

THE EMOTIONAL IMPACT OF WORKING ON A SPECIALIST MENTAL HEALTH INPATIENT  
WARD FOR INDIVIDUALS WHO ARE DEAF: THE EXPERIENCE OF A BRITISH SIGN LANGUAGE  
INTERPRETER

by

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## **Thesis Overview**

This thesis was submitted in partial fulfilment of the requirements of the degree of Doctor of Clinical Psychology at the University of Birmingham. This thesis comprises of a research volume (I) and a clinical volume (II).

### **Volume I: Research Component**

The research component comprises of a systematic literature review, an empirical research paper, and a press release. The systematic literature review outlines and evaluates the evidence for psychological interventions for mental health difficulties with individuals who are d/Deaf. The empirical research paper describes a qualitative study exploring British Sign Language interpreters' experience of the emotional impact of working on a specialist mental health inpatient ward for individuals who are deaf. The author intends for both papers to be submitted to 'The International Journal of Mental Health and Deafness'. The press release provides an overview of both the systematic review and the empirical paper.

### **Volume II: Clinical Component**

The clinical component comprises of five Clinical Practice Reports (CPR's). CPR1 presents cognitive-behavioural and systemic formulations of a 52-year-old male presenting with anxiety in the context of several physical health diagnoses. CPR2 reports an audit, which considered whether a psychology for stroke service was meeting the standards of the 'Royal College of Physicians National Clinical Guidelines for Stroke' in addition to a brief evaluation of the current service. CPR3 describes a Single Case Experimental Design evaluating the effectiveness of a behavioural activation intervention on an inpatient ward, with an 81-year-old female experiencing depression. CPR4 presents a cognitive-behavioural case study of a 10-year-old girl experiencing separation anxiety. CPR5 comprises of an abstract outlining an oral presentation of an integrative case study of a 31-year-old female with a diagnosis of a learning disability, who presented with anxiety and low self-esteem. Difficulties were understood from a systemic perspective and the accompanying intervention utilised techniques from both social constructionist and cognitive-behavioural models.

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## 1. LITERATURE REVIEW

*Psychological interventions for mental health conditions for individuals who are d/Deaf –  
a systematic review of the literature*

## **1.1 Abstract**

### **Introduction**

This systematic review aims to evaluate the evidence base for psychological interventions for mental health difficulties with individuals who experience the medical condition of deafness. Psychological models, assessments, and therapies have been developed in Western society based on a hearing population. In order to increase accessibility of mental health services to this population, it is helpful to know which psychological therapies, if any, are effective.

### **Method**

Four electronic databases were searched, and potential papers were identified according to an inclusion and exclusion criteria. Dependent upon the type of intervention study, one of two quality appraisal checklists were used; the Quality Assessment Tool for Quantitative Studies (Effective Public Health Practice Project, 1998) or the Risk of Bias in N-of-1 Trials Scale (RoBINT; Tate et al., 2015). Two questions related to communication were added to both quality tools.

### **Results**

Eight papers were identified as suitable for review and rated for quality. Seven of these papers were rated as 'weak'. The therapeutic approach differed in all eight studies (Cognitive Behavioural Therapy, Solution-Focused Therapy, Dialectical Behaviour Therapy, Acceptance and Commitment Therapy, Reality Therapy, Cognitive Processing Therapy, and Psychoeducation). The target of the intervention included social anxiety (n=1), depression (n=4), anger difficulties (n=1), PTSD (n=1), and anxiety or depression (n=1).

### **Discussion**

There is little evidence to suggest that psychological therapies are effective with this client group. However, firm conclusions cannot be made due to the poor quality of studies. Future research focused on the implementation of psychological therapy with individuals who are d/Deaf would benefit from more rigorous design including incorporation of a control group

and/or control conditions, increased sample size and completion of culturally valid outcome measures with appropriate statistical analysis.

## 1.2 Introduction

This systematic review aims to evaluate the evidence for psychological interventions for mental health difficulties with individuals who experience the medical condition of deafness. There are two predominant ways of referring to this population group i.e. 'deaf' and 'Deaf' with the difference associated to the significance of the capital 'D'. 'Deaf' refers to the Deaf community, a group of individuals who "share a perception of the world through an emphasis on visual and kinaesthetic input" (British Deaf Association, 2015a) i.e. it relates to culture. Individuals who are described as 'Deaf' have often experienced deafness prior to the onset of language (Signhealth, no date) and often communicate using sign language (Emond et al., 2014). On the other hand, 'deaf', refers solely to the medical condition of deafness.

According to the British Deaf Association (2015b), "deafness is the third most common disability in the world" and can be described as a heterogeneous condition (Fellinger, Holzinger & Pollard, 2012). Deafness can occur before the onset of language and is known as prelingual deafness, or after the onset of language, known as post lingual deafness. Prelingual deafness occurs in 0.07% of the general population (Bubbico, Rosano, & Spagnolo, 2007; Mitchell, 2006). British Sign Language (BSL) is the main language for 22,000 individuals in the United Kingdom (Office for National Statistics, 2013). However, the actual number of individuals who communicate using BSL is likely to be much higher when one considers individuals who may be bilingual, the potential census completion difficulties for individuals who are deaf, and the national census response rate of 94% (Emond et al., 2014). Throughout this systematic review, the term d/Deaf is used to incorporate both deaf and Deaf and refers to all individuals who are deaf, regardless of whether they are part of the Deaf community or whether they use sign language to communicate.

Individuals who are d/Deaf experience poorer general health compared to individuals in the general population (Emond et al., 2014). Emond et al. (2014) attributes this to several possible factors such as; lack of awareness of health conditions, under-diagnosis of health conditions and under treatment of chronic health conditions. Wilson and Wells (2009) suggest that improved access to health literature and/or psychoeducation may provide

d/Deaf individuals with the necessary information required to improve awareness of health conditions and consequently improve the general health of this population. With regards to the prevalence of mental health conditions in individuals who are d/Deaf, there is mixed evidence regarding this when compared to the general population. Kvam, Loeb and Tambs (2006) stated that individuals who are d/Deaf experience significantly more anxiety and depression. Diaz, Landsberger, Povlinski, Sheward, and Sculley (2013) explored the types of psychiatric disorders in d/Deaf and 'hearing' individuals who were receiving treatment at a mental health outpatient clinic. However, it is important to note that the sample included individuals who identified as hard-of-hearing (5.8% of sample) and individuals who identified as deaf-blind (1.2% sample of sample), as well as individuals who identified as d/Deaf. Individuals within the d/Deaf group experienced significantly higher rates of attention deficit hyperactivity disorder, pervasive developmental disorder, impulse control disorders, and intellectual disability than the hearing group. Whereas individuals within the hearing group experienced significantly higher prevalence rates of anxiety disorders, bipolar disorders, and substance abuse disorders. There was no difference between the groups in the prevalence of eating disorders, psychotic disorders, personality disorders or depressive disorders. Prevalence rates of mental health conditions have also been found to differ amongst the d/Deaf community. Individuals with post-lingual deafness report more mental health symptoms than individuals with prelingual deafness (de Graaf and Bijl, 2002). Mental health difficulties within the d/Deaf community may also be exacerbated by limited education and employment prospects, and marginalisation within society (Department of Health, 2005). Furthermore d/Deaf individuals are likely to be admitted to a mental health ward for twice as long as hearing individuals (Baines, Patterson, & Austen, 2010).

With regards to treatment of mental health difficulties, d/Deaf people are supported in both specialist deaf mental health services and general mental health services. However, it is acknowledged that Deaf adults within mental health services prefer to be supported by clinicians who can sign (Feldman and Gum, 2007). There are currently three specialist deaf mental health services within the United Kingdom, which offer service users a 'signing environment' and an appreciation and understanding of the culture and experience of Deaf people (Baines et al., 2010).

Prior to evaluating the evidence base for psychological therapies with d/Deaf individuals, it is useful to consider why the evidence base may be different for this population compared to the hearing population. It is important to acknowledge that psychological models, and subsequently psychological assessments and therapies, have been developed in Western society based on a hearing population. It is well recognised that adaptations to psychological tests and mental health assessment measures are required when working with d/Deaf individuals due to poor validity, as a consequence of being designed for and normed with the hearing population (Fellinger et al., 2012). On the other hand, Fernando (2004) stated that there has been an overemphasis on difference when comparing working therapeutically with d/Deaf people and working with hearing people. It has also been argued that there needs to be a focus on ensuring that psychological therapies are adapted for d/Deaf individuals, therefore increasing accessibility to this population, rather than focusing on whether or not psychological therapies work with this population (Glickman and Harvey, 2008). However, in order to explore what adaptations have been successful, we need to know which psychological therapies have been effective.

With regards to cultural differences, the Deaf population has been recognised as having different cultural values and beliefs to the hearing population (Cornes and Napier, 2005). The Deaf population have historically experienced oppression and paternalistic treatment by the hearing population (O'Rourke, 2000). This history may affect the therapeutic relationship, and subsequently the effectiveness of psychological therapy, in particular when there is a hearing therapist and a Deaf client. In order to counteract this, Fernando (2004) stated that psychological therapists should utilise a transcultural model of practice, which should include placing value in Deaf culture as well as having an awareness of their own prejudices.

There are also linguistic differences between the d/Deaf population and hearing population (Crump and Hamerdinger, 2017). Mental health difficulties typically affect thought processes, and subsequently can affect communication in Deaf individuals (Boness, 2016), in both the production and comprehension of sign language. However, individuals who are d/Deaf are a heterogeneous group, incorporating both linguistically competent individuals and individuals who have difficulties with both language and learning (Glickman and Harvey,

2008). Furthermore, some deaf individuals can also be described as language “dysfluent”, referring to individuals who are not competent in sign language or their preferred language (Glickman and Crump, 2013). Boness (2016) reported that language dysfluency may be a result of the individual not grasping the language, or the individual experiencing mental health difficulties or brain damage. Additionally, previous research has found the average reading age of d/Deaf individuals to be lower than hearing individuals, with reading comprehension scores of d/Deaf children being below scores of hearing children (Wauters, Van Bon, & Tellings, 2006). Due to the above factors, a reliance on written aids during psychotherapy may affect the accessibility of psychotherapy to all d/Deaf individuals, in particular those with linguistic dysfluency, therefore affecting the effectiveness of psychotherapy with this population. In order to make psychotherapy more accessible to d/Deaf individuals, an emphasis on nonverbal and visual communication, in particular use of visual aids such as drawing and video is recommended (O’Rourke, 2000; Roberts and Hindley, 1999).

There is a considerable lack of published empirical research with the d/Deaf Population (Landsberger, Sajid, Schmelkin, Diaz, & Weiler, 2013). The limited research that does exist has focused on the adaptation of specific psychological therapies, such as dialectical behaviour therapy, brief solution-focused therapy, and cognitive therapies for d/Deaf individuals (O’Hearn and Pollard, 2006; Estrada and Beyebach, 2007; Glickman, 2009). However, to date, there has been no systematic review of the literature regarding psychological interventions for mental health difficulties with individuals who are d/Deaf. For the purpose of this review, psychological interventions include any talking therapy or training based on the following psychological approaches; psychodynamic, behavioural, humanistic, integrative, and third wave cognitive behavioural approaches. Mental health conditions refers to anxiety disorders (including post-traumatic stress disorder; PTSD), depression, and anger. The aims of this systematic review are therefore to:-

- Describe the type of psychological interventions that have been investigated and reported with the d/Deaf population and the type of psychological difficulties that the interventions have been applied to
- Explore whether psychological interventions with d/Deaf individuals are effective

## 1.3 Method

### 1.3.1 Database Selection

The Cochrane Library database of systematic reviews was searched to see whether any previous reviews existed in the area of psychological interventions and deafness. This was established by exploring whether the terms “deaf”, “hearing loss”, or “hearing impairment” were present in the title, abstract or keyword of previous Cochrane reviews. This resulted in 24, 71 and 22 reviews respectively, none of which were related to psychological interventions for mental health.

Following this, a systematic search was undertaken in April 2019 with a focus on articles that reported the use of a psychological intervention with individuals who are d/Deaf. The following databases were searched; PsycINFO, PsycArticles, Embase, and OVID Medline. The search strategy examined (mental illness or mental health or mental disorder or anxiety or depression or PTSD or trauma) and (therapy or psychotherapy or intervention or training), in population groups classified as (deaf or Deaf or hearing impair\*). Studies that focused on acquired and/or partial hearing loss after the period of language acquisition were excluded due to the cultural and linguistic differences between d/Deaf population and hearing population. Individuals with acquired hearing loss will have initially been part of the hearing culture from birth, therefore they are likely to identify with the hearing population from a cultural and linguistic perspective. Such important differences might influence the outcome of interventions in different ways for these two groups, therefore it was decided to focus just on the d/Deaf population.

Table 1 shows the combination of search terms and associated number of results. Titles and abstracts were reviewed in order to identify relevant papers. The full text of relevant papers were then reviewed fully, and papers that met the inclusion and exclusion criteria were selected (Table 2).

Table 1. Search strategy

Step	Search term	Results
1	(deaf* or Deaf* or hearing impair*).ab,kf,sh,ti.	149646
2	(mental illness or mental health or mental disorder or anxiety or depression or PTSD or trauma).ab,kf,sh,ti.	2408365
3	(therapy or psychotherapy or intervention or training).ab,kf,sh,ti.	7232068
4	1 and 2	6437
5	1 and 3	19943
6	4 and 5	1160
7	remove duplicates from 6	914

Table 2. Inclusion and Exclusion criteria for review

Inclusion Criteria	Exclusion Criteria
Studies focused on the adult population ( $\geq 18$ years old)	Acquired hearing loss in adulthood ( $\geq 18$ years old)
Participants with a diagnosis of prelingual or post-lingual deafness in childhood	Non empirical papers including reviews or opinion pieces
Participants described as deaf or Deaf	Articles not written in English
Articles reporting the implementation of a psychological intervention (including training) with individuals with a recognised mental health condition	
Psychological interventions including any talking therapy or training based on the following psychological approaches; psychodynamic, behavioural, humanistic, integrative, and third wave cognitive behavioural approaches.	
Studies published in a peer review journal	

### 1.3.2 Study Quality

Dependent upon the type of intervention study, one of two quality appraisal checklists were used; the Quality Assessment Tool for Quantitative Studies (Effective Public Health Practice Project, 1998) or the Risk of Bias in N-of-1 Trials Scale (RoBiNT; Tate et al., 2015). In the Quality Assessment Tool for Quantitative Studies (Effective Public Health Practice Project, 1998), quality is assessed through the rating of six different components; selection bias, study design, confounders, blinding, data collection methods, and withdrawals and drop-outs. Each component is rated 'strong', 'moderate', or 'weak', and a global rating is also given for each paper using the same descriptive terms (appendix A). Advantages of the use of this tool include its ease of use because of an accompanying dictionary (appendix B), its established reliability and validity (Thomas, Ciliska, Dobbins & Micucci, 2004), and its developmental origins in public health research. On the other hand, The RoBiNT Scale, is more beneficial for studies which only have one participant, otherwise known as a case study or single case design. The RoBiNT Scale is made up of 15 items exploring aspects of internal and external validity. A subscale score for each domain plus an overall total score is provided at the end (appendix C).

Two questions related to communication were added to both quality tools. The first additional question is related to whether the intervention was delivered via a sign language proficient therapist or whether a sign language interpreter was used. The therapeutic relationship between a therapist and client is significantly affected when an interpreter is present during therapy, for example if the clinician engages in eye contact with the interpreter rather than the Deaf client (Iezzoni, O'Day, Killeen, & Harker, 2004). The second additional question explores whether outcome measures were communicated via sign language or via written communication. Outcome measures via written communication may not be the participant's first language, which may then affect understanding and hence outcomes.

In order to review the global quality of all of the papers together, the author applied the global rating classifications of 'strong', 'moderate', and 'weak' from the Quality Assessment Tool for Quantitative Studies (Effective Public Health Practice Project, 1998) to the N-of-1

studies assessed using the Risk of Bias in N-of-1 Trials Scale (RoBiNT; Tate et al., 2015). It was hoped that utilising the same global rating system would allow for a more seamless process when evaluating the papers together. Table 3. shows how the global rating criteria was used for each of the respective checklists. A narrative summary of the strengths and weaknesses of each study is included, in addition to the global rating.

*Table 3. Global Rating System*

	<b>Strong</b>	<b>Moderate</b>	<b>Weak</b>
Quality Assessment Tool for Quantitative Studies (Effective Public Health Practice Project, 1998)	No weak component ratings	One weak component rating	Two or more weak component ratings
Risk of Bias in N-of-1 Trials Scale (RoBiNT; Tate et al., 2015)	No scores of 0	One score of 0	Two or more scores of 0

### **1.3.3 Data Extraction and Synthesis**

A data extraction tool was used which included the study design, the characteristics of participants, the type of psychological therapy, target of intervention, whether an interpreter was used, what outcome measures were used (if any) and the results (appendix D).

A meta-analysis was not possible due to the heterogeneity of the client groups, interventions and outcome measures. Furthermore, not all studies published data from psychometrically validated outcome measures therefore a narrative review is more suitable.

## 1.4 Results

### 1.4.1 Overview

Four databases were searched for relevant studies. A total of 1160 papers were identified and following removal of duplicates, 914 titles were screened for relevance. Of these titles, 63 abstracts were reviewed for eligibility. At this stage papers were removed if; they were not empirical, if participants acquired their hearing loss over the age of 18 years old, and if participants were children. This resulted in 19 papers left for full text review. Eight relevant papers were identified following full text review. The reference lists and citations of papers were also searched, however no additional papers were identified from this. Figure 1 presents the breakdown of the search process.

Table 4 summarises the studies included in this review. The therapeutic approach differed in all eight studies (Cognitive Behavioural Therapy, Solution-Focused Therapy, Dialectical Behaviour Therapy, Acceptance and Commitment Therapy, Reality Therapy, Cognitive Processing Therapy, and Psychoeducation). With regards to location of the studies, none of the studies were UK based. Three studies were carried out in Europe (König, 2013; Estrada and Beyebach, 2007; Hassinen and Lappalainen, 2018), three studies originated in USA (Glickman, 2009; Bhargava, 2013), one study took place in Australia (Davidson, Cave, Reedman, Briffa, & Dark, 2012) and one study took place in Iran (Dehnabi, Radsepehr & Foushtangh (2017)). Only one study (Glickman, 2009) took place in an inpatient setting. A total of 105 participants were included across the eight studies, however three studies had only one participant and one study reported three individual cases. The target of interventions included social anxiety (n=1), depression (n=4), anger difficulties n=1, PTSD n=1, and anxiety or depression (n=1).

