

A Thesis Submitted in Partial Fulfilment of the Registration for the
Degree of Doctor of Clinical Psychology in the University of
Birmingham

Volume I: Research Component

Literature Review – “The Impact of Interpreters in Therapy with
Refugees”

Empirical Paper – “Clinical Psychologists’ Experiences of Working with
Refugees”

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Overview

This Thesis is submitted in partial fulfilment of the requirements for the degree of Doctorate of Clinical Psychology (Clin.Psy.D) at the University of Birmingham. The Thesis contains research and clinical reports which have been undertaken during training.

Volume I of the Thesis holds three research papers. The literature review examines the current research evidence related to the impact of interpreters in therapy with refugees. This paper has been written in accordance with the guidelines for submission to the journal 'Social Science and Medicine'. The word count for this paper is 11,566. The second paper is an empirical study, which explores clinical psychologists' experiences of working with refugees. This paper has been prepared in accordance with the guidelines for submission to the journal 'Cultural Diversity and Ethnic Minority Psychology'. The word count for this paper is 9,401. Lastly the public domain briefing paper, which provides an overview of both the literature review and empirical study.

Volume II contains five Clinical Practice Reports completed over the course of training. They represent clinical work carried out during placements in the specialties of Child, Adult, Older Adult and Learning Disabilities. CPR1 presents cognitive and psychodynamic formulations of a young woman who suffered with obsessive compulsive disorder. CPR2 reports a small scale service related project which evaluates staffs views of developing psychological skills as part of their role, and whether teaching was the most effective way to develop these skills. Using a single case experimental design, CPR3 explores the outcome of a behavioural intervention

for a child with behavioural difficulties. CPR4 details a case study of an adult with learning disabilities who experienced difficulties with anger. Finally, CPR5 was presented as an oral presentation of life story work conducted with a looked after child. The abstract of this work is presented.

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Impact of Interpreters in Therapy with Refugees

Abstract

This review of the literature provides an assessment and evaluation of the current research literature in relation to the impact of interpreters in therapy with refugees. Nine papers were identified where the paper related specifically to working with refugees in some form of ‘therapy’ context and interpreters were used to aid communication within this therapy context. Two qualitative papers offered detailed accounts of the role and impact of interpreters in therapy with refugees. They suggest how a discrepancy can occur in therapists’ views of the interpreters’ role in therapy, viewed either as simple and detached, or complex and involved. It is suggested that interpreters may act as a ‘responsible messenger’ in changing the perspective of interpreted dialogue. Quantitative studies tended to explore the effectiveness of a particular therapeutic intervention through a measurement of a reduction of symptoms, in which interpreters were involved in aiding communication. Most demonstrate an improvement in symptomology concluding the effectiveness of the intervention. However, studies largely fail to consider the impact of interpreters on therapeutic intervention. Common failings are: models or standards of interpreting are unclear, interpreters are not seen as a variable in need of control and measurement, and measures used often fail to be culturally appropriate. Methodologies often appearing weak and varied means that the exploration of the impact of interpreters in therapy continues as exploratory.

Introduction

What is therapy?

Individuals' psychological needs are often thought to be best met through engagement in therapy. Therapy can be a hugely diverse practice with reports of up to 200 different kinds of psychological therapy in existence (Orlinsky, Grawe & Parks, 1994). A broad definition of therapy is offered by Holmes and Lindley (1991), who define therapy as

“the systematic use of a relationship between therapist and patient – as opposed to pharmacological or social methods – to produce changes in cognition, feelings and behaviour.” (p.3)

Although therapy appears to be a diverse and complex concept it is argued that there are certain qualities that are apparent in all forms of therapy. Orlinsky et al. (1994) discuss the Generic Model of Psychotherapy, summarising six aspects of process found in all therapies, which include, a therapeutic contract, therapeutic operations, therapeutic bond, self-relatedness, in-session impacts and sequential flow. In this model the 'therapeutic contract' refers to both clients' and therapists' understanding of goals and conditions of engagement. Orlinsky et al. highlight how this becomes more complex as the number of individuals involved in the therapy session increase from dyad to triad. 'Therapeutic operations' encompasses the process of problem presentation on the part of the client, expert understanding on the part of the therapist with some form of intervention, and a client's active cooperation and involvement in this. During the process of therapeutic contracting and operations, a 'therapeutic bond' is formed. An effective bond consists of expressive attunement, mutual

affirmation, interactive co-ordination and investment in the role. The expression of 'self-relatedness' is in each person's manner or behaviour, because of their increased focus on intentions, desires, thoughts and feelings. 'In-session impacts' relates to shifts in the therapeutic operation or bond which cause positive or negative shifts, largely in the client, but also the therapist. These can include insight and catharsis, or confusion and embarrassment. Lastly 'sequential flow' describes the orderly and often patterned nature of sessions as they develop. This model of the generic qualities of psychotherapy is useful because it is important to have an understanding of the key elements that make up therapy and what processes occur in order to be able to understand the impact interpreters may have on this process.

What are the needs of refugees?

The term 'refugee' is used throughout this review of the literature to include people at different stages of the asylum process (Mahtani, 2003). Tribe and Morrissey (2004) highlight the increasing numbers of people migrating from different countries, many seeking refuge in Britain under the terms of the 1951 UN Convention Relating to the Status of Refugees. These individuals may have been subject to severe torture, organised violence and the trauma of exile, including the loss of job, country, loved ones and identity, as well as the ability to communicate and be understood (Tribe, 1998). On reaching places of safety, individuals are often in need of immediate health care and psychological support, due to high levels of post-traumatic stress, depression, anxiety and stress (Silove, Steel, McGorry & Mohan, 1998). However, receiving countries are often unprepared to respond to the needs of such individuals (Raval, 2005), with mental health care still failing to provide culturally appropriate and

equitable services to people from ethnic minorities in Britain (Department of Health, 2003).

The role of language and culture

Working psychologically with this particular client group poses great challenges and raises questions about whether Westernised models of therapy are effective or appropriate (Summerfield, 2001). Raval (2003) emphasises that the inability to speak the language of the host country is a major barrier to accessing psychological therapy. In addition to this Kramsch (2003) discusses how language is bound up with and embedded in culture in many complex ways, thus expanding this barrier. Culture is defined as the way of life of a particular society, including its beliefs, norms and values (O'Donnell, 1997). Kramsch describes how the words and language that we use refer to common experiences that 'others' share collectively with us, usually reflecting the culture of that social group or community. Culture thus provides resources for making sense of experience. O'Donnell explains how cultures produce a shared collection of meanings which enable members to make sense of, understand and anticipate each other's actions. Without these understandings, misinterpretation occurs. Tribe (1999) describes how language itself is not a transparent medium, but is a defining structure reflecting historical and cultural contexts. This is particularly evident in the language of psychology, largely based on a western world view, culture and vocabulary. This suggests that the aim of 'merely translating' meanings across languages is unrealistic, as concepts and meanings are not always interchangeable. Tribe urges clinicians to recognise that translated language can at best be an approximation of the client's account.

The role of the interpreter

As a consequence, the interpreter's role is complex and will often include much more than 'simply' translating language. The varying roles that an interpreter can adopt are discussed by Raval (2003). The roles can include translator, bilingual co-worker, cultural broker, cultural consultant, advocate for the service user, intermediary, conciliator, community advocate or link worker. Depending on the role adopted by the interpreter, this will influence the approach they take. Tribe and Morrissey (2004) in their good practice guidelines in using interpreters in therapy describe four appropriate models of interpreting language:

- Linguistic mode - Where the interpreter attempts to interpret word-for-word.
- Psychotherapeutic/constructionist mode - Where the meaning and feeling of words is primarily conveyed.
- Advocate/community interpreter – Where the interpreter advocates for and represents client's interests.
- Bicultural worker/cultural broker - Where cultural and contextual information is conveyed, in addition to interpreting the spoken word.

Tribe and Morrissey caution that it is important that therapist and interpreter are clear about how they will work together and what their roles are.

Considering the impact of interpreters on therapeutic process

Both positive and negative issues of using interpreters in therapy have been documented. Some of the benefits noted in literature regarding the positive aspects of using interpreters in therapy are summarised by Tribe (1999) who describes an enhanced sense of 'being understood' for clients, and higher rates of engagement with services. Faust and Drickey (1986) highlight how using an interpreter can be

invaluable to the accuracy of the interaction and may enhance therapist-patient co-operation. However negatives are discussed by Westermeyer (1990) who emphasises the impact that untrained or inexperienced interpreters can have in therapy, such as breaking the bounds of confidentiality or not translating all material discussed. As this literature shows, both clients and therapists can benefit from the presence of an interpreter in therapy, but there can also be potential negatives to using interpreters which therapists have to be aware of and consider. The aim of this review is to examine literature which has involved interpreters in therapeutic interventions in order to summarise what it can tell us about the potential impact of interpreters.

Client and therapist interactions within 'therapy' are purposeful and influenced by both parties. Adoption of these 'social roles', and expectations regarding these roles, influence adherence or deviation in therapy for both client and therapist. However for individuals from different cultures, therapy may be a strange or complex concept which may evoke very different meanings within their own culture. Knowledge of the 'roles' in therapy, such as what to do and how it will be done, is often informal and based on culturally held beliefs and values (for example, the belief in the benefit of talking as therapeutic). Knowledge of the 'roles' is also formalised and context dependent; Orlinsky et al. (1994) describe how the context, such as the setting and therapy type, determine the therapeutic process and possible instruction from the therapist on expected roles. Individuals from different cultures may be unaware of the process of therapy and their role, or may misinterpret what their role is, and this may impact on the effectiveness of and engagement in the therapeutic intervention.

Orlinsky et al. start to contemplate what impact it may have to introduce another individual and role in therapy. They speculate that if more than two people are

involved, the alliance as a dyad of client and therapist, in fact becomes a group process.

Method of review

Definition of terms

In this review, the term therapy is defined as the systematic use of a relationship between therapist and patient to produce changes in cognitions, feelings and behaviour (Holmes & Lindley, 1991). Therapy, using Orlinsky et al. (1994) Generic Model of Psychotherapy, has six aspects that are apparent in all forms of therapy. These include a therapeutic contract, therapeutic operations, therapeutic bond, self-relatedness, in-session impacts and sequential flow. The term interpreter is used as an over-arching name to describe a number of roles an interpreter can adopt including translator, advocate and bilingual co-worker (Raval, 2003).

Rationale for the review

There appears to be growing consensus that interpreters should be utilised within therapy with refugees and asylum seekers. There is growing literature around the best practice for this. When interpreters are used well and appropriately in therapy it is considered that the benefits include greater understanding, better engagement and more accurate cooperation for both client and therapist (Faust & Dricky, 1986; Tribe, 1999). However the negatives of using interpreters were described, such as interpreters breaking confidentiality and not translating all material (Westermeyer, 1990). It would be interesting to see whether these issues arise in studies and how they are managed. The complexity of language being bound up in culture (O'Donnell, 1997; Kramsch, 2003) raises questions of whether interpreters can directly translate

material so that it is understood by individuals from different cultures, within a therapeutic context, or whether this is an added complexity which impacts upon the effectiveness of the therapeutic encounter. Additionally, issues around the adoption of 'roles' in therapy may be an added difficulty for individuals from different cultures because these are both culturally and contextually dependent (Orlinsky et al, 1994). Individuals from different cultures, who may include interpreters, may be unaware of the process of therapy and their role, or may misinterpret what their role is, and this may impact on the effectiveness of and engagement in the therapeutic intervention. Mental health services in the U.K have been highlighted as failing to provide culturally appropriate and equitable services to people from ethnic minorities (Department of Health, 2003). It is therefore important to know more about the impact that interpreters may have on psychological therapy. The relationship between interpreters, clients and therapists and their impact on therapy has not been exhaustively researched. There is here, however, a sufficient number of relevant studies to merit an exploratory review.

Search strategy

Searches for relevant papers were carried out in four bibliographic databases, these were PsychInfo, Applied Social Sciences Index and Abstracts (ASSIA), International Bibliography of Social Sciences (IBSS) and Web of Science. The following key words were used for searches:

'Refugee' or 'asylum seeker'

AND

'Interpreter' or 'translator' or 'bilingual co-worker' or 'foreign language translator'

The results of the searches identified 81 research papers. All abstracts were scanned. Papers that were accounts of anecdotal evidence, case studies, included children as participants or children's services, and those that obviously did not relate to the subject of review were discarded. The reference sections of appropriately identified papers were also hand-searched to find relevant papers. Papers which appeared relevant were read and assessed for whether they met the criteria for inclusion. Criteria for inclusion were that: participants needed to be of adult age; the paper needed to relate specifically to working with refugees in some form of 'therapy' context; and interpreters had to be used to aid communication within this therapy context. The strict criteria were chosen in order to obtain a manageable number of papers for review on a subject which had had little in-depth exploration of the research evidence. Nine articles were found that met the research criteria. Two of these were qualitative in methodology and the remaining seven papers were quantitative (see Appendix 1 for particulars of each study).

Order of review

This review of research studies is organised according to the methodology employed by the researchers. Research employing a qualitative methodology will be considered first; these will be followed by papers using a quantitative methodology. Papers with a quantitative methodology will be separated into two sections, the first looking at research using archival data where the authors have used data from routine service monitoring of clinical outcomes and past client assessments from an earlier period of time. The second section will look at research where data have been purposefully collected to answer the research questions about whether symptoms had improved as a result of an intervention involving interpreters. Many of these papers have included

some interesting commentary and reflections on the role and contributions of interpreters to their therapeutic outcomes. However, very few of them have provided explicit or controlled analysis of the interpreter's impact. As a consequence, many of the recommendations of this review point toward requirements for more focused and direct research in this area.

Qualitative studies

Two qualitative studies were identified which provided illustration of the impact of interpreters in the context of therapy. Miller, Martell, Pazdirek, Caruth and Lopez's (2005) paper explores the role of interpreters in psychotherapy with political refugees, using semi-structured interviews to gain the experiences of both therapists and interpreters. One of the paper's specific aims is to explore the impact of interpreters on the therapeutic relationship (moving from dyad of therapist and client, to the triad of therapist, client and interpreter) and their impact on therapeutic alliance. Their interviews with therapists and interpreters reveal a discrepancy in the interpreter's role in therapy. Miller et al. describe how sometimes in an attempt to eliminate the impact of the interpreter on therapeutic alliance, therapists would treat interpreters as a 'black box' who merely translated material, unobtrusively facilitating communication in therapy sessions word for word. The interpreter's personality and relationship with the client were viewed as not clinically significant and the focus would be on the therapist-client alliance only. However Miller et al. highlight that most therapists and interpreters viewed the interpreter's role as an integral part of a three-person alliance, with the interpreter viewed also as a witness to clients' stories, experience and trust. There appeared to be a discrepancy between the minority, who viewed the role of the interpreter as simple and detached, compared to the majority who felt that the

interpreter's role was more complex and involved. Therapists described various complicating factors to the therapeutic process when using interpreters, such as the formation of a stronger alliance between the client and interpreter, rather than client and therapist, in initial therapy sessions. Therapists struggled with complex emotional reactions within the triad, as well as with clients' concerns about the assumed political stance of the interpreter, and mistrust. All of these have a potential impact on the therapeutic relationship.

Unfortunately this study appears to suffer from several methodological flaws. Although Miller et al. (2005) are able to justify the benefits of a qualitative methodology as an exploratory approach, allowing participants to identify relevant variables in previously unstudied domains, they fail to state the exact methodology used to analyse their interview data. Qualitative analysis represents a number of fundamentally different approaches (Yardley, 2000), whereas Miller et al. only describe the use of the NUD*IST qualitative software programme. As Robson (2002) points out, NUD*IST is not a qualitative methodology, and following it merely helps the user to organise codes, and records the process to achieve this. It has been argued that this approach to analysis may distance people from their data, leading qualitative data to be analysed in a quantitative and unmeaningful way (Barry, 1998). In addition to this, Miller et al. describe an inductive approach to identifying themes (codes) from the data, but then describe assessing interrater reliability for this. The use of interrater reliability could be considered inappropriate because it is a check on the reliability of a coding scheme. This is somewhat pointless in qualitative methodologies, which must accept a degree of subjectivity in the interpretations in the first place. All this tells the reader is that each code is an interpretation agreed upon by all researchers

(Yardley, 2000) which risks reducing the insights of analysis to the lowest common denominator. In fact Miller et al's. study appears to be relatively insightful despite these methodological flaws. However a more interpretivist use of methods and analysis may have allowed the study to be more robust and transparent to enable firmer conclusions to be drawn.

Miller et al. (2005) conclude that both therapists and interpreters expressed a high degree of motivation to participate in the research, suggesting that this supports the view that the data presented are an accurate reflection of participants' actual experiences. Yardley (2008) however argues that there is a need to be sensitive to the context in which research is carried out. Miller et al. do not consider the possible impact the characteristics of the researcher may have had on participants or why other particular views may not have been expressed, interviewers being either a Psychologist or research student both overseen by Miller. Yardley cites issues around the possible impact of individuals who are seen in positions of authority. It could be questioned whether interpreters felt they could be open and honest about their experiences, as participants may have had fears about repercussions or causing offence.

Miller et al. (2005) conclude that in terms of clinical practice, their findings suggest that interpreters with characteristics similar to those possessed by therapists, such as a high degree of empathy and self-awareness, would be most suited to working as interpreters in a psychotherapeutic context with therapists and refugees. It would appear that this would allow for the ease of development of the therapeutic alliance as a triad. This raises issues regarding hiring and training of interpreters. However, it

appears unclear where these claims have come from and whether they are appropriately evidenced within Miller et al.'s study. Suggestions such as these would be more appropriate to a quantitative examination, and more usually based on comparisons between therapists' and clients' ratings of the effectiveness of interpreters and/or observer-measured levels of specific characteristics such as empathy and self-awareness. The focus of Miller et al.'s paper is on the therapeutic process of using interpreters, and of therapist's and interpreter's reaction to the work, and interpreter well-being, but it fails to consider, in depth, how language is interpreted. A paper by Bot (2005) considers this in more detail.

Bot (2005) looked at how interpreters interpreted language in psychotherapy sessions with patients who were asylum seekers with a diagnosis of PTSD. The languages spoken were Dari and Persian. Bot (p.238) describes how "users (therapists) of the interpreting services believe the interpretation is good when they note that interpreters render the translation in the first person," placing importance in psychotherapy on the direct contact between therapist and patient, and their alliance. However, Bot argues that it may not be helpful for interpreters to interpret directly, referred to as the 'American way', while acting as a 'non person' and conveyor of messages only. Bot describes the 'Arabic way' born out of the Arabic proverb 'the one who repeats an insult is the one who is insulting you' (p.240). This suggests that interpreters may wish to act as more of a 'responsible messenger' who may change the perspective of interpreted dialogue to inform the listener about who is responsible for the ideas and opinions. This is considered by Bot to be a more interactive model where interpreters are viewed as active participants. Bot argues that if there is complete rejection by therapists of a change in perspective in interpreted language, this may lead to denial of

the three-party character of the interaction affecting both quality of the interaction and alliance. This denial could be likened to therapists' use of interpreters as a 'black box' in an attempt to eliminate the impact of the interpreter on the therapeutic alliance as described by Miller et al. (2005).

