feeling all over again, so I found it really challenging.*

Donna (Counsellor)

4.4.2.2 *Post-experience*

Having risen to the challenge of working in this new and different way, all of the participants in this research felt extremely positive about the experience. What emerged was some real passion. It became clear that it had enhanced the practitioners’ professional skills but had also changed all of the participants’ personal perspectives.
The language used in the final section of the focus group contains far more emotion than the other sections. The language used to describe how the practitioners felt before they started this work include:

*Very nervous, de-skilled, scary, daunted, unnerving, anxious, challenging, terrified.*

The language used about how they felt post experience is equally evocative but positive and exhilarating. It reflects their changed perspective and their personal and professional commitment to the work.

*Fantastic, confident, positive, comfortable, fascinating, intense, glad, grateful.*

**The Clients**

Working at a level of interpersonal attunement with an interpreter had moved the clients from trauma to re-integration and given them a second life. Oluwaseyi gave an insight into her own culture and how her life had changed:

*A New Me! Because in (country of origin) I don’t have freedom. But here I have freedom now. First time that I feel good of my life.... When I am in (country of origin) I am not empowered...because I don’t have freedom from my brother or husband (they) treat me like slave. Beat me...he can take this bottle hit it on my head, beat me anyhow. I don’t have freedom in (country of origin), but when I am in UK I know that this is freedom land so I have freedom now. Nobody can harass me. Nobody can bully me, no. So that’s it. Yeah I just have my new life now.*

Oluwaseyi (Client)

**The Interpreters**

The interpreters were extremely vocal about the pleasure they derived from the work. Fatima explained how the process of witnessing the therapeutic alliance and
the extra skills she has acquired would stay with her forever. Martin echoed Fatima’s point:

….. but definitely I have improved my skills and I’m much more confident and professional as long as I don’t forget my role and don’t try to get involved (laughs).

Martin (Interpreter)

Kim referred to the famous course, re-iterating the usefulness all the interpreters felt about their specific training by the agency and says she felt quite confident about working in a therapeutic setting now.

The Counsellors

Donna and Rita talked about the positive experience of having another skilled practitioner in the room. They had gained confidence, relaxed and let the three-way relationship develop naturally just as they would in any therapeutic relationship.

Donna explained the challenge and the thrill she felt when faced with a new client. Now she sees herself as a competent practitioner with an interpreter, the focus has returned to the client, the anxieties are about what the client will bring, just as they are for all counsellors facing a new client:

The feelings change, but I still become anxious but I did with other clients that weren’t (asylum seekers) you know. I would think I don’t know what I’m gonna get today, or what this person’s gonna bring and maybe that’s part of what I enjoy about the work as well, something different.

Donna (Counsellor)

For Victoria and Isara the experience allowed them to re-connect with their own cultural backgrounds. Sitting in a room where they could not understand the client
felt *comfortable* for both counsellors. Victoria explained that she had been brought up in a Polish community. Isara told the group that her father was Nigerian and that she was used to family members speaking in languages she did not understand:

*I don't know if that's why I'm fascinated and enjoy doing it…… it's the dynamic of working with people who have different languages…*

Isara (Counsellor)

The overwhelming theme of the discussion was how much the work had changed the counsellors’ view of the world. Isara said she has been very interested to learn how other cultures and communities approach mental health issues from alternative perspectives.

*I'd say it's changed me most definitely for the better. I've heard things, I've seen things, and I've shared different parts of people’s culture that I probably wouldn't have done in any other situation and that I'm extremely grateful for...*

Donna (Counsellor)

Victoria said she was *terrified* to move into this field of work but now felt *very, very positive*. This new experience had also impacted on her personal life:

*I'm glad I made that choice without a shadow of a doubt…..it's made it harder for me sometimes outside of this situation. When you sometimes understand more….. ‘cos once you’re aware there’s no going back is there? I wouldn't swap it really.*

Victoria (Counsellor)

Isara summed up the feelings of the counsellors when she said:
There’s so much to learn……it’s opened up my world. Doing this work it has a very positive slant to it really. Isara (Counsellor)
Chapter 5 Discussion

The warmth and the affection in the room between the three of us is quite clear, you know, it’s worked, it’s been wonderful.

Donna (Counsellor)

The aim of this research was to produce a detailed examination of the triadic relationship from three perspectives in order to reveal unique lived experience. However, IPA also explores the similarities and differences between each case through integrative analysis. This discussion is divided into three sections. The first examines the findings from this study in relation to the research questions and places them in the wider context of existing literature. The second looks at other issues not directly raised by the research questions but pertinent to the findings. This is followed by a critique of the research process.

The initial research question asked:

Is it possible to work therapeutically through an interpreter with asylum seekers and refugees who have lived through traumatic experiences?

Three sub-questions explore this in further detail:

What happens to the therapeutic alliance when a third person is involved and is it possible to work at a deep level of interpersonal attunement?

What is the experience like from a personal perspective for each participant in the room (the Client, the counsellor and the Interpreter)?

What is good practice in this situation? What helps or hinders a ‘dialogue with three voices’?
The findings from this research suggest that it is possible to work therapeutically through an interpreter with asylum seekers and refugees who have lived through traumatic experiences. This first section gives an overview of the findings in relation to the research questions and looks at their relationship to previous work in these areas.

5.1 What happens to the therapeutic alliance when a third person is involved and is it possible to work at a deep level of interpersonal attunement?

5.1.1 The therapeutic alliance

For the purpose of this study a therapeutic alliance was defined as:

A means of promoting and applying a set of values concerning respect for others, acceptance of difference, the worth of human beings and the importance of connectedness and human relationships.

(McLeod, 2007, p. 82)

All twelve participants in this study said that they had experienced a therapeutic alliance. The clients (n=4) all came to counselling with issues of complex trauma, further complicated by the fact that they were asylum seekers, unsure if they would be allowed to stay in this country. All four talked of the counsellor making them feel safe; that the decision to trust both counsellor and interpreter initiated the therapeutic alliance and that the interventions gave them hope for the future. The clients (n=4) saw the alliance as important to their recovery. The therapeutic alliance was achieved in a variety of theoretical orientations, including EMDR, trauma focused CBT and person centered therapy. This is consistent with current research that identifies that a strong therapeutic alliance is essential to effective psychotherapy and not the theoretical orientation of the clinician (Wampold, 2001). All of the counsellors (n=4) said that they had worked in an effective therapeutic alliance with an interpreter. They measured the success of the triadic relationship...
in terms of their ability to make a connection with the client. They agreed that when the therapeutic alliance was successful, having a third person in the room made the relationship different but stressed that this did not impact on the intensity of the connection they felt with the client. The interpreters (n=4) had all experienced a therapeutic alliance and were initially surprised that clients included them into the relationship, as this rarely happened in other work they completed. Two, Kim and Majid, though that this was because of the continuity of the work, both length of individual session and length of engagement in the same relationship, as well as the connection felt by the sharing of intense emotions through the process of therapy.

5.1.2 Alliance dynamics

The dynamics within a triad have been described as a series of alliances (Lago, 2006; Tribe and Thompson, 2009). However, Lago asserts that all alliances are mutually exclusive to two out of the three participants. By contrast, Tribe and Thompson (2009) say any configuration of a two-way alliance: "spells trouble for good three-way work" (p. 17).

In this research some alliances began as two-way connections. When the client group (n=4) discussed their first impressions one had an immediate connection to both interpreter and counsellor (a three way alliance), one just to the counsellor (a two way alliance) and two were wary of both practitioners. All of the clients in this research said that they felt an alliance with both practitioners as the sessions developed, illustrating that two-way alliances have the potential to transpose into three way connections over time. However, some alliances cannot change if they exist on a factual basis such as the shared ethnicity of two out of the three participants. This could never change into a three-way alliance but could become a three way emotional alliance. The findings of this study were that the dynamics in the room were in constant flux. Linguistic issues, relationship issues and alliances created within the triadic relationship changed and developed as the alliance grew.
All three participant groups (n=12) saw the client/ counsellor relationship as the primary one. Three out of the four clients, Nadia, Val and Oluwaseyi had worked in both a triad and later in a dyad but they identified that the key relationship was with their counsellor throughout the therapeutic intervention. All of the clients (n=4) were clear that it was the therapist they wanted to speak to and build a relationship with. They saw an interpreter as the means to that end. This matched the priorities of the counsellors (n=4) who said their professional aim was to create a direct connection with their client. The interpreters’ (n=4) expectation was to facilitate the dyadic relationship between the counsellor and the client, creating a dialogue with three voices (Rielo, 2000). The interpreters saw establishing the therapeutic relationship as the counsellors’ responsibility but did acknowledge that in some cases they felt part of the alliance as time passed.

The data from the counsellors (n=4) and the clients (n=4) revealed that if the interpreter had not joined the alliance they all believed that the therapy would not have moved forward and the clients would not have been able to reveal their true selves. Ravel and Smith (2003) found that there was implicit tension in the triadic working alliance. This was raised during the discussions of triads that had not worked and in the discussion between Rita, one of the counsellors and Kim, one of the interpreters, about observed practice. However, the majority of the data produced in this study focused on a nuanced, professional relationship between the therapist and interpreter in which they worked as a team in order for the triadic relationship to emerge. The participants articulated this relationship in different ways. For the clients this was expressed in metaphors of family and safety. For the interpreters this was identified by the unique role they experienced in their therapeutic work. The counsellors (n=4) felt that the presence of the interpreter provided extra support for themselves and their client. This is consistent with Miller et al. (2005) who found that when the interpreter was actively engaged in the relationship the outcome was more successful.

The introduction of a third person clearly adds to the alliances and dynamics in the room but there is a danger of making this sound complicated.
I suggest that nearly all communication is to some degree cross-cultural in the sense that no two people have exactly the same background and, consequently precisely the same expectations about interaction. Expectations, however, are more strikingly different when backgrounds diverge more drastically.

(Tannen, 1980, p. 327)

A conversation between two people on a bus could be seen as having linguistic, cultural, and emotional alliances as well as socio-economic and power issues. I would suggest that professional counsellors deal with these dynamics in any therapeutic relationship. In this study the four counsellors saw facilitating dynamics as part of their usual therapeutic role:

*I don't see it as any different to any other therapeutic relationship and sometimes it works and sometimes it doesn't.*

Isara (Counsellor)

5.1.3 The unique role of the interpreter

There is no clear consensus about how an interpreter should work in the mental health field within the existing literature (Williams, 2005) and this was reflected in this study. The existing research seems to indicate that interpreters are broadly concerned about the technical issues in their work while clinicians worry about the therapeutic relationship (Tribe and Keefe, 2009). The findings of this research differ slightly from this where the interpreters interviewed (n=4) had a variety of approaches. Their discussions and the contribution of both the counsellors (n=4) and clients (n=4) indicate a spectrum of interventions. These ranged from a process model in which the interpreter’s intervention was kept to a minimum and facilitated a two-way alliance between counsellor and client:
We’re number three in a room with two people talking to us, that’s what we do. I am not aware that there’s anything unusual in that for us ‘cos we always have to interpret between people.

Kim (Interpreter)

An attitude shared by Blackwell (2005, p. 87):

It is an axiom in the world of football that a good referee is distinguished by the fact that players and spectators forget he is there. The same is true for interpreters in counselling and psychotherapy. A good interpreter is the one you are unaware of in the course of the session.

However, it has been suggested that when working with asylum seekers, the interpreter should understand the context they are working in (Williams, 2005). “The work is as much about understanding the relationships that develop between them as it is about the process of language translation” (Mudarikiri, 2003, p. 182). Another interpreter, Majid, talked about creating a three way communication alliance in which his presence and skills actively enhancing the therapeutic alliance:

I think the interpreter plays an important role because the client talks to the interpreter rather than the counsellor,….. if the client feels happy, relaxed and confident (with the interpreter)….the more the client talks in depth, the more the counsellor…..can do. So I think the interpreter isn’t just sitting there transferring the words.