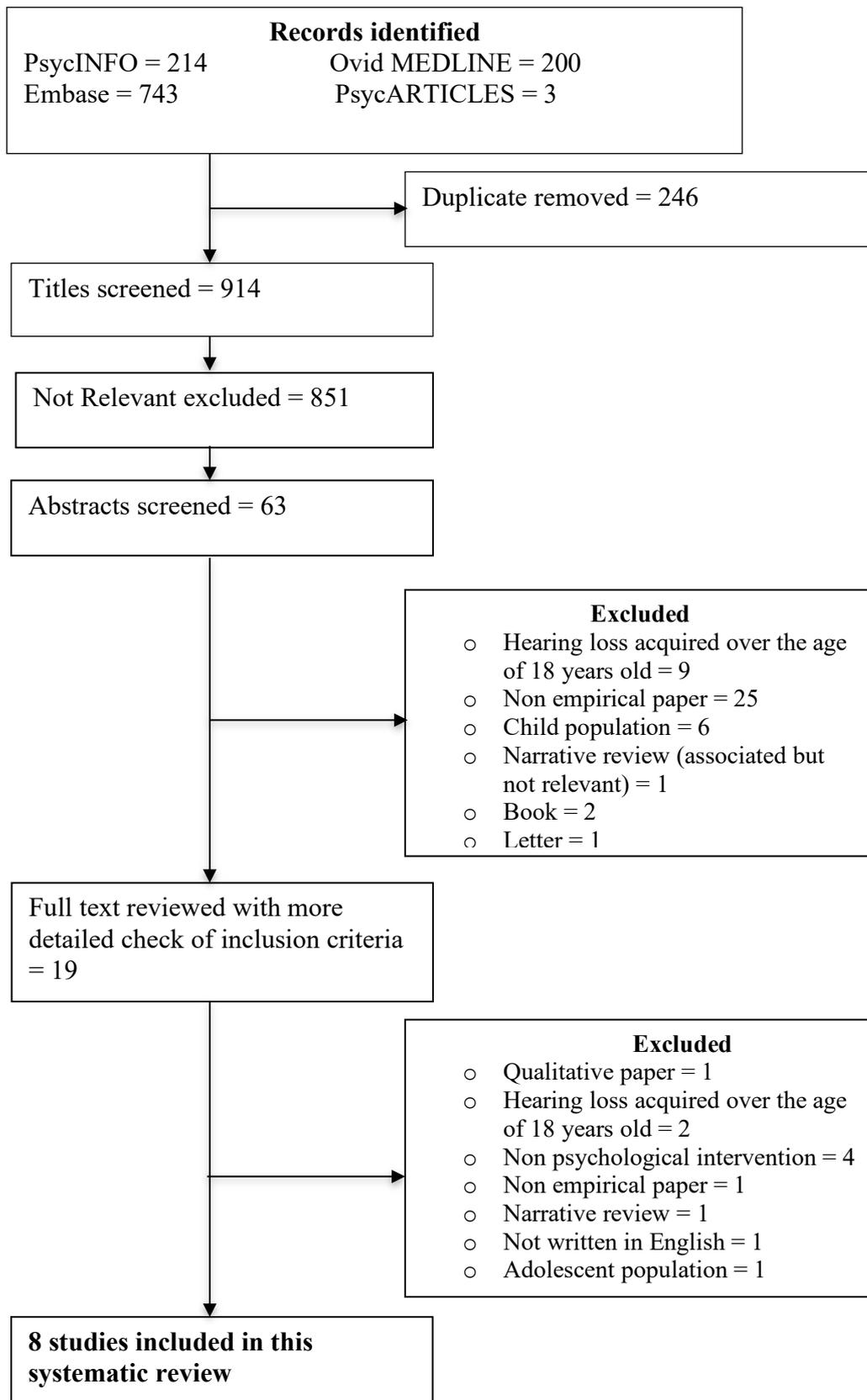


Figure 1 - Summary of search process

Table. 4 Summary of studies

Quality Framework	Authors (Year)	Study setting and population size	Psychological therapy	Target for intervention	Mode of communication	Outcome measures	Key findings
The Quality Assessment Tool for Quantitative Studies (Effective Public Health Practice Project, 1998)	Davidson, Cave, Reedman, Briffa and Dark (2012)	Australia Outpatients Four participants	Dialectical Behavioural Therapy (DBT)	Reduce symptoms of depression or panic disorder through development of interpersonal effectiveness, emotional regulation, and crisis management skills	Australian sign language (Auslan) via professional interpreters	Outcome Rating Scale (ORS-Auslan)  Session Rating Scale (SRS-Auslan)	<ul style="list-style-type: none"> <li>• ORS and SRS data not published</li> <li>• Authors reported that participants were able to identify specific skills and explain the usefulness of the skill post intervention</li> </ul>
	Dehnabi, Radsepehr and Foushtangh (2017)	Iran Outpatients 24 participants	Mindfulness-based stress reduction (MBSR)	Social anxiety	Specific language not stated  Deaf teaching assistant	Social Phobia Inventory (SPIN)	<ul style="list-style-type: none"> <li>• The authors report MBSR reduced social anxiety however no statistically significant changes in scores were determined</li> </ul>
	Hassinen and Lappalainen (2018)	Finland Outpatients 16 participants	Acceptance and Commitment Therapy (ACT)	Depression (and consequently psychological well-being)	Finnish Sign Language (FinSL) speaking staff members  No interpreters	Beck Depression Inventory (BDI)  Symptom Checklist 90 (SCL-90)  Acceptance and Action Questionnaire II (AAQ-II)	<ul style="list-style-type: none"> <li>• No statistically significant change in BDI scores</li> <li>• No statistically significant change in psychological flexibility</li> <li>• No statistically significant change in overall psychological symptoms</li> </ul>

	Wilson and Wells (2009)	United States of America Outpatients 55 participants	Psychoeducation	Depression	American Sign Language (ASL) via professional interpreter using Telehealth, or written format	Beck Depression Inventory (BDI-II) Beck Hopelessness Scale (BHS) Client Satisfaction Scale (CSS) Therapist Satisfaction Scale (TSS)	<ul style="list-style-type: none"> <li>• Statistically significant decrease in BDI-II score post intervention</li> <li>• Mean BDI-II score reduced from clinical category “mild depression” pre intervention to clinical category “minimal depression” post intervention</li> <li>• No statistically significant change in BHS score post intervention</li> <li>• Mean BHS score reduced to below clinical cut off post intervention</li> </ul>
Risk of Bias in N-of-1 Trials Scale (RoBiNT; Tate et al., 2015)	Bhargava (2013)	United States of America Outpatients One participant	Reality Therapy	Depression	American Sign Language (ASL) via ASL proficient clinician	No outcome measures used. Anecdotal report of client provided.	<ul style="list-style-type: none"> <li>• The author reported that the client was “noticeably happier and appeared to be more content with his life. He indicated that he no longer felt depressed, stated that he is able to confidently identify with the deaf world, and is in the pursuit of fulfilling his desire of becoming a certified horticulturalist”</li> </ul>
	Estrada and Beyebach (2007)	Spain Outpatients	Solution-Focused Brief Therapy (SFBT)	Depression	Spanish sign language via professional interpreter	Beck Depression Inventory-II Adapted for Deaf persons (BDI-IIAD)	<ul style="list-style-type: none"> <li>• All three participants’ BDI-IIAD scores above clinical level pre intervention</li> <li>• All three participants’ BDI-IIAD</li> </ul>

		Three participants				Progress Scaling Question  2 x treatment integrity measures	scores below clinical level post-intervention • Statistical significance between phases not investigated
Glickman (2009)	United States of America  Inpatients  One participant	Cognitive Behavioural Therapy (CBT)	Anger	American Sign Language (ASL) via ASL proficient clinician	No outcome measures used. Anecdotal report of client provided.		• Following intervention, the client was able to notice anger and utilise coping strategies, such as walking away and writing/drawing feelings in a book
König (2013)	Germany  Outpatients  One participant	Cognitive Processing Therapy (CPT)	Post-traumatic Stress Disorder (PTSD)	Deutsche Gebärdensprache (DGS) via professional interpreter	Posttraumatic Diagnostic Scale (PDS)  Impact of Event Scale – Revised (IES-R)  Brief Symptom Inventory (BSI)  Posttraumatic Cognitions Inventory (PTCI)  Inventory of Interpersonal Problems – Circumplex Version (IIP-C)		• Statistical significance between phases not investigated • PDS not at clinical level pre-intervention • IES-R above clinical level pre-intervention and reduced to below clinical level post-intervention • BSI score above average pre-intervention and below average post-intervention • PTCI and IIP-C not at clinical level pre-intervention

### 1.4.2 Study Design and Quality

The eight studies identified, employed various study designs including, controlled clinical trial (n=2), cohort (n=2), case study (n=3), multiple case study (n=1). With regards to the quality of the studies with more than one participant, three of these studies were given a global rating of weak (Dehnabi, Radsepeher & Foushtangh, 2017; Davidson et al., 2012; Wilson and Wells, 2009). This was due to likely selection bias caused by method of recruitment, no consideration given to confounding variables and either no reporting of the drop-out rate or less than 80% completion rate. Only one of the group studies was given a global rating of moderate (Hassinen and Lappalainen, 2018).

With regards to the quality of N-of-1 studies, the internal validity of all four of the case studies was rated as poor due to lack of withdrawal/reversal phase, lack of randomisation, lack of multiple data points, and lack of blinding of assessor and participant. Only one study (Estrada and Beyebach, 2007) collected data relating to treatment adherence, only one study (Estrada and Beyebach, 2007) collected outcome data via the use of outcome measures at multiple time points and only one study (Glickman, 2009) provided detailed information regarding the setting of the study.

None of the studies included participant and/or practitioner blinding. Convenience sampling was the method of recruitment in the majority of studies meaning that selection bias was not minimised. Statistical analysis was not included in the majority of the studies. In reference to mode of communication, five of the studies utilised a sign language proficient therapist to communicate the intervention, whilst the remaining three studies utilised a sign language interpreter. Two studies (Hassinen and Lappalainen, 2018; Davidson et al., 2012) utilised visual aids such as DVD's to express psychological concepts during the intervention phase, whilst Estrada and Beyebach (2007) used a video recording to communicate outcome measures. König (2013) acknowledged that their client found it difficult to complete worksheets during the Cognitive Processing Therapy intervention and worksheets had to be abbreviated to reduce the amount of language used. Glickman (2009) utilised concrete visual aids such as a 'red, yellow, green' traffic light card system to convey CBT concepts, however this was applied in the context of language and learning challenges rather than because of deafness. In the six studies that utilised outcome measures, these were

communicated via sign language in four studies and two studies did not report the mode of communication of measures. The full quality ratings for each study are presented in tables 5 and 6 below.

Table. 5 Quality ratings for studies reviewed using the Quality Assessment Tool for Quantitative Studies (Effective Public Health Practice Project, 1998)

		Study			
		Hassinen and Lappalainen (2018)	Dehnabi, Radsepeher and Foushtangh (2017)	Davidson et al. (2012)	Wilson and Wells (2009)
<b>Component Ratings</b>	<b>A) Selection Bias</b>	<u>Moderate</u> Participants were recruited via a clinic so somewhat likely to be representative of the target population. 80% of selected individuals agreed to participate.	<u>Weak</u> The paper does not report how participants were selected for the study.	<u>Weak</u> Participants were service users of a clinic, however the paper does not report how they were selected for the study.	<u>Weak</u> Participants were service users of a clinic, however the paper does not report how they were selected for the study.
	<b>B) Study Design</b>	<u>Moderate</u> This study utilised a cohort design i.e. one group of individuals were pretested, given an intervention, and then tested after the intervention. No control group was included.	<u>Strong</u> The study can be classified as a controlled trial. The authors report the study to be randomised but do not describe the process of randomisation.	<u>Weak</u> Post-test only design study. Participants were not tested prior to intervention.	<u>Strong</u> The study can be classified as a controlled trial. The authors report the study to be randomised but do not describe the process of randomisation.
	<b>C) Confounders</b>	<u>Weak</u> No mention of confounding variables.	<u>Weak</u> There were differences in average age and gender between the two groups prior to the intervention.	<u>Weak</u> No mention of confounding variables.	<u>Weak</u> No mention of confounding variables.
	<b>D) Blinding</b>	<u>Moderate</u> Outcome assessors were aware of participants' intervention condition, however it is not clear whether participants were aware of the research question.	<u>Moderate</u> It is not clear whether outcome assessors were aware of the intervention condition, or whether participants were aware of the research question.	<u>Weak</u> Outcome assessors were aware of participants' intervention condition. Participants were aware of the research question.	<u>Moderate</u> Outcome assessors were aware of participants' intervention condition. Participants were not aware of the research question.

	<b>E) Data Collection Methods</b>	<u>Strong</u> Data collection tools used were reliable and valid. References to check this provided.	<u>Strong</u> Data collection tools used were reliable and valid. References to check this provided.	<u>Strong</u> Data collection tools used were reliable and valid. References to check this provided. However, the data itself was not published in the paper.	<u>Strong</u> Data collection tools used were reliable and valid. References to check this provided.
	<b>F) Withdrawals and Drop-Outs</b>	<u>Strong</u> All participants completed the intervention.	<u>Weak</u> Withdrawals and drop outs were not reported.	<u>Moderate</u> 75% of participants completed the study.	<u>Weak</u> Withdrawals and drop outs were not reported.
<b>Global Rating for Paper</b>		<u>Moderate</u> Overall, the study is rated as moderate due to one of the component ratings rated as weak.	<u>Weak</u> Overall, the study is rated as weak due to three component ratings rated as weak.	<u>Weak</u> Overall, the study is rated as weak due to four component ratings rated as weak.	<u>Weak</u> Overall, the study is rated as weak due to three component ratings rated as weak.
<b>Added Criteria</b>	<b>Communication (intervention)</b>	<u>Strong</u> Intervention delivered via a sign language proficient therapist.	<u>Strong</u> Intervention delivered via a sign language proficient teaching assistant.	<u>Strong</u> Intervention delivered via a sign language proficient therapist.	<u>Moderate</u> Intervention delivered via a professional interpreter.
	<b>Communication (outcome measures)</b>	<u>Strong</u> Outcome measures translated into Finnish Sign Language and communicated via sign language.	<u>Weak</u> No mention of how outcome measures were communicated to participants.	<u>Strong</u> Outcome measures translated into Australian Sign Language.	<u>Strong</u> Outcome measures communicated via sign language.

Table. 6 Quality ratings for studies reviewed using the RoBiNT Scale quality framework

	König (2013)	Bhargava (2013)	Glickman (2009)	Estrada and Beyebach (2007)
<i>Internal Validity (IV) Subscale</i>				
1. Design with control	0	0	0	0
2. Randomisation	0	0	0	0
3. Sampling of Behaviour	0	0	0	0
4. Blinding of people involved in the intervention	0	0	0	0
5. Blinding of assessor (s)	0	0	0	0
6. Interrater agreement	0	0	0	0
7. Treatment adherence	0	0	0	1
<i>External Validity and Interpretation (EVI) Subscale</i>				
8. Baseline characteristics	1	1	0	0
9. Setting	1	0	2	1
10. Dependent variable (target behaviour)	2	1	1	2
11. Independent variable (therapy/intervention)	2	2	1	1
12. Raw data record	0	0	0	2
13. Data analysis	0	0	0	0
14. Replication	0	0	0	1
15. Generalisation	2	0	0	0
<i>Additional criteria added to EVI Subscale:-</i>				
16. Communication (intervention)	1	2	2	1
17. Communication (outcome measures)	0	N/A	N/A	2
<b>IVI Subscale Total</b>	<b>0/14</b>	<b>0/14</b>	<b>0/14</b>	<b>1/14</b>
<b>EVI Subscale Total</b>	<b>9/20</b>	<b>6/20</b>	<b>6/20</b>	<b>10/20</b>
<b>Overall Total</b>	<b>9/34</b>	<b>6/34</b>	<b>6/34</b>	<b>11/34</b>
<b>Global (overall) Rating</b>	<b>Weak</b>	<b>Weak</b>	<b>Weak</b>	<b>Weak</b>

### 1.4.3 Synthesis of Findings

Findings have been synthesised according to the target of the intervention within the study.

#### **Anxiety**

Two out of the eight studies focused on the reduction of symptoms of anxiety using therapies based on cognitive and behavioural models of psychology (König, 2013; Dehnabi, et al., 2017). The authors claimed that the interventions were effective, however statistical significance was not established in either study. Both of these studies were rated 'weak' in quality. Furthermore, the participants did not seem to have been showing clinical levels of anxiety prior to the intervention.

König (2013) explored the treatment of Post-traumatic Stress Disorder (PTSD) using Cognitive Processing Therapy (CPT) with a 42-year old female in Germany. This manualised intervention took place over the course of 20 sessions rather than the usual 15 sessions, with the number of offered sessions increased to account for the fact that content may take longer to cover due to communication. A sign language interpreter assisted in the interpretation of the intervention. Although CPT for PTSD is a manualised intervention, the author acknowledged that only preliminary data for the German manual adaptation had been published with a hearing sample. The same author had published the preliminary data. The participant completed a battery of outcome measures both pre and post intervention and at 6-month follow up. Completed outcome measures included; Posttraumatic Diagnostic Scale (PDS), Impact of Events Scale-Revised (IES-R), the Brief Symptom Inventory (BSI), the Posttraumatic Cognitions Inventory (PTCI) and the Inventory of Interpersonal Problems-Circumplex Version (IIP-C). The IES-R was also completed weekly for 90% of the intervention. Only the IES-R and BSI were at a clinical level prior to the intervention commencing. However, it is important to acknowledge that the outcome measures were not completed in the participant's first language i.e. they were completed in written German rather than sign language, and the participant reported symptoms of PTSD. The IES-R scores were no longer clinically significant post-intervention and at 6-month follow up.

Dehnabi et al. (2017) summarised a Mindfulness-based Stress Reduction (MBSR) in the reduction of social anxiety symptoms in 24 participants. Participants were allocated to either an experimental condition (N=12) or a control group (N=12). Participants in the experimental condition completed eight sessions of MBSR intervention. A deaf teaching assistant assisted in the delivery of the MBSR intervention, however the author does not explicitly state whether or not communication is via sign language. The nature of the control group is not reported, i.e. whether it was a wait-list control or a different intervention. Participants completed the deaf Social Phobia Inventory (SPIN) outcome measure before and after the intervention. The authors reported a significant decrease in SPIN scores post-intervention, however the clinical significance of the change in scores is not reported. Furthermore, potential confounding variables, such as differences in ages of participants between the experimental group and the control group was a problem. The authors do not report how participants were selected for the study therefore it is not known whether the sample is representative of the target population.

### **Depression**

Four studies focused on the reduction of symptoms of depression (Estrada and Beyebach, 2007; Wilson and Wells, 2009; Bhargava, 2013; Hassinen and Lappalainen, 2018), however one study (Bhargava, 2013) did not collect any data from psychometrically validated measures. All of these studies were rated as 'weak' in quality, apart from the study by Hassinen and Lappalainen (2018), which was rated 'moderate'. Of the two studies that carried out statistical analysis, a statistically significant decrease in depression symptoms following intervention was only established in one study (Wilson and Wells, 2009) via the use of Beck Depression Inventory-II (BDI-II).

Estrada and Beyebach (2007) utilised Solution-Focused Therapy with three individuals experiencing depression. The intervention was delivered with the assistance of sign language interpreters. All three individuals completed the BDI-II, adapted for Spanish Sign Language and shown via videotape, at multiple time points. All participants were classified as having either minimal or no depression at the end of the intervention, however only two participants had severe depression prior to the intervention. The third participant had minimal depression pre and post intervention therefore no clinically significant

improvement was observed. Participants also self-referred to take part in the study meaning that they are unlikely to be representative of the target population. Despite being manualised, the number of therapy sessions varied amongst participants and ranged between four sessions and eight sessions. On the other hand, treatment integrity measures were completed to ensure that treatment was sufficiently solution-focused.

Psychoeducation, delivered in the form of a lecture communicated in sign language (telehealth condition) or delivered in printed written format (placebo condition), was used to treat depression in a controlled between-subjects pretest-posttest crossover control group design by Wilson and Wells (2009). The study aimed to establish the viability of telehealth as a way to disseminate psychoeducational material, compared to written psychoeducational material. Fifty-five participants were randomly allocated to either the telehealth condition or the written material placebo condition. After one session of each condition they switched and completing the other condition. The telehealth condition was delivered via sign language interpreters, and all participants could access translation support from interpreters when completing subsequent questionnaires. Participants completed the BDI-II and the Beck Hopelessness Scale (BHS) prior to the intervention and one-week post-intervention. In addition to participants completing the BDI-II and the BHS, participants also completed a knowledge of depression questionnaire before and after each condition. The authors reported statistically significant change in BDI-II scores when comparing post-intervention scores with pre-intervention scores. Clinical significance was also demonstrated with mean BDI-II score categories reducing from 'mild' to 'minimal'. No statistical significance was found in BHS scores when comparing post-intervention scores with pre-intervention scores, however clinical significance was found with mean BHS scores reducing from 'mild' to 'normal'. The authors acknowledged that any statistical differences between the two groups had to be interpreted with caution due to the discrepancy in sample size between the two groups, although the authors did not report how many participants were in each group. One of the main advantages of this study is that it assesses both the feasibility of psychoeducation in the treatment of depression and the format of delivery of psychoeducation. In addition to this, adherence to psychoeducational transcripts was measured using a published Therapy Adherence Scale to ensure standardisation and consistency across the conditions. However, the BDI-II and the BHS were not completed

between the two conditions, therefore it cannot be said whether one of the conditions had a greater effect on outcomes compared to the other condition. Furthermore, follow-up data was not collected therefore inferences related to the maintenance of scores post-intervention cannot be made. Validity of the depression knowledge questionnaires was ascertained by administering the questionnaires to hearing undergraduates (n = 17) rather than a d/Deaf sample, therefore this questionnaire may not have been culturally valid. Furthermore, participants also self-referred to take part in the study meaning that they are unlikely to be representative of the target population.

Bhargava (2013) reported the use of Reality Therapy with a 19-year old male who was struggling with depression, low confidence and low self-esteem. Reality Therapy is a future-focused psychological intervention that focuses on helping an individual make decisions and take control over their life (Wubbolding, 2000). The intervention took place in a community clinical setting and was delivered by a sign language proficient counsellor. No outcome measures were completed at either pre or post intervention, however the client reported concerns regarding sadness, agitation, and argumentativeness prior to intervention. Bhargava (2013) claimed that the participant was “noticeably happier” after 12 sessions of Reality Therapy but it is not known whether this reported improvement would be clinically significant. At the three follow-up sessions, the participant reportedly identified skills learned during therapy, but it is not reported whether earlier improvements had been maintained.

Hassinen and Lappalainen (2018) stated that the target of their intervention was to improve psychological well-being in participants, however this was operationalised as a reduction in depressive symptoms. The authors utilised the BDI-II as one of their outcome measures. The intervention itself focused on the implementation of Acceptance and Commitment Therapy (ACT) by sign language proficient rehabilitation centre staff. The majority of participants were classified according to the BDI-II as having at least mild depression (94%) prior to the intervention with 69% of these participants classified as having at least a moderate diagnosis. The authors claim that a decrease in mean BDI-II scores was found between pre-intervention to post-intervention, which was maintained at 6-month follow-up. On further inspection, any claimed differences in scores were not statistically significant. The study did

not utilise a control group therefore it cannot be assumed that clinical significance was solely due to the intervention.