The paper's findings explain that these interpreters did in fact change the perspective of the person by using 's/he says' and changing 'I' in to 's/he', to inform who is responsible for the ideas and opinions, as is the view of the 'Arabic way'. However, this was dependent on the particular interpreter's style and factors such as turn length, structure, and difficulty of ideas. Bot (2005) discussed whether the change in person can be seen as an attempt by interpreters to distance themselves from the words they render. However, there is emphasis that the interpreter is part of the dialogue and at the same time is defining his position as 'reporter'. It seems unclear from this study whether the interpreters' view is one where they influence and wish to be part of the therapeutic alliance or whether they wish to distance themselves from it. This is in contrast to the Miller et al. (2005) paper which highlights how most interpreters viewed their role as an integral part of the three person alliance.

Bot (2005) concluded that the findings do not suggest any real reason why the use of a reporting verb, or change from first to third person in interpreted language, cannot be 'good interpreting practice'. Bot summarises that the voice of the interpreter looms large in interpreted language and that it is inevitable that the interpreter will influence the session. However, Bot goes on to contradict herself somewhat in her conclusions suggesting that it is "worthwhile to try to limit this influence" including "limiting changes in the perspective of person" (Bot, 2005, p.260).

Unfortunately the study appears to suffer from issues of coherence and transparency (Yardley, 2008). Although the author appears to attempt to make a good argument for the study, it lacks the traditional structure and sections of research (such as, method and results which are excluded) and details are merged in to other sections. There is also no explanation of whether any particular methodology was used to analyse the data. Yardley argues that a firm grounding in a method and its theoretical background is needed in order to carry out qualitative research that is coherent.

The researcher makes little consideration of the patient's view of the impact of interpreting. A future study may be interesting, that gathers and analyses data further from this group, to employ a form of 'triangulation' in order to achieve a more rounded and multi-layered understanding of the research topic (Yardley, 2000).

Quantitative studies

Research and treatment studies conducted looking at treatment and therapy with refugees and asylum seekers have tended to be hampered by language barriers (Otto & Hinton, 2006). Silove et al. (1998) observe how few studies have focused primarily on asylum seekers. Those that have, are laden with limitations in sampling and the absence of comparison groups. Furthermore, the diversity of their cultural and linguistic backgrounds makes transcultural comparisons difficult. It has been suggested that the effects of interpreter-mediated interviews have not been studied systematically (Marcos, 1979), partially due to psychological treatments for refugees being so varied. It has been emphasised that there has been little published evidence on treatment outcome (D'Ardenne, Capuzzo, Ruaro & Priebe, 2005), with published

studies being open to criticism, because of their lack of objective and scientific standards, which may limit the conclusions that can be made about the impact of interpreters in therapy. Research employing a quantitative methodology will now be considered. Research using archival data will be looked at first. These studies will be followed by studies where data has been purposefully collected to answer the research questions about whether symptoms had improved as a result of an intervention involving interpreters. Many of these papers have included some interesting commentary and reflections on the role and contributions of interpreters to their therapeutic outcomes. However, very few of them have provided explicit or controlled analysis of the interpreter's impact.

Archival

Three studies using archival data were identified. Renner's (2007) paper studied the effectiveness of psychotherapy with refugees and asylum seekers, using largely retrospective data and a small amount of comparative data. All participants were assessed by a psychotherapist and only those with severe traumatisation and marked traumatic symptoms were accepted into the study. Renner explains that if symptoms were too severe then patients would first undergo psychiatric treatment prior to psychotherapy and then would go into the study. The types of psychotherapy undertaken in Renner's research are varied; 27 participants completed psychodramatic treatment (17 individually, 10 in a group setting); 6 undertook behaviour therapy; and 4 existential analysis. The author highlights that all therapies were conducted with the aid of an interpreter, however no attempt was made to elaborate on how many were used or how this was done. The results found a positive effect, with 85 percent of clients reporting significant improvement in their symptoms through the

Questionnaire of Change in Experience and Behaviour. However, Renner fails to state whether this measure is validated for the population so it is difficult to draw any firm conclusions from this. Unfortunately this approach also raises questions regarding whether we can be sure if it is the psychotherapy or psychiatric input that caused any positive outcomes. It could be argued that if individuals are suffering with severe symptoms, they are almost guaranteed to show at least some improvement due to some degree of spontaneous recovery (Barker, Pistrang & Elliot, 2005). A major limitation of Renner's study is the absence of a comparison group. A slight improvement is seen in D'Ardenne, Ruaro, Cestari, Fakhoury and Priebe's (2007a) study which does employ comparison groups.

As with Renner's (2007) work, D'Ardenne et al. (2007a) used a retrospective approach, comparing routine clinical outcomes of interpreter-mediated trauma-focused cognitive behaviour therapy (TF CBT) with refugees. Their aim was to ascertain whether interpreted TF CBT with refugees is feasible and associated with comparable outcomes when compared with TF CBT with refugee patients not requiring interpreters and non-refugee patients. All patients between the period of 2000 to 2004 who had completed two or more of the three routine psychological measures pre and post treatment were included in the study, in total 128 patients. Forty-four refugee patients required interpreters, 36 refugees patients did not require interpreters, and 48 non-refugee patients were also included in the study. The authors state that for patients who did not require interpreters, all treatment sessions were conducted in English. Unfortunately they fail to state whether English was the patient's first language. They further fail to state the patient's level of competence in English if it is not their first language, or to describe how decisions were made about

who did and did not require an interpreter. Two CBT therapists and 8 Trainee Clinical Psychologists conducted the therapy. In contrast to Renner's omission, D'Ardenne et al. state that 22 interpreters were used throughout the study period. D'Ardenne et al. explain how interpreters were provided with basic information on CBT and trauma and the department's 'interpreter protocols.' However, there is no further explanation or standardised information provided about the model of interpreting used in sessions, such as those provided by Tribe and Morrissey (2004). The findings of the study show that the 'refugee group with an interpreter had a higher proportion of patients who had improved than the group of refugees without' but this was not a statistically significant difference. The authors highlight that a significant improvement was seen for all groups, and conclude that the findings confirm the effectiveness of CBT in the treatment of PTSD.

Schulz, Resick, Huber and Griffin (2006) again used archival data that was collected from a service-based community organisation providing treatment to traumatised refugees. This was over a period of approximately 5 ½ years from Dec 1998 to April 2004. The study's main aims, like Renner's (2007) and D'Ardenne et al.'s (2007a), were to determine whether cognitive processing therapy (CPT), in a manualised form, was effective with traumatised refugees. Effectiveness of CPT was measured by comparing pre and post scores of the Posttraumatic Symptom Scale (PSS). Outcomes of the impact of interpreter use on therapy were explored by comparing the PSS scores across 2 conditions: participants who had completed therapy with an interpreter present, or participants who had completed therapy with a therapist who could speak the participant's native language. The therapist in the later condition was a native of the former Yugoslavia, providing treatment in Serbo-Croatian. Interpreters were used

in the therapy for 25 out of 53 participants. There is little standardised information provided about the model of interpreting used in sessions, such as those provided by Tribe and Morrissey (2004). Schulz et al. suggest only that the interpreter's role was viewed as translator and facilitator of the therapist–patient relationship. Schulz et al. reported that their results did demonstrate that CPT was highly effective regardless of whether or not interpreters were used.

Within Schulz et al.'s (2006) study the decision of which treatment condition participants were assigned to was not a random selection, but was based on therapist availability. This was acknowledged by the authors, explaining that due to the data coming from a community service organisation using therapists not researchers, and being retrospective in nature, it unfortunately lacks the methodological rigour seen in controlled clinical trials. D'Ardenne et al. (2007a) also make mention of this factor, however Renner (2007) failed to take account of this in his research. In Schulz et al.'s study, being more naturalistic could be considered a strength, as controlled clinical trials can often seem far removed from real clinical situations, and so less relevant and useful to populations seen in clinical practice (Barker et al. 2005). However, what is gained from Schulz et al. is limited due to the need for a proper comparison group and more in-depth cultural information.

Sample size appeared to be a limitation, and was discussed by both D'Ardenne et al. (2007a) and Renner (2007). D'Ardenne et al. describe how, in assessing whether there was an interaction between groups, pre and post variables and a General Linear Model was used. However, the results of this were not reported as there were no statistical differences between the 3 groups (refugees requiring interpreters, refugees not

requiring an interpreter, non-refugee patients). The authors note that because of the relatively small sample, the power of the study was not sufficient to reliably detect interaction effects.

In consideration of interpreter characteristics, D'Ardenne et al. (2007a) explained that interpreters had at least one year's experience in health interpreting. However, they do not qualify whether this was physical or mental health experience. An attempt was made to ensure that interpreters did have a basic understanding of trauma and the CBT approach, as they were provided with a basic briefing and information to read. Schulz et al. described the interpreters within their study as well educated, and all had attended training to be interpreters. D'Ardenne et al. appeared to endeavour to closely match patients with interpreters in terms of gender, ethnicity and any political sensitivities, and the same interpreter was used throughout treatment, unless a request was made for a different one by patients. This occurred on four occasions. Schulz et al. (2006) highlighted 3 cases where it was not possible to have the same interpreter but felt that these changes were well tolerated, causing minimal discomfort. However, neither author goes into any further depth to explore why the changes occurred or were requested or its possible impact on therapy.

The role of interpreters was most thoroughly considered by Schulz et al. (2006). The interpreter's role was clearly presented. The interpreter was to act as a translator, translating clearly and completely what patients and therapists had said. In sessions, interpreters were sat next to patients and therapists sat opposite to facilitate eye contact between therapist and patient. Interpreters were viewed as facilitators of the therapist-patient relationship, in order, it appears, to have as little impact on therapy as

possible. This matches with the 'black box' approach as described by Miller et al. (2005). Five female therapists provided CPT, 4 required the aid of an interpreter and one therapist provided treatment in Serbo-Croatian which was the native language of many of the participants from the former Yugoslavia. The authors consider the impact this may have had on their results, if only one therapist was providing therapy in participant's native language. It could be argued that any changes seen in this group are actually more due to the consistent effect of one therapist and not necessarily due to the CPT or the impact of using interpreters in the other group.

D'Ardenne et al. (2007a) considers the impact using interpreters has on therapy in terms of the increased length of time therapists spent on each session, increasing by as much as 50 percent. In contrast Schulz et al. (2006) found that therapists in total spent less time in sessions, and had fewer sessions when using an interpreter. This outcome seems a little surprising when compared to D'Ardenne et al.'s findings, but unfortunately Schulz et al. provide no explanation for this. Due to the lack of standardised information on the models of interpreting used in sessions, it is difficult to be able to draw any firm conclusions about how this was achieved or the quality, effectiveness and impact of using interpreters in the therapeutic context. Schulz et al. describe that "once treatment goals were achieved, the therapist-interpreter-patient triad terminated the therapeutic relationship" (p.328). The authors conclude that "interpreter use need not add considerably to the course of therapy" (p.329), however there do appear to be concerns about the impact of interpreters on the maintenance of the therapeutic relationship within therapy. D'Ardenne et al. suggest that future research may investigate whether there is an optimum number of sessions for interpreted treatments.

D'Ardenne et al. (2007a) go further to highlight the challenges of interpreting and the impact that interpreters have on therapy, such as issues of trust, confidentiality and disempowerment, all concepts relevant to and influencing the therapeutic bond in therapy. Limitations of their study are identified regarding patients who would choose to have interpreters interpret in patient's second or third language, but no description of the consideration of how this impacts on therapy is made. Schulz et al. (2006) discuss some of the feedback received from therapists on working with refugees. Much of this is around the perceived stress that using interpreters adds. Stressors were around concerns that interpreters may be late for sessions, that therapeutic skills may be judged, or extra time needed for preparation and debriefing.

The findings of D'Ardenne et al. (2007a) study suggest that "the use of interpreters is no barrier to therapeutic outcome" (p.298) and their findings confirm the effectiveness of CBT in the treatment of PTSD. The study does demonstrate an attempt at creating a control group for the interpreter condition. However a downfall of the study is that there was no adequate control group for TF CBT employed. The use of a waiting list control or comparisons with another treatment would have enabled them to draw more conclusions from their findings. Renner (2007) argues that using interpreters in therapy with refugees and asylum seekers is a complicating factor. Renner discusses the interpreter's impact on the therapeutic bond, describing how this relationship can "lack immediateness" (p.68) where "emotionally laden subtleties are difficult to communicate" (p.68). Unfortunately it is hard to be able to draw any firm conclusions from Renner's paper regarding whether interpreters had an impact on therapy or not,

as there is a lack of depth on this subject and the study included no comparative group.

Findings from Schulz et al.'s (2006) initial analysis of their results suggested that the group with the treatment delivered directly through a therapist who could speak the patient's native language (no-interpreter condition) had shown a greater improvement in PSS scores than the group with treatment delivered with the aid of an interpreter. However it was recognised that the no-interpreter condition was entirely the work of one therapist who tended to have, in total, longer and a greater number of sessions. Once these factors were accounted for, the no-interpreter effect disappeared. Despite these initial results Schulz et al. concluded that their results did demonstrate that CPT was highly effective regardless of whether or not interpreters were used.

Purposeful

There were four studies using data collected for the explicit purpose of examining outcomes, which involve interpreters. As previously highlighted, many of these papers have included some interesting commentary and reflections on the role and contributions of interpreters to their therapeutic outcomes. However, very few of them have provided explicit or controlled analysis of the interpreter's impact. Initially the focus will be on what the studies have tried to do and problems with this. We will then move on to what we have learnt from these studies about the role and impact of using interpreters. The earliest of these studies is Weine, Kulenovic, Pavkovic and Gibbons (1998) who explore the use and effectiveness of Testimony Psychotherapy (TP) in 20 traumatised refugees from Bosnia-Herzegovina. Participants were recruited through outreach work either by volunteering or being asked. In total there were 8

women and 12 men, and all participants completed TP. All testimonies were conducted in the Bosnian language, by either a Bosnian speaking psychiatrist, or an American psychiatrist with the aid of an interpreter. Unfortunately no data are given as to numbers of participants seen by each psychiatrist. The role of interpreters is described in some depth by the authors, which shall be considered later in this review, however despite this there is little consideration of the impact of interpreters on TP. The authors report that the results of the study show that TP reduced PTSD symptom severity and decreased rates of PTSD diagnosis. Initial consideration of the participant group suggests that there may have been an element of ‘cherry picking’ the clients. It could be argued that individuals who volunteer may have increased motivation and determination to improve and so may be more likely to report recovery. Additionally, in asking particular clients to participate, researchers may have been looking for particular qualities that they felt would have matched with the TP approach. These variables may have positively influenced the outcomes achieved, not necessarily being truly representative of a clinical population and therefore difficult to generalise.

Another study which also appears to suffer with flaws in their sampling is Otto, Hinton, Korbly, Chea, Ba, Gershuny and Pollack (2003). They conducted a pilot study comparing the effectiveness of the selective serotonin reuptake inhibitor (SSRI) sertraline, with sertraline plus CBT for the treatment of PTSD in Cambodian refugees. All participants within the study were female and were considered to have failed to respond adequately to treatment with medication, which was clonazepam in combination with an SSRI other than sertraline. All participants also met the criteria for a current diagnosis of PTSD as determined by the structured clinical interview for DSM-IV (SCID). However, the authors do not query whether it has any validity with

this population. Participants' first language was Khmer. The researchers describe how all participants were illiterate in English and Khmer, so all services were provided in Khmer through an interpreter. Participants were randomly assigned to treatment groups, five in the sertraline alone treatment group, and five to sertraline treatment plus ten sessions of CBT. The authors describe how the results of the study suggest that the addition of 10 sessions of CBT in the combined group provided a substantial benefit compared to the sertraline alone group. Unfortunately the authors fail to report any tests of statistical significance of difference and fail to acknowledge the impact and role of interpreters in their study. The authors described how psychiatric comorbidity was high within the sample and was not comparable between the treatment conditions. Unfortunately this raises a question as to how comparable each group is and the potential impact this may have on each treatment condition's results. It would have been more effective for the researchers to have controlled for this, to make the groups more similar and therefore more comparable, and so to be able to draw firmer conclusions about the results (Barker et al., 2005). In addition to this, the small number of participants is also a clear draw back, however the authors emphasise how this is a pilot study and that effect sizes may therefore be unreliable.

A follow-up study to Otto et al. (2003) was conducted by Hinton, Pham, Tran, Safren, Otto and Pollack (2004) who looked at the effectiveness of CBT with Vietnamese refugees. Twelve participants were considered to be treatment resistant due to having spent at least one year on an SSRI and received supportive counselling without improvement. All participants met criteria for PTSD as assessed by the SCID. However, similar to Otto et al., the authors do not query whether it has any validity with this population and so may not be measuring difficulties and symptoms

accurately. Six participants were allocated to an immediate CBT group, and six participants to a delayed CBT group, with authors reporting their attempts to match the participants across the groups. It is unclear how often interpreters were used in sessions and what model of interpreting was used. The authors only describe that interpreters provided translation and cultural consultation. There is no consideration of interpreters as a variable and the possible impact using interpreters may have on therapy and outcomes. The results of the study are reported to be positive, with the interaction term for all outcome measures being significant. The results particularly demonstrated a greater improvement from the first assessment to the second assessment in the initial CBT group compared to the delayed CBT group. This study is again plagued by the small number of participants, as was its predecessor. The authors acknowledge the need for larger better-powered studies to be able to draw firm conclusions.

It could be questioned whether there were issues around the impact of medication use on the outcomes of the Otto et al. (2003) and Hinton et al. (2004) studies. Both authors fail to acknowledge within their studies that not all patients were on the same medication combination, meaning that the medication was not standardised. It therefore makes it difficult to conclude that any improvements seen would be purely due to a particular treatment condition without taking the possible effects of differing medication into consideration. Further concerns arise out of the Otto et al. paper, which reported that forty percent of patients in each group experienced at least one adverse symptom from changing medication. Although this resulted in no treatment discontinuation, the ethics of this appears questionable. It appears detrimental to continue patients, throughout the trial, on medication on which they were having

adverse effects. It is unclear whether patients felt able to discontinue medication, especially as the authors acknowledge that the research is supported by a grant from a pharmaceutical company. This brings in to question whether the welfare of the participants was truly a priority (Elliott, Fischer & Rennie, 1999) or whether the aims of the research and influence of the pharmaceutical company became more important.

The final paper is from Carlsson, Mortensen and Kastrup (2005). The aim of the study was to measure the impact of a multidisciplinary treatment programme (MDTP) on symptoms of PTSD, depression, anxiety and improvement in health-related quality of life (QOL). The MDTP consisted of psychotherapy, physiotherapy, social counselling and medical help. Some participants were also reported to have received additional special treatment including psychoeducation for families and group therapy for women. Unfortunately little data is provided on what specific combinations of treatment people may have received or how this was decided. Participants were included in the study if they had attended a pre-treatment assessment between a set time period from Jan 2001 to May 2002, however no thoughts are provided from the authors on why this time period was chosen. The final sample consisted of 55 participants who had all completed assessment, baseline evaluation, MDTP and follow-up evaluation after 9 months of treatment. Background and premigratory data regarding participants are not described until the results section where the reader is referred to a table of data. This table and information may have been more pertinent in the 'method' section. The authors state how interpreters were used when needed, however, it is unclear how often interpreters were needed in sessions and what model of interpreting was used. Like Hinton et al. (2004) study there is again no consideration of interpreters as a variable and the possible impact using interpreters

may have on therapy and outcomes. The findings of the study are reported to be a lack of significant change in mental symptoms and health related QOL after a mean of 8 months treatment.