Majid (Interpreter)

In this study it became clear that all the counsellors (n=4) and the interpreters (n=4) had at some point experienced working in a sophisticated and skilled way
together. It was acknowledged by the practitioners that it was not always possible to achieve this and relationships where this can happen took time to develop. If achieving interpersonal attunement was the outcome, the output to achieve this was a nuanced inter-relationship between two practitioners working seamlessly together rather like mirror images or dancers moving together. The fusion of skills was discussed by the counsellors and interpreters as a professional aspiration when working in a therapeutic triad. It was not just about synchronicity but responding and reacting to each other in a seamless way that allowed the counselling responses to flow naturally:

_It feels like we’re one person for a little bit….. really engaged._

Rita (Counsellor)

_I feel that, the connection….you feel a part of it and you’re more connected to them because you get to know each other...So you feel closer._

Fatima (Interpreter)

It has already been established that good therapy entails “attunement of right-to-right hemisphere” between therapist and client (Siegel, 2003, p. 32). From the perspective of interpersonal neurobiology, successful psychotherapy creates a "limbic revision" (Lewis et al., 2000, p. 144); a change within the emotional brain that creates interpersonal attunement (Fishbane, 2007). Perhaps, in the future neurobiology may find that this limbic revision can be achieved between three people, not just two. Empirical evidence from this study would support this premise.

5.1.4 **Interpersonal attunement**

Current research evidence suggests that a key determinate of a positive therapeutic outcome is when therapist and client experience a profound connection to each other (Cooper, 2012). All twelve participants in this research said that they had experienced working at interpersonal attunement, defined for
the purposes of this research as a deep and profound emotional connection that creates a resonance in each participant. Three of the interpreters (Fatima, Kim and Majid) and all four clients talked at length about the impact working at interpersonal attunement had on them as individuals. None of the counsellors chose to talk about how this impacted on them in their discussion.

The practitioners (n=8) acknowledged that working with interpersonal attunement was an intense, taxing and delicate process and adding another practitioner into the relationship clearly increased the workload of the counsellor. The clients (n=4) discussed working on complex issues with intense emotions. Two clients, Mariam and Oluwaseyi, said that they were extremely distressed and immediately engaged with therapy at a very deep and profound level of interpersonal attunement. They were unaware of the processes taking place in the therapy room, they were just aware that they felt safe, understood and supported. All of the interpreters (n=4) stressed that working at such emotional intensity was unique in their professional experience and raised issues of good practice, vicarious trauma and supervision.

As well as experiencing a sense of interpersonal attunement, the participants all talked about "specific moments of encounter" (Knox et al., 2012, p. 3). It was clear that all twelve participants whether client (n=4), interpreter (n=4) or counsellor (n=4), had experienced these. The counsellors saw it as part of their professional responsibility to help create and hold any sense of intimacy and immediacy that happened in the therapy room and the interpreters agreed with this. It was identified that the auditory communication delay that occurred between seeing and hearing what was being said sometimes made this moment more difficult to hold for the counsellor. In this research these moments were described as feelings rather than words:

..even though the interpreter might seem sort of in the background to a certain extent, I can feel that they are feeling, and the client can feel that, so even though you're not actually saying it, you can pick that up in the room.

Isara (Counsellor)
The findings of this research were that for these participants, working interculturally, with different languages or in a triad did not present barriers to creating interpersonal attunement. All twelve participants indicted that the elements and skills that create specific moments of encounter had little to do with linguistic issues and tended to occur in silences and emotional distress.

5.2 What is the experience like from a personal perspective for each participant in the room (the client, the counsellor and the interpreter)?

5.2.1 New cultures

All of the practitioners (n=8) discussed the impact that working together had on them from both a personal and professional perspective. It became clear that they had all faced new challenges when working in a triad and had all encountered new cultures. For the counsellors (n=4), this was into the world of the professional interpreter, working with barriers to communication and engaging with clients from diverse cultures and communities who had different concepts of mental health. For the interpreters (n=4) it was into the field of psychological therapies, brokering issues of mental health between at least two cultures, facing distressed clients and disturbing material in an evolving relationship rather than a single intervention. The clients (n=4) had all entered counselling with complex trauma. They were emotionally and culturally challenged in the triad on every level possible.

5.2.2 Changing perspectives and post-traumatic growth

5.2.2.1 The clients’ perspective

In this study all of the clients (n=4) interviewed began therapy with concerns about sharing their trauma. Emotionally and culturally they were unsure what was expected of them and if they were willing to participate in the experience. They were not concerned with who they would meet but their priorities were to protect themselves while feeling overwhelmed by their traumatic experiences.

The clients (n=4) all identified non-verbal communication as the first tangible step into a therapeutic alliance. As they could not speak the same language as their
counsellor they relied on what they saw not what they heard, to decide if they could relate and trust the counsellor. Also noted was the communication and mirroring of emotion:

*It’s in your faces and it’s especially her voice.*

Nadia (Client)

This supports the assertions made by Ekman (2007) that involuntary universal facial expressions create more common ground than we may think. If some of our non-verbal communication is innate and physiological it could imply that it has cross-cultural universality. “Human connections create neuronal connections” (Siegel, 1999, p. 85). "When two people feel rapport…their very physiology attunes” (Goleman, 2006, p. 28). As Nadia could not understand the words of the counsellor she relied on observation, gut feelings and body language (Mahrabian, 1972). The very sound, the tone and pace of the counsellor’s words and the mirroring by the interpreter created a therapeutic atmosphere that she began to understand and trust.

Post experience, the situation for the client group (n=4) had changed considerably. From their descriptions of the process it would appear that they had all experienced –post-traumatic growth. –Post-traumatic growth has been identified as an increase in psychological functioning categorised by changes in self-perception, changes in perspective on life and changes in relationships (Joseph, 2012). These three aspects were described by each of the clients individually. They talked about being given a “new life” (Val), “a second life” (Mariam), and “freedom” (Oluwaseyi). However, “It is perhaps naïve to assume a state of serenity in trauma survivors” (Hollander-Goldfein, Isserman and Goldberg, 2012 p.23). The experience of the client group (n=4) in this study is consistent with current research that integrates post-traumatic stress and post-traumatic growth within a single conceptual framework in which personal distress and growth can often coexist (Cadell *et al.*, 2003).
I can’t forget what happened to me, no. It’s there, its there, but…….(the silence and physical shrug implying that it was now something that she was able to manage within the context of her life), I am so grateful what these women done for me.

Nadia (Client)

5.2.2.2 The interpreters’ perspective
The interpreters in this study (n=4) were experienced practitioners who had worked in a range of professional and sometimes challenging environments. Collectively they had worked for the legal profession, the UK Border Agency, the NHS, and the International Criminal Court (ICC). Their experience as interpreters ranged from 4 to 11 years; however, all described their first experience of a therapeutic triad as unlike any other work situation they had encountered. The significant change was the emotional intensity of the subject matter, the personal distress of the client and the longer-term therapeutic relationship that was created. This is consistent with the research by Miller et al (2005) who identified that the combination of long-term involvement in therapy and emotionally intense material distinguish this work from more conventional interpreting roles. They also identified the non-judgmental role they were encouraged to take in counselling was in direct contrast to other professional settings where, because of their experience they could be asked to decide the veracity of the client’s story.

Post experience all the interpreters (n=4) felt more skilled, confidant and professional. They believed that this had been transferred into other interpreting work that they undertook. The spontaneity of therapy meant that the interpreter was tested personally and professionally. There was an acknowledgement that as well as capturing, processing and delivering the right words tone and pace, they had to maintain a dignified and professional demeanor. Three out of the four interpreters, Fatima, Majid and Kim described how it was a struggle to remain professional when confronted with distressing trauma material and witnessing the impact this had on the client.
5.2.2.3 The counsellors’ perspective

Before they started working in a triad, the counsellors (n=4) said they had all focused on the differences to working in a dyad, worrying about how to connect directly with the client and working with linguistic and cultural difference. Two of the counsellors (n=4) interviewed, Isara and Rita, were also concerned about competency issues. They were wary of professional comparisons with other colleagues, as it is rare for counsellors outside of training situations to be observed when working. Post experience, the same two counsellors talked about the positive experience of having another skilled practitioner in the room. They had gained in confidence, relaxed and were able to let the three-way relationship develop naturally just as they would in any therapeutic relationship. All of the counsellors (n=4) discussed the realisation that a measure of their competency was when they had overcome their fears and the aim of the interventions became the same as any dyad. The content and subject matter of the therapy became paramount rather than the triadic process.

It was not only the clients that had experienced considerable change during the therapeutic process. The practitioners’ (n=8) descriptions of starting work in this field were:

very nervous, de-skilled, scary, daunted, unnerving, anxious, challenging and terrified.

Their changed perspective and personal and professional commitment to the work are reflected in the words they used to describe how they felt as experienced practitioners:

fantastic, confident, positive, comfortable, fascinating, intense, glad, grateful.

This is consistent with other studies exploring vicarious posttraumatic growth in trauma practitioners. These report positive outcomes such as increased appreciation for human resilience, learning opportunities and job satisfaction, greater appreciation of life, tolerance and empathy, a sense of joy and inspiration.
and personal growth (Arnold et al., 2005; Splivens et al., 2010; Barrington and Shakespeare-Finch, 2014). When evaluating their experience, it became clear that working in a therapeutic triad had enhanced all of the practitioners’ (n=8) professional skills but had also changed all of the participants’ personal perspectives.

*I'd say it’s changed me most definitely for the better. I’ve heard things, I’ve seen things, and I’ve shared different parts of people’s culture that I probably wouldn’t have done in any other situation and that I’m extremely grateful for...* (Donna, Counsellor)

5.3 What is good practice in this situation? What helps or hinders a ‘dialogue with three voices’?

All of the practitioners (n=8) discussed their positive and negative experiences of the therapeutic triad. The counsellor small group (n=4) gave examples of instances when the triad had failed because they believed that the particular interpreter did not understanding the subtlety of the therapeutic alliance. They cited interpreters who had a lack of understanding and sometimes a lack of respect for the counsellor and the therapeutic process, who added their own values and ideas to the interventions which were at odds with the concepts of therapy, not acting in a professional manner and wanting to mother/smother the client as reasons for failure. The interpreter small group (n=4) cited lack of confidence on the part of the counsellor and a failure to take control of the dynamics in the session. These findings are broadly in line with other research about why some therapeutic triads fail such as (Ravel and Smith, 2003; Miller et al., 2005; Century, Leavey and Payne, 2007)

5.3.1 What is good practice?

The good practice identified in this study was consistent with the good practice outlined in the BACP general code of practice and those written specifically for working with asylum seekers and refugees for the BACP (Travisse, 2008) and the BPS, (Tribe and Thompson, 2008). These include using qualified interpreters,
meeting a new interpreter before working with them and debriefing after every session. All of the participants (n=12) agreed that good practice included a commitment to the relationship and creating an atmosphere of safety and trust. The clients (n=4) wanted clear contracting, an emphasis on confidentiality and a simple explanation of what therapy would entail at the first session. Adherence to the continuity of staff, including the ability to be re-referred and see the same two practitioners, was reported by one client, Mariam, as having saved her life. The practitioners in this research (n=8) agreed that a successful therapeutic triad should embrace an ever-evolving and dynamic process, asking the constant question what is working for this client and what is not. This is a reflective process that the BACP code of good practice recommends in clinical supervision whether the practitioner is working in a dyad or a triad and so should be a familiar process for all clinicians.