### **Other**

The two remaining papers focused on the implementation of Cognitive Behavioural Therapy (CBT; Glickman, 2009) and Dialectical Behaviour Therapy (DBT; Davidson et al., 2012) with individuals struggling to cope with anger and different overwhelming feelings. Both of these studies were given a quality rating of 'weak'. Both papers claim that the interventions were effective, however neither statistical significance or clinical significance could be determined due to lack of formal outcome measures and lack of objective data.

Glickman (2009) utilised CBT when working with a 19-year-old male with language and learning difficulties, who struggled with feelings of anger. The intervention took place in an inpatient environment, delivered by sign language proficient counsellors, and focused on the development of psychosocial skills in order to reduce angry behaviour. This was achieved in three ways; helping the individual to notice and label skills that he had, helping the individual to use these skills when stressed, and teaching the individual new skills. The author claimed that the individual had learned new coping strategies by the end of the intervention, however no formal outcome measures were used throughout the intervention. Due to this, it is difficult to ascertain whether any differences in presentation post-intervention were significant.

Davidson et al. (2012) described the implementation of DBT with four individuals who reportedly were struggling with overwhelming emotions when stressed. The four participants also had various diagnoses including depression with borderline personality traits (n=2), depression (n=1), and panic disorder (n=1). The 23-session group intervention was delivered in sign language with the assistance of professional interpreters, and culturally appropriate resources were presented in visual and video formats. One participant withdrew half way through the intervention. Davidson et al. (2012) utilised the Session Rating Scale (SRS) and the Outcome Rating Scale (ORS) throughout the intervention, however the authors did not publish this data. Furthermore, it could be argued that these measures do not measure change in the variable of interest and the SRS in particular,

measures the general effectiveness of any therapy. On the other hand, these scales are visual analogue scales and therefore not fully dependent upon client language abilities. The authors reported positive subjective feedback from participants post-intervention, but a lack of specific formal outcome measures makes it difficult to ascertain clinical effectiveness.

## 1.5 Discussion

This review aimed to describe the type of psychological interventions that have been investigated and reported with the d/Deaf population and the type of psychological difficulties that the interventions have been applied to, in addition to systematically evaluating the evidence for effectiveness. Of the eight relevant papers identified, only five studies published data using formal outcome measures. Two studies did not utilise any outcome measures at all and anecdotal client information was provided instead (Glickman, 2009; Bhargava, 2013), whilst one study utilised outcome measures but did not publish the outcome data due to lack of consent (Davidson et al., 2012). In the five studies that did report data from outcome measures, reductions in symptom specific outcomes were observed, however a statistically significant reduction in symptoms was only determined in one study (Wilson and Wells, 2009) in relation to symptoms of depression. These studies reported the use of several different types of psychological therapy including; Solution Focused Brief Therapy, Acceptance and Commitment Therapy, and Cognitive Processing Therapy for various emotional difficulties.

The Cognitive Processing Therapy (König, 2013) and Mindfulness-based Stress Reduction (Dehnabi et al., 2017) interventions for anxiety were not implemented with individuals with clinical levels of anxiety, therefore conclusions about effectiveness cannot be established. Furthermore, the studies were of 'weak' quality due to selection bias and lack of blinding. Regarding interventions for depression, the findings suggested that Psychoeducation, disseminated via telehealth or in printed written format, was effective in the reduction of symptoms of depression (Wilson and Wells, 2009). Clinical improvements were also reported following implementation of Solution-Focused Therapy (Estrada and Beyebach, 2007), Reality Therapy (Bhargava, 2013) and Acceptance and Commitment Therapy (Hassinen and Lappalainen, 2018). However these studies were rated 'weak' in quality typically due to possible selection bias and lack of reporting of withdrawals and drop outs. Furthermore, only the study by Wilson and Wells (2009) incorporated a control group, therefore it cannot be assumed that any positive clinical outcomes in the other interventions were solely due to psychological intervention. The Cognitive Behavioural Therapy (Glickman, 2009) and Dialectical Behavioural Therapy (Davidson et al., 2012)

interventions implemented with individuals experiencing anger and other overwhelming feelings reported positive subjective feedback from participants post-intervention. However, both papers were also rated 'weak' in quality due to potential selection bias and lack of raw data and subsequent data analysis, again making it difficult to draw conclusions about possible effectiveness.

There were multiple limitations with all the studies included, making it difficult to draw conclusions about the effectiveness of psychological therapy with this client group. Due to limitations of the studies, only one study could be rated as 'moderate' quality (Hassinen and Lappalainen, 2018) with the remaining seven studies rated as 'weak'. However, this study did not find any statistical differences in symptoms of depression, overall psychological symptoms, or psychological flexibility following the implementation of an Acceptance and Commitment intervention. Any conclusions across all of the studies must be interpreted with caution due to small sample sizes, lack of control groups, and lack of statistical analysis. Not all of the studies incorporated the use of outcome measures, further contributing to the difficulty establishing statistically significant change. However, it has been acknowledged that there is a lack of cross-culturally validated outcome measures specific to the d/Deaf population, which increases the difficulty in collecting outcome data (Wilson and Wells, 2009). Consequently, this makes it difficult to assess whether psychological interventions are clinically effective. Furthermore, not all studies incorporated a follow-up, therefore it is not known whether any of the claimed therapeutic benefits were maintained long-term.

There are a number of limitations of this review itself. Firstly, because there are so few studies in this area, this review focused on all psychological interventions covering a wide range of difficulties. However, it would have preferable for the review to focus on a specific psychotherapy and/or specific mental health condition as the heterogenic nature of the review makes it difficult for comparisons across studies to be made. Secondly, this review only includes studies that were written in English and published in peer reviewed journals, therefore publication bias may mean that papers with less favourable results were excluded. A further limitation of the review concerns the difficulty in synthesising findings across diverse methodologies and the use of two different quality frameworks. Randomised controlled trials are considered to be the highest level of evidence due to the methods

employed within the design to minimise bias (Cochrane Consumer Network, n.d.) compared to other study designs. Due to the small number of studies in the current literature base, it was not considered beneficial to weight the studies based on methodological merit. This lack of synthesis presents limitations as the smaller studies that are of poor validity and reliability may have overly contributed to the conclusions of the review. It is worth noting however, that the smaller and methodologically weaker studies found similar results in terms of no statistically significant positive effects. However, more weighting should be given to the methodologically stronger controlled clinical trial (Wilson and Wells, 2009), which found a more encouraging positive effect for change. Unfortunately, it may be difficult to access large enough numbers of deaf individuals who are experiencing the same mental health condition, in order to have a sufficiently homogenous sample to carry out further good quality randomised controlled trials in the future.

To conclude, there is little evidence as yet that helps to establish whether psychological therapy can be effective with this client group. However, an encouraging positive effect for change on Beck Depression Inventory was found in the RCT based evidence (Wilson and Wells, 2009). Whilst this was only one study, RCT's are considered the 'gold standard' in research due to the removal of bias found in other research designs (Hariton and Locascio, 2018). This is in contrast to the findings of psychological interventions with hearing individuals, in which the effectiveness of psychological interventions for mental health and emotional difficulties is well established (Bohlmeijer, Fledderus, Rokx & Pieterse, 2011; Twomey, O'Reilly & Byrne, 2014; Stiglmayr et al., 2014). Due to this, it could be said that the findings of this systematic review does not support the argument that there is too much focus on emphasising difference between d/Deaf population and hearing population, as the evidence between the d/Deaf population and hearing population regarding effectiveness of psychological therapy is actually different. However, firm conclusions cannot be made due to the poor quality of studies.

With regards to recommendations for future research, future research focused on the implementation of psychological therapy with individuals who are d/Deaf would benefit from more rigorous design including incorporation of a control group and/or control conditions, increased sample size and completion of culturally valid outcome measures with

appropriate statistical analysis. Further research studies are also needed to develop more culturally validated outcome measures. In terms of clinical implications, more sign language proficient therapists are required, who also have an awareness of transcultural values, to deliver psychological interventions with d/Deaf people.

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## 2. EMPIRICAL PAPER

*The emotional impact of working on a specialist mental health inpatient ward for individuals who are deaf: the experience of a British Sign Language interpreter*

## 2.1 Abstract

### Introduction

The present study explores the emotional experience of British Sign Language (BSL) interpreters working on a specialist mental health inpatient unit for individuals who are d/Deaf. The term 'd/Deaf' is used to incorporate individuals who experience the medical condition of deafness and individuals who experience deafness who also subscribe to the Deaf community. The emotional impact of interpreting may manifest in several different ways, including vicarious trauma and burnout (Daly, 2016; McCartney, 2006; Bower, 2015). However, there is limited published research focused on the emotional impact of sign language interpreting.

### Method

Interpretative Phenomenological Analysis (IPA) was the chosen qualitative methodology for this study. Six BSL interpreters were interviewed to explore how they made sense of any emotional impact of interpreting. Following the interviews, the audio was transcribed and the data was analysed by using the analytical process described by Smith, Flowers and Larkin (2009).

### Findings

Three superordinate themes were identified following analysis; "people forget that we're human as well", "I still wish I knew where to stand", and "as interpreters we're not necessarily looked after". The overarching themes were underpinned by eight themes.

### Discussion

The present findings highlight the need for emotional support for BSL interpreters who work in mental health settings, in particular for those interpreters based on an inpatient ward. The emotionally challenging nature of BSL interpreting in inpatient settings is discussed in the context of Demand-control theory (Karasek, 1979; Dean and Pollard, 2001). Clinical

recommendations, such as individual clinical supervision, and implications for future research are discussed.

## 2.2 Introduction

The present study explores the emotional experience of British Sign Language (BSL) interpreters working on a specialist mental health inpatient unit for individuals who are d/Deaf. In this article the term 'd/Deaf' is used to incorporate individuals who experience the medical condition of deafness and individuals who experience deafness who also subscribe to the Deaf community.

The emotional impact of interpreting manifest in several different ways, including vicarious trauma and burnout (Daly, 2016; McCartney, 2006; Bower, 2015). The British Psychological Society (BPS; 2017) recommend that psychologists are aware of the wellbeing of all interpreters in health settings and the potential for vicarious traumatisation. Vicarious traumatisation refers to "a negative transformation in the self of a trauma worker or helper that results from empathic engagement with traumatised clients and their reports of traumatic experiences" (Pearlman, 2012, p.2). Signs and symptoms of vicarious traumatisation include social withdrawal, difficulties maintaining boundaries with patients, anxiety and depression (Pearlman, 2012). Vicarious trauma can be present at the same time as burnout (Pearlman, 2012). Burnout refers to a psychological syndrome that develops in response to prolonged emotional and interpersonal stress (Thompson, Amatea and Thompson, 2014). Symptoms of burnout include emotional exhaustion, fatigue, irritability, and physical complaints (Maslach, Schaufeli and Leiter, 2001; Pearlman, 2012) and interestingly, stress has been found to play a mediating role in the link between maladaptive perfectionism and burnout in sign language interpreters (Schwenke, 2012).

Surprisingly, little work has explored the emotional impact of spoken language interpreting in mental health settings. Doherty, MacIntyre and Wyne (2010) assessed the emotional impact and challenges of mental health interpreting in 18 interpreters using a quantitative survey design. The authors found that 56% of participants stated that they had been affected emotionally by mental health interpreting over the course of their career, for example thinking about their client and the client's difficulties following the session. The authors also stated that the participants attributed their own distress to causes such as the client's distress and 'hearing about suffering and misery'. Participants reported that

interpreting in mental health settings affected their personal and professional lives. Interpreters are also integral to the mental health care of refugees (Gartley and Due, 2017). Splevins, Cohen, Joseph, Murray and Bowley (2010) interviewed eight interpreters who worked in a therapeutic setting with refugees and asylum seekers. Using Interpretative Phenomenological Analysis (IPA), the researchers found that all the participants experienced some form of distress, such as becoming emotionally involved with their clients, due to the intensity of the trauma that they were hearing. Additionally, the participants reported a lack of supervision and a lack of mental health training in their role leading to a lack of clarity about professional and personal boundaries. This was further supported by Green, Sperlinger and Carswell (2012) who interviewed six Kurdish refugee interpreters. Through IPA analysis, the authors found similar concerns regarding interpreters feeling overwhelmed by the emotional impact of mental health interpreting, in particular in interpreting scenarios where they found it impossible to remain neutral to the content being interpreted. Resera, Tribe and Lane (2015) interviewed 12 interpreters who worked with migrants, in a focus-group setting and used grounded theory to analyse the findings. The interpreters reported that mental health interpreting could be overwhelming at times as they found it difficult to emotionally detach from service users.

Furthermore, there is limited published research focusing on the emotional impact of sign language interpreting. McCartney (2006) examined burnout in sign language interpreters working in both primary and secondary education, and post-secondary education. The interpreters were found to experience burnout in all three settings. Statistically significant variables in predicting burnout included misconceptions about the job role and role overload. More recently, Bower (2015) examined stress and burnout in 424 video relay service interpreters using a mixed quantitative and qualitative survey design. Video relay services (VRS) are a form of video interpreting service whereby Deaf individuals can communicate with a 'hearing' individual in real time, via a sign language interpreter. High levels of stress and burnout were found among this group, with the interpreters highlighting causes such as difficult or uncomfortable call content, for example calls with content that conflicted with the interpreter's own belief system. Daly (2016) explored the effect of vicarious trauma on the professional quality of life of Canadian visual (sign) language interpreters using a quantitative survey design. Eighty-five visual language interpreters

completed a secondary traumatic stress questionnaire and a professional quality of life questionnaire. Professional quality of life was measured via the variables burnout, compassion satisfaction and secondary traumatic stress. A significant positive relationship was found between secondary traumatic stress and burnout variables. Furthermore, a significant negative relationship was found between the variables secondary traumatic stress and compassion satisfaction. This means that a greater level of secondary traumatic stress is associated with a greater level of burnout and a lower level of compassion satisfaction. Burnout was the only variable that independently predicted the variance in secondary traumatic stress.

Rather than focussing on the emotional impact on sign language interpreters, previous research in the area of mental health and deafness has focused upon how the presence of the interpreter has affected the therapeutic relationship (e.g. Gill and Fox, 2012) and the linguistic challenges of interpreting in mental health settings (e.g. Cornes and Napier, 2005). Importantly, the quality of sign language interpretation can be affected by an interpreter's ability to process the emotional impact of material in therapy (Cornes and Napier, 2005). For example, the authors recounted an incident of an interpreter using the word 'molest' instead of 'rape', as the interpreter found the word 'rape' too emotionally laden. The client did not understand what the word 'molest' meant, and the authors felt that the opportunity for exploration of the matter in that therapeutic setting was lost.

To conclude, it could be said that interpreters are vulnerable to emotional stressors. With regards to British Sign Language Interpreters (BSL) specifically, the Department of Health (2005) acknowledged that there was a lack of a specialist mental health training for BSL interpreters who worked in mental health settings. Previous research has demonstrated the importance of the role of the interpreter in mental health settings for individuals who communicate using spoken and visual languages, and the emotional impact of this. However, there is a lack of research in the area of the experience of BSL interpreters in inpatient settings. The current study aims to contribute to the evidence base regarding the emotional experience of BSL interpreters who work in inpatient mental health services. Although much of the literature above has focused on vicarious trauma and burnout, this

study is concerned with the overall emotional impact of BSL interpreting in inpatient mental health settings in order to remain true to an inductive approach.

*Aims:*

To explore how BSL interpreters make sense of the emotional impact of working on a specialist mental health inpatient unit for individuals who are d/Deaf.

## 2.3 Method

Interpretative Phenomenological Analysis (IPA) was the chosen qualitative methodology for this study. IPA was chosen due to its idiographic and phenomenological approach, in other words it is concerned with an individual's perception of an event (Smith and Eatough, 2015). IPA focuses on the detailed experience of each individual and how the individual makes sense of what they have experienced, which fits with the aim of this study in terms of understanding how BSL interpreters in inpatient settings make sense of the emotional impact of their work. The use of thematic analysis as the chosen qualitative methodology was also considered, however it was discounted due to its lack of ideographic nature and sole focus on patterns of meaning across participants (Braun and Clarke, 2019). Within IPA research, the researcher (in this case the chief investigator) engages in a double hermeneutic. In other words, the researcher attempts to make sense of the participant trying to make sense of what has happened to them (Smith, Flowers and Larkin, 2009). The main consequence of a double hermeneutic is that one may not acquire an objective 'true' picture of reality (Hood, 2016). The researcher's epistemological position and lived experience may impact on the double hermeneutic, therefore this is discussed further below.

### 2.3.1 Recruitment

In preparation for the study, a clinical psychologist working on the ward from which participants were eventually recruited (see below), provided the chief investigator with details of the agency who provided interpreting services. The chief investigator then approached the relevant manager within this agency to explore whether he/she felt that the interpreters would be willing to take part in this research. After this had been agreed, he/she acted as the link between the chief investigator and the interpreters once ethics approval had been granted.

Once the relevant ethics approvals had been obtained from the Health Research Authority (appendix A), the above convenience sampling method was utilised to recruit eligible participants. In keeping with IPA based research, a comparable sample of participants was identified in order to answer the specific research question (Smith, Flowers and Larkin,

2009). All participants were engaged in BSL interpreting on the same mental health ward. Further specifics regarding the location and nature of the ward are not included in order to maintain anonymity of participants. The following inclusion criteria were applied:-

- Qualified BSL interpreters registered with the National Register of Public Service Interpreters (NRPSI)
- A minimum of three months experience of working in inpatient mental health
- Having worked at least five shifts within inpatient mental health

Participants were excluded from taking part in the research if they failed to meet the inclusion criteria.

### 2.3.2 Participants

Six BSL interpreters volunteered to partake in a semi-structured face-to-face interview from a possible pool of 10. The mean age of participants was 40 years old whilst the mean number of years of work on the ward was 5 years. The chief investigator recognises the increased risk of participants being identified due to the niche area of mental health. In order to protect the anonymity of participants, specific details regarding the gender and ethnicity of participants are purposefully excluded in addition to details concerning the range of ages of participants and number of years of experience. Details related to the name of their employer and the location in which they worked are also excluded for this reason. Participants' names have been changed to further protect anonymity, and gender-neutral names have been chosen to prevent gender identification (Table 1).

Table 1. Participant details

Participant Number	Participant Name
One	Charlie
Two	Alex
Three	Sam
Four	Jamie
Five	Jordan
Six	Frankie

### **2.3.3 Procedure**

Potential participants were informed of the research project and details of the study via email by the link manager. This email included a participant recruitment letter (appendix B) and participant information sheet (appendix C). In addition to this, the chief investigator attended an interpreters' team meeting to discuss the aims of the study and to answer any questions or discuss potential concerns.

Participants were told they could contact the chief investigator via email to express an interest in taking part in the study. Potential participants also had the opportunity to ask any questions and/or raise concerns via email with the chief investigator. To ensure that potential participants had received all the information regarding the study, they were sent the participant information sheet (appendix C) a second time via email. If they still wished to take part following this, the time and location of interviews was agreed. A minimum of 48 hours between receiving the participant information sheet (appendix C) and the interview taking place was allowed in order to ensure that participants had time to read through the information before the interview took place and reconsider if necessary.

### **2.3.4 Interview Process**

Prior to the interview commencing, participants were asked to confirm that they had read the participant information sheet (appendix C) and then to read and sign a consent form (appendix D). Participants also had another opportunity to ask the chief investigator any questions regarding participation in the study. Semi-structured interviews, guided by an interview schedule (appendix E), were utilised for data collection to explore how participants made sense of their emotional experience of their role. This allowed for a flexible approach to data collection whilst also ensuring that the main topics of interest were covered.

All interviews were facilitated by the chief investigator and took place either at the interpreter's place of work or at the chief investigator's university. Interviews varied in length, lasting between 27 minutes and 75 minutes with a mean length of 52 minutes. The interviews were digitally recorded using an Olympus DS-9000 encrypted voice recorder.

Following the interview, participants were provided with a debrief form (appendix F), which explained the nature of the study, in addition to providing contact details of the chief investigator and the chief investigator's academic supervisor. The debrief form also outlined nationwide counselling services that the participants could access in the case of distress after participating in the interviews. Participants were also reminded that they had two weeks to withdraw from the study, in part or in full, if required. One interview was transcribed by the chief investigator and the remaining five interviews were externally transcribed by a professional transcription company. A confidentiality agreement (appendix G) was in place between the chief investigator and the transcription service, prior to external transcription taking place.

### **2.3.5 Analysis**

Following transcription, the data was analysed by the chief investigator using the analytical process described by Smith, Flowers and Larkin (2009). The chief investigator read and re-read the first transcript prior to making initial notes and developing emergent themes. Following this, connections across emergent themes were explored. This process was then repeated for the remaining five transcripts and patterns across cases were identified. The worked transcript for Jamie is provided in appendix H, in addition to the development of superordinate themes (appendix I) and an example of how supporting quotes were chosen for each theme (appendix J).