Outcome measures were widely used to obtain pre and post measures of treatment for all four studies. Otto et al. (2003) and Hinton et al. (2004) do appear to attempt to use some measures, such as the Hopkins Symptom Checklist-25 (HSCL-25) that are validated for their study populations. Otto et al. also describe the development of a novel 17-item Khmer Anxiety Sensitivity Index (ASI) that explores specific cultural contexts around fears about anxiety symptoms. However, it is unclear, due to lack of description within the paper, as to how it was developed and whether this had been validated and checked for reliability with a Cambodian population. Hinton et al. also use some measures that are not validated for their study population, such as the Headache Panic Attack Severity Scale (HPASS) and Orthostatic Panic Attack Severity Scale (OPASS). The authors do report good levels of test-retest reliability and interrater reliability. Nevertheless Barker et al. (2005) caution that reliability gives no detail of what the measure means, merely that it is repeatable; it does not give us confirmation that it measures what we want it to measure. Weine et al. (1998) and Carlsson et al. (2005) fail to state whether any of the outcome measures used within their studies were validated for their populations. Weine et al. acknowledge the impact of linguistic and ethnocultural differences of the population on the measures. However they do not explore any further what these are, or what exactly the impact might be. A contradiction is made however, as the authors then describe how the use of the standardised instruments provided substantiation of their findings, suggesting the instruments are reliable and valid with this population.

The translation and interpreting of instruments was considered to varying degrees within studies. Weine et al. (1998) emphasise how all instruments were translated into Bosnian and back translated to check accuracy by a team of Bosnian interpreters and clinicians. Instruments were rated by Bosnian physicians and an American psychiatrist from the team, however no mention is made regarding measures of interrater reliability. Hinton et al. (2004) also report that measures were translated for use with participants. However, they omit any information on processes to check accuracy of translation, such as the common method of back translation as used by Weine et al, and whether assistance was given in completing measures and levels of literacy in participants. Carlsson et al. (2005) also describe the use of translated questionnaires, exploring patients' experience of traumatic events through participants describing the incidents of torture. Barker et al. (2005) however, discuss the disadvantages of self-report data, particularly of this sensitive nature, suggesting that people do not always tell the truth – e.g. they may 'over' or 'underplay' events or may be unable to provide the level of detail the researcher is interested in - suggesting that the accuracy of the data may need to be considered with caution. Barker et al. suggest that observational data is often useful and advisable to gather as an addition to self-report data in order to enable the researcher to make a judgement about over or under reporting. Observer rating scales were also used to assess symptoms of PTSD, depression, anxiety, and health-related QOL and were completed at baseline and follow-up. The use of an observer rating scale however raises questions of the reliability of these ratings (Barker et al., 2005).

The role and impact of interpreters in each of the four studies shall now be considered in further depth as part of this review of the literature. The role of interpreters in therapy is described in the greatest depth by Weine et al. (1998). In their account of the interpreter's role in TP, they explain how the client is encouraged to tell their story, while the therapist uses clarifying questions, structure, and support, to explore the participant's account of significant historical and traumatic experiences (all testimonies were conducted in the Bosnian language, by either a Bosnian speaking psychiatrist, or an American psychiatrist with the aid of an interpreter, but numbers are not stated). Testimonies were tape-recorded and transcribed into English and read and translated back into Bosnian by the therapist and/or interpreter, so that, together, they could correct any mistakes. Disappointingly, the authors fail to explore what these mistakes were and whether using an interpreter within therapy was impacting on them. Hinton et al. (2004) provide very little on the role of the interpreter, describing only that interpreters provided translation and cultural consultation. The role of interpreters is not mentioned in the Otto et al. (2003) or Carlsson et al. (2005) papers. This omission leaves the reader only to guess what the interpreter's role was in Otto et al. and Carlsson et al.'s studies, since they stated only that interpreters were used when needed.

A considerable flaw of all four papers is the failure to consider in any depth the impact of interpreters on therapy. For example, Weine et al.'s (1998) paper describes how the relationship in psychotherapy must be safe, trusting and caring, emphasising the process of participants signing for informed consent, which was felt to mark "the point in the relationship where the survivor and the listener make an explicit agreement to document the trauma testimony" (p.1724). However, no mention is

made of an interpreter's involvement in this process and their impact on this, leaving the reader unable to conclude whether the participant felt safe within TP and the therapeutic relationship. Weine et al. continue to neglect the question of the impact of interpreters when TP is described as "relational with two individuals, a survivor and a listener, entering in to a relationship that centres on the task of documenting and communicating the survivor's story" (p.1724). The interpreter as a third person in the relationship is not considered. The author describes how TP aims to move the trauma story outside the 'psychotherapeutic dyad' but in doing so fails to acknowledge the existence of any impact from the presence of an interpreter. Although all authors describe that interpreters were used within treatment, there is a general failure to monitor, explore or measure what the interpreters' impact on therapy was. It is therefore difficult to make any firm conclusions about the impact of interpreters in therapy.

Despite each study failing to consider the impact of interpreters, Otto et al. (2003), Hinton et al. (2004) and Weine et al. (1998) all report positive outcomes for their studies. This leads Otto et al. to conclude that their findings "demonstrate that CBT can be successfully modified for Khmer-speaking Cambodian refugees" (p.1275). The failure to acknowledge the impact and role of interpreters in their study, however, brings this claim into question. The authors also fail to report any tests of statistical significance of difference making it difficult to conclude that this research is evidence in support of the use of CBT, as the positive results may just be due to chance. Hinton et al. also report that the results from their study demonstrate greater improvement from the first assessment to the second assessment in the initial CBT group compared to the delayed CBT group. However this improvement within the immediate group

compared to the delayed group raises some ethical concerns as highlighted by Elliott et al. (1999). They stress how researchers must make appropriate considerations when conducting research, emphasising respectful practice, ensuring ethical principles are fulfilled regarding patients. However it is questionable whether it is ethical to delay and withhold treatment to a group of participants. The authors give no explanation as to the purpose of one group's treatment delay. The reader can only guess as to its purpose, perhaps being about therapist availability or group size. In highlighting the positive results of the TP approach, Weine et al. use a single quote to highlight the positive view expressed by one of the participants. However, questions around coherence are raised as the authors have adopted a quantitative approach to data collection and analysis. It is then inconsistent to use a singular quote for qualitative evidence (Yardley, 2008) as this cannot be tested for objectivity being subjective and qualitative in nature.

Carlsson et al. (2005) reported a lack of significant change in mental health symptoms and health-related QOL. The authors acknowledge that 9 months for treatment may be too short a period to expect any changes as it is reported that 47 participants were still in treatment at follow-up. Carlsson et al. suggest that a second follow-up at 22 months maybe able to indicate if there is a significant change later in the treatment period to suggest effectiveness of MDTP. The authors discuss how this may be due to participants suffering from chronic conditions, and that current circumstances for the participants were exacerbating symptoms, such as war in the country of origin impacting on friends and family and discrimination in the country in which they are refugees. However, from a review of Carlsson et al.'s paper it could be argued that the lack of significant change could be due to a number of factors. These factors included

the lack of consideration of the appropriateness of outcome measures for the population, the limited reliability of self-report and observer ratings and the lack of clarification of what treatment combinations patients were participating in.

Conclusions

Summary of the main findings of the review

From this review of the literature it has been found that most studies which include interpreters, tend to suffer from a number of flaws, many of which appear across a number of the studies. A consistent problem was a small sample size that meant that the studies lacked statistical power, and so authors may have failed to observe important effects (Barker et al., 2005). Within studies, it was unclear what standards of interpreting or models of interpreting had been employed. This made it difficult to be able to draw any conclusions about the role of interpreters, how they were used, and the impact they may have had on therapy. To improve this, it is important for future studies to use clear guidelines on their use of interpreters to allow for firmer conclusions to be made about the impact of interpreters in therapy. It appears that much of this problem may have stemmed from researchers failing to see interpreters as an additional variable requiring control and measurement. Interpreters were perhaps viewed as a ‘black box’ as described by Miller et al. (2005) and not understood to be an additional factor in the therapeutic context. Another consistent flaw was in the use of outcome measures that were not validated for the populations they were being administered with. There appeared to be almost a lack of awareness of the impact this may have on the reliability and validity of outcomes and therefore impacted on the measures of effectiveness of intervention.

There appears to be a scarcity of papers looking specifically at the impact of interpreters in therapy with refugees. The only study with a specific aim to do this was by Miller et al. (2005) using qualitative methodology. They suggest that there was a discrepancy in the interpreter’s role in therapy. Sometimes in an attempt to eliminate

the impact of the interpreter on the therapeutic alliance, therapists would use interpreters as a 'black box' unobtrusively facilitating communication word for word. The interpreter's relationship with the client was viewed as not significant and the focus would be on the therapist-client alliance only. However most therapists and interpreters viewed the interpreter's role as an integral part of a three person alliance. There appeared to be a discrepancy between the minority, who viewed the role of the interpreter as simple and detached, compared to the majority who felt the interpreter's role was more complex and involved. The voice of the interpreter was felt to loom large in interpreted language and it was thought to be inevitable that the interpreter would influence therapeutic sessions (Bot, 2005). The interpreter was viewed as also being witness to clients' stories, experience and trust, just as the therapist is. Clients' formation of a stronger alliance with the interpreter, compared to the therapist, in initial therapy sessions was described by therapists, as were complex emotional reactions within the triad, such as issues of assumed political stance and mistrust impacting on therapeutic relationship. Interpreters with characteristics similar to those possessed by therapists, such as empathy, were felt to be most suited to working as interpreters as part of a triad within a psychotherapeutic context (Miller et al., 2005). However, as discussed it appears unclear where these claims have come from and whether they are appropriately evidenced within Miller et al.'s study, as suggestions such as these would be more appropriate to a quantitative examination.

The impact of the interpreter on the translation of language is considered by Bot (2005). The impact on the perspective used, either 'I' or 's/he', were felt to be dependent on the interpreter's own style and the difficulty of ideas. It was felt that the interpreter was an inevitable part of the dialogue, but at the same time they would

often define their position as the 'reporter' (Bot, 2005). It seems unclear from findings whether interpreters view their position as one of influence, and whether they consider themselves as part of the therapeutic alliance, or whether this is something they would rather distance themselves from.

Studies using a quantitative methodology tended to look at the effectiveness of particular approaches and therapies, where the use of interpreters was a part of providing that approach. Authors consider the role and impact of interpreters in therapy with refugees to varying degrees. It appears that many authors did not consider interpreters as an important variable that may impact on the outcomes of their study (Weine et al., 1998; Otto et al., 2003; Hinton et al., 2004; Carlsson et al., 2005). The interpreter was largely described as a facilitator of the therapist-patient relationship, the 'psychotherapeutic dyad' (Weine et al., 1998). Schulz et al. (2006) describes how the reasons for this in their study was so that interpreters had as little impact on the therapeutic alliance as possible. This links with the 'black box' approach discussed by Miller et al. (2005) where the interpreter is seen as a mere conduit for communication. It was suggested that once treatment goals are achieved the therapist-interpreter-patient triad terminated the therapeutic relationship (Schulz et al., 2006). This implies that interpreters impacted on the maintenance of the therapeutic relationship, but there was failure to explore this further. Issues around the 'good practice' of using interpreters appears appropriate to consider here as many of the authors used interpreters as a mere conduit for communication. Tribe and Morrissey (2004) highlight that good practice in the context of psychotherapeutic approaches is to use the psychotherapeutic mode of interpretation. This is where the meaning of words and emotions is principal and this is conveyed by the interpreter,

rather than the focusing on word for word translation. This requires some flexibility in both the therapist's and interpreter's approach to enable this. The role and the impact of the interpreter cannot be ignored, as it has been by many authors, because the patient-therapist approach requires trust between the client, interpreter and therapist in order to work well. Additional guidance and clarity may be needed from the therapist by the interpreter in order to work this way. Tribe and Morrissey suggest that it is important to use the same interpreter throughout a series of meetings. If these issues are ignored, it appears that neither the client's nor the interpreter's needs will be listened to, acknowledged or met, which will impact greatly on therapeutic outcomes and the effectiveness of the study.

Using interpreters was argued to be a complicating factor in therapy (Renner, 2007). Interpreters were considered to impact on the therapeutic bond, meaning that it may 'lack immediacy' where 'emotionally laden subtleties' can be difficult to communicate. Issues of trust, confidentiality and disempowerment were all felt to be relevant to the impact of interpreters on therapy (D'Ardenne et al., 2007a). However, even when accounting for this, it was argued that the use of interpreters was no barrier to therapeutic outcome.

The aid of interpreters in providing cultural consultation was highlighted (Hinton et al., 2004) but the impact of this within therapy was again not considered. Interpreters also appeared to play an important role in translating questionnaires for use as outcome measures (Weine et al., 1998; Hinton et al., 2004). However their impact on this process was only regarded as useful to check accuracy of translation. There appeared to be disagreement in whether working with interpreters increased length

and time spent in therapy. D'Ardenne et al.'s (2007a) findings were that sessions increased in length by up to fifty percent. In contrast, Schulz et al. (2006) found that therapists in total spent less time and had fewer sessions when using an interpreter.

Methodological considerations

A number of methodological limitations were identified in the research reviewed. Within papers using qualitative methodology (Miller et al., 2005; Bot, 2005) there appeared to be a failure to state clearly the exact methodology used. Unfortunately this impacts on the strength of the conclusions that can be made about the validity and coherence of these studies (Yardley, 2008). The structuring of research papers was also questionable at times, with no clear method or results sections (Bot, 2005) and an example of the participant background information appearing in the results section (Carlsson et al., 2005), which may have been more pertinent in the method section.

The use of archival data was considered as a potential flaw because participants were often not randomly selected to condition groups but were selected based on therapist availability (Schulz et al., 2006) due to coming from community service organisations. Although the data lack the methodological rigour of controlled clinical trials, these can often seem removed from real clinical situations and so less relevant and useful to populations seen in clinical practice (Barker et al., 2005). Taking account of this and this review's findings it is clear that studies are needed which make a clear comparison between treatment with interpreters and treatment without interpreters. It is important that key variables, such as the use of interpreters, are controlled for and well defined, particularly providing information about the

standard and/or model of interpreting used. It is also important that measures used with refugee populations are culturally appropriate, valid and reliable.

Particular ethical considerations were felt to be omitted within two studies. Patients' experienced adverse symptoms but were continued on medication even though there was acknowledgement of funding from a pharmaceutical company (Otto et al., 2003), which may have pressured researchers into continuing inappropriate treatment. Additionally participants were delayed and withheld treatment of CBT for a period of time, but the purpose was not explained (Hinton et al., 2004). It appears that perhaps the welfare of clients was not a true priority as ethical principles were not fulfilled regarding patients (Elliott et al., 1999). This may call for the need of more intensive, thorough and continued exploration of research proposals and procedures by ethics committees to ensure continued monitoring of research in order to avoid participants welfare being unnecessarily effected.

There was failure by most authors to include clients' views of using interpreters and their thoughts about the impact on therapy. It may have been advantageous to gather data from clients to employ a form of 'triangulation' of data collection in order to achieve a more rounded and multi-layered understanding of the research topic.

Implications

It appears that there has been a recent growth of research in this area as six out of the nine studies identified were published in the past 5 years. However, as this review has shown, it has been difficult to draw any firm conclusions from these.

Miller et al. (2005) claim that interpreters with characteristics similar to those possessed by therapists, such as empathy and self-awareness, would be most suited to working as interpreters within a psychotherapeutic context with therapists and refugees. Although it is unclear where these claims have come from and whether they are appropriately evidenced within Miller et al.'s study, it would be interesting to develop this further. This may be done through perhaps measuring whether client and therapist satisfaction matches with particular interpreter qualities. Further research could also look at interpreter style and approach and outcomes of therapy. The further exploration of Miller et al.'s claim would provide evidence as to whether interpreter characteristics are important or whether this is in fact therapeutic professionals projecting their own model of working and characteristics on to interpreters. If Miller et al.'s claims are founded in evidence this may have implications for the hiring, training and supervision of interpreters. The qualities of empathy and self-awareness may become important for employers to look for and identify within potential candidates applying for the position of mental health interpreter. These qualities may need to be increased through training to aid their understanding of mental health difficulties. Opportunities for reflection on their work and the process of therapy, such as through the opportunity of supervision and debriefing after client sessions may increase self-awareness.

It seems unclear from findings whether interpreters consider themselves an important part of the therapeutic alliance or whether this is something they would rather distance themselves from (Bot, 2005). It would be interesting to develop this further by exploring with interpreters what their understanding is of the therapeutic alliance; whether they consider they have had experience of being a part of this; whether they

are encouraged to be a part of this by therapists; what their thoughts and feelings are about whether they want to be a part of this; and what it has been like when they have been a part of this and excluded from being a part of this. This is an important question to consider in order to gain a further understanding of interpreters' impact on therapeutic alliance; times when its difficult to be a part of the alliance; or how others' working practices may limit this alliance. Exploring these issues will allow development of ways to support interpreters and therapists to work more effectively together.

It was suggested that once treatment goals were achieved, the therapist-interpreter-patient triad terminated the therapeutic relationship (Schulz et al., 2006), suggesting that interpreters impacted on the maintenance of the therapeutic relationship. Unfortunately, this was not explored any further. It would be interesting to develop this further to explore with therapists and interpreters what their experience was of this and what they thought the reasons were.

Adherence to good practice guidelines, as developed by Tribe and Morrissey (2004), appeared to be an important issue to consider as interpreters were consistently being used as a 'black box' (Miller et al., 2005) as opposed to the appropriate psychotherapeutic mode of interpreting recommended by Tribe and Morrissey. It appears from much of the research that good practice guidelines are not being adhered to by both therapists and researchers in working with interpreters, this can be detrimental to all parties involved in the therapeutic process (Tribe and Morrissey, 2004). Services may need to implement service-specific protocols of good practice in working with interpreters to ensure work with interpreters is carried out appropriately

and effectively in both therapeutic and research contexts. The development of a protocol has been demonstrated by D'Ardenne, Farmer, Ruaro and Priebe (2007b) for interpreting TF CBT, showing a developed awareness and consideration of the importance of the impact of interpreters in therapy with refugees. The development of protocols needs to be further encouraged and supported across services, to enable therapists to develop their practice to work more appropriately and effectively. This may include allowing therapists time out for training and development of their skills so that they may become more confident and competent in working with interpreters. Continued supervision for therapists and interpreters would also be important to support this process and allow consideration of specific issues such as issues of trust, confidentiality and disempowerment which were all felt to be relevant from the impact of interpreters on therapy (D'Ardenne et al., 2007a).

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Clinical Psychologists' Experiences of Working with Refugees

Abstract

Working therapeutically with refugees is largely considered to be a complex process. Literature and guidance available suggests a number of factors that contribute to the complexity of the work. These include multifactorial presentations; cultural and political issues; therapists being confronted with unfamiliar experiences and the impact of these at both a personal and professional level; insufficient or reductionist models; and working with interpreters. Clinical psychologists' experiences of working with refugees are explored as there is little qualitative data and what is available appears to be largely anecdotal. Clinical psychologists were interviewed and the data were analysed using Interpretative Phenomenological Analysis (IPA). Results suggest that working therapeutically with refugees impacts on psychologists in both challenging and positive ways and that levels of support in this work could be variable. Amazement at refugees' strength and resilience was voiced, with psychologists describing their experience of fighting and advocating for refugees within their work. Participants appeared to experience a changing view of the world through their experience of frustrations at the context of delivery, with their understanding of the system challenged. Psychologists' experiences of working with difference and their understanding of the complexity of the work both evolved in working with refugees. Lastly an evaluation of the IPA approach is made, the findings from this study are linked with the literature, and clinical implications are considered.