5.3.1.1 Working as a team
Working in the mental health field is a relatively new phenomenon for interpreters (Tribe and Ravel, 2003). Because of the importance of the three-way alliance the counsellor small group (n=4) went so far as to ascribe success or failure of the intervention to the temperament of their co-worker. As well as the obvious linguistic skills the interpreter had to be part of the team; be able to work collaboratively, be emotionally literate, mature and self-aware. It would appear from the findings of this research that the qualities of a good interpreter should match those of a good therapist. The BACP guidance on good practice identifies these qualities as: “empathy, sincerity, integrity, resilience, respect, humility, competence, fairness, wisdom, and courage” (BACP, p. 3). This is consistent with the study by Miller et al (2005), which identifies that individual interpreters may have the appropriate language skills but may not be temperamentally suited to this work.

All of the practitioners in this study (n=8) were clear that they approached the task of working together as two professionals with complementary skills trying to achieve the same aim. The findings run counter to some primary care counsellors who saw the interpreter as: “a cumbersome conduit in dealing with highly sensitive
issues” (Century, Leavey and Payne, 2007, p. 30). In this study all of the practitioners (n=8) agreed that the counsellor and interpreter must work together with a shared aim and mutual respect for each other’s roles. This required the two practitioners to view each other as professionals with different but inter-dependent skills. "The therapist remains the main driver with the interpreter as co-driver who is sometimes allowed to drive, using their own expertise and knowledge" (Patel, 2003, p. 228). The interpreters in this research (n=4) wanted to be considered as part of a team and asked for help with the emotionally demanding aspects of the work. They also wanted training in different therapeutic approaches, mental health and trauma. It is clear from the focus group discussion (n=8) that they would benefit from the same clinical supervision structure as counsellors if they are to work effectively with this client group and avoid vicarious trauma. This is consistent with the recommendations of Doherty, MacIntyre and Wyne (2010), Ravel and Smith (2003), Miller et al, (2005), and Tribe and Thompson (2009).

5.3.1.2 Matching interpreter to client
Tribe and Raval (2003) recommend matching the gender, age, religion and tribe or caste of the client to the interpreter. Two of the client group, Mariam and Nadia, identified gender as their most important factor. Tribe and Thompson (2009) report that using same gender interpreters when working with women who had experienced sexual violence resulted in some ”commonality of experience, allowing the witnessing of traumatic experience to work with much greater effect” (p. 19).

The counsellors (n=4) discussed the concept of a good match between an interpreter and client. They raised the point that what may be effective for a specific client may not be obvious at assessment and while important, giving a client the choice may not be an informed decision if the client had no concept of the therapeutic experience they are about to enter. The client group (n=4) all discussed factors that enhanced their particular alliance. This revealed that there were no common denominators; each configuration was different and that to achieve a therapeutic alliance each triad has to address the individual and unique needs of that specific client. For example, two of the client group (n=4), Mariam
and Oluwaseyi, had similar needs at assessment and both came from African
countries. They were matched for gender and language but from pure expediency
one used an African interpreter, the other a European interpreter, although neither
had specified any preference. When interviewed after the therapy was complete,
one said she was pleased to see a European interpreter because they would not
judge her by the values of her own community where she would have been seen
as disgraced. The other said she felt relaxed and at home because the interpreter
was from the same community as she was. If the clients had been assigned the
other interpreter would they have still ended the therapy with a positive
perspective? It is possible that the clients may have re-framed their opinions in
light of the good experience and positive outcome they had. The findings in this
research highlight practitioners who have a clear commitment to developing good
collaborative practice. Both interpreters created a strong therapeutic alliance with
the client creating a safe space for the client to explore their traumatic experience.
This illustrates that matching clients to interpreter and counsellor is an inexact
science and presents practitioners with a greater challenge than those described
in the good practice guidelines. However, with skilled communicators, who are
willing to reflect and adapt to the specific needs of the client, the chances of a
successful outcome are greatly increased.

5.3.2 What hinders good practice?
All of the counsellors (n=4) recounted stories of when triads that had not worked
which they attributed to the particular interpreter not understanding the subtlety of
the therapeutic alliance. The counsellors felt that the interpreter needed to respect
and value the client, to understand the differing roles between them and have an
understanding of what the counsellor was trying to achieve, the subtle nuances of
the therapeutic alliance. The interpreters group (n=4) identified that what may be
obvious to a mental health practitioner may not be clear to a professional
interpreter. Whether the interpreter is born in this country or elsewhere they
emphasised that it is necessary for the counsellor to meet a new interpreter before
any sessions are completed to explain what interventions will be used and what is
expected from them. All four counsellors agreed that it was the counsellor’s
responsibility to induct the interpreter into the work. When this did not happen
there was more likelihood of problems later.
The counsellors (n=4) agreed that a good working relationship with the interpreter was vital in creating interpersonal attunement. If there was no trust between the two professionals, the client would intuitively know this and in the experience of the counsellors interviewed, the dynamic alliances between all three would not succeed. They suggested that re-employing the same skilled interpreter would re-convene an effective team to work with new clients ensuring good practice. NHS employed counsellors reported difficulty getting the same interpreter regularly for a single client, let alone requesting a specific interpreter for a new case. This may explain why some NHS practitioners do not believe working in a triad is possible: "some counsellors reported feeling that the counselling was ‘inferior’ and that the work felt ‘compromised” (Century, Leavey and Payne, 2007, p. 30).

All of the interpreters (n=4) agreed that the de-brief after a session was beneficial but were clear that therapeutic work left them in an emotionally vulnerable position, without professional support or supervision. They were dealing with the same issues as the counsellor but without any professional training or on-going back up.

[I had to] learn how to manage my emotions as well. Just to cope because it's a very different thing to listen to someone’s situation, to just walk out the door and forget about it.

Majid (Interpreter)

The interpreters discussed the emotional impact that conveying distressing trauma narratives exposed them to. This is consistent with the three domains identified in the existing literature as having the potential to facilitate vicarious trauma in practitioners: "empathic engagement and exposure to trauma material, empathic engagement and exposure to the reality of human cruelty and therapist involvement in traumatic re-enactment within the therapy relationship" (Splevins et al., 2012, p. 1706). There is some evidence that the interpreter is more vulnerable to vicarious trauma than the therapist (Satkunanayagam et al., 2010). A lack of clinical training can add to this risk, (Becker and Bowles, 2001; Tribe, 2011). It is
clear that best practice should replicate the support structures in place for counsellors working in this field: "opportunities to reflect on work with clients in the context of a supportive relationship with an experienced colleague" (McLeod, 2003, p. 652).

5.3.3 Added value

Little research has been done into the advantages and opportunities that working in a triad can bring (Tribe and Thompson, 2009). The findings of this research raise the issue of whether the presence of a third party could, on occasion, actually enhance the therapeutic relationship.

All of the counsellors (n=4) felt that the presence of the interpreter provided extra support for the client. Not only were two people bearing witness to the trauma narrative but there was the possibility that one came from within the client’s own community while the other represented an external and different society, providing a double validation for the client. Two of the client group, Val and Nadia, and all of the counsellor group (n=4) identified that a good interpreter was a positive element to bearing witness within the therapeutic alliance. This is supported in the findings of Bot and Wadensjo (2004) who state that their patients ”liked the fact that two people heard their stories. The more people that know about these terrible things the better” (p. 375).

One counsellor also identified how the presence of an empathic and skilled interpreter supported her as a practitioner, when listening to distressing trauma narratives:

*Having someone there is company in the situation. You’re not alone (with the trauma)…. just to feel that understanding, that’s something you can’t get when it’s just you and the client.*

Rita (Counsellor)
The findings of this research suggest that when an interpreter becomes part of the therapeutic alliance the presence of an extra skilled professional may actively enhance the therapeutic work and support both the counsellor and the client.

The second section of this discussion explores issues not directly raised by the research questions but pertinent to the findings. This focuses on training; the culture of mental health and its cross-cultural implications and verbal and non-verbal communication.

5.4 Training
In this study the interpreter small group (n=4) discussed the need for specific training to work therapeutically with asylum seekers and refugees. The mental health specialism within the diploma issued by the Institute of Linguists does not feature any interpersonal skills, non-verbal communication or trauma models. Rather, it focuses on technical language in order to work within a psychiatric medical model. The interpreters said that the specialised training they had received from the agency had helped them to facilitate the therapeutic alliance and work at a deep level of interpersonal attunement. It had taught them to respect silences, to manage the impact of emotions within the triad and on themselves, and to feel confident. The skills that they had learnt were transferable to other contexts and one interpreter, Fatima, said they had enhanced her life skills generally. However, receiving specific training from an agency is unusual. The research of Miller et al. (2005) identified that only three out of fifteen interpreters interviewed in their study had received any sort of training in mental health interpreting and Becker and Bowles (2001) say that lack of training can put interpreters at greater risk of vicarious trauma.

The findings of this research agree with Summerfield (2001) that with some small amount of training and the right recruitment: "A properly resourced, supervised and utilised Interpreter service is the most quickly achievable means of raising the standard of mental health services for this [asylum seeker and refugee] population" (p. 162). The interpreters suggested that joint training with counsellors before engaging in therapeutic triads would be valuable. Miller et al. (2005)
recommend the development of empirically based training programmes as "likely to enhance the triadic therapy experience for each of its members" (p. 38) and note that this has received little consideration in the clinical literature.

5.5 Working across cultures
All of the participants (n=12) identified two specific and different cultures that co-existed in the therapy room. One was the diversity and layers of cultural dynamics working simultaneously between the three people who formed the triad. The other was the concept of mental health and the professional system surrounding it.

5.5.1 Working inter-culturally
Carter (1998) asserts that the psychotherapy and counselling process is always influenced by the participant's race and culture. The counsellors in this study (n=4) said that the experience of working with asylum seekers and interpreters had changed their world view and had resulted in more awareness of their own culture and the impact this could have on any client they saw, not just those from an ethnic background. The counsellors (n=4) identified that there may be a number of layers of cultural dynamics working simultaneously creating a unique mix for each client dependent on community and personal preference. All four counsellors saw it as their responsibility to negotiate these layers of difference or similarity into a safe and comfortable configuration in order to foster a therapeutic alliance. During the interviews each member of the client group (n=4) identified a different and specific cultural requirement including specific gender, language, ethnicity and age; illustrating the importance of seeing each client as unique and avoiding assumptions and cultural stereotypes (Aneas and Sandin, 2009).

5.5.2 Power inside the triad
Although the power dynamics of a therapeutic triad were not discussed explicitly by any of the participants in this research, there were implicit references to it in the discussion about alliances and the changing dynamics in the therapy room. One of the counsellors, Donna, jokingly referred to this as:
Who’s the boss?

Donna (Counsellor)

When asked ‘Who do you think was in charge of the session?’ eleven participants said the counsellor and one of the clients, Oluwaseyi, said God. Three of the counsellors (n=4), Donna, Rita and Isara, said that as they could not understand what the interpreter was saying to the client they had to relinquish some control of the session and trust in the interpreter to carry some of the therapeutic process. This was not an easy experience for them because they also felt a duty of care to the client and responsible for monitoring quality assurance. They recounted some positive and negative experiences. All of the interpreters interviewed in this study (n=4) were highly skilled practitioners able to act as bi-cultural as well as bi-lingual experts. However, it may be that the interpreter’s cultural knowledge is specific and their experience of working inter-culturally may be more limited than the counsellor. A less experienced and skilled interpreter may also exhibit specific personal values, attitudes or cultural beliefs that may appear racist or sexist in the context of western more liberal values and may cause problems for a client who feels shame about the subject matter they bring to therapy. In this study, one of the counsellors, Donna, described working with an interpreter who told the client off for saying they wished they were dead.

_The interpreter has the authority, or the power because of the language don't they, so, there's a potential for them to take over… I think that's a diplomatic way of saying it (laughs)._ 

Rita (Counsellor)

Some of the practitioners’ descriptions of triads that had not worked were with issues of power and control, including interpreters taking over and counsellors who did not take charge. In this research the clients (n=4) did not raise any negative issues of power or problems with feeling unvalued or disrespected. In fact, all four talked about how the therapeutic alliance helped them feel more powerful in their lives:
…she let me know that I can empower my future….First time that I feel good of my life.