### **2.3.6 Reflexivity**

Due to the dynamic nature of IPA, it is important for the researcher to be aware of the influence of their own experience and assumptions on subsequent interpretations of data. I am a 29-year-old Black British female. I have a maternal aunt who is Deaf and who uses BSL to communicate. Prior to completing the research, I had experience of working with spoken language interpreters in community mental health settings. Following my interactions with these interpreters, I was always aware that they may not be used to interpreting in mental health settings and/or may have found the content distressing. Unfortunately, there was not always time to offer anything more than a brief debrief following sessions, due to time constraints of both myself and the interpreter. I would define my epistemological and

ontological stance as 'critical realism', in other words I believe that a reality exists independent of myself as the observer, but we cannot know that reality with certainty (Coyle, 2015). This stance influenced my interpretation when looking at the language that participants used. We cannot know whether the same word has the same meaning for each individual, therefore I had to assume that participants meant the same thing when the same word was used. My prior work experiences and personal experiences led to my interest in the topic of BSL interpreters in mental health settings, and the subsequent development of the current study. Although these experiences may help to assist in the process of IPA analysis, they may also result in bias. In order to counteract this as much as possible, I kept a reflective diary whilst completing the interviews and analysing the transcripts. Furthermore, I spoke with my research supervisors during analysis, and attended an IPA tutorial group at the university. In order to reduce the risk of researcher bias, analyst triangulation was implemented, in the form of sharing potential themes with research supervisors and fellow trainees at the IPA tutorial group.

## 2.4 Findings

Three superordinate themes were identified following analysis; “people forget that we’re human as well”, “I still wish I knew where to stand”, and “as interpreters we’re not necessarily looked after”. Each superordinate theme is a direct quote from a participant. The overarching superordinate themes were underpinned by eight themes. The final themes were chosen due to their frequency throughout the transcripts and the importance placed on them by participants. The participants who contributed to each theme are shown in Table 2 below.

Table 2. Participants contributing to each theme

Themes		Participants who contributed to the theme					
		Charlie	Alex	Sam	Jamie	Jordan	Frankie
People forget that we’re human as well	The interpreter is not a person	Yes	Yes	Yes	No	No	Yes
	Impact of work experiences on personal experiences	Yes	Yes	Yes	No	Yes	Yes
	Power and responsibility	Yes	Yes	Yes	Yes	No	No
I still wish I knew where to stand	Lack of team belonging	Yes	No	Yes	Yes	No	Yes
	Lack of physical place on the ward	Yes	No	Yes	No	No	No
As interpreters we’re not necessarily looked after	Emotions and professionalism	Yes	No	Yes	Yes	No	Yes
	No time or space to talk about emotions	Yes	Yes	Yes	No	No	Yes
	Avoidance as a coping strategy	Yes	Yes	Yes	Yes	Yes	Yes

Each theme is discussed in more detail below, supported by quotes from relevant participants. The participant's name and the page and line number of the transcript is presented in brackets following the quote.

### **2.4.1 Superordinate Theme One – “People forget that we’re human as well”**

The superordinate theme “people forget that we’re human as well” is a direct quote from Charlie (16: 521), encompassing participants’ discussions of issues relating to being both an interpreter and a human being, how their time working on the ward has impacted on their personal experiences, and the power and responsibility that their professional role on the ward brings. The first theme ‘the interpreter is not a person’ provides a supportive narrative of this superordinate theme, whilst the latter two themes ‘the impact of work experiences on personal experiences’ and ‘power and responsibility’ outline the interpreters’ justification of why they are human.

#### **1. The interpreter is not a person**

The theme ‘the interpreter is not a person’ reflects the participants’ narrative that as an interpreter, they believe that they are viewed as a machine by their clinical colleagues and they make sense of this by seeing it through the lens of a specific linguistics and communication model.

*“it’s a difficult role in the sense that I’m human but then at the same time, sometimes you guys don’t see me as that because I’m just this, this is a very blunt way of putting it, I’m just this person that just tells you what people are saying and I tell them what you’re saying [...] they call it a conduit model of theory, where you know, I’m just here I’m the robot and I translate” (Charlie – 36: 1246-1253)*

However, the interpreters also spoke of the conflict that they experience between the conduit model of interpreting and their perception of how things actually are on the ward.

*“...you’re meant to be, seen but not heard but actually you do need to be heard because you, you’re saying what this person says and you’re not meant to be seen but I am seen because I am in the room and I am affecting the interaction with everybody”. (Charlie – 31: 1086-1091)*

Throughout the interviews, the interpreters often described their experience as not being seen as a 'person', and this was emphasised through the repeated use of the word "human". In the following quote, Charlie experienced being seen as a human as an exception to normality, which emphasises how much the interpreters do not think they are seen as a human.

*"actually they've made the time and day to say thank you to you when that's quite nice when somebody remembers to say thank you (laughing) because you're a human as well." (Charlie – 27: 931-934)*

Alex and Frankie highlighted the consequences of not being seen as a person, in terms of their experience of being forgotten by clinical staff and not receiving adequate communication and preparation prior to interpreting. They made sense of their reactions by hypothesising that clinical staff view interpreters as outside of their sphere of care, perhaps because it is assumed that they do not need looking after.

*"...but I could have been prepared for that, but it was presumed. And I don't know why it would have been presumed, I don't know. I introduced myself as the interpreter but I didn't introduce myself as a member of staff, medical staff at all, and I was just sent into the room with no pre-preparation at all, and that was a real shock. Yeah, so that was distressing." (Alex – 8: 246-254)*

Frankie spoke of the frustrations of being neglected, and how this experience is exacerbated by the fact that he/she is experiencing it from people who should know better.

*"it just highlights that as interpreters we're kind of left as an afterthought, and not only in mental health in all settings, but in mental health you have an expectation that it's going to be better. You think you know about this, you know about vicarious trauma, you know all of this – you should be better at supporting us. I think I still get really angry about it." (Frankie – 8: 249-254)*

## **2. The impact of work experiences on personal experiences**

This theme highlights the effect that interpreting in inpatient settings has had on the interpreters' personal life.

Alex and Frankie reflected on the effects of experiencing the same physical health condition as a patient on the ward, despite the fact that their experience happened at a different time point to the patient. Furthermore, Alex's understood their distress as being exacerbated by the longer length of the time that they had known the patient, due to the length of time the patient had been on the ward.

*“And also, interestingly, that reared its head again [...]. That came back to my mind, because I'd forgotten about it for a long time, and then that came back to my mind [...]. Like I say, that's not specific to here, but I think because I'd had so much contact with [them] over the months, up to that date, I think it does make it a different experience than just you've got this booking today with someone that I hadn't met”. (Alex - 10: 316-322)*

Frankie became more aware of their own symptoms of the physical health condition, as a result of the patient on the ward. This manifested in the form of excessive note keeping about their own symptoms of their health condition. However, this increased awareness was actually negative, as it interfered with their day-to-day life.

*“Yeah but I think I did do it a lot and I think I even kept notes – I did, I kept notes [...] I wouldn't say it was interfering – I've only just remembered this – I wouldn't say it was interfering but every night I would look at my notes, so yes it probably was interfering and I hadn't really realised. I think it became my daily routine to do it, yeah, so it probably was interfering without me realising that it was”. (Frankie – 7: 219-232)*

At times the interpreters found they continued to hold patients in mind when they were not at work and long after the events took place, especially if they found a patient's life story particularly upsetting.

*“And she left and I said to the psychiatrist ‘I'm not sure she was telling the truth there [...] And he said.... ‘sometimes we have patients who are in certain states and they start to say “yes, I'm fine, it's fine, it's grand, everything's brilliant, everything's perfect,” and that's when you need to worry when people are saying that everything is fine. He said ‘she's not going to kill herself. I'm going to take steps and measures and get in contact with who I need to.’ But I left that really sad. [...] And that really upset me for a long time. It still sits with me now and when I hear her name being mentioned, I'm like, ooh, how's she doing? just*

*checking, and I know I'm checking that she's still alive, that's what it is, but I'm probably sure that at some point it will happen, and that's stuck definitely" (Frankie – 4: 113-139).*

This also occurred when the patient's life story resonated with Charlie's own experience causing them to 'over-empathise', resulting in a feeling of helplessness.

*"I feel it in my chest and, and then that's when I go home going "gosh, I hope they're okay. Oh no, I totally get that feeling. That person must be feeling that. They must be feeling that way. They must be feeling X, Y, Z. Oh gosh, I feel terrible. I, I wish there was something I can do but I can't". (Charlie – 39: 1358-1362)*

The interpreters spoke of other professionals not realising the effect that mental health interpreting has had on the interpreters' own human characteristics. There was an acknowledgment that the role of a BSL interpreter is to make sense of d/Deaf individuals' communication; however this is not always possible in mental health settings which also resulted in some self-doubt for the interpreter. For example, for Jordan, self-doubt arose in the context of a client whose communication was impaired by their mental health difficulty. This was understood in the context of the effect of severe mental health difficulties on communication and language. This experience of self-doubt was worsened by perceived expectations that clinical staff would expect them to understand the patient.

*"Well when I first started obviously it was very new and dealing with the communication side of things with some people who were, obviously have a bit more...have mental health issues and it affects their communication and you suddenly feel very, very challenged and you sit there thinking, am I understanding this person, they're not making any sense to what they're signing and you do feel I suppose when you self-reflect you think, did I really make a good job of that?" (Jordan – 6: 190-196)*

For Sam, self-doubt was worsened when their interpreting ability was questioned by a patient, in particular when this occurred in front of other professionals.

*"And obviously when people are unwell they say things that they wouldn't say if they were well, so they can be even more cruel [...] To be there with three other professionals in the field of deafness as well as for mental health, a patient absolutely slagging you off is not great for your self-esteem. Even if you know I'm not rubbish, you know it's not true, but*

*sometimes you think, 'Maybe I was rubbish today. Oh gosh. Nobody else has seen this and what are they going to think about me now? That patient's told them I'm rubbish and they don't understand me, then what's the consultant going to think?'. (Sam – 25: 807-818)*

There was also an acceptance that despite knowing the above, the interpreters still required validation following situations that they found challenging.

*“And normally I want validation that I did the right thing or that this is what I should do now. Yeah, I think that’s how I deal with it.” (Frankie – 13: 417-419)*

### **3. Responsibility and power**

Their role as communication experts left participants with a feeling of responsibility for and power over the d/Deaf individuals’ life. This feeling of responsibility and power is heightened in inpatient settings, due to the potential ramifications of the interpretation.

*“I think I'm sometimes overwhelmed by potentially the amount of influence or power, and it is a power that you may have over somebody's life, and one wrong move in that scenario in a mental health setting, and in particular in an inpatient unit, can have massive consequences. [...] And by influencing you can be as impartial as you want, but that lexical choice you made or that tone of voice or that bit you didn't realise you'd missed, we are human, we're not machines and there will be errors, can have a massive impact on people's lives. And that's a big responsibility to take and you've got to think do I have the skills to do this? There are clients I won't interpret for because I don't feel that I understand them well enough”. (Sam – 21: 669-683)*

Participants also reflected on the experience of occasionally being the only BSL speaking staff member on the ward and the frustrations of not being understood by the non-BSL speaking staff member, in addition to not being able to help the patient be understood.

*“... the person that was unwell wasn't communicating very effectively, was unable to, and the member of staff that was with them, I don't know whether they quite understood that she actually wasn't signing anything. Because they're asking me to ask what she wanted over and over and over again, but she was unable to express herself to me. So I was saying that, but I didn't think they quite understood that, and I ended up saying she's not signing anything [...] and to juggle that was quite difficult, because in that situation you feel*

*like it's your responsibility, and obviously the patient is looking at me to explain, and I can't because she can't, and that was quite challenging. And that individual that was on shift didn't quite understand that she's not able to tell me". (Alex – 6: 158-174)*

When they were the only BSL speaker on the ward and so the only person who could understand the patient, the interpreters wanted to ensure that non-BSL speaking staff were aware of what the d/Deaf patients were talking about. However, there was a sense that non-BSL speaking staff, in particular bank staff, were not always interested. This meant that the interpreters were left holding the information, and therefore felt responsible.

*"So it's hard work interpreting. So it's weighing up whether I interpret non-stop, not getting a break to somebody who's not listening, or I go "oh okay well you're not listening, I'm not gonna interpret". And those situations I like to still try and do a summary just so they have an awareness. [...]cause I wouldn't want something to be missed because ultimately in that situation, I feel quite responsible. Yes they should be paying attention, but I feel a bit more responsible because it's me that knows what's being said not them. [...] because if I'm the only one that knows what's being said, and nobody else knows, I, I feel like I need to pass it on". (Charlie – 7: 217-232)*

#### **2.4.2 Superordinate Theme Two – “I still wish I knew where to stand”**

This superordinate theme, which is also a direct quote from Charlie (29: 1011), encompasses the participants' experience of not feeling like they belong with the team, and also their physical presence on the ward.

##### **1. Lack of team belonging**

The effect of the interpreters having a separate employer to clinical staff was discussed.

There was a sense of ambivalence amongst the interpreters regarding whether or not they were part of the wider team.

*"I don't really work for you guys but I do kind of work for you because I see you every week so I don't really know. I don't know where I belong sort of thing (laughing). That's what it feels like". (Charlie – 31: 1091-1094)*

Jamie identified as not being part of the wider team and recognised the difficulty in maintaining boundaries due to this.

*“I will admit it, I've even tiptoed into it myself where you do forget that you are not part...you are part of the team but you're not part of the team. And it's so easy to get your barriers and your lines blurred a little bit” (Jamie – 8: 217-221)*

This feeling of not belonging was worsened by not always having important information relayed to them *“Not unless I actively make the effort to go “erm, right, do you want to tell me what the risks are?”.” (Charlie, 8: 284-285).* Furthermore, interpreters were not always able to relay information effectively to clinical staff due to lack of access to computer systems on the ward.

*“I think internally with shifts, handovers, things get missed, things get lost, it's like Chinese whispers [...] And because we're not [...] staff, we don't have access to things like [computer system], we don't have access to progress notes. If we were to write a communication assessment, which we have done previously, we have to write it on paper and then it gets passed to someone and then where does that go? (Frankie – 20: 667-674)*

However, it was also acknowledged that not having access to computer systems helped to maintain a clear boundary between the interpreters and clinical staff. There was a sense that this boundary helped participants feel contained in terms of the remit of their professional role on the ward, particularly at times when there was not enough clinical staff on the ward.

*“I think the risk we've got with [access to computer system] is I think boundaries are going to get even more blurred [...]because they, the staff, the ward is very very often short staffed, so if they know for example interpreters have access to [computer system] “would you mind typing some notes? Would you mind getting the phone number for this patient? Would you mind doing this? Would you mind doing...?” and then I think boundaries get blurred whereas at the minute it's very clear, I can't do anything so there isn't anything I can do about it [...] That's the boundary and it's very clear. I, I very much like the black and white thinking personally. [...] So there's a right and a wrong and there we go. That's the right answer because I can't help you with that because I can't access it, sorry”. (Charlie – 21: 730-748)*

Furthermore, the interpreters did not always feel valued by the clinical team, in respect of their role as a communication expert.

*“we’re not clinically trained, we’re not clinical professionals, but I think that actually our expertise of being communication professionals is not always seen or understood as much. [...] They think ‘oh we’ve got an interpreter so that’s fine.’ Yeah, you do have an interpreter but you’ve got an interpreter who has all of this knowledge and is trying to impart something on you and you’re not recognising it for what it is” (Frankie – 20: 642-654)*

## **2. Lack of physical place on the ward**

Lack of belonging was also demonstrated in the form of not knowing where to physically be present on the ward due to not having an allocated space, and it was felt that it was not appropriate to remain in the nurse’s office on the ward. This was due to the frequency of discussions about patient care that take place in the nurse’s office and these discussions may not be of relevance to the interpreters.

*“I suppose I kind of wish. No, because it’s, it’s not really a wish. It’s still a, I still wish I knew where to stand (laughing) in the most productive place that isn’t getting in the way and it isn’t going to be detrimental to anybody” (Charlie – 29: 1009-1013)*

The interpreters also experienced a conflict in terms of trying to keep themselves physically safe on the ward, *“there are times when you could be there and there are no other staff around and you could be vulnerable to... I had a bowl of sick thrown down me the other week!” (Sam – 25: 821-823)* whilst also being physically present on the ward when required, particularly when their physical safety was at risk.

*“When you’re watching the [clinical] staff going off sick because they’re being flung off left, right, and centre. And again you’re trying to be far, far enough way to not get hurt but then near enough to help where you need to” (Charlie – 29: 994-997)*

### **2.4.3 Superordinate Theme Three – “As interpreters we’re not necessarily looked after”**

This superordinate theme, which is a direct quote from Frankie (9:289), refers to the participants' experience of emotions and professionalism, not having any time or space to talk about emotions on the ward, and using avoidance as a coping strategy for emotional distress. The theme 'avoidance as a coping strategy' has been placed within this superordinate theme as a reflection that the interpreters used this coping strategy as a consequence of not being looked after.

### **1. Emotions and professionalism**

Not displaying emotions is an important aspect of the role of an interpreter, due to the importance of remaining impartial *"I just try to stay as professional as you can do really. We are impartial and not to be seen to be showing anything really"* (Jamie – 6: 158-160). However, this was can be difficult in inpatient settings due to the severity of patients' mental health compared to community settings.

*"I've never seen anybody self-harm that way, and I was quite... Obviously we never show it on our face and I think, as interpreters, we get very used to that internal panic and very non-committal expression!"* (Alex – 7: 215-218)

There was also a reflection that not displaying emotions maintains professionalism within a general work setting and is not solely related to the role of being an interpreter. Charlie reflected on their own thought process during an emotionally challenging situation whilst in ward review.

*"it was thinking "oh right I can't really react right now because I'm in a room full of professionals and I've got the contract with this job so I need to not react really to it". I kind of reacted with a bit of "oh God, are you okay? Oohh well that didn't go very well did it? Yeah" and then it was when I got to walk out the room and sit down somewhere, I had a little cry in my bag. You know trying to kind of hide my face going "I can't let anyone know that I'm sitting here crying in my bag [...] I, I don't know. I suppose it's the professionalism I suppose, and also right I had to go back into ward review (laughing)"* (Charlie – 24: 824-837)

Furthermore, the interpreters did not know whether or not they were allowed to access emotional support from clinical staff on the ward and were concerned about maintaining professional boundaries.

*“And then also it’s knowing what support I’m, I’m actually allowed to get and from where. I don’t know, I don’t know who to talk to [...] I could talk to, as I said my interpreter buddies but I don’t know if I can access the psychologist here or I thought they were just here to see the patient [...] It’s just knowing, and then, because I don’t want to mess up or merge any boundaries so that’s it, you know”. (Charlie – 37: 1269-1277)*

There was also a recognition that they might feel judged by ward staff if they did share any emotions *“I think it would be helpful to talk to the psychologists because I know the ones on the ward here know about working with interpreters and they know about working with deaf people. However, that might feel uncomfortable in ward reviews say, and I start interpreting something along a similar theme. That might suddenly be going, “oh gosh, ooh yeah I remember [they] told me before that that was a problem”.” (Charlie – 19:627-633)* and there was a preference for being able to access impartial support to counteract these feelings.

*“If there is a boundary between...you may not want to disclose things or offload how you really truly are feeling to members of staff on the ward, even if that's a psychologist, a counsellor, whoever else. If you are then next week interpreting for them and trying to look professional, you want somebody that’s more impartial than that. So finding appropriate people that could do that is needed” (Sam – 26: 838-844)*

## **2. No time or space to talk about emotions**

Participants reflected on not always having an appropriate person to talk to about emotions on the inpatient ward. Although the interpreters receive individual linguistic supervision, this is facilitated by another interpreter rather than a clinical professional *“If you just wanted to offload that would be more in your one-to-one supervision. Then obviously they're not a psychologist, they're not a counsellor, they are just another interpreter, so they may not necessarily be able to offer you the appropriate advice. I think perhaps that support in supervision for interpreters in general is not robust enough” (Sam – 12: 375-381).* There was an acknowledgment that clinical supervision had been offered on an ad-hoc basis in a group format, which had not been successful.

*“And I think that as interpreters we’re not necessarily looked after in that aspect. We have supervisions with our managers who aren’t clinical professionals [...] And now there*

*has been an offer of 'oh I can do a clinical supervision for you' but I think it should be integral, I think we should be having it anyway. And we did have a couple of group clinical supervision sessions [...] and for me they just didn't work at all because it was a group of interpreters together, who just started moaning about interpreter stuff and more about the logistics of the service and the way that we work rather than the emotional impact of it" (Frankie – 9: 289-303).*

In addition to not having an appropriate space to discuss emotional impact, there is not always time to talk about emotions due to the business of the ward.

*"I didn't really know what anybody could've done at that time because you know, they've got their agenda. They want to meet all these patients within this afternoon [...] I don't feel like I could just kind of walk out and then go "actually I need a debrief with the psychologist. Right, I know you need to be here but actually can you come out with me right now and sit down and lets have a talk about it" [...] You know I guess it's just being aware of the time pressures and knowing I've got to get on with the job anyway (laughing)" (Charlie – 24: 839-849).*

Furthermore, there was also a recognition that not receiving adequate support was not always interpreter specific, and a sense of accepting this because other clinical staff had experienced a worse situation.