Introduction

There is a firm body of literature that looks at good clinical practice in psychological work with refugees, with expanding guidance on good practice in working with interpreters in this field. However, there appears to be little qualitative data on therapists, specifically clinical psychologists', experiences of working with refugees, as what is available appears to be largely anecdotal.

Working therapeutically with refugees is largely considered to be a complex process. It is important to note that the term refugee is used throughout this research to include people at different stages of the asylum process (Mahtani, 2003). Maslin and Shaw (2006) emphasise how refugees are not a homogenous group. They describe how when working with refugees, clinical psychologists are faced with multifactorial clinical presentations that are influenced by a huge range of cultural and political factors. Psychologists can be confronted with unfamiliar experiences and these can impact at both a professional and personal level. Woodcock (1995) explains how refugees' experiences of atrocity and loss can be difficult for professionals to consider because they are usually so different from their own experiences.

It is a therapist's responsibility for the formation of a safe, trusting, and respectful therapeutic relationship in working with refugees (Patel, Bennett, Dennis, Dosanjh, Mahtani, Miller & Nadirshaw, 2000) who at times may present as acutely distressed with multiple difficulties. However, as Rees, Blackburn, Lab and Herlihy (2007) discuss in a short paper reflecting on their own clinical experience, the perceived complexity of refugees' experiences can leave therapists feeling overwhelmed, disempowered and hopeless. Patel and Mahtani (2007) suggest how feeling

overwhelmed can act as an obstacle to providing an effective psychological service. Herman (2001) suggests that therapists' experience of helplessness, in working with clients who have suffered atrocities and resultant trauma, can be explained by the process of countertransference, which is where the clients' experience of helplessness is empathically shared by the psychologist. Herman further describes the contagious nature of trauma often termed as vicarious traumatisation (McCann & Pearlman, 1990) or compassion fatigue (Figley, 1995), suggesting that the therapist may begin to experience their own symptoms of post-traumatic stress. Fischman (1991) reflects on how a therapist's sense of vulnerability can be increased by repeated exposure to stories of extreme brutality and torture, causing a challenge to their own beliefs. The importance of a reliable and structured support system in working with individuals who have suffered trauma is emphasised by Comas-Diaz and Padilla (1990) explaining that, to be effective, it should consist ideally of both individual supervision and peer support groups, which facilitate the safe expression of emotional reaction to trauma.

A considerable amount of literature looks at models of good practice for therapists in working with refugees, being particularly focused around issues of trauma and loss. It has emphasised how traditional westernised models can be insufficient and reductionist (Woodcock, 1995). Tribe (1999) highlights how in order to engage effectively with refugees, therapists and services alike need to be innovative, employing more eclectic models of working. Woodcock discusses how issues of cultural difference need to be considered by therapists in order to allow them to work effectively with clients, and this requires therapists to be open to explore new challenges and to question their own assumptions and methods of working. The

therapist's position of 'solidarity' in recognising and understanding the injustice of a client's traumatic experience, to allow resolution and a sense of justice, is also considered an important element of the therapeutic context (Patel, 2002). Patel warns that therapists must be careful not to recreate for clients the experience of being silenced and disempowered, highlighted especially in relation to working with interpreters. Difficulties of working therapeutically with the aid of interpreters are highlighted in Raval and Smith (2003) in their qualitative study of therapists' experiences of working with interpreters. Therapists attributed the difficulties to a deficiency of appropriately trained interpreters, inaccurate translation and a sense of the work being taken over by the interpreter.

In criticism of psychological therapies, Summerfield (1999) discusses the 'rise' of psychological therapies that have grown out of the medicalisation of 'survivor populations'. He argues that westernised approaches tend to ignore the survivor's methods of meaning making, traditions and priorities, highlighting how there is little evidence of survivors seeking this kind of talking therapy. Psychologists' roles in examining psychological models applied to refugees are discussed by Patel and Mahtani (2007). Patel and Mahtani argue that 'psychology's eurocentric biases' are apparent in psychological theories and methods and that these need to be critically examined. However, the pressure on therapists to conform to traditional westernised psychological models in work with refugees is a clear struggle (Patel, 2002). This work is in a context of often limited resources and restrictive policies, as well as hostile media coverage, public resentment and punitive political policies (Tribe & Patel, 2007).

It is important to consider how institutional racism has impacted on black and minority ethnic (BME) groups, including refugees, accessing psychological services (Mahtani, 2003). This may influence psychologists' experience of working with refugees through the potential negative response and lack of support they may receive from other professionals and agencies. This idea is supported by Mahtani, who describes how institutional racism disadvantages BME groups through both overt racist views, and more covert acts such as the omission of appropriate support and services.

In a largely quantitative exploration of issues that impact on clinical psychologists, willingness to work with asylum seekers, and the impact of these issues on the development of the therapeutic relationship, are described by Maslin and Shaw (2006). Their findings highlight a number of issues, including therapeutic issues (such as trust, uncertainty and inadequate theoretical frameworks); difficulties of communication; legal and social issues; and client displacement and adaptation. Maslin and Shaw reported how the greater the psychologist's perceived difficulties in working with refugees, the lower the feelings of perceived competence and confidence, resulting in less willingness to work with the client group. From their findings they suggest how psychologists may feel overwhelmed by the client's complexity and trauma, causing clinicians to feel discouraged and deskilled. Clinical psychologists' experience of working with refugees is identified as needing further research due to the complexity with which refugees present to a psychologist. Clinical psychologists' experiences are particularly interesting due to their being highly trained in formal psychotherapies and duly accredited as a profession, and so they are

well placed to work with complexity, as Parry (1996) reinforces in his review of psychotherapy services.

The present research originates from the literature discussed, which provides a perspective on the current understanding of clinical psychologists' experiences of working with refugees. There appears to be a firm body of literature describing good clinical practice in psychological work with refugees, yet a gap exists as there appears to be no qualitative data of any significant depth exploring therapists', specifically clinical psychologists', experiences of working with refugees, as what is available appears to be largely anecdotal. As Maslin and Shaw's (2006) findings suggest, psychologists may feel overwhelmed by refugee clients' complexity and trauma, causing clinicians to feel discouraged and deskilled. A more qualitative understanding of this experience may shed useful light on how and why this happens and have implications for future practice. The present research approaches clinical psychologists' experiences of working with refugees from an exploratory and phenomenological perspective in response to the lack of other qualitative research of this nature.

Methodology

The research aims to gain an insight into clinical psychologists' experiences of working psychologically with refugees. It is hoped that this will contribute to current understanding on this subject. This will be achieved through using the approach of Interpretative Phenomenological Analysis (IPA) (Smith & Osborn, 2008) to analyse data from semi-structured interviews.

Interpretative Phenomenological Analysis

IPA aims to explore the individual's personal experience. Smith and Osborn (2008) explain how this is achieved through researchers attempting to make sense of the participant's sense-making of their world. Through exploring the participant's involvement and relatedness to the world, we are able to understand them in context (Larkin, Watts & Clifton, 2006). Willig (2008) highlights how direct access to participants' perspectives is realistically unobtainable, thus making the process interpretive, implicating the researcher's perspective within this. IPA is idiographic in approach with intensive analysis of a single or a small number of cases; and therefore studies tend to use small homogeneous samples. Ultimately the aim is to capture the integrity and quality of the participant's experience.

Participants

Participants were identified through word of mouth, approached, and chosen due to the apparent relevance of their experience to the research question; being clinical psychologists with experience of working with refugees. Together the research team identified a total of six clinical psychologists who could be potential participants. The inclusion criteria for the study were that participants were working as a clinical psychologist within the NHS, and were currently or recently working with refugees in a psychological capacity in trauma-focused work, within an adult mental health service. Additionally, all participants were currently working in the Midlands. Five clinical psychologists agreed to participate. All were female and of white European ethnicity. Three psychologists were currently working with refugees and two had worked with refugees in a prior role. All the psychologists had at least 2 years of experience of working with refugees as a qualified clinical psychologist. By

identifying participant characteristics it is hoped this may provide some context to participants' accounts. However, due to the small number of clinical psychologists working with refugees within the West Midlands region it was felt that providing further information regarding participant characteristics may threaten participant anonymity and so this information is kept brief. All Clinical psychologists were given a participant information sheet explaining the details of the study and consequently gave their written consent. The method of purposive sampling has been used to recruit a narrowly defined group, for whom it is hoped the research question will be particularly significant.

Ethical Approval

Ethical approval was granted by the National Research Ethics Service (NRES) after review by Coventry Research Ethics Committee (Appendix 2) and the relevant NHS Research and Development departments.

Data Collection

Each psychologist participated in a semi-structured interview conducted by the primary researcher, Ann-Marie Munday. The semi-structured interview schedule (Appendix 3) was developed with reference to Smith, Flowers and Larkin (2009) to allow participants the opportunity to speak reflectively and freely about their experiences. The interview schedule was developed to have a flexible structure that ensured key areas of interest were covered, but allowed the participant to tell their story and explore their experiences in an order that made sense to them. It aimed to capture a wide range of experiences encountered by psychologists through working with refugees. It was used flexibly to facilitate the participants' exploration of the

research question, to gain a rich account of the participants' experience and perspective. The interviews lasted between one to two hours and were undertaken at the participant's place of work and at their convenience. Throughout the interviews, the participants appeared able to articulate their experiences with ease, exploring these in depth and breadth. For some psychologists the strength of emotion in reflecting on their work was physically evident. The interviews were digitally recorded and all were transcribed by the primary researcher.

Data Analysis – The Process

One at a time, the participants' transcripts were read through to develop further familiarity with the data. When this was achieved, the next stage was to use the left hand margin to note items of significance or interest at the descriptive phenomenological level. Following this, the interpretive stage was undertaken, where the right hand margin was used to document inferences made about the meaning of participants' claims, and these were recorded as codes (see Appendix 4 for a section of transcript to illustrate the coding process). Codes were organised into table form for each transcript (Appendix 4). This process was undertaken for all transcripts.

The next stage involved assimilating similar codes across transcripts, considering the presence of repetition and variability. Meaning is made of the connections and patterns between codes so that initial broad clusters are developed, creating emerging themes (Appendix 4). Subsequent phases of development bring together themes, creating more encompassing and coherent superordinate themes. Continual reference back to the original transcripts was important throughout this process to make sure that the interpretation did not develop into something where the original meaning was

altered or lost. A total of four superordinate themes were identified. Two of these were further divided with subordinate themes as detailed in Table 1.

Yardley (2008) emphasises the importance of being able to demonstrate that qualitative analysis is sound and rigorous. Evidence for this is provided through a number of methods. Throughout the research process the primary researcher kept reflective notes. These notes related to the experience, observations and reflections of different elements of the research process including; recruiting participants, the interview and transcription process and stages of analysis. Consultation with peers at each stage of the research process allowed for exploration and examination of my interpretations and developing themes. The combination of both reflective notes and peer supervision provided useful information in recognising my possible over- or under- emphasis of issues related to my experiences, in exploring the meaning and interpretation of the participants' accounts. The continuing examination of my interpretations to check for credibility and validity was also done through supervision, with both my research supervisor and another professional knowledgeable about the approach. In reading my account it was felt that it was plausible. The process of supervision was important in making small but significant changes, for example, the subordinate theme of 'Broken Mirror' developed from interpretations around the complexity of working with refugees. Through supervision it was identified that the use of a participant's phrase 'Broken Mirror' would be a meaningful title for the theme. Other methods included the frequent process of reference to the original transcripts to ensure, as far as possible, that the original meaning was not altered or lost. A transparent account of the process of interpretation and meaning-making is made above and is supported through examples of a worked transcript, and tables of

clustered codes and themes. Lastly, through providing verbatim quotations from the participants' transcripts, the reader is able to view the source of interpretation. The psychologists' pseudonyms, derived from common trees, were chosen in order to maintain the participants' anonymity. It was decided that the psychologists would be referred to as 'Dr.' to reflect the fact that all psychologists interviewed were Doctors of Clinical Psychology. Additionally, considering Parry's (2006) review of psychotherapy services, which emphasises psychologists' high level of training and accreditation as a profession, it was felt that this should be acknowledged through the use of the doctoral title.

Reflexivity, Position of the Researcher & Research Team

The research team included Dr. Michael Larkin and myself. Michael is a qualitative research tutor who supervised both the clinical and academic aspects of the research. It is important to acknowledge that he held particular expectations about the research, such as the impression that the strength of the impact of the work on psychologists might be less than has been uncovered. Michael also has past experience of supervising research about interpreters' experiences. I was also aware of my own career path, as a Trainee Clinical Psychologist completing the research as part of my Clinical Psychology Doctorate to become a Clinical Psychologist. Prior to and during my training I had worked in different mental health settings where I had carried out psychological therapy with refugees. I had also encountered refugees within my personal life. I was aware of feeling great empathy for the plight of refugees that I had met. I held particular beliefs about the complexity of working psychologically with refugees, including issues such as the challenge of working through interpreters, the multiple social and psychological difficulties experienced and the impact that the

uncertainty of deportation can have on the therapeutic process. I was conscious to reflect on my past and current experiences recognising how the IPA approach seeks to acknowledge the researcher’s perspective, rather than to isolate and disregard it.

Analysis Section

The analysis produced four main themes. The first theme ‘ripple effect’ captures how working therapeutically with refugees has impacted on the psychologists. The second theme explores the psychologists’ reports of ‘amazement at refugees’ strength and resilience’; while the psychologists’ urge to ‘fight and advocate’ for refugees is discussed in the next theme. Finally the psychologists’ ‘changing view of the world’ examines how working with refugees has affected the participants’ view of systems, working with difference and complexity (see Table 1).

Table 1. Superordinate and subordinate themes

Superordinate Theme	Subordinate Theme
1. Ripple Effect	a. Traumatic Reaction
	b. Therapists Dilemma
	c. Support
	d. Inspiring and Moving
2. Amazement at Refugee’s Strength and Resilience	
3. Fighting and Advocating	
4. Changing View of the World	a. Frustrations at the Context of Delivery
	b. Working with Difference
	c. Broken Mirror

Theme 1. Ripple Effect

The psychologists gave consistent descriptions of how working therapeutically with refugees had impacted on them, both in challenging and positive ways. This included the many dilemmas that the work raised for them including issues of helplessness and

powerlessness, the vulnerability of clients, and the uncertainty of refugees' circumstances. The majority of the psychologists reflected on their experiences of support within this work and how this could be quite variable.

1a. Traumatic Reaction

All the psychologists described many incidents where working therapeutically with refugees, particularly on issues around trauma and loss, had impacted on them emotionally. Dr Juniper emphasises this as she describes her shock at experiencing such an extreme and unexpected reaction to the work:

“I thought I’d heard lots of stories about people’s experiences erm I was very shocked by the stories that I heard from people, and erm (pause) so I think I spent the first sort of 2 months of the placement probably having nightmares and um going through my own traumatic reaction to to hearing the stories.”

(Dr Juniper, 43)

Many of the psychologists described the difficult nature of the stories they heard from refugees, suggesting a difficulty in being able to prepare for this. Emphasis was placed on the struggle of leaving what they had heard within the confines of work:

“That’s heavy, that one’s coming out the building with me back home and, my last thoughts before I go to sleep.”

(Dr Aspen, 359)

In working therapeutically with refugees, there appeared to be a definite struggle for the psychologists in balancing the need to ‘off load’ some of the extreme quality of the work, while also trying to protect others from it:

“Something about you know looking after yourself but also looking after each other and how do you get that balance right sometimes? Erm, I doubt there’s an answer and I suppose where does the trauma stop? So I guess what you’re trying to do is alleviate some of the effect of the trauma with the people who you are working with and it’s like / it’s like when you drop a stone in a pond and the ripples go round and it’s like every person you talk to, potentially is affected by what happened to the person over here, and just being aware that that might be quite a dangerous thing.”

(Dr Oak, 503)

Dr Oak provides a powerful metaphor of the ‘ripple effect’ of trauma, and how an event can affect each person that hears about it. This seems to create a dilemma, experienced by the psychologists in undertaking this work, as to who it is most appropriate for psychologists to seek support from. Psychologists may experience a reluctance to talk to other professionals who may not be aware of, or prepared for, the types of stories they may hear in work with refugees. However, the need to ‘off load’ appears important for the psychologist’s to enable them to continue working therapeutically with refugees. This issue is further explored in subordinate theme 1c. Support.

A number of the psychologists drew on the psychoanalytic model to help explain their experiences, reflecting in this case on countertransference; referring to the feelings, images and experiences evoked in the therapist that are in response to the client:

“Annoying, frustrating angry, you know, I feel like shouting at them, but get angry, but I guess you know I’m / feel / that’s countertransference isn’t it really. What you’re experiencing as a result of working with people”

(Dr Aspen, 509)

Dr Aspen recognises and makes sense of her anger and frustration by understanding that her emotions are actually evoked by what her client is feeling.

From most of the participants, there were descriptions of how listening to refugees’ stories had resulted in a questioning of their own circumstances, highlighting how their view of the world had shifted as a result of the work:

“Although it’s very unlikely that I’m ever to be a victim of torture, it’s like it is possible, this is happening to people who are people like me, ordinary people who are going about their job and their family or whatever, and something happens to them, and they get caught in something.”

(Dr Oak, 24)

In this account, Dr Oak is confronted by the evidence that things like torture can and do happen to ‘ordinary people’ like herself, in some circumstances, perhaps

challenging her ideas of the world as a safe place. Dr Aspen's view of the world also appears challenged:

“The shock of what people are so capable of / beyond the imagination / beyond, it you know sort of you can reason why people behave like this, sort of er trust in humanity that people are basically ok and good and will work to the good of others, you know you / you have to sort of come out from your other relationships to hold on to the fact that that is out there, and that you don't go round with this skewed perspective that's er, you know / this is a representation of humanity this is sort of an exception of / of utter cruelty for political economic and madness that seems to consume.”

(Dr Aspen, 364)

There is an expression of shock from the stories she has heard, causing a challenge to Dr Aspen's ideas about the capabilities and motivations of the perpetrators of torture, but also of humanity itself. There is a real sense of her struggle to try and understand, in the complex, hesitant language and syntax that she uses to describe her experiences and beliefs. Comfort is sought by reflection on her other 'normal' relationships, and that refugees' experiences are the result of an exception.

The psychologists' changing view of the world, as a result of working with refugees, is well reflected in Dr Willow's account:

“...What does it mean to be human and what does it mean to (inaudible) your life, what does it mean, what is important in your life, what does it mean when what’s important in life is taken away really. And you know being in touch with things at that level is very difficult to just say, ”Alright now then it’s just work today,” because it overlaps with my own questioning of those things I suppose...”

(Dr Willow, 503)

Dr Willow’s experience appears to resonate with her own questioning of what it means to be human at an absolutely fundamental level. It highlights how the process of therapy is more than just ‘work’ for her. It challenges and shifts her own beliefs.

The emotional impact of working therapeutically with refugees is evident within this section. The psychologists’ views of the world, particularly as a safe and predictable place, are challenged by the work.

1b. Therapist’s Dilemma

Participants within the study appear to face many dilemmas. A consistent theme was the dilemma of managing the feelings of helplessness and powerlessness experienced while working with refugees. In contrast, the psychologists’ also described an awareness of the power they do have and the impact this could have on the work.