Oluwaseyi (Client)

However, the research literature identifies that power relationships in interpreting can be complex with the potential for any of the three participants to exert power over the other two (Williams, 2005). The differential between client, clinician and interpreter can increase when there are differences in language and culture (Ravel, 2003). Although not raised in this study, there may also be unresolved issues of cultural imperialism from all participants in the triad. If the counsellor is unaware or finds it difficult to raise issues about power inside the therapy room there is further potential to subject the client to issues of disempowerment and racism by their unconscious actions (Ravel, 2003). One of the most experienced interpreters in this study remarked:

I think this, three people in a room, this affects the counsellor more than the interpreter. Martin (Interpreter)

A counsellor who comes from a white British background may be experiencing a new phenomenon, that they are culturally outnumbered for the first time in their therapeutic, or even their personal experience (Carter, 1995). "Whiteness as a set of normative cultural practices is visible most clearly to those it definitively excludes and to those to whom it does violence. Those who are housed securely within its borders usually do not examine it." (Frankenberg, 1993, p. 228).

5.5.3 Counselling as a unique culture

The interpreters (n=4) talked about the challenges of working in a therapeutic role. Some aspects of the therapeutic culture, such as conveying emotion and working with silences were new experiences. The style of facilitation and use of open questions used by therapists also caused problems:
language [used in therapy] is sometimes quite vague....and it’s not always easy to translate..... talking about things like being in a safe place.. If you translate that, it means a safe place, literally.... it doesn’t mean your state of mind at all. Kim (Interpreter)

Kim’s words illustrate those of Farooq and Fear (2003, p.105):

Interpretation is a very much more complex process than is word-for-word translation...it calls for the deciphering of two linguistic codes, each with its own geographical, cultural, historical and linguistic traditions.

Two of the interpreter group, Majid and Martin, discussed their struggle with the concept of being non-judgmental because this was so alien within their own culture. This was compounded by the fact that the non-judgmental role they were encouraged to take in counselling was in direct contrast to other professional settings where they worked with asylum seekers.

Culture may shape the psychological aspects of an individual’s response to traumatic events (Marsella, 2010). In many cultures there is a strong stigma attached to problems with mental health, creating a sense of shame (Amri and Bemak, 2013). The participants (n=12) in this research emphasised that, in their experience, no assumptions should be made about how the client will understand the concept of mental health. Both practitioner groups (n=8) stressed the importance of explaining mental health and the process of counselling to the client at the first session. This was illustrated by Mariam, one of the clients in this study. She said that when she came to her first session she was very confused. She had been living in a country where the ruling party had such power that she believed that giving personal information about her life would result in her death. Yet, the counsellor wanted her to talk about what happened to her. There was agreement by all the participants that the culture of psychotherapy itself had to be understood by both the interpreter and the client if any intervention was to succeed. Kim, one
of the interpreters, pointed out that this confusion was not unique to asylum seekers and that counselling and psychological therapies were a confusing concept for people born in the UK, further complicated by the myriad of different practitioners involved in providing mental health services.

5.6 Communication
The psychotherapeutic world has only engaged with issues of race and cultural diversity relatively recently, with the result that there is very little research into the impact of using a variety of languages in the therapy room (Burck, 2004). Yet, all of the participants in this research (n=12) discussed communication as the obvious issue when working therapeutically in a triad. They expressed the desire to communicate on a variety of levels that included conveying narrative and content, the expression of emotion and the developing relationships inside the triad. They discussed both verbal and non-verbal communication.

5.6.1 Verbal communication

5.6.1.1 Language
The client group (n=4) expected to see an interpreter during therapy as they had experience of this in other settings. They all assumed that the interpreter would be linguistically competent and said their real concern was about being understood on a more profound and emotional level. Two clients worried if their accent and patois would cause a problem.

All of the clients in this study (n=4) talked about scrutinizing the specific meaning of the words used by their counsellor, remembering in detail how the work had been contracted and explained. During the time they were in therapy, three acquired the ability to speak English and they all discussed this as a significant achievement in their lives. Two, Val and Oluwaseyi, felt that the connection to their counsellor did not change when they began to work as a dyad. Only one, Nadia, felt that this had changed her relationship with her counsellor for the better.

All of the counsellors (n=4) said that their linguistic practice had changed during the time they had been working with interpreters. They believed that working with
non-English speakers had enhanced their communication skills. They identified that their language and phrasing had become simpler, shorter and more effective. This had impacted on their work with English speakers as well becoming more attuned to the linguistic and cultural difference within English speaking communities. One, Donna, had noticed that she engaged with all her clients quicker since acquiring these skills.

5.6.1.2 Pacing
All of the practitioners (n=8) discussed the problems inherent in working with an interpreter because of the vocal delay. They agreed that the pace and flow of the session was dictated by the client but that the two practitioners had to work in harmony to find a way of creating intimacy and a sense of immediacy. The counsellor group (n=4) discussed working with both continuous interpretation, in which only one person speaks at any given time, and simultaneous interpretation, in which the interpreter speaks over the voice of the speaker, agreeing that both were useful in different circumstances. Continuous interpretation created a slower pace that felt appropriate to work with complex trauma, where the depth of feeling was often enhanced by repetition. Simultaneous interpretation may give some immediacy for specific situations. The interpreters (n=4) discussed the variety of tasks that needed to be performed simultaneously in order to get the pacing right. All agreed a skilled interpreter worked between two languages and a number of cultural idioms, further complicated when trying to capture emotion, particularly if the client was experiencing an emotional catharsis. Emotionally intense material distinguish this work from more conventional interpreting roles (Miller et al., 2005; Doherty et al., 2010) and working with asylum seekers and refugees is recognised as subtly different from other interpreting work in the literature (Boyles, 2010; Blackwell, 2005; Williams, 2005; Tribe, 2011). One interpreter, Majid, felt strongly that simultaneous interpretation was therefore too complicated a process to introduce into a therapeutic triad.

5.6.1.3 The therapeutic experience of speaking in a mother tongue
An issue that was not raised by any of the participants in this study was the therapeutic aspects of conversing in the mother tongue. This surprised me as a
researcher. In my professional experience I have observed a number of therapeutic advantages to conducting therapy using the client’s first language. The importance of speaking in a mother tongue is slowly emerging in the research literature (Costa and Dewaele, 2012; Pavlenko, 2012; Harris, 2006; Burck, 2004). Clinical studies are beginning to be supported by research literature in psycholinguistics (Matsumoto, 2000) and neurology (Perez-Foster, 1998). Native languages have an advantageous emotionality (Pavlenko, 2012) because intense emotions developed in early years will have been encoded in the native language, (Harris, 2006). “Certain experiences can best, and possibly only be elicited in a first language” (Burck, 2004, p. 334).

Sometimes the therapy session is the only opportunity that a client has to talk in their own language. It is also a connection to a life and world they have left behind, a connection to severed roots they may never find again. In London a group of holocaust survivors have continued to meet as a Yiddish-speaking group for over 60 years. "Recognising the importance of Yiddish in the lives of survivors may help to overcome their separation from the dead…by recreating these lost sources of strength and stability, they bring their former selves to life” (Hassan, 2009 p. 207). The group described why speaking their mother tongue was so important:

It makes my heart and mind feel better to speak in Yiddish.

I came back to myself by listening to Yiddish,

In Yiddish I can express both sadness and humour,

Through Yiddish we won’t forget who we once were. Yiddish binds us.

I feel very near to someone if they speak Yiddish. I feel the warmth of my family in this group.

(Hassan, 2009, p. 204)
Using a client’s mother tongue connects the client to the first language in which they expressed feelings and emotions. It has the potential to connect them to a resilience and attachment that they may have had before the trauma. Working in their mother tongue is a respect and an affirmation of a culture and life they have left behind.

5.6.2 Non-verbal communication

Eleven of the participants (n=12) agreed that non-verbal communication was a significant factor when engaging with clients who did not speak English. One client, Oluwaseyi, did not discuss this.

5.6.2.1 Body language

Three of the client group, Val, Mariam and Nadia, (n=4) said that because of the vocal delay, they relied on their observations and gut feelings to decide if they trusted the counsellor and interpreter. The auditory and visual stimulus including facial expressions and the tone and pace of the counsellor’s voice, mirrored by the interpreter reflecting their own emotion added to the therapeutic atmosphere in the room. The practitioners (n=8) also discussed how they were able to engage clients through reflecting emotion in their faces supporting Mehrabian’s theories (1972) and the assertions made by Ekman (2007) that involuntary facial expressions such as sadness and happiness create some universal common ground. However, in discussion, all the practitioners (n=8) warned against making assumptions based on body language. Three of the counsellors (n=4), Victoria, Donna and Rita, talked about instances when they had interpreted non-verbal communication wrongly, warning that in their experience it was a mixture of the universal, the culturally specific and personal, further complicated because of the delay between auditory and visual stimulus when using an interpreter. This is consistent with the existing literature (Farooq and Fear, 2003; Cushing, 2003). As experienced practitioners, they now approached non-verbal communication as the unique expressions of an individual client that could be slowly understood over time.
5.6.2.2 Trauma beyond words: silence

Seven of the participants (n=12), interpreters Fatima, Kim and Majid, and all of the clients (n=4), talked about the use of silence in therapy. This was not raised by any of the counsellors although "Many of the therapists we spoke to said that their most in-depth moments of relating occurred in silence" (Mearns and Cooper, 2005, p. 47). In this study all the interpreters (n=4) emphasised that non-verbal communication was part of their professional responsibility. However, two of the interpreters, Kim and Fatima, identified the use of silence as unique to therapeutic interpreting. Another, Majid, described a non-verbal communication flow in which the interpreter must reflect the emotion held in the therapy room. "The fragility of language and the limitations of what can be tolerated in our conceptual thinking tend to render words to describe these horrific memories void and redundant" (Hassan, 2009, p. 11). Three of the client group (n=4), Val, Mariam and Nadia, identified this silence as being given space and time to express emotion that is beyond words. Two clients, Oluwaseyi and Mariam, said that when they came for therapy they were unable to function and displayed great distress. They were allowed the space to process this distress in a therapeutic safe space and both described experiencing an emotional catharsis.

5.7 Summary
The findings from this research suggest that it is possible to work therapeutically through an interpreter with asylum seekers and refugees. It highlights what can be achieved when triadic work follows good practice guidelines. The aim was to produce a detailed examination of the particular case in order to reveal unique experience. However, during analysis, individual and then specific group (client, interpreter and counsellor) accounts converged in clear ways. Using integrative analysis a number of key themes have been identified.

In order for a therapeutic triad to work effectively the counsellors in this research (n=4) believed that the persona of the interpreter was key. As well as linguistic skills the interpreter had to be part of the team; able to work collaboratively, be emotionally literate, mature and self-aware. They believed that the qualities of the interpreter and counsellor should match. The BACP identify these as: "empathy,
sincerity, integrity, resilience, respect, humility, competence, fairness, wisdom, and courage” (BACP, p. 3). The interpreters in this research (n=4) were concerned about the management of emotion. They stressed that working at such emotional intensity was unique in their professional experience and raised issues of good practice both in terms of how to conduct themselves inside the therapy room and the impact hearing disturbing trauma narratives had on them personally. Their discussions matched the three domains identified as having the potential to facilitate vicarious trauma in practitioners (Splevins et al., 2012). They stressed that a triadic alliance rarely happened in other work contexts. Two of the interpreters suggested that the continuity of contact and the connection felt by the sharing of intense emotions through the process of therapy were contributing factors. The clients (n=4) in this research all came to counselling with issues of torture and trauma. They discussed working on complex issues with intense emotions. The decision to trust both counsellor and interpreter initiated the therapeutic alliance and the interventions they experienced gave them hope for the future. They said that when they started therapy they were extremely distressed but had all been able to engage at a very deep and profound level of interpersonal attunement. They were unaware of the processes taking place in the therapy room, they were just aware that they felt safe, understood and supported.