*"I think it was more due to the amount of staff. I kind of didn't expect it, because of how volatile it was – there was no staff because they were all injured and they'd all been attacked, they were all physically harmed. So I kind of just I'm alright with nobody asking how I am at the moment because I haven't been punched in the face, I'm alright and getting on with it" (Frankie – 24: 774-779).*

Containment was identified as an important factor in reducing emotional distress of interpreters.

*"I came out with the nurse, and I said to her, 'Oh, you were very calm in there, you handled it really well.' Because her manner, the way she spoke, and the way that I was then able to interpret that [...] and it put me at ease [...] And she sort of came out and she said, 'I've never seen that much blood.' And I was like ((gasps)), I was thinking the same thing, but*

*she absolutely didn't show it [...] So yeah, that was one of the situations that could have been, but was just handled so well. And I think, as interpreters, the only things that really stick in your mind are the things that haven't been handled so well" (Alex – 7: 223-238).*

### **3. Avoidance as a coping strategy**

This was the only theme in which all of the interpreters contributed to, highlighting its significance in the understanding of the emotional impact of their job role and their place of work. Avoidance appeared to be both a conscious and unconscious reaction to coping with the emotional distress experienced on the ward. The interpreters used different phrases to describe the conscious experience of avoidance, such as “disengage” (Jamie – 6: 174), “shut them off” (Frankie – 3: 420), “put it to the back of my mind”(Alex – 13: 406) and “switch off” (Jordan – 5: 137). However, avoidance was also used as an involuntarily way of coping.

*“I was able to, not ignore it, but actually separate myself so much and shut myself off so much to enable me to do my job that I got quite worried about myself for a second because I thought surely [...] I was very much able to separate. After the initial shock, I was very much able to separate that, and I was bit concerned about that afterwards, thinking, oh, I've got no compassion, I don't know how I feel about that. Not compassion, but yeah” (Alex – 11: 331-340).*

Despite using avoidance as a way of coping, there was a recognition that visual language may increase the likelihood of the experience of vicarious trauma “so I think it is a general issue that perhaps interpreters don't see the value enough in how useful it can be to get that emotional support, because the vicarious trauma of being with other people and their emotions are coming through you, you're relaying what they're saying just in another language, and perhaps the visual expressive nature of BSL emphasises that” (Sam – 26: 860-865). Distress was also identified as an emerging concept over time, and not something that solely occurred at the time of an incident “I am definitely one of those that just push it aside and carry on, but I'll find that, not normally later that night, it's normally a couple of days later, it will pop back into my head. And it will be something else really small that will trigger it, and then I will either cry, but I don't like to do that in front of anybody else” (Frankie – 13: 408-412). There was also a likelihood that distress could re-emerge when a patient who had been involved in a distressing incident was readmitted.

*“But then again, you never know what's going to happen again in future that might bring you back to that, or you think somebody's... Because when you're working on a ward like that some of those patients have been there years, which is perhaps different from any other ward, they're turning over the patients very fast” (Sam – 15: 475-479).*

## 2.5 Discussion

This research aimed to explore the emotional impact of working as a BSL interpreter on a specialist mental health inpatient ward for individuals who are d/Deaf. The findings of this study have increased our understanding of the experience of BSL interpreters in inpatient settings whilst also providing further support of the emotionally challenging nature of interpreting. Three superordinate themes were identified in the current study, “people forget that we’re human as well”, “I still wish I knew where to stand”, and “as interpreters we’re not necessarily looked after”.

Consistent with the literature, the BSL interpreters reflected on the impossibility of remaining neutral in interpreting sessions and understood this within the context of being human (Green et al., 2012; Splevins et al., 2012; Resera et al., 2015) and consequently experiencing human emotions. Similar to the findings by Doherty et al., (2010), participants also found it difficult to not think about patients at home. This difficulty in maintaining boundaries is consistent with one of the symptoms of vicarious trauma described by Pearlman (2012). Interpreters recognised the importance of containment in preventing emotional distress and, similar to Green et al., (2012) highlighted the impact of lack of preparation in exacerbating distress. Interpreters actively need to develop coping strategies in order to cope with the emotional content of interpreting (Splevins et al., 2012). In the current study, avoidance was employed by the BSL interpreters as a way of coping with the emotional impact of the work. Avoidance has been identified as an effective strategy in reducing over identification with patients (Butler, 2008) and as a way of distraction from the content of the interpreting session (Doherty et al., 2010). Similar to the findings of Green et al., (2012), participants wanted an appropriate space to discuss the emotional impact of the work and to make sense of their emotional responses to interpreting. The BSL interpreters in the current study acknowledged that although monthly supervision took place, it primarily focused on linguistic concerns rather than the emotional impact of interpreting. However, dependent upon the professional code of ethics of the interpreter’s country of work, discussing the client’s trauma outside of the interpreting session may break interpreter-client confidentiality (Daly, 2016). Consistent with previous findings, the interpreters considered displaying emotions to be unprofessional (Splevins et al., 2012;

Resera et al., 2015) and there appeared to be a conflict between wanting space to reflect but also thinking that displaying emotions was unprofessional. However, this is understandable when one considers that interpreters are advised to remain neutral whilst interpreting. In addition to providing evidence in support of previous research findings, the current study also identified challenges specific to inpatient settings. Participants described a sense of not being part of the team, and specifically to an inpatient setting, one of the attributed factors was related to not having an allocated physical place on the ward. The interpreters also reflected on the discomfort they felt regarding the perceived amount of power and responsibility that they had over patients on the ward. It has been recognised that d/Deaf people are likely to have experienced oppression by hearing individuals (O'Rourke, 2000) and a possible source of this discomfort could be a perception that they are repeating this pattern of oppression.

The BSL interpreters appeared to be engaged in a vicious cycle of avoidance. In the first theme 'the interpreter is not a person', the interpreters reflect on their perception that they are not seen as a human being by others and consequently are thought of as merely a conduit or robot. Throughout subsequent themes, the interpreters present evidence against this, for example through discussion of the impact of work experiences on their personal experiences. There is a sense that the interpreters feel restricted by not being able to talk about emotions, however by the final theme 'avoidance as a coping strategy' this has become a self-fulfilling prophecy and the interpreters are avoiding the emotional consequences of interpreting. By adopting a detached professional attitude, they may be giving the impression to clinical staff that they do not experience any emotions, and therefore staff may not think that the interpreters require any emotional support. The interpreters then use avoidance as a way of coping with the perceived lack of emotional support and continue to adopt a detached a professional attitude. Consequently, interpreters in ward settings may require support to break this cycle.

Interestingly, a dichotomy that was not anticipated is that the eight themes, which underpin the three superordinate themes, can perhaps be divided into factors related to 'vicarious trauma' and factors that have implications for 'professional practice'. The themes 'impact of work experiences on personal experiences' and 'avoidance as a coping strategy' could be

explained in the context of vicarious trauma. Pearlman (2002) identified anxiety and difficulty maintaining boundaries as symptoms of vicarious trauma. In the current study, the participants spoke of experiencing anxiety and some of the interpreters found it difficult to maintain boundaries with patients, both as a result of situations that had happened at work. The remaining six themes can be associated more with outcomes related to professional practice issues. For example, the interpreters' perceived amount of responsibility and power and not feeling part of the wider multidisciplinary team, which have implications for policies and process within the service as discussed below. Demand-control theory (Karasek, 1979) has been used to understand the stressors of sign language interpreting (Dean and Pollard, 2001). This theory of occupational stress suggests that workplace stress is dependent upon how many demands an employee has placed upon them and how much control the employee has. Within the theory, 'demand' relates to the requirements of a job, such as environmental aspects and the required task, whilst 'control' refers to "the degree to which the individual has the power to act on the demands" (Dean and Pollard, 2001, p.2). In the context of sign language interpreting, Dean and Pollard (2001) suggest that sign language interpreters experience work-related stressors as they have to contend with high demands with little control within their job role. The types of demands that sign language interpreters may have to contend with include linguistic demands, environmental demands, interpersonal demands, and intrapersonal demands. The BSL interpreters in the current study identified factors that could be considered a source of demand, which they had little control over, such as doubts over their own ability as an interpreter, (lack of) availability of supervision and support, and safety concerns. More recently, the job demands-resources model (Demerouti, Bakker, Nachreiner and Schaufeli, 2001) has been developed to describe the process of burnout. However this theory has not been specifically applied to sign language interpreters. This model proposes that burnout develops when excessive 'job demands' result in exhaustion, in addition to a lack of 'job resources' preventing the individual from completing job demands resulting in disengagement. 'Job demands' can include factors such as the physical environment, which in the current context could include factors such as the BSL interpreters lack of a designated physical place on the ward and the potential risk posed from patients on the ward. 'Job resources' refers to factors such as supervisor support and feedback, which in the current context would be the lack of

supervision offered to the BSL interpreters and lack of pre and post session feedback that the BSL interpreters felt they were subjected to.

### **2.5.1 Limitations**

The title of the study, in particular the term “emotional impact” may have introduced a sampling bias in support of interpreters who had experienced a negative emotional impact on the ward. There may have been other interpreters who had experienced a positive emotional impact of the work but may not have thought it was appropriate to take part in the study. The sample size of six participants could be considered as small, however it is in keeping with the idiographic nature of IPA (Smith et al., 2009). Furthermore, as the pool of interpreters was small, there is a greater likelihood that the interpreters are aware of who took part in the study, thus reducing anonymity. To ensure homogeneity amongst the sample, only participants who were employed by a specific agency were invited to take part in the study. However, there were other BSL interpreters who work on the ward on a freelance basis. The freelance interpreters were not invited to take part, therefore another perspective has potentially been missed. With regards to recruitment, participants were invited to take part in the study via their team leader. Participants may have felt more obliged to take part in the study, due to the possible power dynamic between management and employees. In relation to data analysis, member checking or participant validation could have been used to check the credibility of identified themes (Birt, Scott, Cavers, Cambell & Walter, 2016).

### **2.5.2 Reflections**

During the course of the research I felt shocked at times, in particular when participants recounted distressing incidents that they had experienced on the ward. I also noticed myself becoming angry when hearing about the lack of support received by the interpreters. As a Trainee Clinical Psychologist, I have completed a clinical placement on an acute inpatient ward. I noticed myself empathising with some of the interpreters’ experiences as it resonated with my own experience of working on an acute ward.

### **2.5.3 Conclusions**

In conclusion, the BSL interpreters highlighted three superordinate themes in relation to how they made sense of the emotional impact of working in inpatient settings. Their experience was understood on both a personal level and wider systemic level. The findings support previous research whilst also providing new insights into the challenges of interpreting in inpatient mental health settings.

### **2.5.4 Recommendations**

With regards to future research, as all participants were recruited from one ward, the findings may have been specific to the ward in question, rather than specific to BSL interpreters. Future research could repeat the study at a different location and compare the findings with the current study, in order to increase the generalisability of the results. Future research could also include interviewing freelance interpreters, to explore whether their experience is similar to their permanent colleagues.

In terms of clinical recommendations, the present findings highlight the need for emotional support for BSL interpreters who work in mental health settings, in particular for those interpreters based on an inpatient ward. This support could be provided in the form of regular clinical supervision, in addition to linguistic supervision already provided. The interpreters may also benefit from additional clinical supervision at a later point following an incident, rather than solely at the time of the incident in acknowledgment that emotional distress is not time specific. To help reduce the possible occupational stress, Anderson (2011) suggested that interpreters should be offered peer support in the form of group meetings, to help increase professional support and self-care strategies. However, in the current study, individual supervision was highlighted as the most preferable format for receiving emotional support, rather than group supervision. This would allow for the incorporation of reflection of the effect of personal life events on work experience, in a confidential setting. Chatzidamianos, Fletcher, Wedlock and Lever (2019) suggested that clinical supervision should commence within interpreter training and continue after training, which would allow for the development of reflexivity amongst interpreters. Service commissioners should be aware of the need for the provision of supervision for

interpreters, and funding for this should be included in service budgets. It would also be helpful if health professionals are familiarised with the professional ethos and values of interpreters and not just how to work with them. Furthermore, there is a need for healthcare professionals to consider interpreters as an integral part of the team where possible and/or have an open discussion and a clear understanding of where they do 'stand' in addition to a designated physical space on the ward. Finally, healthcare professionals should consider the level of responsibility that interpreters hold, and services should consider how this is reflected in local policies. For example, a specific policy could be developed that outlines what an interpreter's responsibility is when they are the only hearing member of staff on the ward.

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### 3. PRESS RELEASE

*A public dissemination document*

## **3.1 Psychological interventions for mental health conditions for individuals who are d/Deaf – a systematic review of the literature**

### **3.1.1 Background**

This review aimed to evaluate the evidence for psychological interventions with individuals who experience the medical condition of deafness. There are two main ways of referring to this group of individuals i.e. 'deaf' and 'Deaf'. 'Deaf' refers to the Deaf community i.e. it relates to culture. Individuals who are described as 'Deaf' have often experienced deafness before they developed verbal language and often communicate using sign language. On the other hand, 'deaf', refers only to the medical condition of deafness. Throughout this review, the term d/Deaf is used to include all individuals who are deaf, regardless of whether they are part of the Deaf community or whether they use sign language to communicate. It is important to recognise that psychological therapies have been developed in Western society with individuals who are hearing, however there are cultural and linguistic differences between the d/Deaf population and the hearing population. There needs to be a focus on making sure that psychological therapy is adapted for d/Deaf individuals, so that they can access mental health services. However, in order to explore what adaptations have been successful, we need to know which psychological therapies have been effective.

### **3.1.2 What did the study do?**

The study looked at previously published research and identified eight papers that reported using a psychological intervention with d/Deaf people. A quality assessment tool was used to look at the quality of the eight papers. Two extra questions related to communication were added to both quality tools. The first question looked at whether the intervention was delivered by a therapist who knew sign language or whether a sign language interpreter was used. The second extra question looked at whether outcome measures were communicated via sign language or via written communication.

### **3.1.3 What did the systematic review find?**

The type of psychological therapy used was different in all eight of the studies (Cognitive Behavioural Therapy, Solution-Focused Therapy, Dialectical Behaviour Therapy, Acceptance and Commitment Therapy, Reality Therapy, Cognitive Processing Therapy, and Psychoeducation). The psychological therapies aimed to reduce symptoms of social anxiety (one paper), depression (four papers), anger difficulties (one paper), PTSD (one paper), and anxiety or depression (one paper). A total of 105 participants were included across the eight studies but three studies had only one participant and one study reported three individual cases. Of the eight studies, only one study was given a quality rating of 'moderate'. The remaining seven studies were rated as 'weak'. Two of the eight studies focused on reducing symptoms of anxiety (social anxiety and posttraumatic stress disorder). The authors said that the interventions were effective but participants did not have clinical levels of anxiety before the intervention. Four studies focused on the reduction of symptoms of depression and a significant decrease in depression symptoms after the intervention was found in one study. The two remaining papers looked at the application of Cognitive Behavioural Therapy and Dialectical Behaviour Therapy with individuals struggling to cope with anger and different overwhelming feelings. Both papers claimed that the interventions were effective, however we can not say whether any differences in symptoms after the intervention were significant as objective data was not collected.

### **3.1.4 What does this mean?**

The systematic review shows that there is currently little evidence to demonstrate whether psychological therapy can be effective with d/Deaf people. This is different to the findings of psychological interventions with hearing individuals, where there is a lot of published research that shows effectiveness. The limited research that is published with the d/Deaf population is of poor quality, which makes it difficult to make firm conclusions. Better quality research is needed to determine whether psychological therapies are effective with this population. It would be helpful if future research included; more participants, a control (placebo) condition and an appropriate measure of symptoms.

## **3.2 The emotional impact of working on a specialist mental health inpatient ward for individuals who are deaf: the experience of a British Sign Language interpreter**

### **3.2.1 Background**

The emotional impact of interpreting has been found to manifest in several different ways, including vicarious trauma and burnout. However, there is limited published research focused on the emotional impact of sign language interpreting. The research that has been published has shown that sign language interpreters experience burnout. Previous research has demonstrated the importance of the role of the interpreter in mental health settings for individuals who communicate using spoken and visual languages, and the emotional impact of this. However, there is a lack of research in the area of the experience of British Sign Language (BSL) interpreters in inpatient settings. The current study aims to contribute to the evidence base regarding the emotional experience of BSL interpreters who work in inpatient mental health services.

### **3.2.2 What did the study do?**

Six BSL interpreters were interviewed to explore whether there was an emotional impact of working on a deaf mental health inpatient ward and to understand how they made sense of this emotional impact. The interpreters chose to be interviewed at either their place of work or at a local university. The researcher recorded all of the interviews on an audio device. Following the interviews, the audio was transcribed by either the researcher or an independent company called 'AudioSec'. Participants' transcripts were looked at, using a type of data analysis called Interpretative Phenomenological Analysis, and important themes were identified.

### 3.2.3 What did the study find?

Three overarching themes were identified following analysis; “people forget that we’re human as well”, “I still wish I knew where to stand”, and “as interpreters we’re not necessarily looked after”. The overarching themes were underpinned by eight themes. The final themes were chosen due to their frequency throughout the transcripts and the importance placed on them by the interpreters.

The first overarching theme “people forget that we’re human as well”, encompasses the interpreters’ discussions of issues relating to being both an interpreter and a human being, how their time working on the ward has impacted on their personal experiences, and the power and responsibility that their professional role on the ward brings. The second overarching theme “I still wish I knew where to stand”, discusses the interpreters’ experience of not feeling like they belong with the team, and also their physical presence on the ward. The final overarching theme “as interpreters we’re not necessarily looked after”, discusses the interpreters’ experience of emotions and professionalism, not having any time or space to talk about emotions on the ward, and using avoidance as a coping strategy for emotional distress. The theme ‘avoidance as a coping strategy’ has been placed within this overarching theme as a reflection that the interpreters used this coping strategy as a consequence of not being looked after.

Consistent with the literature, the BSL interpreters discussed the impossibility of staying neutral in interpreting sessions and acknowledged that they are human and so will experience human emotions. Some of the interpreters also found it difficult to not think about patients at home, which fits with one of the symptoms of vicarious trauma. The interpreters stated that not being prepared for what might be spoken about made their distress worse and the interpreters used their own coping strategies, such as avoidance, to cope with the emotional content of interpreting. The interpreters also highlighted that it would be helpful for them to have someone to talk to about the emotional impact of the work, to understand why they experienced certain emotional responses when interpreting. However, the interpreters struggled with wanting to talk about emotions but then also thinking that showing emotions was unprofessional. However, this is understandable as

interpreters are advised to remain neutral whilst interpreting. Specific to inpatient settings, one of the reasons that they did not feel part of the wider team was because they did not have an allocated physical place on the ward. The interpreters also spoke of the uneasiness they felt about the amount of power and responsibility that they had over patients on the ward.

### **3.2.4 What does this mean?**

The present findings highlight the need for emotional support for BSL interpreters who work in mental health settings, in particular for those interpreters based on an inpatient ward. This support could be provided in the form of regular individual clinical supervision focused on emotions, in addition to supervision already provided, which focuses on language. The interpreters may also benefit from further clinical supervision at a later point following an incident, and not just at the time of the incident.

It is important to recognise that there are limitations with the current study. As all the interpreters came from the same ward, the findings may be specific to that ward. Future research could repeat the study at a different location and compare the findings with the current study, in order to increase the generalisability of the results.