What emerges from all respondents is the strong sense of helplessness and powerlessness that is evoked from working with refugees. Dr Aspen provides an apt description:

“Oh paralysing, helpless, hopeless, um, that must be some of the most / that must be some of the hardest work I think you do. I can feel the emotion just from talking, just that sort of, ‘Can’t believe I could be I / I / I could be in a job where you know I can’t do something here’.”

(Dr Aspen, 58)

The sense of powerlessness seems almost unbearable for Dr Aspen who appears to characterise herself as someone who is usually in a powerful position. It becomes clear from Dr Juniper’s description, below, how the uncertainty of the threat of deportation for refugees seems to destabilise and disempower both the client and the psychologist:

“The first phase I guess is making people feel safe, and um often that was very / you couldn’t get past that because people didn’t feel safe because they were under the threat of deportation. There are quite a few clinics that say that they erm they won’t start work with trauma in terms of refugees until people are in a place of safety and until they’ve got their asylum status sorted but often that can take many many years and / and that doesn’t seem seem ideal either.”

(Dr Juniper, 307)

The conflicting position of the client’s vulnerability appears to be a difficult thing to balance for many psychologists. There is recognition that clients may struggle to work therapeutically around their trauma prior to a decision regarding an asylum claim because of the threat of deportation. However, Dr Juniper appears to struggle with the

idea of not undertaking any therapeutic work with refugees until they have their asylum status sorted. There is a sense of wanting to do something helpful, but also not wanting to do any harm. This apparent conflict for the psychologists of when it is most appropriate and effective to intervene seems to actually increase the psychologists' sense of helplessness. There was a clear urge for the psychologists to reduce the unpleasant feelings of helplessness and powerlessness. The psychologists spoke of their attempts to try and do something with the power they do possess, such as writing court reports, and that this made them feel as if they were being helpful, and so reducing feelings of helplessness:

“I suppose in a way that some of it was kinda to do it because it made you feel helpful erm and it made you feel like you were doing something useful, but my experience of actually the court erm responses to the report was actually very mixed, erm that some / I think the courts got to the stage where really every refugee has access to a report that says that yes they think that they've been tortured and yes they think those things have happened and so, a lot of the time they were dismissed.”

(Dr Oak, 347)

The case as illustrated by Dr Oak highlights the psychologist's experience of the dilemma of vulnerability in working with refugees. She appears to have a need to reposition herself as helpful. However in exerting her power, the strength of Dr Oak's report within the court arena seems unvalued, raising question of whether reports submitted to court have on occasions actually been detrimental to refugees' cases.

As opposed to feeling powerless, psychologists also described feeling powerful in comparison to the refugees they were working with:

P: "I felt very powerful, err which felt very uncomfortable in terms of err how people errm..how..what people were experiencing in this country in terms of housing an errm poverty erm not having jobs not being able to get jobs their asylum status, so that felt very uncomfortable[...]and I wasn't prepared for that [either....]"

I:.. "Could] you explain that power for you you described the [powerful]"

P: "Yeah] because I was white for a start errm, which is quite unusual there errm most therapists were black, errm and most the clients were black. Errm so I was seen as a very white woman err a very white middle class woman err who was educated erm who had money umm, who wasn't worried about the safety of her family and so so in that respect I guess it it felt as if umm I had quite a lot of power in terms of my place in society compared to the people I was seeing."

(Dr Juniper, 57)

Dr Juniper appears to struggle with the differential in power between herself and the client group, emphasising the stark differences between her experience, and her clients' experiences. Despite being in a position of power, Dr Juniper is left feeling uncomfortable, due to the powerlessness of the people she is working with.

The complexities of power dynamics are further discussed by Dr Cherry in relation to working with the aid of interpreters in work with refugees:

“If you’ve got two of you who are seen in a position of power it sort of makes me feel like, it must be so difficult for someone who’s been / had all their power taken away from them by being raped or something or tortured, for the interviews by two people who they position in a / you know, as powerful if you like in someway, so I didn’t feel as comfortable.”

(Dr Cherry, 884)

This excerpt emphasises the refugee’s positioning of Dr Cherry and the interpreter as powerful, and the impact this may have therapeutically on someone who feels already powerless, perhaps experiencing this encounter as another abusive experience. The therapist’s dilemma of client vulnerability is prominent. It seems that in an attempt to communicate effectively with clients, with the aid of an interpreter, there may be issues of potentially doing more harm, reinforcing the client’s position as powerless and abused.

For the psychologists, issues around power and powerlessness, uncertainty and vulnerability appear to be a real dilemma. There is a sense of trying to grapple with different methods of working to meet the refugee’s complex needs, whilst acknowledging how this process can be very complicated. The next theme explores experiences of support in managing these dilemmas and the ‘traumatic reaction’.

1c. Support

A re-occurring theme for the majority of the participants was the importance of appropriate support to enable them to work with refugees. Participants also highlight

their experiences of when support was not adequate or available and the impact of this.

There is a clear sense from Dr Willow's account that working therapeutically with refugees has a quality that is beyond the norm of her experience as a psychologist. On reflecting on this, she qualifies the benefit of being supervised by another professional who has also worked with refugees:

“Some things are beyond words and so, you can't easily put them in to words, erm and so erm that was a difficult part of the work and it was very helpful then to be supervised by someone who had worked with refugees, not that she necessarily did give me lots of erm you know, practical advice or anything like that but she just knew the work [...] sort of implicitly and there was something that was very important about that, I think.”

(Dr Willow, 545)

It appears that receiving support from someone who implicitly understands the work has great value for the psychologist in feeling understood and contained, to enable them to continue working therapeutically, and that more practical advice was less important in this work. In contrast, Dr Cherry is able to acknowledge and find value in peer supervision with professionals who do not work with refugees:

“I just think that is really good having a group, you know, having peer supervision because, you know people / there's counsellors who come to it

as well trainees and then qualified staff so you just get very different view points and, people who are more sort of psychotherapeutic people, who are more CBT people, who are more, I don't know, client centred and I / you know, you get a good range and, I think in terms of professional practice it is very helpful, you know. Sometimes people say things, you think, "Oh, I didn't think of that", you know, if you're one person working in isolation, you know that's really helpful looking at it like that."

(Dr Cherry, 1222)

There is recognition that, for a single psychologist working in isolation, it is helpful to have the multiple perspectives of other professionals. However it is difficult to conclude whether this goes beyond a level of practical support to also contain some of the toxicity of the work for the psychologist, as for example Dr Willow expressed. It may also be important to consider Dr Oak's metaphor of the 'ripple effect' (Dr Oak, 503) of trauma again here. She describes the potential effect trauma can have on each person that hears about it, and questions who it is most appropriate to seek support from. There appears to be a general sense across many of the psychologists that standard professional support is somewhat inadequate in working therapeutically with refugees. Dr Oak also highlights how working with refugees could be isolating:

"I suppose in a way [it] felt like quite an isolated thing to do / isolating thing to do, and a bit of, 'Oh do I really want to go here because actually people would be quite happy if I didn't, and the team would be quite happy for these people to be (inaudible) or not given anything and just kind of shuffled off out of the system really'."

(Dr Oak, 63)

This description gives a snapshot of Dr Oak's experience of the response of professionals in her 'team' to working with refugees. She appears to be alone in her opinion of the value of working with refugees, and this results in her being isolated in working with the client group. Isolation was also experienced due to more practical factors:

"They're spread I think quite far apart geographically you know, erm and also cos we're all so busy."

(Dr Cherry, 828)

For some of the participants' the sheer practicalities of being an isolated therapist working with refugees in a team added to the difficulties of obtaining adequate support. Dr Cherry demonstrates how issues around demands of work and geographical distance from other professionals carrying out similar work were problematic, acting as a barrier to accessible peer support.

There was an overall tendency for psychologists to describe working with refugees as isolating. Difficulties appeared to arise due to the complexities of acquiring appropriate support. In the next section, another aspect of the 'ripple effect' is explored.

1d. Inspiring and Moving

Although working therapeutically with refugees could be incredibly challenging for psychologists, there was also a consistent narrative about some very positive aspects experienced from the work:

“Umm although that’s not to say that erm, the work was draining all the time, it was very inspiring, some of my sort of top moments of doing therapy with people and my relationships with people during therapy, are from that time.”

(Dr Juniper, 540)

Through Dr Juniper’s description it seems that the inspirational nature of individuals’ stories and recovery appears to re-energise psychologists. This quote from Dr Willow further explores some of the reasons for this:

“There was something very humbling about the work [...] it was something to do with being invited in to help and being at the same time aware of having, having something to offer, I’m not saying I didn’t have anything to offer but I had very, I only had a (pause) quite a small amount to offer given that / given / erm person’s circumstances and um, you know its erm, you know / there’s something in that that’s very humbling [...] I think it was so moving, yeah not in a grand dramatic way, but in a very sort of slow gradual way it could be very moving.”

(Dr Willow, 251)

Dr Willow experiences the work as incredibly humbling, recognising the enormity of refugees' experiences yet still being invited in to help. There is a sense of a quiet confidence of what she can offer her clients, feeling emotionally 'moved' in a slow gradual way through this work, as echoed by many of the participants.

To summarise this theme, all psychologists recounted experiences of the emotional impact of the work and its 'ripple effect'. The extreme nature of the work resulted in a sense that the work was challenging their view of the world. Working with refugees raised many dilemmas around issues of power and vulnerability, with the psychologists' accounts highlighting their struggle to achieve a balance of being helpful, while doing no harm. Psychologists communicated the value of adequate support from their experiences of isolation within teams. The experience of the work as inspiring and moving appeared to be very significant for psychologists, recognising the enormity of refugees' experiences. There is a clear link between this and the next theme.

Theme 2. Amazement at Refugees' Strength and Resilience

The psychologists voiced amazement at refugees' strength and resilience. They stressed that, despite the refugees' past and current circumstances, there is a resilience that people possess that has enabled them through this process. The following excerpt illustrates this:

"I think it comes down to this thing, the fact that people show remarkable resilience and er capacity, and I've seen people / people who've become refugees, are the people who had enormous psychological resource that

got them in to the situation which meant they had to leave. I mean, its not always the case but sometimes it is and that, you know people hadn't changed and there's a sense of agency than even we realise and for some people, the (inaudible) got something to be a refugee are also a reflection of their sense of agency and trying to do something to make something better you know."

(Dr Willow, 760)

Dr Willow describes a relationship that she has found in individuals, between psychological resource and making a stand to try and make things better. This has resulted in those individuals having to flee their own country for safety. Dr Oak further explores how these individuals' resilience has made their survival possible.

"I think one of the things I marvel at and this maybe this is something about why these people have survived is, in one sense they're very / they've kind of lost their trust in people and the world, and yet in another way somehow they've trusted me, and it's sort of erm can feel quite emotional even saying it, it's like a huge privilege, and part of me just thinks how do you / its like that part of the human spirit / how do you have such bad experiences, and yet somehow you still find that ability to trust? And actually you need to in order to survive because actually you can't do this on your own and maybe that's the difference about why these people are here and because actually at some point, they left the country wi.. their own country with no money no idea where they were going and they had to, and these people probably may not have been very trust worthy

cos probably it was all done for money or something, but they had to put their trust in something whether it was fate or life.”

(Dr Oak, 768)

Dr Oak identifies the key role that trust plays for refugees in their survival. She expresses her privilege at being trusted by people who find it so hard to trust because of their experiences of being hurt by people in positions of authority. Dr Oak acknowledges that for refugees who have made it to Britain, trust may have been a fundamental personal characteristic that enabled their survival.

Psychologists were also able to reflect on refugees' resilience in relation to the progress made in therapy, as highlighted here:

”Being erm, sort of, erm sort of exposed to, erm the sort of human capacity for er resilience and for growth in, you know, the very troubling circumstances [...] people did er show a great feeling and and, you know there was a continued, however difficult things were what I often came across was people where there was a continued erm attempt to make some kind of meaning or to try and struggle on to make things better for themselves. Erm, you know, and for some people it was very stark that you know, particularly people I worked with very briefly, how some people got very little from me but really took it and used it, and you know really tried very hard an.. and were really successful in building their lives up, and as a clinician that was you know amazing to see.”

(Dr Willow, 229)

Dr Willow claims that even when her contribution to therapy seemed insignificant, an individual's capacity for resilience and growth enabled them to continue striving to make things better for themselves, no matter how difficult circumstances continued to be. She clearly states her amazement as a professional at being witness to this.

The psychologists seem to show great admiration for the human capacity for resilience as embodied by refugees and their experiences. Even though there was recognition that resilience may have played a part in the development of their circumstances, it became apparent that it was seen as a quality that enabled survival and perhaps even promoted change for the greater good for themselves and others.

Theme 3. Fighting and Advocating

A prominent feature of the discourse of the psychologists interviewed was of fighting and advocating for refugees. This appeared to take various forms whether through a personal interest, research, working individually with clients or expressed within the 'teams' the psychologists were working within. There seems to be recognition that, at an early stage in the psychologists' careers, an interest in people's circumstances and wanting to make a difference were significant:

"I guess my interest erm started at university when I erm started to volunteer for (organisation), erm, and so I was very interested in human rights."

(Dr Juniper, 13)

It seems that for Dr Juniper her interest in human rights and volunteering with an associated organisation were in an attempt to make some kind of difference, as demonstrated in Dr Juniper's next account:

“I also erm..erm felt very strongly in terms of err erm sort of a kind of advocacy cam.. campaigning kind of role which I didn't / I wasn't in my other placements that hadn't come out quite so much, but I felt that / felt quite energised to / to make things / to do things differently.”

(Dr Juniper, 53)

There is a real sense of there being something different experienced when working with refugees, compared to working with other client groups. It seems that there is awareness that refugees are a particularly disempowered group, and this appears to inspire Dr Juniper to want to campaign and make a difference. This is echoed in Dr Aspen's narrative of her direct therapeutic work with refugees:

P: “Part of me still fights to sort of think / try and sort of, reach out and what ever is going on or whatever people are working with that, um that might work you know, cos I'm still hungry for more and, still keen and eager, I guess the helplessness matched with, not letting it sort of completely overrule, but with a sort of desperation and determination, 'ok lets just do what we can'.”

I: “umm, and what keeps that kind of fighting on that hunger going, that determination? [...] where does that come from?”

P: "I guess its got a question / this can't be it. That torture over there cannot impact and is not going to succeed at this point in time and this place in the world, you know they are not that powerful, you know that was not going to win and I am not going to allow that, to win over me."

(Dr Aspen, 129)

The determination to keep fighting on and reaching out to help her clients in some way is striking. She is keen that refugees' past horrific experiences do not succeed in the present, associated with her belief in the safety of a country such as Britain. Dr Aspen articulates her belief in the diminished power of the torturers and the past, exerting her power as a psychologist to be able to make a difference, not allowing it to win over her in the present.

A reoccurring theme for many psychologists was about a conflict of opinions within their 'team' about the value of working with refugees. Dr Oak emphasises the effect of this:

"I suppose one of the things I felt sometimes with my work is that I was kind of sticking up for these people all the time, so in the team I was sticking up for them."

(Dr Oak, 532)

Dr Oak identifies that her response was to advocate for refugees, often as a lone worker, as a consequence of other professionals discounting the value of work with refugees. It appears that this was in an attempt to try and eradicate inaccurate or

problematic beliefs about working with refugees. Dr Cherry illustrates how psychologists are well positioned to do this:

“I’ve had a long standing interest in research and using research what I term action research I guess, using research to try and effect change, and I think clinical psychologists are really well placed for that cos we work in services we see a problem, then we can try and use the information as best as we can to try and change things.”

(Dr Cherry, 358)

Dr Cherry highlights how using research can be a useful tool in creating change. She especially equates the powerful role of the psychologist as being particularly appropriate to identify problems and to use research as a means to change things, in an attempt to advocate for refugees.

It became clear that for the psychologists, the compulsion to fight and advocate for refugees was a much more intense experience than had been encountered for other client groups. It seemed to result in the psychologists having to exert their power as professionals to give refugees a voice and to change inaccurate beliefs about working with them as a client group.

Theme 4. Changing View of the World

An overarching theme throughout the psychologists’ interviews was about how their experience of working with refugees had led to a change in their view of the world. This related to the psychologists’ frustrations at the context of delivery and how their

understanding of the system was challenged. This also included their evolving experiences of working with difference, and their understanding of the complexity of the work.

4a. Frustrations at the Context of Delivery

All the psychologists spoke of various frustrations that related to services and systems around refugees. A persistent theme evolved around the lack of adequate services for refugees, and barriers to creating these:

“I also did try and write a paper to the Trust about setting up a particular service for people who’d had very traumatic experiences including all refugees, but at the time the ser.. the Trust was going through financial, erm problems, now its hit a recession, so that paper didn’t really go anywhere.”

(Dr Cherry, 166)

There is a sense that trying to bring about change and improve services for refugees is very challenging. It seems that this is an area that is particularly undervalued by Dr Cherry’s Trust and so it is easily dismissed and not viewed as important or a priority. Dr Aspen describes additional difficulties. She refers to professionals oversimplifying complex issues with regard to refugees:

“... tiny minds just think “Oh yes you know, we’ll give a diagnosis of PTSD” and, that’s that’s just a label for something, it’s more than PTSD. This person’s lost their whole life, their home. PTSD is for people who

were going from the Vietnam war who were coming back to their home and were traumatised by their experiences but came back, these people have left / trauma's only part of this, it's not enough, to explain this you know."

(Dr Aspen, 501)

There seems to be an expression of frustration at psychiatrists in simplifying and reducing refugees' difficulties to a diagnosis of PTSD. Dr Aspen reflects on the enormity of refugees' experiences of losing their whole life, and how a simplistic label is not enough to make sense of their difficulties. This expression of frustration at 'tiny minds' perhaps reflects wider frustrations held by psychologists about the profession of psychiatry, in viewing people as diagnoses and not individuals with complex difficulties and needs. The psychologists frequently also described frustrations with other professionals associated with services provided to refugees:

"Like it felt a bit like here that people choose to work with refugees, so when I think about those refugees that had social workers / its particular social workers, and I was the only psychologist [...] and I suppose I've not really thought about that but the implication of that is that other people chose not to and what's that about because actually we / if I said "Well I don't want to work with people with psychosis because I think they're mad and I / you know / think they should all be locked up," people would kind of go "You can't say that," and so its like its like so its almost like people are allowed to choose but the reasons for that are never really

questioned and I think there's probably quite a lot of prejudice goes on there that is sort of just left uncovered really."

I: "Ummm. Why is that, why do you think that happens?"

P: "Erm I think partly because I think they're a group of people that it's ok to be prejudiced against, its certainly ok to put things in the paper..."

(Dr Oak, 1126)

Dr Oak explores her experience of the attitudes of other professionals towards working with refugees. It seems part of the difficulty relates to professionals not viewing refugees as part of their work. She reflects on her awareness of a covert prejudice towards refugees as a group of people, and how this is never uncovered or considered but is reinforced by more overt prejudice, particularly within the media. It appears that covert prejudice was an ongoing struggle for individual psychologists to challenge. Her views are largely representative of the majority of the psychologists' views, and as Dr Oak tended to go into more detail than other participants, she provides further useful accounts for this theme here.

Dr Oak further explores issues of prejudice within the context of the wider system particularly relating to her experience of the immigration system and how refugees were treated:

"I was glad I went [to the immigration office] because its sort of / but it felt like I am part of a / I am part of this white British system that's treating people like this, and almost like things are being done in my name

that I kinda have no idea about, erm that its all a bit kind of hidden and a bit secret [and”

I: “What] kinds of things?”