The analysis revealed a number of challenges. The counsellors focused on competencies, the interpreters on emotional impact. One client described a negative experience, in which the guidelines for good practice were breached. All of the participants (n=12) discussed the impact that working together had on them from both a personal and professional perspective. It became clear that they had all faced new challenges when working in a triad and had all encountered new cultures. The practitioners reported the rewards that the work brought including personal growth and professional development. This experience mirrored the progress made by their clients and is consistent with previous studies of clinicians who work long term with trauma survivors (Barrington and Shakespeare, 2014). The clients described experiences that are consistent with post-traumatic growth, (Joseph, 2012).
The limited research literature in this field has often interviewed practitioners in services that do not always adhere to good practice (Raval and Smith, 2003; Century et al., 2007). All of the participants in this research had worked in long-term therapeutic alliances that had lasted for a minimum of six months. The research questions were focused towards the personal relationships in a triad rather than the subject matter of working with trauma, the challenges of which have been previously documented (Barrington and Shakespeare, 2014; Century et al., 2007; Miller et al., 2005). This research became an examination of what can be achieved when triadic work follows good practice guidelines. This enabled the study to explore if therapeutic relationships could build between three people and a working alliance between the two practitioners could develop in an atmosphere of good practice. The findings present a small amount of non-generalisable data, which nevertheless does run counter to "a literature that can appear somewhat negative about the challenges and possibilities involved" (Tribe and Thompson, 2009, p. 4).

5.8 Critique of the research process
5.8.1 Methodology
5.8.1.1 Interpretative Phenomenological Analysis
IPA is a postmodern methodology that uses a hermeneutic cycle in its research design. Based on the philosophy of Heidegger, it asserts that everything is subjective and open to interpretation. It acknowledges the double hermeneutic that exists when the researcher interprets the participants interpretation and suggests that the researcher’s perceptions may in fact be necessary to enable participants to make sense of their experiences (Smith and Osborne, 2008). I am a researcher who has particular knowledge of the phenomena that was explored. My interpretation is inevitably influenced by my knowledge of trauma and post traumatic growth, and my own experience as a therapist working with both asylum seekers and interpreters. This should be viewed as an influence on my selection and presentation of themes during interpretation and analysis. It “illustrates the dual role of the researcher as both like and unlike the participant” (Smith, Flowers and Larkin, 2009, p. 35).
5.8.1.2 Using two qualitative methods – IPA and a focus group

IPA is concerned with understanding and making sense of significant life experiences for participants from an insider, lived perspective (Larkin et al., 2006). It is concerned with the idiographic, the distinct experiences of particular people and the particular contexts in which those experiences occur (Eatough and Smith, 2008; Smith, Flowers and Larkin, 2009). It is concerned with the intrapersonal rather than group experiences (Millward, 2012). Combining IPA methods using both a focus group and individual interviews clearly presents challenges. It raises the methodological complexity of multiple voices and group dynamics which may inhibit experiential narratives, the ideographic aspects at the heart of IPA (Smith, Flowers and Larkin, 2009). Using suggestions from Tompkins and Eatough (2010) I combined IPA and the focus group for the practitioners and semi-structured interviews for the clients. Although some of the data was collected in a group situation I believe that I have been able to represent individual narratives in line with the idiographic commitment of IPA.

IPA is characterised by its flexibility of analytical development (Smith, Flowers and Larkin, 2009) with no prescriptive, definitive protocol. IPA has a set of common processes such as moving from the particular to the shared and from the descriptive to the interpretative. Analysis is an iterative and inductive cycle. This accommodated a fluidity in my analysis of the focus group transcripts as I revisited the same data a number of times for group patterns and dynamics and subsequently, for idiographic accounts. When the eight individual narratives were identified I followed the analytic process as if they had been individual interviews.

Four process stages have been identified as reading and re-reading; initial noting; developing emergent themes; and searching for connections across emergent themes (Smith, Flowers and Larkin, 2009). I carried out this process twice on the focus group data deviating from the order of this process because when I finally reached stage four, the connections across emergent themes between the focus group data had already been identified.
5.8.2 Validity

I used the criteria suggested by Yardley (2000) to reflect on the analysis and representation of the findings in this study. I consider that I made the appropriate choice of a research method to examine individual cases using in-depth systematic analysis, with a double hermeneutic. Relevant literature was used to orientate the topic under investigation, particularly post viva when new suggestions were incorporated into the body of this research.

I believe I have demonstrated sensitivity during the data collection process and to the meaning making of the participants during the analytic process. I also took into consideration the sociocultural setting. In this study understanding each participant’s sociological and ethno-cultural perspectives was an important dynamic in the analysis. Through purposive sampling I was able to find difficult to access groups who shared a particular lived experience, some of whom had experienced trauma in their past. It was therefore essential to be sensitive to their needs and make this an ethically and psychologically safe experience for participants.

In terms of commitment and rigor I have had an in depth engagement with this research for over five years. The reflexivity sections and methodology chapter describe the processes I completed in an attempt to ensure transparency and validity as well as methodological competence. I believe that I have presented a thorough and systematic analysis to the best of my knowledge and ability with transparent methods and data presentation, including how the findings were shaped by my experience. Within my narrative I had aimed to demonstrate the detailed knowledge that I had gained of the participants unique experiences of working in a therapeutic triad and to interpret, rather than simply describe these whilst acknowledging that these interpretations are influenced by my own knowledge and experiences.
5.8.3 Strengths of this study

This research is an attempt to explore if it is possible to work therapeutically through an interpreter with asylum seekers and refugees. It examines what can be achieved when triadic work follows good practice guidelines.

The limited research literature that exists has often interviewed practitioners and services that do not always adhere to good practice (Raval and Smith, 2003; Century et al., 2007). An agency that purports to good practice was therefore intentionally chosen. It receives statutory funding from CAMHS and adult CCG’s as well as additional money from Comic Relief: “the service established itself as an accessible and appropriate therapy service, seen by other organisations to be culturally skilled and effective and to be a lead service in Liverpool” (Greater Manchester West Mental Health NHS Foundation Trust evaluation, 2004).

All of the participants in this research had worked in long-term therapeutic alliances that had lasted for a minimum of three months. I interviewed eight practitioners who were committed to the work and, through purposive sampling, four clients who had competed therapy. This enabled the study to explore if therapeutic relationships could build and a working alliance between the two practitioners could develop in an atmosphere of good practice.

This research is a postmodern study with a subjectivist ontology and epistemology. It is understood that the perspective of the researcher will inevitably impact on any research undertaken, whether they work inside an agency or as an external researcher entering into a new community. Although a challenge, I made the decision that the practical and substantial advantages of being an insider-researcher outweighed the disadvantages. Insider research accepts the fact that participants will be known to each other and sees this as a positive advantage in the development of knowledge into a phenomenon. In order to access participants, particularly ex-clients of the service, the fact that I was known and employed within the agency meant that I would not be a researcher who parachuted in, took a snapshot and withdrew. It was important that I was accepted as someone who
would continue to have an on-going sense of involvement and commitment to the issue and the people involved in order to establish credibility and trust.

My aim was to produce a detailed examination of the particular case in order to reveal unique experience. Interviewing all three participants in a therapeutic triad created rich data and an equality to each experience. The voice of the client is rarely heard in counselling research and interviewing asylum seeking clients increases this difficulty because of issues of access, trust and language. I had unique access to a single service. This, by definition meant that I was able to find participants who traditionally have been seen as hard to reach.

Four clients were interviewed in this study, constituting one third of the participants and data from their findings was given equal weight to that of the practitioners. Focusing on one agency also allowed me to interview members of two complete triads (Victoria, Val and Fatima and also Rita, Mariam and Kim). The data collected allowed a correlation of experience which created a strong commitment and rigor (Yardley, 2000).

5.8.4 Limitations of this study

I believe that the advantages of being an insider-researcher outweigh the disadvantages. However, my role as service manager inevitably impacted on this research and the findings need to be evaluated against the backdrop of this methodological problem. The findings are also restricted by the fact that all of the participants come from one single third sector agency using a small sample of counsellors (n=4), interpreters (n=4) and clients (n=4). A potential limitation of the research is that all of the participants had worked in long-term therapeutic alliances that had lasted for a minimum of six months. This enabled the study to explore if therapeutic relationships could build and a working alliance between the two practitioners could develop. However, this, together with purposive sampling, made it less likely to find interpreters or clients who had negative experiences. I believe this limitation would be true whether the research was carried out across a range of agencies or within one. However, interviewing clients who had negative
experiences would widen the scope of the findings, as would interviews with participants from different agencies.

If I had infinite time and resources to complete this research I would have conducted semi-structured interviews with all of the practitioners as well as run the focus group. I will never know if semi-structured interviews would have captured any different data, but using both would have provided more data and enabled me to have the best of both data gathering methods. I also made a decision that it was not appropriate to facilitate a focus group for the client participants. I decided to interview them separately so that they would be able to talk freely and because I was concerned about re-traumatisation and confidentiality. However, in hindsight I could have invited the ex-clients to a homogenous focus group as well. They may have accepted or refused but would have made their own choice about what was best for them.

There are inherent linguistic and conceptual challenges in cross language research. Although the wording of the research questions were carefully chosen, it is important to note that of the twelve participants, six were interviewed in their second language and the client group (n=4) had acquired this language relatively recently. Although every effort was made to understand and scrutinise the meaning of statements it is impossible to be sure that everything was completely captured. Another limitation of the analysis was that a third cycle of hermeneutics was unintentionally added by the use of a professional transcriber. I became aware that this also created a parallel process between the participant, the transcriber and myself as the client and counsellor are linked in their meaning making narrative by the interpreter.

When I devised the sub question “What is the experience like from a personal perspective for each participant in the room (the client, the counsellor and the interpreter?” I was unaware of its resonance. The aim was to hear individual narratives from either a professional or personal perspective. As I analysed the findings and became more aware of the issues about cross-cultural mental health I realised that this assumes a western Cartesian model of mind and body from an
individualist perspective. Although all the ex-clients were open and appeared happy to disclose their feelings about their recovery, I am now aware that I was using western constructs to assume a universal framework, (Splevins et al., 2010). It is unclear from these findings whether the clients have assimilated over time and embraced western models that focus on individual wellbeing or whether their recovery has incorporated resilience, cultural and socio-political meaning (Tribe and Keefe, 2007) from the perspective of their own community. I would now have asked a supplementary question about whether your old self would have valued the changes you now feel or have the changes come because you feel like an English person?

5.8.5 Reflexivity

The postmodern construct is that reality is contemporaneous. We each carry beliefs, presuppositions and predilections that make up our unique understanding (Gadamer, 1975). Heidegger (1962) argued that when we encounter new things we experience them as already interpreted. "Representation and object are not distinct; they are intimately interconnected" (Woolgar, 1988, p. 20).

An ideal research interview will create rapport and rich data (Kvale, 2006). When the researcher and the researched are linked by interest, subject matter and genuine emotion, they are “intimately interconnected” (Woolgar, 1988, p.20). It is important to examine how this may impact on the research when gathering and analysing the data. Woolgar’s (1988) continuum of reflexivity is a useful way to evaluate whether a researcher is involved in reflection or reflexivity. Reflection, which Woolgar (1988 p.22) calls “benign introspection” presents an accurate representation of participants’ accounts. Reflexivity, which he calls “radical constitutive reflexivity” (ibid p.21) aims to critically reflect upon one’s own biases, preferences and preconceptions to examine how they affect the research and how the research affects them. The aim of reflexivity is not to edit the researcher out of the research but to be mindful of their place in it.
This research was initially motivated by my experience as a practitioner. I had hoped to find some generalisability that would result in a model of good practice. My initial focus was to hear the three distinct voices of counsellor, interpreter and client talking as experts by experience. During the process of completing this research I learnt how to become a researcher and my interest changed into a desire to document the participants’ unique stories and experiences. I became concerned that my experience of working in this field could easily distort the research findings and this became a major factor in the design of the methodology. In order to manage any distortions, I acknowledged my own beliefs about this issue and then designed a study that reframed my experience into a research question that asked if my experience was the same or different for other practitioners.