**1. Literature Review: Psychological interventions for mental health conditions for individuals who are d/Deaf – a systematic review of the literature**

**Appendix A - Quality Assessment Tool for Quantitative Studies (Effective Public Health Practice Project, 1998)**



**QUALITY ASSESSMENT TOOL FOR QUANTITATIVE STUDIES**

**COMPONENT RATINGS**

**A) SELECTION BIAS**

**(Q1) Are the individuals selected to participate in the study likely to be representative of the target population?**

- 1 Very likely
- 2 Somewhat likely
- 3 Not likely
- 4 Can't tell

**(Q2) What percentage of selected individuals agreed to participate?**

- 1 80 - 100% agreement
- 2 60 – 79% agreement
- 3 less than 60% agreement
- 4 Not applicable
- 5 Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

**B) STUDY DESIGN**

**Indicate the study design**

- 1 Randomized controlled trial
- 2 Controlled clinical trial
- 3 Cohort analytic (two group pre + post)
- 4 Case-control
- 5 Cohort (one group pre + post (before and after))
- 6 Interrupted time series
- 7 Other specify \_\_\_\_\_
- 8 Can't tell

**Was the study described as randomized? If NO, go to Component C.**

No Yes

**If Yes, was the method of randomization described? (See dictionary)**

No Yes

**If Yes, was the method appropriate? (See dictionary)**

No Yes

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

**C) CONFOUNDERS**

**(Q1) Were there important differences between groups prior to the intervention?**

- 1 Yes
- 2 No
- 3 Can't tell

**The following are examples of confounders:**

- 1 Race
- 2 Sex
- 3 Marital status/family
- 4 Age
- 5 SES (income or class)
- 6 Education
- 7 Health status
- 8 Pre-intervention score on outcome measure

**(Q2) If yes, indicate the percentage of relevant confounders that were controlled (either in the design (e.g. stratification, matching) or analysis)?**

- 1 80 – 100% (most)
- 2 60 – 79% (some)
- 3 Less than 60% (few or none)
- 4 Can't Tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

**D) BLINDING**

**(Q1) Was (were) the outcome assessor(s) aware of the intervention or exposure status of participants?**

- 1 Yes
- 2 No
- 3 Can't tell

**(Q2) Were the study participants aware of the research question?**

- 1 Yes
- 2 No
- 3 Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

**E) DATA COLLECTION METHODS**

**(Q1) Were data collection tools shown to be valid?**

- 1 Yes
- 2 No
- 3 Can't tell

**(Q2) Were data collection tools shown to be reliable?**

- 1 Yes
- 2 No
- 3 Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

**F) WITHDRAWALS AND DROP-OUTS**

**(Q1) Were withdrawals and drop-outs reported in terms of numbers and/or reasons per group?**

- 1 Yes
- 2 No
- 3 Can't tell
- 4 Not Applicable (i.e. one time surveys or interviews)

**(Q2) Indicate the percentage of participants completing the study. (If the percentage differs by groups, record the lowest).**

- 1 80 -100%
- 2 60 - 79%
- 3 less than 60%
- 4 Can't tell
- 5 Not Applicable (i.e. Retrospective case-control)

RATE THIS SECTION	STRONG	MODERATE	WEAK	
See dictionary	1	2	3	Not Applicable

**G) INTERVENTION INTEGRITY**

**(Q1) What percentage of participants received the allocated intervention or exposure of interest?**

- 1 80 -100%
- 2 60 - 79%
- 3 less than 60%
- 4 Can't tell

**(Q2) Was the consistency of the intervention measured?**

- 1 Yes
- 2 No
- 3 Can't tell

**(Q3) Is it likely that subjects received an unintended intervention (contamination or co-intervention) that may influence the results?**

- 4 Yes
- 5 No
- 6 Can't tell

**H) ANALYSES**

**(Q1) Indicate the unit of allocation (circle one)**

community    organization/institution    practice/office    individual

**(Q2) Indicate the unit of analysis (circle one)**

community    organization/institution    practice/office    individual

**(Q3) Are the statistical methods appropriate for the study design?**

- 1 Yes
- 2 No
- 3 Can't tell

**(Q4) Is the analysis performed by intervention allocation status (i.e. intention to treat) rather than the actual intervention received?**

- 1 Yes
- 2 No
- 3 Can't tell

**GLOBAL RATING**

**COMPONENT RATINGS**

Please transcribe the information from the gray boxes on pages 1-4 onto this page. See dictionary on how to rate this section.

<b>A</b>	<b>SELECTION BIAS</b>	<b>STRONG</b>	<b>MODERATE</b>	<b>WEAK</b>
		1	2	3
<b>B</b>	<b>STUDY DESIGN</b>	<b>STRONG</b>	<b>MODERATE</b>	<b>WEAK</b>
		1	2	3
<b>C</b>	<b>CONFOUNDERS</b>	<b>STRONG</b>	<b>MODERATE</b>	<b>WEAK</b>
		1	2	3
<b>D</b>	<b>BLINDING</b>	<b>STRONG</b>	<b>MODERATE</b>	<b>WEAK</b>
		1	2	3
<b>E</b>	<b>DATA COLLECTION METHOD</b>	<b>STRONG</b>	<b>MODERATE</b>	<b>WEAK</b>
		1	2	3
<b>F</b>	<b>WITHDRAWALS AND DROPOUTS</b>	<b>STRONG</b>	<b>MODERATE</b>	<b>WEAK</b>
		1	2	3
				Not Applicable

**GLOBAL RATING FOR THIS PAPER (circle one):**

- |   |          |                            |
|---|----------|----------------------------|
| 1 | STRONG   | (no WEAK ratings)          |
| 2 | MODERATE | (one WEAK rating)          |
| 3 | WEAK     | (two or more WEAK ratings) |

With both reviewers discussing the ratings:

Is there a discrepancy between the two reviewers with respect to the component (A-F) ratings?

No      Yes

If yes, indicate the reason for the discrepancy

- |   |   |
|---|---|
| 1 | Oversight                                 |
| 2 | Differences in interpretation of criteria |
| 3 | Differences in interpretation of study    |

**Final decision of both reviewers (circle one):**

- |          |                 |
|----------|-----------------|
| <b>1</b> | <b>STRONG</b>   |
| <b>2</b> | <b>MODERATE</b> |
| <b>3</b> | <b>WEAK</b>     |

## Appendix B - Quality Assessment Tool for Quantitative Studies (Effective Public Health Practice Project, 1998) Dictionary

### Quality Assessment Tool for Quantitative Studies Dictionary



The purpose of this dictionary is to describe items in the tool thereby assisting raters to score study quality. Due to under-reporting or lack of clarity in the primary study, raters will need to make judgements about the extent that bias may be present. When making judgements about each component, raters should form their opinion based upon information contained in the study rather than making inferences about what the authors intended. Mixed methods studies can be quality assessed using this tool with the quantitative component of the study.

#### A) SELECTION BIAS

**(Q1)** Participants are more likely to be representative of the target population if they are randomly selected from a comprehensive list of individuals in the target population (score very likely). They may not be representative if they are referred from a source (e.g. clinic) in a systematic manner (score somewhat likely) or self-referred (score not likely).

**(Q2)** Refers to the % of subjects in the control and intervention groups that agreed to participate in the study before they were assigned to intervention or control groups.

#### B) STUDY DESIGN

In this section, raters assess the likelihood of bias due to the allocation process in an experimental study. For observational studies, raters assess the extent that assessments of exposure and outcome are likely to be independent. Generally, the type of design is a good indicator of the extent of bias. In stronger designs, an equivalent control group is present and the allocation process is such that the investigators are unable to predict the sequence.

##### **Randomized Controlled Trial (RCT)**

An experimental design where investigators randomly allocate eligible people to an intervention or control group. A rater should describe a study as an RCT if the randomization sequence allows each study participant to have the same chance of receiving each intervention and the investigators could not predict which intervention was next. If the investigators do not describe the allocation process and only use the words 'random' or 'randomly', the study is described as a controlled clinical trial.

See below for more details.

*Was the study described as randomized?*

Score YES, if the authors used words such as random allocation, randomly assigned, and random assignment.

Score NO, if no mention of randomization is made.

*Was the method of randomization described?*

Score YES, if the authors describe any method used to generate a random allocation sequence.

Score NO, if the authors do not describe the allocation method or describe methods of allocation such as alternation, case record numbers, dates of birth, day of the week, and any allocation procedure that is entirely transparent before assignment, such as an open list of random numbers of assignments.

If NO is scored, then the study is a controlled clinical trial.

*Was the method appropriate?*

Score YES, if the randomization sequence allowed each study participant to have the same chance of receiving each intervention and the investigators could not predict which intervention was next. Examples of appropriate approaches include assignment of subjects by a central office unaware of subject characteristics, or sequentially numbered, sealed, opaque envelopes.

Score NO, if the randomization sequence is open to the individuals responsible for recruiting and allocating participants or providing the intervention, since those individuals can influence the allocation process, either knowingly or unknowingly.

If NO is scored, then the study is a controlled clinical trial.

**Controlled Clinical Trial (CCT)**

An experimental study design where the method of allocating study subjects to intervention or control groups is open to individuals responsible for recruiting subjects or providing the intervention. The method of allocation is transparent before assignment, e.g. an open list of random numbers or allocation by date of birth, etc.

**Cohort analytic (two group pre and post)**

An observational study design where groups are assembled according to whether or not exposure to the intervention has occurred. Exposure to the intervention is not under the control of the investigators. Study groups might be non-equivalent or not comparable on some feature that affects outcome.

**Case control study**

A retrospective study design where the investigators gather 'cases' of people who already have the outcome of interest and 'controls' who do not. Both groups are then questioned or their records examined about whether they received the intervention exposure of interest.

**Cohort (one group pre + post (before and after))**

The same group is pretested, given an intervention, and tested immediately after the intervention. The intervention group, by means of the pretest, act as their own control group.

**Interrupted time series**

A study that uses observations at multiple time points before and after an intervention (the 'interruption'). The design attempts to detect whether the intervention has had an effect significantly greater than any underlying trend over time. Exclusion: Studies that do not have a clearly defined point in time when the intervention occurred and at least three data points before and three after the intervention

**Other:**

One time surveys or interviews

**C) CONFOUNDERS**

By definition, a confounder is a variable that is associated with the intervention or exposure and causally related to the outcome of interest. Even in a robust study design, groups may not be balanced with respect to important variables prior to the intervention. The authors should indicate if confounders were controlled in the design (by stratification or matching) or in the analysis. If the allocation to intervention and control groups is randomized, the authors must report that the groups were balanced at baseline with respect to confounders (either in the text or a table).

**D) BLINDING**

(Q1) Assessors should be described as blinded to which participants were in the control and intervention groups. The purpose of blinding the outcome assessors (who might also be the care providers) is to protect against detection bias.

(Q2) Study participants should not be aware of (i.e. blinded to) the research question. The purpose of blinding the participants is to protect against reporting bias.

**E) DATA COLLECTION METHODS**

Tools for primary outcome measures must be described as reliable and valid. If 'face' validity or 'content' validity has been demonstrated, this is acceptable. Some sources from which data may be collected are described below:

Self reported data includes data that is collected from participants in the study (e.g. completing a questionnaire, survey, answering questions during an interview, etc.).

Assessment/Screening includes objective data that is retrieved by the researchers. (e.g. observations by investigators).

Medical Records/Vital Statistics refers to the types of formal records used for the extraction of the data.

**Reliability and validity can be reported in the study or in a separate study. For example, some standard assessment tools have known reliability and validity.**

**F) WITHDRAWALS AND DROP-OUTS**

Score **YES** if the authors describe BOTH the numbers and reasons for withdrawals and drop-outs.

Score **NO** if either the numbers or reasons for withdrawals and drop-outs are not reported.

Score **NOT APPLICABLE** if the study was a one-time interview or survey where there was not follow-up data reported.

The percentage of participants completing the study refers to the % of subjects remaining in the study at the final data collection period in all groups (i.e. control and intervention groups).

**G) INTERVENTION INTEGRITY**

The number of participants receiving the intended intervention should be noted (consider both frequency and intensity). For example, the authors may have reported that at least 80 percent of the participants received the complete intervention. The authors should describe a method of measuring if the intervention was provided to all participants the same way. As well, the authors should indicate if subjects received an unintended intervention that may have influenced the outcomes. For example, co-intervention occurs when the study group receives an additional intervention (other than that intended). In this case, it is possible that the effect of the intervention may be over-estimated. Contamination refers to situations where the control group accidentally receives the study intervention. This could result in an under-estimation of the impact of the intervention.

**H) ANALYSIS APPROPRIATE TO QUESTION**

Was the quantitative analysis appropriate to the research question being asked?

An intention-to-treat analysis is one in which all the participants in a trial are analyzed according to the intervention to which they were allocated, whether they received it or not. Intention-to-treat analyses are favoured in assessments of effectiveness as they mirror the noncompliance and treatment changes that are likely to occur when the intervention is used in practice, and because of the risk of attrition bias when participants are excluded from the analysis.

### **Component Ratings of Study:**

For each of the six components A – F, use the following descriptions as a roadmap.

#### **A) SELECTION BIAS**

**Good:** The selected individuals are very likely to be representative of the target population (Q1 is 1) **and** there is greater than 80% participation (Q2 is 1).

**Fair:** The selected individuals are at least somewhat likely to be representative of the target population (Q1 is 1 or 2); **and** there is 60 - 79% participation (Q2 is 2). 'Moderate' may also be assigned if Q1 is 1 or 2 and Q2 is 5 (can't tell).

**Poor:** The selected individuals are not likely to be representative of the target population (Q1 is 3); **or** there is less than 60% participation (Q2 is 3) **or** selection is not described (Q1 is 4); and the level of participation is not described (Q2 is 5).

#### **B) DESIGN**

**Good:** will be assigned to those articles that described RCTs and CCTs.

**Fair:** will be assigned to those that described a cohort analytic study, a case control study, a cohort design, or an interrupted time series.

**Weak:** will be assigned to those that used any other method or did not state the method used.

#### **C) CONFOUNDERS**

**Good:** will be assigned to those articles that controlled for at least 80% of relevant confounders (Q1 is 2); **or** (Q2 is 1).

**Fair:** will be given to those studies that controlled for 60 – 79% of relevant confounders (Q1 is 1) **and** (Q2 is 2).

**Poor:** will be assigned when less than 60% of relevant confounders were controlled (Q1 is 1) **and** (Q2 is 3) **or** control of confounders was not described (Q1 is 3) **and** (Q2 is 4).

#### **D) BLINDING**

**Good:** The outcome assessor is not aware of the intervention status of participants (Q1 is 2); **and** the study participants are not aware of the research question (Q2 is 2).

**Fair:** The outcome assessor is not aware of the intervention status of participants (Q1 is 2); **or** the study participants are not aware of the research question (Q2 is 2).

**Poor:** The outcome assessor is aware of the intervention status of participants (Q1 is 1); **and** the study participants are aware of the research question (Q2 is 1); **or** blinding is not described (Q1 is 3 and Q2 is 3).

#### **E) DATA COLLECTION METHODS**

**Good:** The data collection tools have been shown to be valid (Q1 is 1); **and** the data collection tools have been shown to be reliable (Q2 is 1).

**Fair:** The data collection tools have been shown to be valid (Q1 is 1); **and** the data collection tools have not been shown to be reliable (Q2 is 2) **or** reliability is not described (Q2 is 3).

**Poor:** The data collection tools have not been shown to be valid (Q1 is 2) **or** both reliability and validity are not described (Q1 is 3 and Q2 is 3).

#### **F) WITHDRAWALS AND DROP-OUTS - a rating of:**

**Good:** will be assigned when the follow-up rate is 80% or greater (Q1 is 1 and Q2 is 1).

**Fair:** will be assigned when the follow-up rate is 60 – 79% (Q2 is 2) **OR** Q1 is 4 or Q2 is 5.

**Poor:** will be assigned when a follow-up rate is less than 60% (Q2 is 3) or if the withdrawals and drop-outs were not described (Q1 is No or Q2 is 4).

**Not Applicable:** if Q1 is 4 or Q2 is 5.

**Appendix C - Risk of Bias in N-of-1 Trials Scale (RoBiNT; Tate et al., 2015)**

		König (2013)	Bhargava (2013)	Glickman (2009)	Estrada & Beyebach, (2007)
<b>Internal Validity (IV) Subscale</b>					
<b>18. Design with control</b>	<p>2 points: At minimum: ABAB with 4 phases; concurrent multiple baseline design (MBD) with 6 phases, 3 tiers; alternating treatments design (ATD) with 4 sets of alternating sequences; changing-criterion design (CCD) with 4 steps; for medical N-of-1: 3xAB pairs</p> <p>1 point: ABA or 3 phase variant; concurrent MBD with 4-5 phases, 2 tiers; ATD with 3 sets of alternating sequences; CCD with &lt;3 steps; non-withdrawal treatment in ABA</p> <p>0 points: AB; AB+follow up; non-concurrent MBD: ATD with &lt;3 sets of alternating sequences; CCD with &lt;3 steps; non-withdrawable treatment in ABA</p>	0	0	0	0
<b>19. Randomisation</b>	<p>2 points: Randomise: sequence order and/or onset for all phases</p> <p>1 point: Restricted randomisation (e.g. participants to blocks of sequences); counterbalancing</p> <p>0 points: No information; randomisation of other aspects of the study (e.g. stimulus materials)</p>	0	0	0	0
<b>20. Sampling of Behaviour</b>	<p>2 points: 5 or more data points in every phase with data presented</p> <p>1 point: at least 3 data points in every phase with data presented</p> <p>0 points: &lt;3 data points in any phase</p>	0	0	0	0

21. Blinding of people involved in the intervention	<p>2 points: Both participant and practitioner blind to phase of study. If technological intervention is used, consult manual</p> <p>1 point: Participant or practitioner blind to phase. If technological intervention used, consult manual</p> <p>0 points: Neither participant or practitioner blind to phase</p>	0	0	0	0
22. Blinding of assessor (s)	<p>2 points: Assessors blind to all phases; use of computer/machine free from human involvement; outcomes self-report and participant is blind</p> <p>1 point: independent assessor (s) but not blind to phase</p> <p>0 points: practitioner collects/extracts/scores/processes the data; no mention of blinding or independence of assessor(s)</p>	0	0	0	0
23. Interrater agreement	<p>2 points: Machine-generated data or data sampled from &gt;20%per condition, with &gt;=80% agreement (<math>k \geq 0.6</math>)</p> <p>1 point: A reasonably objective measure (as defined in the manual) used or agreement is &gt;=70% (<math>k \geq 0.4</math>) even if a) data are not calculated and reported per condition and/or b) &lt;20% of data is sampled per condition</p> <p>0 points: Agreement &lt;70% (<math>K &lt; 0.4</math>); subjective measure used, consensus ratings alone, inter-rater agreement only reported for a previous study</p>	0	0	0	0
24. Treatment adherence	<p>2 points: Machine-delivered intervention free from human implementation or adherence assessed i) against a clear rating system ii) assessor is independent of practitioner/participant iii) &gt;=20% of is data sampled iv) resulting in &gt;=80% adherence</p> <p>1 point: adherence meets 2/4 criteria above, and includes a) assessor independent of practitioner and b) adherence &gt;=70%</p> <p>0 points: adherence &gt;=70%, assessor not independent of practitioner; components only loosely related to adherence.</p>	0	0	0	1
External Validity and Interpretation (EVI) Subscale					

25. Baseline characteristics	<p>2 points: analysis of baseline characteristics and age, sex, aetiology, severity of condition</p> <p>1 point: analysis of baseline characteristics or age, sex, aetiology, severity of condition</p> <p>0 points: no analysis of baseline conditions or incomplete listing of the four participant characteristics</p>	1	1	0	0
26. Setting	<p>2 points: Description of general location and detailed description of specific environment</p> <p>1 point: Description of either general location or specific environment but details are sparse</p> <p>0 points: neither general location nor specific environment are described</p>	1	0	2	1
27. Dependent variable (target behaviour)	<p>2 points: target behaviour is operationally defined in precise terms and the method of measuring it is described</p> <p>1 point: target behaviour is operationally defined but its description and/or method of measurement is not clear and precise</p> <p>0 points: target behaviour is not operationally defined</p>	2	1	1	2
28. Independent variable (therapy/intervention)	<p>2 points: Detailed description of content of the intervention including any equipment/manuals (for medical n of 1: content of the agents, both active and placebo) and 3 procedural details: number, duration (dosage for medical n of 1) and frequency of sessions</p> <p>1 point: General description of content of intervention (and equipment/manuals) and 2/3 procedural details (number, duration/dosage, frequency)</p> <p>0 points: intervention described in general terms; only identified as a treatment approach (e.g. 'cognitive-behavioural therapy') &lt;2/3 procedural details</p>	2	2	1	1

29. Raw data record	<p>2 points: Raw data record with a data point for every session/observation period. If <math>\geq 10</math> individual trials, complete raw data record for <math>\geq 3</math> cases</p> <p>1 point: if <math>\geq 10</math> or more individual trials, complete raw data record for 2 cases, or provision of data record but data aggregated/averaged across sessions/periods, or provision of data record but a prior decision not to record data for every session (e.g. multiple probe studies)</p> <p>0 points: no raw data reported; data only reported for selected phases, omitted data</p>	0	0	0	2
30. Data analysis	<p>2 points: Systematic visual analysis with specified protocol, or visual analysis aided by quasi-statistical techniques, or statistical analysis with rationale</p> <p>1 point: systematic/aided visual analysis with selection of analytic techniques, or statistical analysis but no rationale, or a priori decision re the level of target behaviour constituting an empirically derived clinically meaningful change</p> <p>0 points: visual inspection without data analysis; analysis not conducted on target behaviour; arbitrary selection of level of target behaviour</p>	0	0	0	0
31. Replication	<p>2 points: 1 original + 3 replications (direct inter-subject or systematic including settings, behaviours, practitioners, intervention)</p> <p>1 point: 1 original + 1 or 2 replications (inter-subject or systematic)</p> <p>0 points: no replication</p>	0	0	0	1
32. Generalisation	<p>2 points: specified generalisation measure is probed in every phase</p> <p>1 point: specified generalisation measure is probed in at least pre- and post-treatment phases</p> <p>0 points: no generalisation measures</p>	2	0	0	0