P: “Just a sort of / just the way people were treated really. It felt very disrespectful and like ‘Oh you’re all a bunch of spongers who shouldn’t be here anyway and you have to do / you know we’ve told you to do something and you have to do it and if you don’t we will punish you’. And it felt / I don’t really want to be part of that and yet I am by the very fact that I’m a British citizen and it’s a government that I either did or didn’t vote in but I voted...”

(Dr Oak, 447)

Dr Oak’s surprise at the realisation of how disrespectfully refugees are treated within the British system is evident in the extract. Dr Oak expresses a degree of disbelief at the secret way in which it appears to operate, wishing to separate herself from it, however acknowledging her responsibility within this. What emerges from Dr Oak’s account is the sense of a changing view of the world from safe to secretive and disrespectful. There is a definite sense from the psychologists’ accounts of a covert racism toward refugees running through many aspects of the system, in how it functions and in the service individuals receive. Dr Oak explores these notions further in her experience of the legal system when writing reports for refugees to support asylum claims:

“Therapists lie and we just kinda say what clients want us to say and that we are not very objective and erm and almost like no / don’t really / they

don't really want to have another view point to their own erm, and I think that was quite / it gave me quite a kind of erm disheartened view of the justice system as well its like you know not really about, finding out the truth, which kinda sounds very naive (laughs) but, you know, erm and I did used to feel that there was this sort of / it's a political thing with refugees and their sort of decisions are sort of already made."

(Dr Oak, 982)

She describes her impressions of the court's response, to the reports she would write, as disbelieving of her evidence due to some inherent bias seen to be in therapists. Dr Oak describes her disheartened view of the justice system, recognising that her belief in the system to find out the truth was actually naïve and that the court is much more influenced by political agendas.

This section conveys the frustrations that the psychologists experienced working with refugees within the British system. It emphasises how the participants' understanding of the system was challenged, giving the sense of a new insight into the realities of the system.

4b. Working with Difference

In exploring the psychologists' experiences of working with refugees, an awareness of the obvious differences of culture and identity was apparent. The psychologists conveyed their experience of working with and managing this difference in a variety of ways:

“I found the work very interesting [...] in terms of my knowledge about different countries and different customs and languages and because all the work was through interpreters so erm, (pause) so in all the therapy, I was meeting 2 people from the same country, erm so I found the the language / the how / the communication extremely interesting, how you create a coherent narrative between 3 people, erm using words that might not exist in some languages. [...] The type of people that were attracted to that kind of work erm, they would generally, they were interesting people who again were interested in multiple perspectives and different ways of looking at things an erm having different models to the normal kind of western ideas of clinical psychology and psychiatry. [...] Things were just done in a different way it / it challenged / it challenged my prejudices about stereotypes and it challenged the way I did therapy erm in terms of touch and erm and challenged my err ideas about myself and my ethnicity.”

(Dr Juniper, 86)

Dr Juniper’s interest in difference is enthusiastically conveyed in the opportunity to learn about different cultures and languages. She describes working therapeutically with the aid of interpreters, and the complexities of communication in creating a coherent narrative as a triad. Part of her enjoyment of working with difference is in meeting ‘interesting’ people whether interpreters or therapists, who worked in different ways therapeutically to the more traditional western models of psychology and psychiatry. Emphasis is placed on how working with difference challenged her view of herself and her beliefs, and how she carried out therapy. There is a suggestion

that traditional westernised models may be insufficient when working therapeutically with refugees, and this raises the question whether this, coupled with the psychologists' experience of feelings of helplessness, encouraged them to embrace alternative methods of working.

As expressed by most respondents, the next excerpt from Dr Oak explores the clients' religious beliefs, and how in most cases, these differed from the therapist's own held beliefs:

“A lot of my refugees / they have very strong religious beliefs, and I don't, and er sometimes that been something that's been really useful to me as a therapist when I felt like “How do you, find anything positive about this, how do you help them to feel positive?” They've talked to me about their religious beliefs and how they feel that god is there with them and there's a purpose to this and there's a reason why they survived and, much as I (inaudible) of my own personal view point I kinda think well I'm not sure about that, you know its like actually that clearly gives you some strength and that has got you through some terrible things and who am I to kind of question that?”

(Dr Oak, 782)

Dr Oak observes a high level of religiosity within refugees as a client group. She explores how, although this may not match with her own beliefs, religious beliefs prove to be a beneficial resource to inspire hope and meaning for clients. There is a sense that it aids the course of therapy, and although Dr Oak's beliefs do not match

she acknowledges importance of understanding and working with these. Dr Willow reflects further on her experience of working with difference:

“...just try and make some kind of emotional contact with the person sitting in front of you try and understand their erm / use all your skills you have and ways of thinking to try and come to some sort of sense of what their predicament is. And what you know / not, very quickly pigeonhole people as needing one thing or another because they’re a refugee.”

(Dr Willow, 728)

She stresses the importance of ‘emotional contact’ and developing an understanding of the client’s predicament. Dr Willow appears to be expressing the importance of seeing each person as an individual with varying needs, not as a predictable and overly simplified group, taking account of individual differences. Dr Oak provides an example of the detrimental effects of making assumptions when working with difference:

“Sometimes you can make horrible horrible assumptions, cos I have one interpreter who was a black lady who spoke French and I just assumed that she was from Africa and she wasn’t at all, and you know you kinda just feel a bit of an idiot.”

(Dr Oak, 160)

Dr Oak expresses her feelings of stupidity at making such inaccurate assumptions and how easy it is to do when you look at obvious differences which seem to fit in a

particular category (the kind of pigeonholing that Dr Willow makes reference to) without taking time to explore and understand each individual. However perhaps this highlights the added complexity of working therapeutically with the aid of an interpreter who will come with their own culture and experience.

Overall, the psychologists reported how much they had gained from working with refugees. They described opportunities of working with interpreters, the challenges of communication and the diversity of models and perspectives of therapy. It was highlighted how it was important to try and understand and make an emotional contact with individuals, and to avoid making detrimental assumptions about who individuals are, or what they need, based on the fact that people are refugees. There was an appreciation of how beliefs that refugees often held would challenge their own.

4c. Broken Mirror

What emerges from all psychologists is the tendency to report their experience of working therapeutically with refugees as being more complicated, compared to their usual therapeutic work. This was expressly due to the complexity of the refugees' circumstances and experiences. Dr Willow provides a useful account of the complex issues faced:

“I think it suggests the very complex nature of what’s happened to them really [...] sometimes they’re extraordinary in terms of, you know they’ve experienced something that is erm, you know erm extraordinary or extreme in terms of torture or being erm, you know erm r-repeatedly raped

or the very traumatic experiences, you know being at the receiving end of extreme violence and repeated violence of one form or another, or oppression, over a sustained period. Erm so that's one side of it, but that's not the only / its not just the violent act itself and being victim of the violent act, it's the context in which it occurs so often in, you know within regimes either in war or in oppressive regimes that has an added impact. And then there's the the sort of familial issue of, you know being separated from one's family and what that must be like, being separated from one's home and, you know particular / (pause) you know they forced to / (pause) be separated from ones home as well not choosing to be separate, and all these different levels (pause) impact on, you know on the sort of mental well-being that has to be thought about and considered [...] to be able to understand how they are presenting in the room."

(Dr Willow, 161)

Dr Willow describes the challenges faced when working with refugees because of the extraordinary experiences they have often had. She highlights how not only are refugees often victim to extreme forms of violence, but the context that this occurs in can be incredibly detrimental. She further emphasises the impact of being forcibly separated from one's home and family and the accumulative effect all these experiences have on mental well-being. She stresses how all these things have to be thought about to understand the individual within therapy. Her description provides a sense that psychologists possess a significant level of skill in being able to understand complex issues, and therefore some belief that psychologists are well placed to work

with these therapeutically. Dr Oak provides a powerful metaphor that resonates with Dr Willow's account:

"I think that what happens to them is just so / just shatters their view of the world, their sense of themselves, their trust in people so completely, that actually its like having a mirror in a hundred thousand pieces and trying to put it back together and its like how are you gonna do that..."

(Dr Oak, 704)

There is a clear notion of how severe the impact of individuals' experiences can be, so much so that it shatters their view of the world as a safe place. Dr Oak's metaphor of the broken mirror emphasises the difficulty of the task of trying to put individuals' 'worlds' back together again and to make some sense of their experiences. However there seems to be the overpowering sense that this could be an impossible task.

Issues around the complexities of communication and the use of interpreters were also readily described by most of the psychologists. Dr Juniper highlights a number of commonly expressed concerns for psychologists working with interpreters:

"...you might not get the same person you might not be able to build up a relationship, erm they don't understand the work, you don't know how things are being interpreted, they might not understand what you are doing..."

(Dr Juniper, 325)

Dr Juniper draws attention to how having the same interpreter for consistency to enable the therapeutic relationship to coalesce is somewhat fundamental to the therapeutic process, as there are many factors which can complicate this, particularly the presence of a third person and being unsure of what or how things are being translated. For the psychologists it appears working with an interpreter could be difficult to manage, possibly feeling out of control of the process at times. Interpreters having an understanding of psychological work also seemed to be helpful to the communication and therapeutic process. These issues all appear to add to the complexity of working with and building a therapeutic relationship with a refugee. Wider issues regarding the complexity of communication are demonstrated in the next quote:

“I couldn’t understand their body language at all, and I didn’t understand the tone of their language [...] I couldn’t work it out at all, and you see that was very (pause) it was quite disorientating it was quite undermining of my clinical skills and it made me feel quite uncomfortable because I felt like, half of my repertoire and half of my understanding of people had just been lost really, so I can understand why, people might just want to avoid working with people because its actually very complex.”

(Dr Oak, 98)

The experience of not being able to understand her client’s language appeared to be an incredibly difficult experience for Dr Oak, leaving her feeling disorientated and undermined in confidence as to her ability to understand people, which is so essential

in working therapeutically. She acknowledges, following the power of this experience, why other professionals may wish to avoid the complexities of the work.

Generally most of the psychologists expressed how the complexity of the work was largely born out of the complexity of the refugees' extraordinary experiences. The psychologist's role of making sense of an individual's experiences could be challenging, particularly with the added complications around communication. There was reflection on how the complexity of the work could result in discouraging other professionals, perhaps for fear of not having the appropriate skills to manage such work.

Discussion

Main Findings

The research aimed to explore clinical psychologists' experiences of working therapeutically with refugees. It is evident from the analysis that the impact of the work on psychologists is substantial and complex; this seemed to be a reflection of refugees' extraordinary experiences. Participants on numerous occasions attempted to make sense of, and manage, what was termed the 'ripple effect', where their own traumatic reactions were experienced in relation to what they had heard from their clients' experiences. The work raised many dilemmas that had to be sensitively thought about and balanced, while the difficulties of isolation and the inadequacy of standard professional support created further struggles for psychologists. The positive aspects of the work, such as inspiration and amazement at the refugees' strength and resilience, appeared to be particularly significant for psychologists when juxtaposed with the intense quality of the work. The motivation of psychologists to fight and

advocate for refugees was apparent. They did this in order to give voice to refugees as a disempowered group, and to challenge inaccurate beliefs held by other groups within the context of delivery. The psychologists, as a result, appeared to develop a changing view of the world further influenced by experiences of working with difference and complexity.

Impact

The psychologists' exploration of working therapeutically with refugees, around issues of loss and trauma, clearly illustrated the strength of the emotional impact of the work. The difficult and extreme quality of the stories they heard resulted in their own experience of a traumatic reaction, referred to in the literature as vicarious traumatisation (McCann & Pearlman, 1990) or compassion fatigue (Figley, 1995). The psychologists described their need to offload some of the toxicity of the work, but struggled to do this for fear of the 'ripple effect', in which every person who hears about the trauma is potentially affected. A useful text is provided by Herman (2001) who offers a largely psychoanalytic perspective to understanding and working with trauma, that emphasises the contagious nature of trauma. Participants describe the value of support from someone who understands the work implicitly in order to feel understood and contained. This is echoed by Comas-Diaz and Padilla (1990) who emphasise the importance of a reliable and structured support system that facilitates the safe expression of emotional reaction to trauma.

Isolation and Change

This study highlights the isolating nature of working with refugees. General practicalities of time and geography were considered to be an isolating factor,

restricting the psychologists' ability to meet and support one another. However this was also a consequence of the response of other professionals within the participants' teams, who disregarded the value of working with refugees. A further consequence of this was the failure to create important structures needed to support professionals working with refugees. This finding is substantiated by evidence presented by Herman (2001) who discusses how many therapists end up working with traumatised clients when there is little or no supportive context. Herman considers this to be a product of the history of 'denial' of the atrocities that have happened to clients, within mental health professions. This denial can result in therapists feeling discredited and silenced, just as 'victims' of trauma often do, and so increases their experience of isolation within teams.

For many of the psychologists, listening to refugees' stories resulted in a shifting view of the world as a safe place. It challenged their beliefs about the capabilities of humanity, and they sought comfort in normal relationships as a way of recognising refugees' experiences as the exception. This corresponds with literature presented by Fischman (1991) on how the therapist's own sense of vulnerability can be increased by repeated exposure to stories of extreme brutality and torture, highlighting the inevitable challenge to the therapist's beliefs.

Helplessness and Power

The findings show how the psychologists experienced strong feelings of helplessness and powerlessness in working with refugees. These feelings were related to issues around clients' perceived vulnerability and the level of uncertainty that the threat of deportation raised for both client and therapist. Herman (2001) suggests how this can

be explained by the process of countertransference, whereby the client's experience of helplessness is empathically shared by the psychologist. It was clear within the study that many participants drew on the psychoanalytic model and the concept of countertransference to help make sense of their experiences. In an attempt to reduce the unpleasant feelings of helplessness and to re-exert power that they do possess, some of the psychologists had written court reports. However, these were often felt to be unvalued and perhaps even detrimental to refugees' cases.

Issues of power were reflected on by the psychologists in reference to their experience of the big difference between their own culture, class and status, compared to that of refugees, in terms of their lack of rights and power within British society. Associated with this were issues of balancing power dynamics in working with the aid of interpreters with refugees. Fears of potentially doing harm, and reinforcing the client's position as powerless and abused, were clearly voiced by psychologists, as supported by literature provided by Patel (2002). Working as a triad highlighted the many difficulties of managing work with an interpreter, in which psychologists could feel out of control of at times (Raval & Smith, 2003).

Amazement and Advocacy

In contrast to the challenges faced by the psychologists, there was also a shared narrative about the positive experiences of working therapeutically with refugees. The inspirational nature of individuals' stories and recovery appeared to keep the psychologists energised to continue the work. The psychologists were humbled and moved by being invited to help, acknowledging having something to offer, given the enormity of the refugees' circumstances. The psychologists expressed their

amazement at the resilience that individuals possess that has enabled them to deal with their experiences. There is recognition of a relationship between psychological resource and making a stand to make things better that has often resulted in individuals having to flee their country for safety. The psychologists marvelled at individuals' ability to trust as a means to their survival. This has been identified by Ahmed (2007) as an important internal characteristic in promoting resilience. Great admiration was expressed in being witness to refugees' ability to try to make meaning within therapy, and struggle to make their lives better.

As the results illustrate, the psychologists recognised refugees as a particularly disempowered group within society, and this 'energised' them to fight and advocate. The psychologists acknowledge how experiencing feelings of helplessness evoked determination to fight for refugees. Rees, Blackburn, Lab and Herlihy (2007) recognise the vital role psychologists can play in advocating for refugees. Caution is however emphasised to ensure therapists are not overwhelmed and the client further disempowered. The psychologists faced many conflicts of opinion about the value of working with refugees. They appeared to play an important role in challenging these, either within their team or at a wider service level with research. The Psychologists recognised the powerful position they held in being able to bring about the process of change.

Context

The psychologists' frustrations at the context of delivery are clearly communicated. Frustrations are expressed regarding psychiatry's reduction of refugees' difficulties to a diagnosis of PTSD, arguing that a simplistic label is not enough to make sense of

their difficulties. This finding relates to criticism in the literature about the trend towards the over medicalisation of distress. Summerfield (1999) suggests how a diagnosis of PTSD is not appropriate for war-affected populations due to it ignoring their traditions and methods of meaning-making. The psychologists' frustrations appeared to reflect wider tensions held by the profession of psychology about psychiatry's role in 'over' diagnosis.

Although the psychologists are aware of their powerful position to create change, they clearly find this a challenge, as highlighted by Dr Cherry (166, page 83), and her experience of the NHS Trust appearing to undervalue the need for adequate services for refugees. This appears to be linked to the psychologists' experiences of prejudice within the system. This could take both covert and overt forms. Much of the prejudice was felt to be left covered up and never explored, but reinforced by the overt and inaccurate messages reported through the media. The psychologists reported covert racism toward refugees running through many aspects of the system, in how it functions and in the service individuals receive. This finding is supported by literature provided by Mahtani (2003) who reinforces the findings of the MacPherson report that exposed the occurrence and impact of institutional racism. Mahtani asserts that institutional racism works to maintain the status quo of organisations but disadvantages ethnic minorities. This occurs through overtly racist views, but also through acts such as the omission of appropriate services. The psychologists' views of the world as a safe place were challenged through this experience, shifting as a consequence of their observations of the secretive and disrespectful way it can function.

When faced with ‘working with difference’, psychologists responded in a proactive way. Participants embraced the opportunity to learn about new cultures and ways of working. This would often challenge their view of themselves and the beliefs they held as well as the way they carried out therapy. As emphasised by Woodcock (1995), traditional westernised models appeared to be insufficient or too reductionist in working with refugees, and psychologists are encouraged to adapt their therapy to fit with their clients’ needs.

All the psychologists discussed the complexity of working therapeutically with refugees. Much of the complexity arose from the extraordinary experiences refugees had often had, and the importance of considering all these things to understand the individual within therapy. Psychologists’ skills may mean they are well placed to work with such complexity, as Parry (1996) reinforces in his review of psychotherapy services, due to being highly trained in formal psychotherapies and duly accredited as a profession. However, the metaphor from Dr Oak (704, page 93) of the ‘broken mirror’ portrays the vast difficulty of the task.

Evaluation and Implications

The semi-structured interview appeared to work well in allowing the participants the opportunity to explore their experiences. Psychologists as a profession tend to be articulate and reflective and the semi-structured interview allowed this without the constraint the may be found with other methods of data collection such as structured interviews or questionnaires. The interviews enabled the participants the freedom to discuss experiences that had not been envisaged so these could be explored and accounted for.

It is important to reflect again on the possible impact that my own view of the psychologist's role in working with refugees may have had on understanding the participants' experiences. I may have been influenced by my own experiences which may have prevented me from looking at the data without certain assumptions or existing thoughts, perhaps creating a positive bias in favour of psychologists' abilities to work with this client group and preventing me from looking more critically at the profession and the data. The process of triangulation was important in preventing this.

Within the analysis section, the clearest and most detailed accounts from the participants' transcripts were used. This was due to the substantial amount of material produced through the study which required a great deal of reduction, and to provide transparency in how themes were developed. It is acknowledged that this may make it appear that some of the participants' voices are heard more than others, however, it is important to note that each of the themes were extracted from patterns across all the participants transcripts.