As an insider researcher I was aware that it was essential to critique every decision I made throughout this study. Insider research demands high levels of awareness about the role, interactions with others and the researchers own preconceptions, assumptions and judgments. I used a model advocated by Brannick and Coghlan (2007), based on Bourdieu’s concept of Social Praxeology (Everett, 2002) in which reflexivity and relational thinking create a double focus. Epistemic reflexivity addresses the researcher’s belief system and is a process for analysing and challenging conscious and unconscious meta-theoretical assumptions. Methodological reflexivity monitors the behavioural impact carrying out subjectivist research has on its setting and all the participants, including myself as the researcher (Everett, 2002).

I am aware that the issue of power is pertinent to any research within a subjectivist paradigm. However, the more I examined the issue, the more layers of complexity emerged; I was an insider researcher. I managed the service and was interviewing staff from that service. Interviewing ex-clients presented one issue, interviewing participants from diverse backgrounds another, with the potential for the interview itself to unintentionally oppress or victimise. This required transparency and personal honesty, a hyper-vigilance to complex power dynamics and an ongoing reflexive deconstruction of my own practice and power. Throughout the research process I aspired to adopt Foucault’s (1980) concept of power circulation so that
"refugees, researchers, interpreters, interviewees…are vehicles for the circulation of power, simultaneously undergoing and exercising it" (Dona, 2007, p. 226). I emphasised to the participants that they were the experts by experience; however, I acknowledge that my role within the agency inevitably presents a weakness in this study.

5.8.5.1 An IPA researcher

IPA recognises the significance of the researcher's presuppositions and that they can both hinder and enhance the interpretation of another's lived experience. "A reflexive study will therefore assume the co-construction of meaning within a socially oriented research scenario" (Shaw, 2010, p. 234). The participant's story is heard, analysed and interpreted by the researcher. No one contribution can be valued over another. With the use of reflexivity, the process and the issues become transparent, so that it is possible to claim that the participants and the researcher have co-generated the data. As a reflexive researcher I am involved in the "process of continually reflecting upon our interpretations of both our experience and the phenomena being studied so as to move beyond the partiality of our previous understandings and our investment in particular research outcomes" (Finlay, 2003, p. 108). In IPA this becomes the concept of the double hermeneutic.

5.8.5.2 How reflexivity impacted on my analysis

Throughout my research I kept a reflexive journal in order to explore how I felt my role had impacted on the study. Engaging in reflexivity during analysis helped me to navigate through participant accounts and my response to them. This often involved me revisiting both the data and my reflexive journal at different points in the process. Some of what is presented here was the result of my reflective notes written immediately after each interview or supervision but other aspects are retrospective.

To illustrate how reflexivity was incorporated into my research process I examine the data collected during the research interview with Nadia. My first client interview had been with Val. Val answered the interview questions with confidence and
there felt like a positive rapport between us yet the interview did not produce a lot of rich data. My notes speculated on a number of factors. Nadia was the second interviewee and the only client that I knew before my research. Initially I had been reluctant to contact her. I had been her counsellor and was then interviewing her as a researcher. However, I knew she was articulate and honest about her experiences. I had written several times in my ethics application that I was the ideal candidate for this work precisely because of this overlap as practitioner and researcher. I hoped that because of our previous relationship the interview would produce a rich narrative that she would not have revealed to an unknown and untrusted researcher.

After the research interview I analysed the transcript. IPA required three types of analysis. The first was an initial reading of the transcript to obtain an overview. The second was a phenomenological coding in which the researcher paraphrased what was being said in the participant’s own words. The third looked for interpretative coding patterns of recurring and significant topics and issues. During the interview I realised that Nadia had started to talk about my ethnicity. I had been surprised but wanted to explore this issue. The excerpt quoted below from Nadia’s transcript illustrated that, for a moment, I missed the real point she was making. Nadia said that she never judged anyone and their ethnicity was not an issue. But I continued to ask her about ‘otherness’ missing the fact that what made a difference to Nadia was the counsellor and interpreter’s gender not their ethnicity. The process of interpretative coding patterns allowed me to identify my own mistake and emphasise the issue that was a priority to Nadia. (My words are in bold).

*But you were Jewish, I am Muslim*

*Hmm*

*and what’s going on in Palestine, there is no, we are human before religion, before ah*

*yes*

*yes, yes*

*yeah*
and you were here for me, yeah, this is the most important thing

so actually the kind of cultural stuff, the fact that although in one way, we should be enemies

yes

but in another way we are both different aren’t we

yes

we were both different, in England

yes, yes

so did that matter to you, did it help, did it not help, did that make a difference

(that) you are not English? you are yeah

yeah

for me, I am not er, when I see person it’s a person, it’s not Christian or Jewish

absolutely

or Hindu, no, no it’s human being like me yes

yes

I approach people because they are people yeah

Absolutely. So did you feel (it feels weird to say me,) the counsellor

Yeah

Was sympathetic to you culturally, you know, because it’s different, we come from different places

Yeah

Did you feel comfortable with that? Could you talk about your religion, your feelings, your customs and did you feel understood?

Yes, yes, because first of all she is a lady like me Yeah You are yes and you understand better than man yes

Yeah
I was comfortable because you are a woman like myself, yes to talk to you about things I couldn't talk to my GP because he is a man

Hmm

Yeah, yeah and how to say it, you made me feel comfortable like you said, you are Jewish and I am Muslim but there is no barrier between us

No

Every time I come here, yeah, and see you er its not going to see er Jewish no, never, never

Hmm

Never, I thought about it, she is my counsellor, ah, I talked to my er, my sisters about you

Hmm

I have a friend, she listens to me, she advises me better than you

Hmm

The analytical protocols of IPA provided a check and balance to the fact that I had missed the salient point made by Nadia because of my own interests:

The research process is comprised of the messiness of human relationships, history and culture from which it cannot simply escape. Hence reflexivity offers a mechanism for identifying and managing issues arising from the fusion of horizons we encounter in experiential qualitative research.

(Shaw, 2010, p. 237)

This raised another issue for me as a reflexive researcher. As a counsellor it has been extremely rare for me to share my ethnic background with clients because it has simply been irrelevant. I had revealed it to Nadia because she was grappling
with a number of issues about assimilation. In context it seemed appropriate and it seemed to help. The experience of doing this research has, once again led me to question whether I should bring an overt ethnicity into my work.

Frankl (1959) wrote about surviving in a concentration camp during the Second World War but intentionally did not identified himself as Jewish (Scully, 1995) because he wanted to emphasise the universality of suffering. The fact that I come from another ethnic community does not mean I can claim any special understanding about what it means to be my client, about their unique experience. However, I do know what it feels like not to fit in, to be ‘other’: “the categorization of otherness is attributed to those not conforming or belonging to a dominant norm” (Lago & Smith, 2010, p. 6) and this creates a constant dilemma. As an integrative therapist my role is to facilitate the client’s recovery. As with all self-disclosure I always ask myself ‘will this information help the client?’ so I rarely reveal my ethnic origins. Yet I always come back to the issue that if I were black I would have no choice in the matter. My ethnicity would be visible.

I will never know if the difference in the depth of the interview between Val and Nadia had anything to do with my ‘otherness’; one knew that I had an ethnic, non-English identity, the other saw me as yet another middle class, white professional. However, in my persona as researcher, rather than therapist, I decided to tell the third and fourth interviewee about my ethnic background. I used it as a way of explaining my interest in this area before we started the interview. "Reflective methodologies…. value transparency in relationships" (Etherington, 2004, p. 16). The last two interviews worked well and I was able to establish a rapport with both participants. Anecdotally, when I told Oluwaseyi about my grandparents being asylum seekers she looked up and smiled. My interpretation is that this helped to put things in context for her. As Kim Etherington reminds us, as reflexive researchers “I don’t think it requires us to over-expose but I think it requires a judicious use of self and self-disclosure” (2004, p. 35).
5.9 Implications for future practice

Yardley (2000) suggests that the real validity of IPA research lies in its impact and importance. Whether or not it tells the reader something that is “important, interesting, or useful” (Smith, Flowers and Larkin 2009 p.183). The work should enrich theoretical understanding but also provide a practical contribution to knowledge as well as have socio-cultural relevance. There has been little empirical research done in the field of the therapeutic triad, (Century, Leavey and Payne, 2007), even less with interpreters working in therapeutic settings (Miller et al., 2005). The findings of this research suggest that for practitioners in the field it is useful to see the triad in relational rather than communication terms. This research suggests that a therapeutic alliance is dependent on the working alliance created between the interpreter and the counsellor which can then be developed into a growing sense of trust and connectivity between the client, the interpreter and the counsellor. This requires a shared understanding of the aims of the intervention and reflective practice on the part of the practitioners.

On an organisational level a commitment from procuring agencies to find the appropriate resources, including adequate supervision for all practitioners, will improve the quality of the interventions and prevent vicarious trauma. The findings of this research are that an adherence to good practice including screening for appropriate skills, a briefing before the client is seen, continuity of practitioners, appropriate training for interpreters and debriefing create conditions in which it is possible to work therapeutically through an interpreter with asylum seekers and refugees and a therapeutic alliance and interpersonal attunement can thrive.

5.10 Suggestions for future research

In light of the philosophy of the positive psychology movement I would suggest that future research into working with interpreters might focus on what makes a therapeutic triad work rather than fail. In order to understand best practice I think an area of further development would be to listen to client feedback and encourage more research of clients’ experiences. One avenue of further research could be a bigger sample size of skilled and experienced practitioners and their therapeutic outcomes. The use of appropriate outcome measurement tools such
as the IES (Impact of Events scale) or CORE (clinical outcomes in routine evaluation) could also compare a group of English-speaking asylum seekers in therapy with asylum seekers who require therapy through an interpreter to examine if there are any differences in their experience.
Chapter 6 Conclusion

Timshel

Cold is the water
It freezes your already cold mind
Already cold, cold mind
And death is at your doorstep
And it will steal your innocence
But it will not steal your substance

But you are not alone in this
And you are not alone in this
As brothers we will stand and we'll hold your hand
Hold your hand

But I can't move the mountains for you

(Mumford, Lovett and Marshall, 2009)

Timshel is a Hebrew word which means ‘you have the choice’. It is the title of a song about struggle, choice and a pledge of love and support for a survivor. The chorus of this song provides an apt description of the experiences talked about in this research. The client has to engage actively in the therapy in order to move their own mountain but the counsellor and interpreter can be ‘brothers’ standing strong and walking alongside them, providing a safe haven to explore painful experiences. In this research the clients used a number of family allusions to describe their experience, particularly the word sister, echoing the words of the song and the strong emotional link they felt with both their counsellor and interpreter.
This thesis has emerged as an illustration of what can be achieved if practitioners adhere to good practice guidelines and anti-oppressive practices. When it works well the process of the triad is fairly minimal in the room and the issues brought to therapy become the focus.

Providing psychological therapy through an interpreter with asylum seekers and refugees who have lived through traumatic experiences is complex, skilled and multi-layered work. Not every practitioner, counsellor or interpreter, is temperamentally suited to do this kind of work. The issue is not simply about working through two languages. There is observed practice and the complexity in working inter-culturally which can unearth feeling of powerlessness and otherness. There is working with the language and concepts of therapy which has to be integrated slowly into the relationship. There is a complexity in trauma and the unspoken, non-verbal expressions that “render words..void and redundant” (Hassan, 2009, p. 11).