33. Communication	2 points: intervention delivered via a sign language proficient therapist 1 point: intervention delivered via a professional interpreter 0 points: no mention regarding how intervention was communicated	1	2	2	1
34. Communication (2)	2 points: outcome measures communicated via sign language 0 points: outcome measures not translated/no mention of how outcome measures were communicated/no outcome measures used	0	0	0	2
<b>IVI Subscale Total</b>		<b>0/14</b>	<b>0/14</b>	<b>0/14</b>	<b>1/14</b>
<b>EVI Subscale Total</b>		<b>9/20</b>	<b>6/20</b>	<b>6/20</b>	<b>10/20</b>
<b>Overall Total</b>		<b>9/34</b>	<b>6/34</b>	<b>6/34</b>	<b>11/34</b>
<b>Global (overall) Rating</b>		<b>Weak</b>	<b>Weak</b>	<b>Weak</b>	<b>Weak</b>

**Appendix D – Data Extraction Tool**

<b>Authors (Year)</b>	<b>Study setting</b>	<b>Psychological therapy</b>	<b>Target for intervention</b>	<b>Study Design</b>	<b>Characteristics of Participants</b>	<b>Mode of communication</b>	<b>Outcome measures</b>	<b>Key findings</b>
Hassinen and Lappalainen (2018)	Finland Outpatients	Acceptance and Commitment Therapy (ACT)	Depression (and consequently psychological well-being)	Cohort	16 client participants; 9 males and 7 females  Age; Mean 43.8 (22-60 years old)  Onset of deafness; non stated  Severity of deafness; not stated	Finnish Sign Language (FinSL) speaking staff members  No interpreters	Beck Depression Inventory (BDI)  Symptom Checklist 90 (SCL-90)  Acceptance and Action Questionnaire II (AAQ-II)	<ul style="list-style-type: none"> <li>• No statistically significant change in BDI scores</li> <li>• No statistically significant change in psychological flexibility</li> <li>• No statistically significant change in overall psychological symptoms</li> </ul>
Dehnabi, Radsepehr and Foushtangh (2017)	Iran Outpatients	Mindfulness-based stress reduction (MBSR)	Social anxiety	Controlled clinical trial	24 participants; gender and age not reported  Onset of deafness; non stated	Specific language not stated  Deaf teaching assistant	Social Phobia Inventory (SPIN)	The authors report MBSR reduced social anxiety however no statistically significant changes in scores were determined

					Severity of deafness; not stated			
Davidson, Cave, Reedman, Briffa and Dark (2012)	Australia  Outpatients	Dialectical Behavioural Therapy (DBT)	Reduce symptoms of depression or panic disorder through development of interpersonal effectiveness, emotional regulation, and crisis management skills	Cohort	4 participants; gender and age not disclosed  Onset of deafness; not stated  Severity of deafness; not stated	Australian sign language (Auslan) via professional interpreters	Outcome Rating Scale (ORS-Auslan)  Session Rating Scale (SRS-Auslan)	<ul style="list-style-type: none"> <li>• ORS and SRS data not published</li> <li>• Authors reported that participants were able to identify specific skills and explain the usefulness of the skill post intervention</li> </ul>
Wilson and Wells (2009)	United States of America  Outpatients	Psychoeducation	Depression	Controlled clinical trial	55 adults; 26 males and 29 females  Mean age; 29 years old (range 17-52 years old)  Onset of deafness; not reported	American Sign Language (ASL) via professional interpreter using Telehealth, or written format	Beck Depression Inventory (BDI-II)  Beck Hopelessness Scale (BHS)  Client Satisfaction Scale (CSS)  Therapist	<ul style="list-style-type: none"> <li>• Statistically significant decrease in BDI-II score post intervention</li> <li>• Mean BDI-II score reduced from clinical category “mild depression” pre intervention to clinical category “minimal</li> </ul>

					Severity of deafness; not reported		Satisfaction Scale (TSS)	depression” post intervention <ul style="list-style-type: none"> <li>• No statistically significant change in BHS score post intervention</li> <li>• Mean BHS score reduced to below clinical cut off post intervention</li> </ul>
Estrada and Beyebach (2007)	Spain Outpatients	Solution-Focused Brief Therapy (SFBT)	Depression	Multiple case study	3 adults; 2 males and 1 female  Mean age; 36 years old  Onset of deafness; prelingual  Severity of deafness; profound	Spanish sign language via professional interpreter	Beck Depression Inventory-II Adapted for Deaf persons (BDI-IIAD)  Progress Scaling Question  2 x treatment integrity measures	<ul style="list-style-type: none"> <li>• All three participants’ BDI-IIAD scores above clinical level pre intervention</li> <li>• All three participants’ BDI-IIAD scores below clinical level post-intervention</li> <li>• Statistical significance between phases not investigated</li> </ul>
König (2013)	Germany Outpatients	Cognitive Processing Therapy (CPT)	Post-traumatic Stress Disorder (PTSD)	Case study	1 participant; female  Age; 42 years old	Deutsche Gebärdensprache (DGS) via professional interpreter	Posttraumatic Diagnostic Scale (PDS)  Impact of Event	<ul style="list-style-type: none"> <li>• Statistical significance between phases not investigated</li> <li>• PDS not at clinical</li> </ul>

					<p>Onset of deafness; prelingual</p> <p>Severity of deafness; not stated</p>		<p>Scale – Revised (IES-R)</p> <p>Brief Symptom Inventory (BSI)</p> <p>Posttraumatic Cognitions Inventory (PTCI)</p> <p>Inventory of Interpersonal Problems – Circumplex Version (IIP-C)</p>	<p>level pre-intervention</p> <ul style="list-style-type: none"> <li>• IES-R above clinical level pre-intervention and reduced to below clinical level post-intervention</li> <li>• BSI score above average pre-intervention and below average post-intervention</li> <li>• PTCI and IIP-C not at clinical level pre-intervention</li> </ul>
Bhargava (2013)	<p>United States of America</p> <p>Outpatients</p>	Reality Therapy	Depression	Case study	<p>1 participant; male</p> <p>Age; 19 years old</p> <p>Onset of deafness; post-lingual</p> <p>Severity of deafness; not stated</p>	American Sign Language (ASL) via ASL proficient clinician	<p>No outcome measures used. Anecdotal report of client provided.</p>	<p>The author reported that the client was “noticeably happier and appeared to be more content with his life. He indicated that he no longer felt depressed, stated that he is able to confidently identify with the deaf world, and is in the pursuit of fulfilling his desire of becoming a certified horticulturalist”</p>

Glickman (2009)	United States of America  Inpatients	Cognitive Behavioural Therapy (CBT)	Anger	Case study	1 participant; male  Age; 19 years old  Onset of deafness; prelingual  Severity of deafness; not stated	American Sign Language (ASL) via ASL proficient clinician	No outcome measures used. Anecdotal report of client provided.	Following intervention, the client was able to notice anger and utilise coping strategies, such as walking away and writing/drawing feelings in a book
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**2. Empirical Paper: The emotional impact of working on a specialist mental health inpatient ward for individuals who are deaf: the experience of a British Sign Language interpreter**

**Appendix A – Ethical Approval Letter**



Ms Lauren Calder-Hanley  
Trainee Clinical Psychologist  
Birmingham and Solihull Mental Health NHS Foundation Trust  
B1  
50 Summer Hill Road  
Birmingham  
B1 3RB

Email: [hra.approval@nhs.net](mailto:hra.approval@nhs.net)  
[Research-permissions@wales.nhs.uk](mailto:Research-permissions@wales.nhs.uk)

19 October 2018

Dear Ms Calder-Hanley

**HRA and Health and Care**

<b>Study title:</b>	<b>The emotional impact of working on a specialist mental health inpatient unit for individuals who are deaf: the experience of a British Sign Language (BSL) interpreter</b>
<b>IRAS project ID:</b>	<b>240560</b>
<b>Protocol number:</b>	<b>ERN_18-0424</b>
<b>REC reference:</b>	<b>19/HRA/0429</b>
<b>Sponsor</b>	<b>University of Birmingham</b>

I am pleased to confirm that [HRA and Health and Care Research Wales \(HCRW\) Approval](#) has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

**How should I continue to work with participating NHS organisations in England and Wales?** You should now provide a copy of this letter to all participating NHS

organisations in England and Wales, as well as any documentation that has been updated as a result of the assessment.

Following the arranging of capacity and capability, participating NHS organisations should **formally confirm** their capacity and capability to undertake the study. How this will be confirmed is detailed in the “*summary of assessment*” section towards the end of this letter.

You should provide, if you have not already done so, detailed instructions to each organisation as to how you will notify them that research activities may commence at site following their confirmation of capacity and capability (e.g. provision by you of a ‘green light’ email, formal notification following a site initiation visit, activities may commence immediately following confirmation by participating organisation, etc.).

It is important that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details of the research management function for each organisation can be accessed [here](#).

### **How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?**

HRA and HCRW Approval does not apply to NHS/HSC organisations within the devolved administrations of Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) has been sent to the coordinating centre of each participating nation. You should work with the relevant national coordinating functions to ensure any nation specific checks are complete, and with each site so that they are able to give management permission for the study to begin.

Please see [IRAS Help](#) for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

### **How should I work with participating non-NHS organisations?**

HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your nonNHS organisations to [obtain local agreement](#) in accordance with their procedures.

### **What are my notification responsibilities during the study?**

The attached document “*After HRA Approval – guidance for sponsors and investigators*” gives detailed guidance on reporting expectations for studies with HRA and HCRW Approval, including:

- Registration of Research
- Notifying amendments
- Notifying the end of the study

The [HRA website](#) also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

**I am a participating NHS organisation in England or Wales. What should I do once I receive this letter?**

You should work with the applicant and sponsor to complete any outstanding arrangements so you are able to confirm capacity and capability in line with the information provided in this letter.

The sponsor contact for this application is as follows:

Name: Sean Jennings

Tel: 01214158011

Email: [researchgovernance@contacts.bham.ac.uk](mailto:researchgovernance@contacts.bham.ac.uk)

**Who should I contact for further information?**

Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **240560**. Please quote this on all correspondence.

Yours sincerely

Andrea Bell  
Assessor

Email: [hra.approval@nhs.net](mailto:hra.approval@nhs.net)

*Copy to: Dr Sean Jennings – Sponsor contact  
Katie Williams, Research and Innovation Department – Lead NHS R&D contact*

## List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

<i>Document</i>	<i>Version</i>	<i>Date</i>
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [IRAS 240560 sponsor insurance letter]	1.0	03 October 2018
HRA Schedule of Events	1	19 October 2018
HRA Statement of Activities	1.0	19 October 2018
Interview schedules or topic guides for participants [IRAS 240560 interview schedule]	0.2	14 August 2018
IRAS Application Form [IRAS_Form_05102018]		05 October 2018
IRAS Application Form XML file [IRAS_Form_05102018]		05 October 2018
IRAS Checklist XML [Checklist_05102018]		05 October 2018
Letter from sponsor [IRAS 240560 sponsorship confirmation letter]	1.0	03 October 2018
Letters of invitation to participant [IRAS 240560 - participant recruitment letter]	0.2	24 August 2018
Participant consent form [IRAS 240560 - consent form]	0.3	14 September 2018
Participant information sheet (PIS) [IRAS 240560 - PIS]	0.2	14 August 2018
Research protocol or project proposal [IRAS 240560 protocol]	0.2	24 August 2018
Summary CV for Chief Investigator (CI) [IRAS 240560 - CI C.V]	1	12 June 2018
Summary CV for supervisor (student research) [IRAS 240560 - PI CV]	0.1	03 August 2018
Summary, synopsis or diagram (flowchart) of protocol in non technical language [IRAS 240560 - protocol flowchart]	0.2	24 August 2018

## Summary of assessment

The following information provides assurance to you, the sponsor and the NHS in England and Wales that the study, as assessed for HRA and HCRW Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England and Wales to assist in assessing, arranging and confirming capacity and capability.

## Assessment criteria

<b>Section</b>	<b>Assessment Criteria</b>	<b>Compliant with Standards</b>	<b>Comments</b>
1.1	IRAS application completed correctly	Yes	No comments

2.1	Participant information/consent documents and consent process	Yes	No comments
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	A statement of activities (SoA) has been submitted and the sponsor is not requesting and does not expect any other site agreement to be used.
4.2	Insurance/indemnity arrangements assessed	Yes	No comments
4.3	Financial arrangements assessed	Yes	There is no funding being provided to the organisation by the sponsor, as detailed in the SoA.
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	No comments
5.2	CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed	Not Applicable	No comments
5.3	Compliance with any applicable laws or regulations	Yes	No comments
<b>Section</b>	<b>Assessment Criteria</b>	<b>Compliant with Standards</b>	<b>Comments</b>
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Not Applicable	No comments
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments

6.4	Other regulatory approvals and authorisations received	Not Applicable	No comments
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## Participating NHS Organisations in England and Wales

*This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.*

There is one site type. The organisation will undertake the activities as detailed in the IRAS application and protocol.

The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England and Wales in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. Where applicable, the local LCRN contact should also be copied into this correspondence.

If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England and Wales which are not provided in IRAS, the HRA or HCRW websites, the chief investigator, sponsor or principal investigator should notify the HRA immediately at [hra.approval@nhs.net](mailto:hra.approval@nhs.net) or HCRW at [Research-permissions@wales.nhs.uk](mailto:Research-permissions@wales.nhs.uk). We will work with these organisations to achieve a consistent approach to information provision.

## Principal Investigator Suitability

*This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and Wales, and the minimum expectations for education, training and experience that PIs should meet (where applicable).*

A Local Principal Investigator is required for this type of study, and has been identified at the participating NHS site.

GCP training is not a generic training expectation, in line with the [HRA/HCRW/MHRA statement on training expectations](#).

## HR Good Practice Resource Pack Expectations

*This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken*

No Honorary Research Contracts, Letters of Access or pre-engagement checks are expected for local staff employed by the participating NHS organisations.

Where arrangements are not already in place, research staff not employed by the NHS host organisation undertaking any of the research activities listed in the research application would be expected to hold Letters of Access if interviews were held in clinical areas. Letters of Access would not be expected if interviews were held in non-clinical/administrative buildings.

## Other Information to Aid Study Set-up

*This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales to aid study set-up.*

The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

## Appendix B – Participant Recruitment Letter

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### Participant Recruitment Letter – Version 0.2 (24<sup>th</sup> August 2018)

To Whom It May Concern,

I am inviting you to take part in a research study exploring “the emotional impact of working on a specialist mental health inpatient unit for individuals who are deaf: the experience of a British Sign Language (BSL) interpreter”. The study will be carried out via face to face interviews, which may last up to 1 ½ hours. Some of the interview questions may touch upon sensitive issues, such as discussing incidents that you have witnessed on the ward. I have attached a participant information sheet for further information.

If you would like to take part in the study, or if you have any questions that you would like to ask prior to consenting to the study, please do not hesitate to e-mail me at [lxc648@student.bham.ac.uk](mailto:lxc648@student.bham.ac.uk).

Best Wishes,

Lauren Calder-Hanley  
Trainee Clinical Psychologist

## Appendix C – Participant Information Sheet

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BIRMINGHAM

### Participant Information Sheet – Version 0.2 (14<sup>th</sup> August 2018)

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form.

#### Title of study

The emotional impact of working on a specialist mental health inpatient unit for individuals who are deaf: the experience of a British Sign Language (BSL) interpreter

#### Researcher information

Researcher: Lauren Calder-Hanley (e-mail address: [lxc648@student.bham.ac.uk](mailto:lxc648@student.bham.ac.uk))

Academic Supervisor: Dr Theresa Powell (e-mail address: [T.Powell@bham.ac.uk](mailto:T.Powell@bham.ac.uk))

#### Purpose of research

This research is being carried out as part of the thesis element of a postgraduate Clinical Psychology Doctorate. The research aims to explore the emotional impact of working as a BSL interpreter on a specialist mental health inpatient unit for individuals who are deaf. As this is an area of limited research, findings from this study will contribute to the evidence base in the area of interpreting in mental health settings and in the area of mental health and deafness.

#### Explanation of procedures to be used

At the time of interview, you will be asked to read this information sheet again and read and sign a consent form prior to the interview starting. You will have the opportunity to ask any questions before consenting to the study. Participation in the research is voluntary and will not impact on your employment with the service.

The study will be carried out via face to face individual interviews, which will be recorded on an encrypted/protected audio device. Interviews may last up to 1 ½ hours and take the format of semi-structured open-ended questions. Some of the interview questions may touch upon sensitive issues, such as discussing incidents that you have witnessed on the ward. You will be able to stop the interview at any point if you feel distressed. If this occurs, you will have the choice of continuing with the interview on the same day following a break; continuing with the interview on a different day; or withdrawing from the study. Your interview will not be transcribed or included in analysis if you choose to withdraw from the study.

Following the interview, you will be provided with a debrief form, explaining the nature of the study and contact details of the researcher and the researcher's academic supervisor, as well as providing details of nationwide counselling services in case of distress after participating in the interview.

Please contact the researcher within two weeks of the study if you change your mind and wish to withdraw from the study. You can withdraw at this stage without having to provide a reason. Your interview will be deleted and will not be transcribed or included in analysis. It will not be possible to withdraw from the study after the two-week period, as the interview will have been transcribed and analysis will have started. The interviews will be transcribed verbatim by either the researcher or by the external professional transcription service, 'AudioSec Transcription Service'. A confidentiality agreement will be in place if this company is used.

#### Explanation of any possible hazards

Some of the interview questions may touch upon sensitive issues, such as discussing incidents that you may have witnessed or interpreted. You will be provided with a list of nationwide counselling services following the interview. If you do feel distressed or upset at any point during the interview, you can ask for the interview to be stopped. Your participation in the interview is completely voluntary.

#### Confidentiality and Anonymity of information

The confidentiality of personal information and the anonymity of all volunteers involved in this investigation will be preserved in the following way:

- Personal data, such as consent forms, will be locked in filing cabinet in the academic supervisor's office at the university. Only the researcher and academic supervisor will have access to the consent forms.
- Audio files will be transferred to an encrypted password-protected memory stick following the interview.
- Data from interviews will not be anonymous, as quotes may be included in the research write-up. The data will however be confidential, as pseudonyms will be used instead of your real name.
- Anonymised electronic files will be kept for 10 years from publication, as per university code of practice.
- Neither [REDACTED] nor the [REDACTED] will be named in the research.
- The names of inpatients must not be disclosed in the interview. This is to help prevent the service being recognised. Patients have also not given their permission to be named in the study. If you accidentally name a patient, their name will not be included in the transcript of the interview.

#### How we use your personal data (GDPR)

The University of Birmingham is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. The University of Birmingham will keep identifiable information about you for 10 years after the study has finished.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard

your rights, we will use the minimum personally-identifiable information possible. You can find out more about how we use your information at <https://www.birmingham.ac.uk/privacy/index.aspx>

If you have any questions regarding the study, which you would like to ask prior to consenting to the study, please do not hesitate to e-mail me at [lxc648@student.bham.ac.uk](mailto:lxc648@student.bham.ac.uk) and I will endeavour to respond to your questions as soon as possible. If you have any concerns about the study, please contact Dr Theresa Powell (Academic Supervisor) on [T.Powell@bham.ac.uk](mailto:T.Powell@bham.ac.uk).

Please let the researcher know if you would like the results of the research to be e-mailed to you.

**Appendix D – Participant Consent Form**

**CONSENT FORM – Version 0.3 (14<sup>th</sup> September 2018)**

**UNIVERSITY OF  
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Participant Identification Number: \_\_\_\_\_

*Title of Project:* The emotional impact of working on a specialist mental health inpatient unit for individuals who are deaf: the experience of a British Sign Language (BSL) interpreter

*Researcher:* Lauren Calder-Hanley

Please initial box

1. I confirm that I have understood the information sheet version 0.2 dated 14<sup>th</sup> August 2018 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time during the research interview, without giving any reason.
3. I understand that the research interview will be audio-recorded.
4. I understand that following the research interview I will have a two-week period for reflection. If I change my mind about taking part in the study, I must contact the researcher within two weeks of the interview, at which point I may withdraw my interview entirely or in part, without giving any reason.
5. I understand that the research interview may be transcribed by an external professional agency.
6. I understand that the data collected during this study will be looked at by the researcher and relevant others at the University of Birmingham to ensure that the analysis is a fair and reasonable representation of the data.
7. I understand that direct quotes from my interview may be published in any write-up of the data, and used for training purposes, but that my name will not be attributed to any such quotes and that neither I nor anyone I name during the interview will not be identifiable by my comments.
8. I consent for my personal data to be transferred to University of Birmingham.
9. I agree to take part in the above study.

.....  
Name of participant                      Date                      Signature

.....  
Name of researcher                      Date                      Signature

The emotional impact of working as a BSL interpreter in inpatient mental health services  
IRAS number 240560  
Participant Consent Form – Version 0.3 (14<sup>th</sup> September 2018)

## Appendix E – Interview Schedule

Interview Schedule – Version 0.2 (14<sup>th</sup> August 2018)

*“The emotional impact of working on a specialist mental health inpatient unit for individuals who are deaf: the experience of a British Sign Language (BSL) interpreter”*

### Introduction

Thank you for agreeing to take part in this interview. I am interested in your experience of the emotional impact of working as an interpreter on a specialist mental inpatient unit.