A limitation of this study is that the voices or perspectives of relevant others are not heard or represented, and these may have been helpful in enriching understanding of working with refugees. Interviewing other professional groups such as interpreters or psychiatrists may have provided useful insights into their experiences of working with refugees, especially in relation to the complexity of the work. It would also be interesting to get a multilateral view of the context of delivery. Exploring refugees' experience of therapy with a clinical psychologist may have also enriched our understanding of the process of the therapeutic encounter between refugees and

psychologists, especially in relation to the strength of the impact of the work and the countertransference reactions. Monaghan, Jenkins, Larkin and Clohesy (2009) provide a qualitative exploration of the experiences of asylum seekers who received trauma-focused cognitive behavioural therapy for posttraumatic stress disorder. However, the authors fail to state what profession their participants were from, and this brings into question whether their findings can be directly compared with findings from this study. However many of their findings do appear to ‘fit’ with findings from the current study, such as asylum seekers reporting how feelings of powerlessness undermined their engagement in therapy, the experience of isolation, and their experience of hope and regaining their life through the process of therapy (which may be what psychologists reflected on in the current study as signs of resilience).

There are a number of clinical implications from the study. Firstly the findings are useful at a service level as there may be things that services could do to support psychologists and other professionals in working with refugees. Services could begin to plan for potential service level issues in working with refugees such as resource issues, and encouraging change to more supportive working practices. Implications at the level of the team involve teams putting aside time to allow identification of who is working with refugees and how the team could function better to provide more adequate support to those carrying out the work. The team may be able to begin to address professionals’ fears about working with this client group and this may help with issues around feelings of powerlessness and helplessness. Therapists being allotted timeout from clinical work in order to pull resources together may be helpful. This may include pulling together helpful literature, or meeting with other therapists across other teams to create larger support networks. This would be helpful as it

would enable and empower professionals in this work. This study emphasised the shared narrative of the psychologists' positive experiences of working with refugees. This may be helpful for other psychologists and professionals working in teams who feel more resistant to working with refugees as it may be useful in helping them to see the rewards of this work.

Psychologists may be particularly influential in creating change through practices such as research, at not just a service level, but at a wider system and political level. This study has emphasised the significance of developing an emotional contact and understanding of what an individual's predicament is, and of not pigeon-holing refugees as needing one thing or another just because they are a refugee. This appears to be a relevant message to all services involved with refugees.

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Public Domain Briefing Paper

Clinical Psychologists' Experiences of Working with Refugees

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This research was conducted by Ann-Marie Munday in partial fulfilment of the Doctorate in Clinical Psychology at the University of Birmingham. Research supervision was provided by Dr. Michael Larkin at the University of Birmingham.

Overview

This research is in two parts. The first is a literature review that appraises and evaluates the current research evidence relating to the impact of interpreters in therapy with refugees. The review considers the specific studies that are available on this topic and describes the findings that each study contributes.

The second part is a research study that was conducted with clinical psychologists working in adult mental health services. Psychologists were interviewed about their experiences of working with refugees. The interviews were analysed using a qualitative research approach called Interpretative Phenomenological Analysis (IPA). Four themes were identified that described different aspects of the psychologists' experiences. The psychologists all had varied experiences of working with refugees and their explanations suggest that there are many challenges in working with refugees, however there are also many positives and rewards in the work.

Literature Review – Impact of Interpreters in Therapy with Refugees

Background

Exploration of the definition and qualities of ‘therapy’ is made in order to understand the impact interpreters may have on this process. Orlinsky, Grawe and Park’s (1994) Generic Model of Psychotherapy is considered, summarising six aspects of process which are found in all therapies. Refugees’ health and psychological needs are considered, suggesting that mental health care continues to fail to provide culturally appropriate services to people from ethnic minorities (Department of Health, 2003). The role of language is explored, and is recognised as being bound up with and embedded in culture. This often acts as a barrier to psychological therapy based on a western world view, suggesting that ‘merely translating’ meanings across language is unrealistic, as meanings and concepts are not always interchangeable. Models of interpreting suggest that the most effective model of interpreting in therapeutic contexts is the ‘psychotherapeutic mode’, where the meaning and feeling of words is primarily conveyed (Tribe & Morrissey, 2004). In considering the impact of interpreters on the therapeutic process, benefits and negatives for both client and therapist are considered. Benefits include an enhanced understanding and engagement in therapy, with potential negative issues around breaking confidentiality or interpreters not translating all material. Individuals from different cultures may be unaware of the process of therapy and their role within this. Therapy may be a concept that may have very different meanings within their own culture. Individuals may misinterpret their role and this may impact on the effectiveness of and engagement in therapeutic interventions. It is therefore important to know more about the impact that interpreters may have on psychological therapy.

Method of Review

The review provides an assessment and evaluation of the current research literature in relation to the impact of interpreters in therapy with refugees. Nine papers were identified where the paper related specifically to working with refugees in some form of ‘therapy’ context and interpreters were used to aid communication within this therapy context. Two papers use qualitative methodology and seven use quantitative methodology.

Qualitative studies

Both qualitative papers offered rich and detailed accounts of the role and impact of interpreters in therapy with refugees. The literature suggests how a discrepancy can occur in therapists’ views of the interpreter’s role in therapy. Interpreters were sometimes viewed as a ‘black box’ merely translating material, their role being simple and detached; whereas the majority saw the interpreter’s role as an integral part of the three person alliance, being complex and involved. It is suggested that interpreters may act as a ‘responsible messenger’ who may change the perspective of interpreted dialogue in order to inform the listener about who is responsible for the ideas and opinions, interpreters being more interactive and viewed as active participants.

Quantitative Studies

Quantitative studies tended to explore the effectiveness of a particular therapeutic intervention through a measurement of a reduction of symptoms, in which interpreters were involved in aiding communication. Most demonstrate an improvement in symptomology and conclude that the intervention was effective.

In all studies there is little standardised information provided about the model of interpreting used in sessions. Authors who did provide information on the interpreter's role, explained how interpreters tended to be viewed as translators and facilitators of the therapist–patient relationship (Hinton, Pham, Tran, Safren, Otto & Pollack, 2004; Weine, Kulenovic, Pavkovic & Gibbons, 1998) and, in one case, interpreters provided cultural consultation (Schulz, Resick, Huber & Griffin, 2006). Interpreters' characteristics were considered, such as the interpreter's experience in interpreting, the interpreter's training and their basic understanding of therapeutic approach (D'Ardenne, Ruaro, Cestari, Fakhoury & Priebe, 2007a; Schulz et al., 2006).

One study (D'Ardenne et al., 2007a) compared therapeutic outcomes between a group of refugees requiring an interpreter and a group of refugees who do not require an interpreter. Findings showed how the refugee group with an interpreter had a higher proportion of patients who had improved than the group of refugees without. However, this was not a statistically significant difference and so had to be considered with caution. Conflicting findings were found between studies considering the impact using interpreters has on time spent in therapy. One author suggested how using interpreters increased the length of time that therapists spent on each session, increasing by as much as 50 percent (D'Ardenne et al., 2007a). This was in contrast to findings that therapists in total spent less time in sessions, and had fewer sessions when using an interpreter (Schulz et al., 2006). The challenges of using interpreters were sparsely explored. Challenges included issues of trust, confidentiality and disempowerment (D'Ardenne et al., 2007a). The use of interpreters was considered to be a complicating factor impacting on the therapeutic bond, and it was suggested that

this relationship can lack immediateness where emotionally-laden subtleties can be difficult to communicate (Renner, 2007).

Conclusions

Quantitative studies largely fail to consider the impact of interpreters in therapy with refugees. Common failings are: models or standards of interpreting are unclear; interpreters are not seen as a variable in need of control and measurement; and measures used often fail to be culturally appropriate. Methodologies often appearing weak and varied means that the exploration of the impact of interpreters in therapy continues as exploratory. What is needed in studies is clear comparison groups between treatment with interpreters and treatment without interpreters, and key variables, such as interpreters, need to be controlled for. These variables also need to be well defined, for example by providing standards or models of interpreting. Studies need to ensure that measures are culturally appropriate, valid and reliable.

There were a number of implications from this review of the literature. Further exploration of interpreters' characteristics would provide evidence as to whether these are important. This would potentially impact on the hiring, training and supervision of interpreters. An exploration of interpreters' views of whether they consider themselves as a part of the therapeutic alliance would allow for a deeper understanding of interpreters' impact on therapeutic alliance, and would lead to the development of ways to support interpreters and therapists to work more effectively together. The interpreter's impact on the maintenance of the therapeutic relationship would be helpful to explore with interpreters and therapists, in order to gain further insight about this claim. The development by services of good practice guidelines or

protocols in using interpreters is important to ensure work with interpreters is carried out appropriately and effectively in both therapeutic and research contexts.

Empirical Paper - Clinical Psychologists' Experiences of Working with Refugees

Background

There is a firm body of literature that looks at good clinical practice in psychological work with refugees, with expanding guidance on good practice in working with interpreters in this field. However, there appears to be little qualitative data on therapists' (specifically clinical psychologists') experiences of working with refugees, as what is available appears to be largely anecdotal.

Refugees are not a homogenous group. When working with refugees, clinical psychologists are faced with multifactorial clinical presentations that are influenced by a huge range of cultural and political factors. Psychologists can be confronted with unfamiliar experiences and these can impact at both a professional and personal level. Refugees' complexity can leave therapists feeling overwhelmed, disempowered and hopeless (Rees, Blackburn, Lab & Herlihy, 2007). Refugees' experiences of atrocity and loss can be difficult for professionals to consider because they are usually so different from their own experiences. The contagious nature of trauma and its impact on therapists is termed vicarious trauma (McCann & Pearlman, 1990). It is important to have a reliable and structured support system to prevent this.

Issues of cultural difference need to be considered by therapists in order to allow them to work effectively with clients, and this requires therapists to be open to explore new challenges and to question their own assumptions and methods of working.

Difficulties of working therapeutically, particularly with the aid of interpreters is highlighted (Raval & Smith, 2003). Criticism of psychological therapies argues how survivor's methods of meaning making are often ignored within therapeutic approaches, while the work is often carried out in a context of limited resources (Tribe & Patel, 2007). A barrier to accessing psychological services by ethnic minorities has felt to be largely due to institutional racism (Mahtani, 2003). A number of issues that impacted on psychologists' willingness to work with asylum seekers, and the impact of these issues on the development of the therapeutic relationship are reported. Issues included; therapeutic issues (such as trust, uncertainty and inadequate theoretical frameworks); difficulties of communication; legal and social issues; and client displacement and adaptation (Maslin & Shaw, 2006).

Findings suggest psychologists may feel overwhelmed by refugee clients' complexity and trauma, causing clinicians to feel discouraged and deskilled (Maslin & Shaw, 2006). However a more qualitative understanding of this experience may shed useful light on how and why this happens and implications for future practice. The present research approaches clinical psychologists' experiences of working with refugees from an exploratory and phenomenological perspective in response to the lack of other qualitative research of this nature.

Method

Ethical approval was granted from Coventry Research Ethics Committee and the relevant NHS Research and Development departments. Potential participants were identified and approached and given information about the study. Consequently five psychologists gave their written consent to be interviewed and these took place at

their place of work. The interviews were transcribed and analysed using the IPA approach.

Results

Four themes were identified. Psychologists discussed the ripple effect of the work, namely the 'traumatic reaction', how working therapeutically with refugees had impacted on them in both challenging and positive ways. This included dilemmas that the work raised for them such as issues of powerlessness, clients' vulnerability and the uncertainty of refugees' circumstances. The psychologists' experience of support within this work could be quite variable and isolation was a common feature. The benefits of supervision with another professional who had also worked with refugees was emphasised as well as peer supervision. The psychologists voiced amazement at refugees' strength and resilience, stressing that despite refugees' past and current circumstances, there is a resilience that people possess that has enabled them through this process. The participants were inspired to advocate on behalf of refugees and this took various forms, including research; working individually with clients; and advocating within the teams the psychologists were working in. For many of the psychologists, the experience of working with refugees led to a change in their view of the world from safe to secretive and disrespectful, particularly with regard to how systems and services operated. Working with difference also impacted on their personal beliefs, the view of themselves and how they carried out therapy. The psychologists expressed frustrations at the context of delivery and their understanding of the system was challenged. The psychologists' experiences of working with difference and their understanding of the complexity of the work both evolved in working with refugees.

Evaluation and Implications

The semi-structured interview appeared to work well in allowing the psychologists the opportunity to explore their experiences. As a Trainee Clinical Psychologist I may have been influenced by my own experiences which may have prevented me from looking at the data without certain assumptions or existing thoughts, perhaps creating a bias towards a positive view of psychologists' abilities to work with this client group and preventing me from looking more critically at the profession and the data. The process of triangulation was important in preventing this. It is acknowledged that it may appear that some participants' voices are heard more than others, however, it is important to note that each of the themes were extracted from patterns across all participants' transcripts.

The voices or perspectives of relevant others are not heard or represented. Interviewing other professional groups such as interpreters or psychiatrists may have provided useful insights into their experiences of working with refugees. Exploring refugees' experience of therapy with a clinical psychologist may have also enriched our understanding of the process of the encounter of therapy between refugees and psychologists.

Clinical implications at a service level include resource issues, and the need for services to discuss issues of isolation, and the need to encourage more supportive working practices. Implications at the level of the team involve teams identifying who is working with refugees and how the team could function better to provide more adequate support to those carrying out the work. Beginning to address professionals'

fears about working with this client group may help with issues around feelings of powerlessness and helplessness. Timeout for the therapist to pull resources together including helpful literature or meeting with other therapists across teams to create larger support networks may be useful. The positive experiences of the participants in their work with refugees may be helpful to psychologists who feel more resistant to working with refugees, as it may be useful in helping them to see the rewards of this work. Psychologists may be particularly influential in creating change through research.

Appendices – Literature Review

Appendix 1 Particulars of Reviewed Studies

Qualitative Study

Author Year Country	Type of study	Participants	Methodology / measures and data collection	Outcome	Strengths and limitations
Miller, Martell, Pazzdirek, Caruth and Lopez (2005) USA	Qualitative exploration of the role of interpreters in psychotherapy with political refugees.	n=30 15 therapists: 10 female 5 male All US born native English speakers 15 interpreters: 14 female 3 male 2 US born 13 Eastern European	Not specified methodology Semi-structured interviews, coded and analysed with NUD*IST programme	Discrepancy found in the role of the interpreter: <ul style="list-style-type: none"> Minority of therapists use interpreter as a 'black box' - role simple and uninvolved Majority of therapists viewed interpreters as integral to alliance as a triad - role involved and complex Complicating factors to therapeutic process found: <ul style="list-style-type: none"> Formation of stronger alliance between client and interpreter initially Complex emotional reactions in triad Concerns around assumed political stance & mistrust Interpreters with characteristics similar to therapists such as empathy and self-awareness would be most suited to working in psychotherapeutic contexts 	<ul style="list-style-type: none"> Not stated methodology used Rich reflective qualitative descriptions from therapists and interpreters Interrater reliability stated – not coherent with qualitative methodology Failure to consider the effects of the researchers characteristics e.g. gender, status, on participants ease to talk and honesty

Qualitative study

Author Year Country	Type of study	Participants	Methodology / measures and data collection	Outcome	Strengths and limitations
Bot (2005) Netherlands	Qualitative exploration of how interpreters interpret language in psychotherapy sessions with patients who were asylum seekers with a diagnosis of PTSD	n=9 3 State-certified therapists specialised in working with refugees 3 Patients speaking Dari or Persian, languages of Iran or Afghanistan 3 Interpreters who spoke Dari or Persian as their mother tongue and Dutch as their second language	Does not state methodology used for analysis • Use video recorded interpreter mediated psychotherapy sessions 2 consecutive sessions from 3 groups were recorded, each consisting of the same therapist, patient and interpreter • Sessions recorded from middle phase of treatment • Recordings made at 3 State recognised mental health institutions in the Netherlands.	<ul style="list-style-type: none"> • Interpreters change the perspective of the person by using 's/he' says and changing 'I' in to 's/he' to inform who is responsible for the ideas and opinions – the 'Arabic way' • Change in perspective is dependent on interpreters style and factors such as turn length, structure and difficulty of ideas • Emphasis on the interpreter as part of the dialogue, while at the same time defining their position as 'reporter' 	<ul style="list-style-type: none"> • Not stated methodology used • Contradictory conclusions - suggests findings do not suggest any real reason why use of reporting verb/change from 1st to 3rd person cannot be good interpreting practice then contradicts by saying: - worthwhile to limit influence of interpreter and changes in the perspective of person. • Paper lacks traditional structure such as method, results and discussion sections

Quantitative Study

Author Year Country	Type of study	Participants	Methodology / measures and data collection	Outcome	Strengths and limitations
Renner (2007) Austria	Retrospective study using pre/post comparison looking at effectiveness of psychotherapy with refugees and asylum seekers	n=37 Clients: 16 men 21 women mean age 36.1 yrs Country of origin: 18 Chechnya 7 Afghanistan 4 Kosovo 2 Armenia 2 Georgia 1 Bosnia 1 Iran 1 Iraq 1 Poland	Comparative & retrospective data used Therapeutic method clients are assigned to include: psychodramatic treatment, behaviour therapy or existential analysis • Comparative data: Brief Symptom Inventory given beginning of therapy and then every 6 months • Retrospective data 'Questionnaire of Change in Experience and Behaviour' questionnaire sensitive to perceived change of experience and behaviour	<ul style="list-style-type: none"> • Positive effect found • 85% of clients reported significant improvements 	<ul style="list-style-type: none"> • Difficult to conclude whether outcomes are due to psychotherapeutic or psychiatric input • Failure to acknowledge data lacking methodological rigour of controlled clinical trials • Recognise need for a larger sample size • Acknowledgement but scarcity of depth on role of and impact of interpreters

Quantitative Study

Author Year Country	Type of study	Participants	Methodology / measures and data collection	Outcome	Strengths and limitations
D'Ardenne, Ruaro, Cestiari, Fakhoury & Priebe (2007) UK	Retrospective study comparing routine clinical outcomes of 3 groups of patients with PTSD receiving CBT.	n=128 Patients treated with CBT for PTSD between 2000 -2004 Patients included if completed 2 or more routine measures pre and post treatment 44 refugees required interpreters 36 refugees did not require an interpreter 48 non refugee clients	<ul style="list-style-type: none"> • 2 clinical psychologists specialised in trauma treatment & using interpreters & 8 final yr trainees provided therapy • 22 interpreters from local authority, always same one used • Seen weekly or fortnightly for TF CBT at least 1 hr - bit extra time for interpreted sessions. • Pre/post treatment measures used: <ul style="list-style-type: none"> -Impact of Events Scale -Beck Depression Inventory -Manchester Short Assessment of Quality of Life 	<ul style="list-style-type: none"> • Refugee group with an interpreter had a higher proportion of patients who had improved than the group of refugees without-not statistically significant • An improvement seen for all groups • Conclude that the findings confirm the effectiveness of CBT in the treatment of PTSD • Increased length of time for therapy sessions when interpreter used 	<ul style="list-style-type: none"> • Acknowledgement of data lacking methodological rigour of controlled clinical trials • Recognise need for a larger sample size • Attempt to match clients and interpreters, and ensure interpreters have understanding of trauma and CBT • No information on model of interpreting provided • No control group • Highlights challenges of interpreting and considers some of the impacts -trust, confidentiality & disempowerment. • Fail to consider impact of clients choosing to have interpreters interpret in their 2nd or 3rd language • Fail to explain how decisions were made about who did not require an interpreter