Hassan (2009) writes about the challenges all practitioners face when working with trauma:

The faint-hearted may not wish to enter this space... The sometimes overwhelming sense of powerlessness and de-skilling which we experience in our work with severely traumatised people may be too great a threat to our professional sense of identity...We can however learn new ways of responding; we can tap into our creative minds; we can develop a different language; we can find strengths in ourselves to journey beyond what is familiar and safe in our quest for understanding. This takes courage and confidence, but the determination to adapt to new ways of working can be personally and professionally liberating.

(Hassan, 2009, p. 12)
The aim of this research was to produce a detailed examination of the particular case in order to reveal unique experience. However, by exploring the similarities and differences between each case through integrative analysis the findings from this research suggest that it is possible to work therapeutically through an interpreter with asylum seekers and refugees who have lived through traumatic experiences. It highlights what can be achieved when triadic work follows good practice guidelines. The findings indicate that the presence of an additional skilled and professional interpreter can, in some cases even enhance the work and support both counsellor and client. Above all, successfully working in a therapeutic triad requires two skilled practitioners who have excellent communication skills that exist in multiple layers of communication based on much more than the words we use to express ourselves.

Some of the counsellors and clients in this research contributed metaphors in an attempt to describe how working in a triad felt for them. These included:

*Rainbows always seem to move away as you come nearer to them but they are there.*

Victoria (Counsellor)

*Pushing along a broken cart with precious cargo that sometimes rolls beautifully down the hill.*

Rita (Counsellor)

One of the clients, Mariam, described the interpreter as an umbilical cord connecting the mother and baby, an image of nourishment and nurturing:

*The cord umbilical, of which the mum have on her stomach. If she eat, the baby will eat as well. It's something like that.*

Miriam (Client)
To state the obvious, working in a therapeutic triad with asylum seekers and refugees who have lived through traumatic experiences is all about communication. However, this research suggests that communication is less about the words we choose in order to express ourselves; it becomes deeper and more profound than words. What is in our heart is more important than what is in our mouth and that language can be felt and understood because that language is universal.
SEARCH FOR MY TONGUE

You ask me what I mean
by saying I have lost my tongue.
I ask you, what would you do
if you had two tongues in your mouth,
and lost the first one, the mother tongue,
and could not really know the other,
the foreign tongue.
You could not use them both together
even if you thought that way.
And if you lived in a place you had to
speak a foreign tongue,
your mother tongue would rot,
rot and die in your mouth
until you had to spit it out.
I thought I spit it out
but overnight while I dream,

It grows back, a stump of a shoot
grows longer, grows moist, grows strong veins,
it ties the other tongue in knots,
the bud opens, the bud opens in my mouth,
it pushes the other tongue aside.
Every time I think I’ve forgotten,
I think I’ve lost the mother tongue,
it blossoms out of my mouth

(Bhatt, 1988 pp. 63-66)
References


Appendices
Appendix 1: Participant Information Sheet
From dyad to triad: towards a working model of therapy through an Interpreter.

Participant Information Sheet

You are being invited to take part in a research study as part of my Professional Doctorate programme. I want to interview Clients, Interpreters and Counsellors about their experiences of working together. This is a new area as most therapy is done with two people. I also hope to develop a model that will help other Interpreters and Counsellors work well together to make counselling an easier experience for clients who do not speak English. Before you decide if you would like to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

Who will conduct the research?
Lynn Learman
c/o School of Education, The University of Manchester,
Oxford Road, Manchester, M13 9PL,

Title of the Research
See above. I am really asking “Does using an Interpreter impact on counselling?”

What is the aim of the research?
The aim of this research is to explore the good and bad experiences of all three people in the therapy room (the Client, the Interpreter and the Counsellor). From this I am hoping to develop a model of good practice to be used in the future.

Why have I been chosen?
You have been chosen because you have experienced sitting in a room with 2 other people trying to communicate and express yourself in a counselling situation. Four Interpreters, Four Counsellors and three ex-clients who have all been part of Spinning World (PSS) will be involved in this research, including yourself.
What would I be asked to do if I took part?

If you are an ex-client of Spinning World (PSS) I would conduct a one to one interview which would be recorded. You will not be identified in the research so you are free to say whatever you want. The discussion will be focused on your experiences of the process of working through an interpreter not the issues that brought you to therapy. If you are an Interpreter or Counsellor a group discussion called a ‘fishbowl’ will be used. This too will be anonymised to allow you the freedom to say whatever you want. This will be recorded. I have a plan of some questions I would like to ask all participants but I will also be happy to listen to and follow anything you might wish to discuss.

What happens to the data collected?

All interviews will be typed up and sent back to you to check you are happy with what you said. You can alter them if you wish. When you are happy with the transcript I will start to analyse it and use it to develop my research. I may quote you or your ideas in the finished report but these will be anonymous. If you are interested in seeing the final results please let me know and I will make sure that you receive a copy.

How is confidentiality maintained?

Confidentiality will be safeguarded by disconnecting any information I have about you from any tapes and transcripts I have, you will only be identified by a number or a name of your choice during transcribing. All information will be held securely in a locked cabinet. You will be asked to check and agree to your transcript before it is used in any way. Recordings and transcripts will be destroyed after the completion of this research.

What happens if I do not want to take part or if I change my mind?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time without giving a reason and without detriment to yourself.

Will I be paid for participating in the research?

There is no payment for your involvement in this research, however travelling expenses will be paid up to a maximum of £10.00.

What is the duration of the research?

Ex-clients will be asked to attend an interview lasting one and a half hours. Interpreters and Therapists will be asked to attend the fishbowl exercise which will be conducted over a morning (approx. 3 hours). This will include periods of time when each participant observes and is not involved in the discussion. Refreshments will be supplied.
Where will the research be conducted?

PSS
18, Seel Street, Liverpool L1 4BE

Will the outcomes of the research be published?

In the first instance this is doctorate level research. I hope that the findings will have some far reaching implications in relation to professional practise. If so it is my intention to publish the outcomes of this research in appropriate professional publications.

Criminal Records Check

Lynn Learman has undergone a satisfactory criminal records check.

Contact for further information

Lynn Learman
c/o PSS
18, Seel Street, Liverpool, L1 4BE
Tel: 0151 702 5580

What if something goes wrong?

Time will be given at the end of the interview should this be necessary. Another therapist within PSS will be available to provide a confidential debriefing session should you need further support.

If you want to make a formal complaint about the conduct of the research you can do so by contacting the Head of the Research Office, Christie Building, University of Manchester, Oxford Road, Manchester, M13 9PL.
Appendix 2: Consent Form
From dyad to triad: towards a working model of therapy through an interpreter.

CONSENT FORM

If you are happy to participate please complete and sign the consent form below

Please Initial Box

1. I confirm that I have read the attached information sheet on the above project and have had the opportunity to consider the information and ask questions and had these answered satisfactorily.

2. I understand that my participation in the study is voluntary and that I am free to withdraw at any time without giving a reason and without detriment to any treatment/service

3. I understand that the interviews will be audio recorded

4. I agree to the use of anonymous quotes

5. I agree to take part in the above project

Name of participant___________________________________________________________

Date________________________Signature___________________________________________

Name of person taking consent_________________________________________________

Date________________________Signature___________________________________________
Appendix 3: Letter to Participants of Focus Group
From dyad to triad: towards a working model of therapy through an Interpreter

Thank you for agreeing to take part in my research.

I now need to organize the details of when the focus group will meet.

- I intend to run the group in the Keeling Room at PSS (18, Seel Street).
- There will be coffee and time to meet from 9am to 9.30.
- The session will last from 9.30 to 12.30
- followed by a lunch lasting about an hour.

I will ensure that everyone will be catered for and the food will be strictly Hallal. If you have any other dietary requirement please let me know as this is my way to thank you and the only way I am able to reward participants for their help.

Hopefully the dates below will suit everyone.

Please tick the times you are available below and return to:

Lynn Learman, PSS, 18, Seel Street, L1 4BE.

I will then let everyone know which date the focus group will be on.

Name-------------------
Contact phone number-----------------------------------

I am available to attend the focus group on the morning of Thursday 23rd June

I am available to attend the focus group on the morning of Wednesday 29th June

I am available to attend the focus group on the morning of Monday 18th July

I am available to attend the focus group on the morning of Thursday 21st July
Appendix 4: Letter to Participants Confirming Date of Focus Group
From dyad to triad: towards a working model of therapy through an Interpreter

Thank you for agreeing to take part in my research.

Having spoken to everyone on the phone we have now agreed to meet on

**Monday 4th July**

Just to remind you:

- The group will take place in the Keeling Room at PSS 18, Seel Street, Liverpool L1 4BE.
- There will be coffee and time to meet from 9am to 9.30.
- The session will last from 9.30 to 12.30
- followed by a lunch lasting about an hour.

I want to focus on the unique experience of each participant in order to explore what happens in the counselling room. There are no right and wrong answers and each of you has been asked because your experience will be different to other peoples. I am sending you a copy of the questions we are going to discuss in the group so that you can think about what you would like to say when we meet.

The main research question is:

**Is it possible to work therapeutically through an interpreter?**

A number of issues also need to be considered:

**What is the experience like from a personal perspective for each participant in the room (Client/ Counsellor/ Interpreter?)**

**What happens to the therapeutic alliance when a third person is involved?**

**What is good practice in this situation? What helps and hinders the ‘dialogue with thee voices’?**

You will see that the focus group questions are based on the 3 areas above. As well as my questions I am really interested in whatever you want to tell me about the experience and there should be plenty of space for an open conversation about your experiences.

I am also sending you an information sheet. Please fill this out and bring it with you. This will help me build a picture of the range of people involved in this research. The information will be used anonymously.

Thank you so much for agreeing to take part.

See you on 4th July.

Lynn Learman
From dyad to triad: towards a working model of therapy through an Interpreter

INFORMATION SHEET

Name

Job Title / Role

Address

Email

Tel:

What languages do you speak?

Have you ever worked as an interpreter? Yes / No

Please could you answer these basic questions (all are in line with the new equality legislation 2010)

Age

<table>
<thead>
<tr>
<th>Under 18</th>
<th>18 - 24</th>
<th>25 - 34</th>
<th>35 - 44</th>
<th>45 - 54</th>
<th>55 - 64</th>
<th>65+</th>
</tr>
</thead>
</table>

Gender

<table>
<thead>
<tr>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
</table>
**Religion or Belief** - (based on 2011 Census categories)

<table>
<thead>
<tr>
<th>Religion or Belief</th>
</tr>
</thead>
<tbody>
<tr>
<td>No religion</td>
</tr>
<tr>
<td>Christian (including Church of England, Catholic, Protestant and all other Christian denominations)</td>
</tr>
<tr>
<td>Buddhist</td>
</tr>
<tr>
<td>Hindu</td>
</tr>
<tr>
<td>Jewish</td>
</tr>
<tr>
<td>Muslim</td>
</tr>
<tr>
<td>Sikh</td>
</tr>
<tr>
<td>Any other religion/belief (please specify, if you wish)</td>
</tr>
</tbody>
</table>

**How would you define your own cultural heritage?**

**Ethnicity**
- these are based on the 2011 Census categories. Please choose one.

**White:**
- English/Welsh/Scottish/Northern Irish/British
- Irish
- Gypsy or Irish Traveller
- Any other White background (please specify if you wish)

**Mixed/multiple ethnic group**
- White and Black Caribbean
- White and Black African
- White and Asian
- Any other Mixed/multiple ethnic background (please specify if you wish)

**Asian/Asian British**
- Indian
- Pakistani
- Bangladeshi
- Chinese
- Any other Asian background (please specify if you wish)

**Black/African/Caribbean/Black British**
- African
- Caribbean
### Other ethnic group

| Arab                  | Any other ethnic group (please specify if you wish) |

### What relevant professional qualifications do you have?

- 

### What experience of working as an Interpreter/ Counsellor do you have? (both paid and unpaid).

- 

### How long have you been working in the field of trauma/ asylum seekers? (years/months)

- 

### Approximately how many people have you seen in this time?
Can you describe your experience of working in a triad in a metaphor or simile?