Quantitative Study

Author Year Country	Type of study	Participants	Methodology / measures and data collection	Outcome	Strengths and limitations
Schulz, Resick, Huber & Griffin (2006) USA	Archival outcome data using pre/post comparison of 2 groups to determine whether CPT, in a manualised form was effective with traumatised refugees	n= 53 46 women 7 men Age range: 18- 69yrs 9 Afghanistan 44 former Yugoslavia, specifically Bosnia- Herzegovina. All immigrated to U.S. between 1993 - 2004 All considered multiply traumatised 35 considered torture survivors defined in the torture victims relief act (1998) Patients from service based community organisation that provided treatment to traumatised refugees Interpreters were used for 25 out of 53 participants	<p>Methodology / measures and data collection</p> <ul style="list-style-type: none"> • 5 female therapists • 7 interpreters <p>PTSD Symptom Scale, administered verbally due to lack of fluency in English.</p> <ul style="list-style-type: none"> • Administered at intake and end of therapy or 'treatment termination'. <p>Used contractual interpreters, including a psychologist from former Yugoslavia</p> <p>83% treated at home due to poverty & fears of going out reduced mobility.</p>	<p>Outcome</p> <ul style="list-style-type: none"> • Reported that their results were highly effective regardless of whether or not interpreters were used • Initial analysis suggested group without an interpreter had showed an improvement in PSS scores but when confounding variable of having only one therapist who could speak patients native language (having in total longer and more sessions) the interpreter effect disappeared • Fewer sessions and less time in therapy when interpreters used highlight that 'once treatment goals were achieved the therapist- interpreter-patient triad terminated the therapeutic relationship' • Therapists report perceived added stress of using interpreters 	<p>Strengths and limitations</p> <ul style="list-style-type: none"> • Acknowledgement of data lacking methodological rigour of controlled clinical trials • Benefits of study being more naturalistic but need for a proper comparison group • Interpreter well educated and attended training but fail to state model of interpreting used. State that role of interpreter considered to act as translator and facilitator of therapist- patient relationship • 3 cases where changed interpreter don't explore why it happened or impact • Acknowledgement of 'therapist effect'

Quantitative Study

Author Year Country	Type of study	Participants	Methodology / measures and data collection	Outcome	Strengths and limitations
Weine, Dzubur Kulenovic, Pavkovic & Gibbons (1998) USA	Exploration of the effectiveness of TP with refugees using pre/post, 2 and 6 month follow up	n=20 All survivors of ethnic cleansing Bosnian refugees settled in Chicago for 2 yrs 8 women - 40% 12 men - 60% Age: 23-62yrs mean 45.1yrs Experienced on average 16 types of traumatic experiences Participants recruited through outreach work in Chicago Bosnian community – let testimony project be known, some volunteered, others were asked, 3 were asked but declined All participants completed psychotherapy	<ul style="list-style-type: none"> Psychiatric assessment for traumatic stress, depression, psychosocial functioning Instruments: <ul style="list-style-type: none"> -PTSD Symptom Scale -Beck Depression Inventory Global Assessment of Functioning Scale -Structured Clinical Interview from DSM-IV Average 6 sessions weekly/bi-weekly for 90mins Testimonies conducted in Bosnian, taped and transcribed in to English read or translated back by therapist or interpreter, together correct mistakes etc to create final document. Copy to survivor and copy held in history archives All testimonies done by only 2 people, a Bosnian speaking psychiatrist and an American psychiatrist with aid of interpreter 	<ul style="list-style-type: none"> TP reduced PTSD symptom severity and decreased rates of PTSD diagnosis 2 and 6 month follow up demonstrated further decreases in all symptoms and an increase in the Global Assessment of Functioning Scale 	<ul style="list-style-type: none"> Method of recruitment - possible ‘cherry picking’ Acknowledge difficulties of generalising findings: <ul style="list-style-type: none"> -small sample size, -need for control or comparison group Failure to state if outcome measures were validated for population, acknowledge linguistic and ethnocultural differences of population on measures but fail to explore this further. Contradiction-suggestion that instruments are reliable and valid with population Translation and interpretation of instruments considered but interrater reliability not mentioned Not stated numbers of participants seen by each psychiatrist Good description of role but failure to consider model of interpreting and impact of interpreter

Quantitative Study

Author Year Country	Type of study	Participants	Methodology / measures and data collection	Outcome	Strengths and limitations
Otto, Hinton, Korbly, Chea, Ba, Gershuny & Pollack (2003) USA	Pilot study comparing the effectiveness of the SSRI sertraline with sertraline plus CBT for the treatment of PTSD in refugees	n=10 All women mean age 47.2yrs 5 randomly assigned to sertraline alone 5 randomly assigned to sertraline plus 10 sessions of CBT	All had failed to respond to treatment with clonazepam and SSRI other than sertraline. Participants still met criteria for PTSD determined by Structured Clinical Interview for DSM-IV <ul style="list-style-type: none"> Measures: <ul style="list-style-type: none"> -Structured Clinical Interview for DSM-IV -Clinician Administered PTSD Scale -Hopkins Symptom Checklist-25 SCL-90-R – used 12 item somatisation scale for this only -Anxiety sensitivity index 17 item Khmer ASI addendum After baseline assessment, tapered off old medication. Participants still taking clonazepam and given sertraline. -CBT conducted in group format in local Buddhist Temple 	<ul style="list-style-type: none"> The addition of 10 sessions of CBT in the combined group provided a substantial benefit compared to the sertraline alone group Authors conclude that their findings ‘demonstrate that CBT can be successfully modified for Khmer speaking Cambodian refugees’ 	<ul style="list-style-type: none"> Failure to consider whether Structured Clinical Interview from DSM-IV and ASI is valid with population Failure to report tests of statistical significance of difference Failure to acknowledge model of interpreting used, role and impact of interpreters Not comparative sample Acknowledge small sample size Failure to consider impact of participants taking different medication on outcome Ethical issues of adverse symptoms from medication and funding from pharmaceutical company

Quantitative Study

Author Year Country	Type of study	Participants	Methodology / measures and data collection	Outcome	Strengths and limitations
Hinton, Pham, Tran, Safren, Otto & Pollack (2004) USA	Pre/post comparison looking at the effectiveness of CBT for PTSD with refugees	n=12 6 men 6 women All Vietnamese practicing Buddhists Patients recruited from 2 community based outpatient clinics, specialist services to non English speaking Vietnamese refugees Participants randomly assigned to 2 groups with 6 in each -Group 1: immediate CBT -Group 2: delayed CBT All continued medication	CBT to treatment resistant patients – 12 participants met PTSD criteria (assessed by SCID module for PTSD) despite at least 1 year of an adequate dose of a SSRI and supportive counselling Measures: -Structured Clinical Interview for DSM-IV -Harvard Trauma Questionnaire -Hopkins Symptom Checklist -Anxiety Severity Index -Headache Panic Attack Severity Scale -Orthostatic Panic Attack Severity Scale Measures were translated Tested at 3 points: 1. At pre treatment (first assessment) 2. After group 1 had undergone 11 sessions of CBT (second assessment) 3. After group 3 had undergone 11 sessions of CBT (third assessment) -HPASS & OPASS assessed every 2 weeks	• Results reported as positive with the interaction term for all outcome measures being significant • A greater improvement shown from the first assessment to the second assessment in the initial CBT group compared to the delayed CBT group	• Failure to consider whether Structured Clinical Interview from DSM-IV & HPASS & OPASS is valid with population • Acknowledge small sample size • Failure to consider impact of participants taking different medication on outcome • Failure to state any check of accuracy on translated measures • Failure to state model of interpreting used and unclear of the impact of using interpreters • Brief consideration of interpreters role • Ethical issues in the delay and withholding of treatment

Quantitative Study

Author Year Country	Type of study	Participants	Methodology / measures and data collection	Outcome	Strengths and limitations
Carlsson, Mortensen & Kastrup (2005) Denmark	Measures the effectiveness of a multidisciplinary treatment programme on symptoms of PTSD with refugees Pre/post comparison	n=55 40 male 15 female Age ranges: <29yrs = 9 30-49yrs = 40 >50yrs = 6 32 from Iraq 43 Muslim faith	Treatment at Copenhagen rehab and research centre for torture victims in multidisciplinary rehab programme including: Psychotherapy Physiotherapy Social counselling Medical help Psychoeducation for families Group therapy for women Self administered questionnaires & one observer rating scale used to assess symptoms of PTSD, depression, anxiety and health related QoL at baseline and 9month follow-up • Measures used: -Harvard Trauma Questionnaire -Hopkins symptom checklist-25 (anxiety scale & depression scale) -Hamilton depression scale WHO Quality of Life-Bref Measures translated and back translated Interpreter used when needed	• Findings report a lack of significant change in mental symptoms and health related QOL after a mean of 8 months treatment	• Little data provided on treatment combinations • Participant data more pertinent to method section occurring in results section • Failure to state whether outcome measures were validated for population • Observer rating scales used with question as to their reliability • Failure to consider the model of interpreting used, the role and impact of interpreters

Appendices – Empirical Paper

Appendix 2 Local Research Ethics Committee Approval Letter

[Not available in the digital version of the thesis]

Appendix 3 Semi Structured Interview Schedule

Semi Structured Interview Schedule

Study Title: Clinical Psychologists' Experiences of Working with Refugees

1. How did you first come to work with Refugees?

What did you do before, main areas of interest?

What made you consider working with this client group?

What did you expect your work to be like?

2. What has your experience been of working with refugees?

Can you tell me about the work you currently do/did with refugees?

What would you describe as your main roles in your work with refugees?

Did this match up with your expectations?

3. What are the most positive aspects of working with refugees?

Choose one – could you tell me about...

What specifically made this such a positive experience?

4. What are the most negative aspects of working with refugees?

Choose one – could you tell me about...

What would have made this less negative/challenging?

Was there anyone/thing that could have helped?

5. How does your role fit with other professions/professionals work with refugees?

Is there ever conflict in your work?

Experience of services for refugees?

What are other peoples' feelings/reactions to your work with refugees?

6. Has your work with refugees influenced other areas of work?

Changes in approaches to other client work?

Changes in approach to life in general?

What does the future hold with regard to working with refugees?

Advice you would give?

Appendix 4 The Process of Data Analysis

The process of data analysis

Transcripts are examined line by line, the left hand margin is used to note items of significance or interest at the descriptive level. The right hand margin is then used to document inferences made about the meaning of participants' claims, these are recorded as codes. The table below shows a sample of Dr Aspen's transcript:

Description	Line	Transcript material	Interpretation - Codes
<ul style="list-style-type: none"> • Her experience of the world v others experience/exposed to trauma • Amazement at courage, escape, fight, survival • Puzzlement, sit with someone & see difficulties –fight & survive then effect of collapse, puzzled by this reaction? • Work out what going on now, witnessing, settling, understanding, caring • Not knowing what to do – minimum to listen, care, bare witness • Underestimated level of difficulties and impact on clients • Difficulties with system-time applying for status • Cruelty of own country, guilt, shame, own fears? • Disbelief people in need deported 	35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56	<p>P: erm it was just incredible to think you know out of your own, sort of little world what ever traumas people might have experienced to be exposed to, people who have witnessed such incredible difficulties, and the sort of the puzzlement and the sort of erm witness to such courage to have gone through that to have escaped or to have fought in a way that they survived, erm I guess that my puzzlement is that, even having gone through that you can sit with somebody and you see all their difficulties but you know the puzzlement for me is, as well all the time when you were fighting to survive, and yet now everything seems to have collapsed around you and its you know, there was a (inaudible) what's going on for you now, but just all those sort of experiences of others and and being part of what they've witnessed and, helping them to settle and sort of, um care about what they've been through, you know sometimes I sort of feel like I really don't know what to do but, the minimum I can do is sit with you, and care about and bare witness to you know somebody's difficulties.</p> <p>I: umm. I'm wondering what what did you expect the work was going to be like before you kinda started doing the work?</p> <p>P: um. I think I thought people might get better a little more quickly (both laugh), um and I think I wasn't, I don't think I was quite prepared to sort of one struggle to get through and how long it takes to do the asylum seeking and then get refugee status OR NOT, or many have to be deported and go back, and the cruelty that within this country would um sort of inflict, and um I don't think I quite expected it, its almost like (inaudible) your case now, no you know I didn't expect that you could sit with somebody who may well be deported erm.</p>	<p>Experience of the world v experience of trauma</p> <p>Courage, escape, fight to survive</p> <p>Puzzlement</p> <p>Caring and sitting with their experience, barewitness</p> <p>Speed of recovery</p> <p>Cruelty in British system</p>

Codes were organised in to table form for each transcript. An initial list of codes for Dr Aspen’s Transcript is presented:

Initial code	Page no & line no.	Content from transcript
Important job/role	1, 13	Asked by UN
Escape, assisting refugees to move on	1, 19	Couldn’t go back, accepted in to another country
Levels of trauma and upheaval	1, 24	Moving family, moving home upheaval
Numbers of asylum seekers and refugees and local service	1, 26	Lots of. Local service up road.
Psychological therapies role in trauma and flashbacks from upheaval	1, 28	Flashbacks trauma country moving trauma since arriving
Experience of the world V experience of trauma	2, 35	Little world V witness incredible difficulties
Courage, escape, fight to survive	2, 38	Witness to courage escaped survived
Puzzlement	2, 39	puzzlement fought to survive but now things collapsing
Caring and sitting with their experience, bare witness	2, 44	Being part of what witnessed, minimum can do, care, bare witness
Speed of recovery	2, 50	Thought better more quickly
Cruelty in British system	2, 52	Status, deportation, cruelty
Emotional impact	2, 58	Helpless, hopeless, paralysing, hardest work can do
Helplessness	2, 61	Job I can’t do something
Meeting basic needs - safety and security	3, 69	Maslow’s hierarchy, secure home, safety very very basic way
Psychological working	3, 72	making meaning, making sense
Meeting basic needs	3, 81	Safe, sleep, work, may resolve issues

This process was undertaken for all transcripts. Codes which appeared closely related were grouped together as shown below:

Refugee strength and resilience	Code	Page and line no	Content from transcript
	courage, escape, fight to survive	2, 38	Witness to courage escaped survived
	puzzlement	2, 39	puzzlement fought to survive but now things collapsing
	resilience, survival, fight & strive	7, 224	Place to smile, traumatic & horrid, left in your life, resilient fight strive

The next stage involved assimilating similar codes across transcripts, considering the presence of repetition and variability. Meaning is made of the connections and patterns between codes so that initial broad clusters are developed creating emerging themes. An example of an emerging theme is shown below:

Emerging Theme	Transcript	Page and line no	Code	Summary – Content from transcript
Refugee strength and resilience	1	1, 19	Amazement at escape	Tortured, actually got out
		2, 28	Resilience	Country, resilient, strength
		21, 491	Gratitude	[refugees] released, give back, volunteer
		23, 543	Resilience	Impressed, strengths, confidence, creativity
	2	30, 726	Amazement at resilience	Coping fantastically well, cope with, where coming?, don't speak English, no idea of culture..system, no family, somehow, getting by.
		30, 732	Amazement at human strength and survival	People, same situation, never got out, stayed, hiding, killed, get out, strong instinct to survive, strength, keeps..going against all odds
		31, 768	Marvel at survival	Marvel at, survived, lost trust, trusted me, feel quite emotional, huge privilege
		31, 773	Impact of trust on survival and healing	Human spirit, bad experiences, yet, trust, need to in order to survive, can't do this on your own, difference why people are here, left country, no money etc, had to put trust in something, fate or life
	3	10, 229	Amazement at human capacity for resilience	Exposed, human capacity, resilience, growth, troubling circumstances, great feeling, attempt, meaning, make better for t'selves, little, used tried hard, successful, amazing, positive aspect
		31, 760	Resilience and agency	Remarkable resilience, capacity, refugees, enormous psychological resource, situation, sometimes, sense of agency, make something better
		32, 784	Impact of survival	Experienced, crude, bad things can be, survive, not always, enables, make best..got build on
		15, 356	Therapy - idea v reality	Ideas, might..help people, offer, wanting to help, awful experiences, presented with, contribute, quite small, own resources, sense of agency,
		10, 245	Role of therapy	Very troubled, slowly, gradually, using therapeutic space, gather, life up, feel again, make relationships again
	4	12, 221	Small important improvement	Fairly well, expectations, much lower, hadn't..traumatic experiences, small improvement, significant
	5	2, 38	Courage, escape, fight to survive	Witness to courage, escaped, survived
		2, 39	Puzzlement	Puzzlement, fought to survive but now things collapsing
		7, 224	Resilience, survival, fight & strive	Place to smile, traumatic and horrid, left in your life, resilient, fight, strive

Subsequent phases of development bring together themes creating more encompassing and coherent superordinate themes. Continual reference back to the original transcripts was important throughout to ensure original meaning was not lost. The following table demonstrates theme two, 'amazement at refugees' strength and resilience':

Superordinate Theme	Transcript No	Code	Quote	Summary
Amazement at refugee strength and resilience	0206 31, 768	Marvel at survival	I think one of the things I marvel at and this maybe this is something about why these people have survived is, in one sense they're very / they've kind of lost their trust in people and the world, and yet in another way somehow they've trusted me, and it's sort of erm can feel quite emotional even saying it, it's like a huge privilege, and part of me just thinks how do you / its like that part of the human spirit / how do you have such bad experiences, and yet somehow you still find that ability to trust? And actually you need to in order to survive because actually you can't do this on your own and maybe that's the difference about why these people are here and because actually at some point, they left the country wi.. their own country with no money no idea where they were going and they had to, and these people probably may not have been very trust worthy cos probably it was all done for money or something, but they had to put their trust in something whether it was fate or life.	Psychologist astonished at refugees ability to trust in her and therapy after such horrific experiences feeling it as a huge privilege Questioning whether these people had to trust something in order to survive
	0303 10, 229	Amazement at resilience – taking it and using it	Being erm, sort of, erm sort of exposed to, erm the sort of human capacity for er resilience and for growth in, you know, the very troubling circumstances [...] people did er show a great feeling and and, you know there was a continued, however difficult things were what I often came across was people where there was a continued erm attempt to make some kind of meaning or to try and struggle on to make things better for themselves. Erm, you know, and for some people it was very stark that you know, particularly people I worked with very briefly, how some people got very little from me but really took it and used it, and you know really tried very hard an.. and were really successful in building their lives up, and as a clinician that was you know amazing to see.	Amazement at the human capacity to manage and grow when things are and have been so difficult, expressing the feeling that even if very little was given through therapeutic work people were able to use this to great effect and turn things around
	0303 31, 760	Amazement at resilience – got in to and get out of situation	“I think it comes down to this thing, the fact that people show remarkable resilience and er capacity, and I've seen people / people who've become refugees, are the people who had enormous psychological resource that got them in to the situation which meant they had to leave. I mean, its not always the case but sometimes it is and that, you know people hadn't changed and there's a sense of agency than even we realise and for some people, the (inaudible) got something to be a refugee are also a reflection of their sense of agency and trying to do something to make something better you know.”	This psychologist makes the observation that people with psychological resource and resilience are often the people who wanted to change things and make things better so in some ways got them in to the position of having to leave and seek refuge and perhaps results in them being able to utilise therapy and create a new life with very little

Appendix 5 Instructions for Authors - Social Science and Medicine

[Not available in the digital version of the thesis]

Appendix 6 Instructions for Authors – Cultural Diversity and Ethnic Minority Psychology

[Not available in the digital version of the thesis]