(like trudging through treacle or flying through the air)

Please write down a first name of your choice that can be used in the transcript of the focus group to identify you. This will ensure that all participants are anonymous.

_____________________________________________________________________

286
Appendix 6: Focus Group Questions
Focus Group Questions

**Personal Experiences**

1. How did you feel before your very first session in a therapeutic triad at PSS?

2. Has that feeling changed?

3. How does it feel to be sitting in a room with 2 people talking to you?

**Therapeutic alliance**

During the time you have worked in a triad at PSS,

4. To what extent have you been able to fulfil your usual role (as therapist or Interpreter) or is this experience different?

5. To what extent are you able to work at emotional depth?

6. To what extent are you able to create a therapeutic alliance?  

**Good practice**

During the time you have worked in a triad at PSS,

7. Who do you feel is in charge of the session?

8. Counsellors:
   a) What is the same/ different to working in a therapeutic dyad?
   b) Have you changed the way you now work in a dyad as a result of your experience in triads?

8. Interpreters:
   a) What is the same/ different than other three way interviews?
   b) Have you changed the way you work in other places as a result of working with PSS.

9. What single thing would improve your work in a triad?

10. Is there anything more about working in a triad that you would like to talk about?

---

2 A Therapeutic Alliance = a means of promoting and applying a set of values concerning respect for others, acceptance of difference, the worth of human beings and the importance of connectedness and human relationships’ John McLeod, (2007).
Appendix 7: Letter for One to One Interviews
From dyad to triad: towards a working model of therapy through an Interpreter

Hi,

Thank you for agreeing to take part in my research.

Having spoken to you on the phone we have now agreed to meet on XXX

Just to remind you the interview will take place in a counselling room at XXX and will last about an hour and a half.

I have sent you some information and an official consent form that the University requires you to read and sign. If there is anything you are unsure about please ring me on XXXX XXXX XXXX or we can discuss it when we meet.

When we meet I would like you to tell me about coming to counselling and what it felt like to work with 2 people. I am really interested in trying to understand what it was like for you. You don’t need to tell me anything about the details of your therapy or why you had to come to this country. I am interested in how sitting in a room with 2 people made you feel. I believe that many people are unaware of what happens or how it feels when you can’t talk about things in your own language.

There are no right and wrong answers and each of you has been asked because your experience will be different to other peoples. I am sending you a copy of the questions we are going to discuss so that you can begin to think about what you would like to say when we meet.

As well as my questions I am really interested in whatever you want to tell me about the experience and there should be plenty of space for an open conversation about your experiences.

I am also sending you an information sheet. Please fill this out and bring it with you. This will help me build a picture of the range of people involved in this research. All the information you tell me will be used anonymously.

Thank you so much for agreeing to take part.

See you soon.

Lynn Learman
Appendix 8: Information Sheet for One to One Interviews
From dyad to triad: towards a working model of therapy through an Interpreter

INFORMATION SHEET

Name

Job Title / Role

Address

Email

Tel:

What languages do you speak?

Have you ever worked as an interpreter? Yes / No

Please could you answer these basic questions (all are in line with the new equality legislation 2010)

Age

<table>
<thead>
<tr>
<th>Under 18</th>
<th>18 - 24</th>
<th>25 - 34</th>
<th>35 - 44</th>
<th>45 - 54</th>
<th>55 - 64</th>
<th>65+</th>
</tr>
</thead>
</table>

Gender

<table>
<thead>
<tr>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
</table>

Religion or Belief - (based on 2011 Census categories)

<table>
<thead>
<tr>
<th>No religion</th>
<th></th>
</tr>
</thead>
</table>
Christian (including Church of England, Catholic, Protestant and all other Christian denominations)

Buddhist
Hindu
Jewish
Muslim
Sikh
Any other religion/belief (please specify, if you wish)

How would you define your own cultural heritage?

Ethnicity
- these are based on the 2011 Census categories. Please choose one.

White:
- English/Welsh/Scottish/Northern Irish/British
- Irish
- Gypsy or Irish Traveller
- Any other White background (please specify if you wish)

Mixed/multiple ethnic group
- White and Black Caribbean
- White and Black African
- White and Asian
- Any other Mixed/multiple ethnic background (please specify if you wish)

Asian/Asian British
- Indian
- Pakistani
- Bangladeshi
- Chinese
- Any other Asian background (please specify if you wish)

Black/African/Caribbean/Black British
African
Caribbean
Any other Black/African/Caribbean background
(please specify if you wish)

Other ethnic group
Arab
Any other ethnic group (please specify if you wish)

Approximately how many sessions did you attend in the time you were seeing your counsellor and interpreter?

Can you describe your experience of working with 2 people in a metaphor or simile? You can put two different ones if your experience changed during the time you came to counselling.

*an example of this would be:
like trudging through treacle or
flying through the air

When I write up my research everyone involved will be anonymous. For this reason please choose a different first name you would like to be called. This will be used throughout the transcript of the interview to identify you.
• Tell me about coming to counselling and what it felt like to work with 2 people.
• You don’t need to tell me anything about the details of your therapy or why you had to come to this country.
• I am interested in how sitting in a room with 2 people made you feel
• I have a few questions but really I am interested in whatever you want to tell me about the experience. I will listen, I might ask some extra questions & I might jot some things down. This should take about an hour.

Personal experience

1. Did you expect to see 2 people in the room when you first came for therapy?

2. How did it feel to be in a room with 2 people talking to you?
(Did that change by the end of your time in counselling?)

+ Did they feel like one person in your mind or where they always 2 separate people with 2 separate personalities?
(+extra support of 2 not 1?)

Therapeutic alliance

During the time you were coming for therapy,

3. What were your feelings about your therapist?
(TA: Did you feel understood, respected and valued?)
(Did you feel connected culturally. Did she understand or feel separate?)

4. What were your feelings about your Interpreter?
Prompt: did you feel understood, respected and valued?
Did you feel connected emotionally/ culturally/ linguistically?

5. To what extent were you able to relax, trust the people in the room and talk in detail about your experiences?
(Prompt: Why? What did they do to make you feel that way?)

Good practice

6. Did the Counsellor encourage you to express your emotions or stop you from talking?
(If + What do you think the C did to encourage you to talk?)
(If – What do you think the C did to stop you talking?)

7. What do you think the Interpreter did to help/ hinder this?
(If + What do you think the I did to encourage you to talk?)
(If – What do you think the I did to stop you talking?)

8. Who did you feel was in charge of the sessions?
(At the beginning/ middle & by the end of therapy?)
9. Is there anything more they could have done to help you talk?

+ If you could speak English at the end of the therapy, did having 2 people in the room feel different to having 3?

*(Did anything change when the Interpreter left?)*

**General**

10. How would you describe the experience of working in a triad in a metaphor or simile?

*(Like trudging through treacle/ flying through the air)*

11. Is there anything more about working with a counsellor and an interpreter that you would like to tell me about?
Appendix 10: Example of transcript with amendments post transcriber
<table>
<thead>
<tr>
<th>Speaker One</th>
<th>Lynn</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Just moving on to the last question then, is there anything that could improve your work in the therapeutic triad?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Speaker Two</th>
<th>FATTIMA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Time. Sometimes if the client is late/ a little bit late and they start talking, it's a bit hard for them to stop because next time there might not be a time when they can carry on talking about that subject.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Speaker Three</th>
<th>MARTIN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Inaudible) For me the impartiality of the interpreter is important, unless he is a counsellor and actually works with the counsellor that's different.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Speaker Four</th>
<th>KIM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>For me it's (inaudible) if the client had a better understanding of counselling, but I really don't know how that could be achieved. (Pauses) You know, of what they should expect from the whole thing really. (Pauses) You know because I think they come with so much prior to that having gone to solicitors and here there and everywhere.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Speaker One</th>
<th>MUNJID</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Of course. The counsellor gives an introduction of what counselling is, maybe just extend that a little bit, 'cos for some it is like an extension of their medical treatment and when they ask what happened to you and things like that they think, I came here for treatment (inaudible) so if the counsellor just let them know what they do and what they don't do and what counselling is then I think that they will learn day by day.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Speaker Two</th>
<th>FATTIMA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I agree. It's best to start with an introduction of the counsellor and the interpreter so they do more training and understand each other more without the client being there, do you understand what I'm saying? 'Cos for the client you're just transferring the information what the counsellor's saying and then the information back to the counsellor from the client so more training would be helpful for both the interpreter and...</td>
</tr>
</tbody>
</table>
Appendix 11: Example of transcript with three IPA codings
<table>
<thead>
<tr>
<th>VICTORIA</th>
<th>DONNA</th>
</tr>
</thead>
<tbody>
<tr>
<td>132 I worked with Michael a lot and I do trust him, but I believe there are some discrepancies.</td>
<td>I agree with Victoria.</td>
</tr>
<tr>
<td>132 When I couldn't find the information I was looking for, I tried to reach out to Michael but he didn't respond.</td>
<td>132 I think Michael was trying to help but I didn't feel comfortable with the information he was providing.</td>
</tr>
<tr>
<td>132 Clearly, I was misled about the data and the project timeline.</td>
<td>132 I was also concerned about the quality of the data we were working with.</td>
</tr>
<tr>
<td>132 One of the things that happened to me is about the data, it happened when my computer was down.</td>
<td>132 I will now have an interpreter.</td>
</tr>
<tr>
<td>132 I don't think it's been worked everything and I just think it sounds like something working there.</td>
<td>132 I agree with Victoria.</td>
</tr>
<tr>
<td>132 I know sometimes it doesn't seem right to do that but I'm trying to do that and fix it.</td>
<td>132 And there's also the communication and the information. I mean, you have a bit more.</td>
</tr>
<tr>
<td>132 I think it's important to have clear and effective communication.</td>
<td>132 I agree with Victoria.</td>
</tr>
<tr>
<td>132 She talked about how much of her time she devoted to the project.</td>
<td>132 And I know my role in this.</td>
</tr>
<tr>
<td>132 We need to be clear about what we're working with and the quality of the data.</td>
<td>132 I think Michael was trying to help but I didn't feel comfortable with the information he was providing.</td>
</tr>
<tr>
<td>132 I don't think it's been worked on everything and I just think it sounds like something working there.</td>
<td>132 I agree with Victoria.</td>
</tr>
<tr>
<td>132 Sometimes in order to have trust in the experience of knowing you know the</td>
<td>132 I think they did try to understand you! I think they did try to understand these.</td>
</tr>
<tr>
<td>132 I think they did try to understand you! I think they did try to understand these.</td>
<td></td>
</tr>
<tr>
<td>132 I think they did try to understand you! I think they did try to understand these.</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 12: Looking for individual narratives in the focus group by theme
<table>
<thead>
<tr>
<th>COUNSELLORS</th>
<th>COMMUNICATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>FATIMA</td>
<td>INTERP</td>
</tr>
<tr>
<td>MARTIN</td>
<td></td>
</tr>
<tr>
<td>MARTIN</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INTERP</th>
<th>COUNSELLORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>FATIMA</td>
<td>ISARA</td>
</tr>
<tr>
<td>MARTIN</td>
<td>DONNA</td>
</tr>
<tr>
<td></td>
<td>VICTORIA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VERBAL</th>
<th>NON-VERBAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| FATIMA | 355-359, 44-58 |
| MARTIN | 555-560, 34-34 |
| MARTIN | 365-368, 34-34 |
| KIM    | 355-361, 34-34 |

| FATIMA | 365-368, 34-34 |
| MARTIN | 365-368, 34-34 |
| KIM    | 365-368, 34-34 |

NOTES: (Handwritten notes and comments.)

303
Appendix 13: Creating sub-ordinate and super ordinate themes with post-it notes