### Main Questions

1. How long have you been working as an interpreter?
2. How long have you been working on the ward?
3. What does a typical shift entail?
4. Can you tell me about the last shift that you worked?
5. Can you tell me about a time when you felt distressed after something you interpreted and/or witnessed at work?
6. How did you cope with this situation?
7. Has working in mental health affected you professionally? How?
8. Has working in mental health affected you personally? How?
9. What do you like least about working in this area? What do you like the most?
10. Are there any other comments that you would like to make?

### Demographic Questions

If you do not mind, I would like to ask you some questions regarding socio-demographics...

1. How old are you?
2. What gender do you identify as?
3. What ethnicity do you identify as?
4. What training have you had with regards to interpreting?
5. What training have you had with regards to mental health?

### Closing

Thank you for taking part in this study. Please could you contact me within two weeks if you change your mind and wish to withdraw from the study.

Interview Schedule – Version 0.2 (14<sup>th</sup> August 2018)

The emotional impact of working as a BSL interpreter in inpatient mental health services  
IRAS number 240560

## Appendix F – Participant Debrief Form

UNIVERSITY OF  
BIRMINGHAM

### Participant Debrief Form – Version 0.2 (14<sup>th</sup> August 2018)

***“The emotional impact of working on a specialist mental health inpatient unit for individuals who are deaf: the experience of a British Sign Language (BSL) interpreter”***

Thank you for taking part in the above research study.

The purpose of the research is to explore the emotional impact of working as a BSL interpreter on a specialist mental health inpatient unit for individuals who are deaf. As this is an area of limited research, findings from this study will contribute to the evidence base in the area of interpreting in mental health settings and in the area of mental health and deafness.

#### **Can I still decide to withdraw my data?**

Please contact me within two weeks of the study if you change your mind and wish to withdraw from the study. You can withdraw at this stage without having to provide a reason. Your interview will be deleted and will not be transcribed or included in analysis. It will not be possible to withdraw from the study after the two-week period, as the interview will have been transcribed and analysis will have started. Your interview will be transcribed verbatim by either myself or by the external professional transcription service, ‘AudioSec Transcription Service’.

#### **What will happen to the research findings?**

This research is being carried out as part of the thesis element of a postgraduate Clinical Psychology Doctorate qualification. The thesis reporting data from this study will be held in the University of Birmingham library and written up for publication in a suitable academic journal. Your anonymity will be maintained at all times. Please let me know if you would like the results of the research to be e-mailed to you.

#### **What if I need further support?**

If you have found any of the questions upsetting or if you feel that you require additional support, the following UK wide agencies can be contacted if you wish to access further support. Please contact the agency directly, using the contact details outlined below, to find out where your nearest centre is.

*Relate (nationwide counselling service)*

Contact number: 0300 100 1234

Website: <http://www.relate.org.uk/>

*Samaritans (nationwide service)*

Contact number: 08457 90 90 90

Website: <http://www.samaritans.org/>

*Improving Access to Psychological Therapies (IAPT)*

Accessible via GP however, some IAPT services also accept self-referrals.

Website: <http://www.iapt.nhs.uk/services/>

In addition to the above UK wide agencies, you may also be able to access support from occupational health via your employer.

Please keep this debrief form for future reference.

Thank you again for your participation.

Yours Sincerely

Lauren Calder-Hanley

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Participant Debrief Form – Version 0.2 (14<sup>th</sup> August 2018)

The emotional impact of working as a BSL interpreter in inpatient mental health services  
IRAS number 240560

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Dated 11 April 2019

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## Appendix H – Example of a Worked Transcript

Audio Title: APFO0010 & APFO0012  
Audio Length: 4:08 & 25:21

- 
- 1 I So thank you for agreeing to take part in this interview. I'm interested  
2 in your experience of the emotional impact of working as an  
3 interpreter on a specialist mental health inpatient unit. So how long  
4 have you been working as an interpreter?
- 5 P4 As a qualified interpreter?
- 6 I Yeah.
- 7 P4 Probably about 14/15 years.
- 8 I Okay. And has that always been in mental health settings or have you  
9 done a wide range of things?
- 10 P4 Mostly it's been community based.
- 11 I Community mental health or community?
- 12 P4 Just community. It's only been the last eight years maybe mental  
13 health.
- 14 I Okay.
- 15 P4 Between 5-8 years mental health.
- 16 I And how long have you been working on this ward in particular?
- 17 P4 Four years, possibly more.
- 18 I So you started off doing the community mental health and then you  
19 came onto the ward?
- 20 P4 I did have experience in the old building, do you know it wasn't (ward  
21 name) before.
- 22 I Yeah I remember it was a different building wasn't it?
- 23 P4 My first experience to mental health hospital inpatient was the old  
24 building yeah it frightened me to death, I never came back for  
25 however many number of years. Yeah well out of my league. I think it  
26 was when I was newly qualified, not over-confident but thinking well
- 

*Internalising  
the reason  
why they had  
a negative  
experience*

*Internalised  
disabilities  
reasons*

Not sure what  
it would be  
like?

Not knowing  
less scary  
than knowing?

Not knowing  
what terms  
meant

27 okay I'm qualified let's have a go. Well I had a go, didn't like it, never  
28 went back again.

29 I And so was it just the one time that you tried it?

30 P4 Yeah at an inpatient location, community fine, and I think if I'm honest  
31 back then we were never actually told if it was mental health related it  
32 was just you got that appointment and do it.

33 I And then it would just depend on what happened when you went.

34 P4 Yeah and you'd just deal with it. But no as an inpatient hospital yeah.

35 I So I'm curious so you had the experience before and then thought no  
36 and didn't go back so what changed in terms of them coming back to  
37 the ward when it moved?

38 P4 My own confidence. I remember somebody saying to me getting your  
39 qualification interpreter's degree was like passing your test, you've got  
40 your badge, you've got your licence, you've passed, same as your  
41 driving, you get your driving licence but then you go out and you learn  
42 to drive. The same with interpreting. You get your interpreter's badge  
43 to say you're safe, go out and learn to interpret now. And I think I  
44 started in that bit too early before I'd had that time to learn.

45 I To learn a bit more.

46 P4 Yeah and be comfortable with saying, 'I've missed that, sorry can you  
47 repeat that?' interrupting a big dynamic if you're in a meeting so it  
48 was just having that confidence to know my own skills.

49 I And was there anything in particular that had happened at the old  
50 hospital on the day that you did go that put you off or what was it?

51 P4 The language. Yeah it was the language. It was if I remember either a  
52 managers' lay meeting or it was some sort of professionals meeting  
53 because there was doctors, social workers, it was just the level of  
54 language used, terminology, in-house jargon, medication names, that  
55 sort of thing, it just totally threw me.

Blissful  
ignorance

Self  
esteem  
questioning  
self

Puppy - young inexperienced

56 I Things that I was wondering whether you had come across before so  
57 things like medication that you wouldn't have heard of before.  
58 P4 Yeah never heard of it before. And I think I was a bit under-  
59 experienced on how to manage such a big group of people. So yeah I  
60 walked out not a happy puppy that day and I was like, oh I need to go  
61 back to Level One.

62 I But I can imagine that was quite a big confidence hit...

63 (end of first audio APFO0010)

64 (audio APFO0012)

Managing  
lots of  
professionals  
? perceived  
higher status

65 I ...so it was the dynamics, dealing with lots of people being in the  
66 meeting room as well and getting used to that?

67 P4 And I think it was just their status, like the doctors, professionals,  
68 social workers, yeah it just threw me.

69 I Was it quite intimidating?

70 P4 Yes. That's probably a better word. I totally felt inadequate.

questioning  
self

71 I I imagine for you as an interpreter that must have been then quite  
72 difficult?

Not feeling  
good enough  
Vow = like  
long promise

73 P4 I seemed to manage, I'd got a brilliant co-worker which helped but  
74 yeah you come out, you do a bit of a self-evaluation and yeah I felt  
75 deskilled, I felt as though I didn't deserve the badge that I'd just been  
76 given: totally out of my depth. And then yeah I vowed I would never  
77 touch mental health knowingly again, it's not something I would  
78 choose.

79 I And so after that experience what was the following experience in  
80 mental health? Was it something that you'd kind of booked on to or  
81 was it an incident where you just turned up to interpret and it was  
82 mental health?

? Not expecting  
a deaf person  
to have  
mental health

83 P4 I just turned up to and if I'm honest naïvety again it was just a deaf  
84 person sitting in front of me either going for a doctor, dentist or

? Not aware  
of mental  
health

85 routine hospital, something, I don't think I actually even thought that  
86 it was mental health. It was just a person that was going for that  
87 appointment. Sometimes they'd be on their own; sometimes they'd  
88 have a support worker with them. I never classed it and labelled it as a  
89 mental health it was just an appointment and just a job. And it wasn't  
90 until I had another phone call many years later to say, look new  
91 contract, this agency's now taken over would I be prepared? And I  
92 thought, hmm I'm not sure. They said there'd be lots of support,  
93 mentoring blah, blah, blah, so I thought well okay let's give it a go, X  
94 amount of years. And yeah I've been fine.

95 I So it's been quite a different experience to last time?

96 P4 Yeah totally.

97 I What would you say has been different about this experience  
98 compared to the previous hospital?

Internalised  
reasons

Importance  
of support

99 P4 I suppose me, I've grown, I've got older, I've got more experience on  
100 how to manage different situations and dynamics and people. And I  
101 just think it's my confidence that's just developed. Again doing more  
102 work at the community again, mixing with people, knowing your co-  
103 workers, preparing more before, it just all plays a part. And knowing I  
104 suppose that the agency that I'm booked through there was support  
105 there if I was struggling. I've since then gone on to a couple of mental  
106 health courses, so again knowledge.

107 I So you've been provided more support externally as well?

108 P4 Yeah.

109 I And what does a typical shift entail on the ward for you?

110 P4 Well today we've had patients phoning home. Patient's families  
111 phoning in, translating that. We've had working one to one with the  
112 nurses, meetings, sitting chatting with bank staff that can't sign or  
113 some staff still are learning to sign. So sitting with them in the lounge,  
114 chatting to patients, translating what they're all talking about and  
115 doctors coming down chatting one to one with the patients,  
116 translating that.

- 117 I Quite varied.
- 118 P4 Yeah we have on Monday and Friday outpatients as well. So we can be  
119 on the ward in the morning and then afternoon we will take it in turns  
120 for outpatients which I still like doing that because you get to see  
121 both.
- 122 I Like the mixture of inpatient and outpatient?
- 123 P4 Mm.
- 124 I And can you tell me about the last shift that you worked, so today?
- 125 P4 Yeah it's not been hectic, it's been steady going. We've got two deaf  
126 staff on this morning so that takes up quite a bit helping communicate  
127 with the hearing staff that can't sign. So that was quite full on, phone  
128 calls against putting stuff out. And then this afternoon's a bit more low  
129 key with patients chatting in the lounge with again non-signing staff,  
130 making phone calls. Yeah we do OT sessions as well. Sometimes we  
131 get taken with the OT to do whatever activity they want to do and the  
132 psychologist, get to work with him sometimes.
- 133 I So supporting the rest of the MDT as well?
- 134 P4 Yeah it's basically wherever if two people can't communicate then  
135 we're dragged in to facilitate that.
- 136 I And can you tell me about a time when you felt distressed after  
137 something that you interpreted or witnessed at work if there has  
138 been?
- 139 P4 No. I can't remember a time where I have been distressed or upset or  
140 anything, no, not even when we've had like the bad days a few years  
141 ago we had some patients that were quite challenging, behaviour  
142 challenging. No, they have like a good support here; they're always so  
143 like do you need to sit down, do you need to talk to me? But no I felt, I  
144 must have a really thick skin, either that or I've got no emotion any  
145 more, I don't know. But no. I expect the closest I've ever come to  
146 actually having that sort of feeling was recently they had an elderly  
147 patient on the ward that was not well at all and I'd not long lost my  
148 Dad, but I think that was more because it was a personal experience

? more 'work'  
when deaf  
staff  
compared to  
patients

dragged =  
careful

showing  
emotions

Don't let work and personal affect each other

Hardened = ? "soft" to become emotional

Interpreters shouldn't show any emotion  
Conflict between being human and the role as an interpreter

? Newly qualified or less experience = more bothered  
? Not professional to feel moved

149 to me that then the ward clerk asked me after if I needed to sit down  
150 and chat, if I was all right. But I was fine, walked in and got that, oh  
151 God, I don't think I can do this, but it was like no you're at work,  
152 you're not at home you're at work, so it was that segregation.

I 153 Yeah kind of splitting it off in your mind almost.

P4 154 Yeah and I was fine. But I suppose that's the closest I've ever come to  
155 it but I think you get hardened. It's a horrible thing to say but it's like  
156 GPs isn't it, sometimes you get a nice GP and get others that don't  
157 have a really good bedside manner, they just get hardened to it. I try  
158 not to show that side of it but I just try to stay as professional as you  
159 can do really. We are impartial and not to be seen to be showing  
160 anything really, even though we do. We're human we do take it on  
161 board but no we've got quite a good peer group. So I know if there has  
162 been something that really gets to me I know I can just give them like  
163 a text and it's like a group chat that we've got.

I 164 So you seek out the peers or the other interpreters that work on this  
165 ward if you need to?

P4 166 If I need to yeah, but no touch wood there's not much that's fazed me.  
167 Like when people are restrained or had to be injections for whatever  
168 reason, no I just get on with it.

I 169 Do you think that's always been the case? Can you think back to when  
170 you very first started?

P4 171 No again I think if I'd have come on the ward from just being qualified  
172 no I think it would have fazed me and I'm not sure how I would have  
173 reacted. And again I think that's only come with being in the field for  
174 so long, I've just learnt how to disengage from it. It's like it's  
175 (participant name) at work, this is not (participant name) personal, it's  
176 like there's this barrier that I'm here to do, which makes me sound not  
177 empathetic but I am but I think it just keeps that professionalism.

I 178 And do you think that if you didn't have that barrier almost then  
179 perhaps you would feel more upset by things or more overwhelmed  
180 by things?

Maintaining work/life boundaries

Human  
Conduct  
interpreter  
Conflict

Coping Strategy

uses practical  
nature as a  
reason why

Previously  
need to be  
more practical  
? survival

Being pragmatic  
is superior to  
emotional

"hanging about"  
? wasting time

? getting too  
involved with  
NOT

- 181 P4 I honestly don't know. I'm not actually an emotional person. If there's  
182 a crisis at home or anywhere I actually don't panic I just think, okay  
183 that's what you need to do.
- 184 I So you're quite pragmatic, logical?
- 185 P4 Logical yeah. I mean I've had a couple of things, personal stuff that's  
186 happened which is really weird because my husband's quite practical  
187 and yet he hadn't got a clue and it was me that then was saying, 'You  
188 need to do this, do this, do that, just get that for me...' so it was quite  
189 methodical. So I don't know it's hard to say.
- 190 I But that clearly works for you as a person.
- 191 P4 Yeah even like with the girls when they were growing up if they'd  
192 fallen over, oh my God, come here, you've cut your knee, sit here.
- 193 I I'll clean you up.
- 194 P4 Yeah, yeah. I know that's what I've got to do and I do it.
- 195 I And is that typically how you cope with most situations, so you'll kind  
196 of look to you'll think about that's what you need to do and you'll get  
197 on with the things that you need to do rather than necessarily  
198 focusing on the emotional impact of things?
- 199 P4 Yeah, yeah. It's like I mean it sounds like I'm blowing my own trumpet,  
200 I'm not, but it's like if I see something that's got to be done you think,  
201 well just get on and deal with it and do it. And I must admit it can be  
202 quite negative for me as well because I get a bit frustrated and I think,  
203 do it, what are you hanging about for just do it. Even with interpreting  
204 as a job if I'm working with, I don't know, nurses here for example you  
205 get some fantastic really good pragmatic nurses and you get some  
206 that are a bit slack and lazy, it happens everywhere, normal way of life  
207 and work and everything and I get frustrated because I think well I  
208 know what needs to be done because I've worked with other nurses  
209 that have done it and I'm like why aren't you doing it, come on? And I  
210 almost sometimes find myself saying, 'Well if you did that...' and that's  
211 not my role. So sometimes I do have to hold myself back because I do  
212 step out of my role every now and again. Stop!

213 I Because it is a very interesting dynamic on this ward, yes there's the  
214 interpreters, you're employed by a separate charity and you provide a  
215 service so you're almost part of an NHS, MDT but at the same time  
216 you're separate.

217 P4 Yeah and it's easy to forget that and I've seen some people do it and  
218 like I said I will admit it, I've even tiptoed into it myself where you do  
219 forget that you are not part...you are part of the team but you're not  
220 part of the team. And it's so easy to get your barriers and your lines  
221 blurred a little bit.

222 I Especially when you're spending so much time with the MDT.

223 P4 And it can be quite a sensitive time that you're working with  
224 somebody, if you're working with the doctors or whoever and you've  
225 got the person that you're interpreting for and they're offloading their  
226 intimate thoughts and feelings and everything it can be quite  
227 emotional and upsetting for them that they're offloading things like  
228 that, and you do work very closely together but you still have to  
229 remember at the end of the day I just walk away it's the doctor then  
230 and the patient that's got to deal with it. So it's hard not to get sucked  
231 into that role of giving your opinion and your view, you think you're  
232 not here to do that.

233 I And are you someone who's able to leave work at work, so when you  
234 leave the building are you able to switch off and forget about what  
235 you might have interpreted?

236 P4 I don't necessarily forget, I do, from leaving work and getting home,  
237 that time in the car I'll sometimes have a think about what's gone on  
238 in the day and I'll reassess and it's like, oh yes it's been a pretty good  
239 day today, or actually yeah we struggled with that today, why, why  
240 didn't that go as smooth as it could have been or why didn't it go as  
241 smooth as it has done? And that could be again the patient  
242 themselves not being fluent, it could be us, we could be just tired, I  
243 don't know, maybe the questions from the doctor wasn't coming  
244 across. So I'll do that in between leaving work and getting home. Nine  
245 times out of ten I'll get home and that's it, house head back on.

246 I You process everything and then that's it.

Unintentional  
role change  
? hard to  
initiate  
boundaries

Not the  
interpreters  
role to get  
involved

Focus on  
linguistic  
processing

Team  
boundaries

Responsibilities

Coping  
Strategies  
(Linguistic)

247 P4 Yeah.

248 I And your reflections in the car do they tend to be more about the  
249 linguistic process, like did I interpret this correct, or why wasn't that as  
250 flowing, or is it ever about the more emotional content of things that  
251 you might have interpreted?

252 P4 It's probably more linguistic than emotional side. And I think that's just  
253 again because I don't take on the emotion. I might but it doesn't affect  
254 me as though I need to reassess that, I just think well I know where it's  
255 come from that will go soon and I'll get on with things. I do pick myself  
256 and go well was that the right choice of sign, or was that the right  
257 choice of word to use? But again that's something that's developed  
258 that I do less of than I did when I first started. So when I first was  
259 qualified I was very critical, very critical of myself and thinking well  
260 that wasn't very good, that didn't work, for various reasons. But again  
261 over the years it's like I've learnt not to take ownership, it's not always  
262 me that's wrong, like I said it could be the deaf person, it could be the  
263 other hearing person that I'm with, it could be a number of things. It  
264 could be just because it was raining and I got wet this morning or,  
265 everybody's moaning because they're all wet and what have you. So I  
266 have learnt again and I think that just comes with experience.

267 I Like not the whole way through.

268 P4 Yeah and being able to let go of it.

269 I And has working in mental health affected you professionally in terms  
270 of, so I guess you were saying before about you had quite a bit of a  
271 negative experience the very first time then you took a big gap,  
272 thinking about the present day do you now feel that you want to do  
273 more work in mental health? Is it something that you want to carry on  
274 in or would you like to change at some point?

275 P4 I wouldn't necessarily say do more, I like doing my one day a week  
276 here and then the odd various shifts that I cover but I find it  
277 fascinating and I find it's helped in some ways where, you know  
278 somebody says something at face value and it's not necessarily,  
279 doesn't mean what they've said it's helped me to understand a little  
280 bit better about people and I've sort of maybe questioned, if I'm  
281 voicing over for somebody for example and they've gone, 'Phh I don't

Links with  
models of  
interpreting  
- conduit/  
machine  
model, i.e.  
not talking  
on emotions

Letting go/  
not taking  
ownership  
of others  
emotions  
or difficulties

Doesn't want  
to do more  
than one day  
a week

Different  
interpreting?  
- content  
and actual  
meaning not  
always the same

Conduit  
model

Change in  
role? not  
just  
translating  
but also  
assigning  
meaning

Translating  
vs  
interpreting

Focus on  
linguistics

- 282 know, I've just rabbited on something and I've gone, oh, whereas  
283 before I've just said it and that's it because that's what they've signed,  
284 I might now think, actually that might also mean this and I'm quite  
285 wary that I'll actually say, say for a doctor I might say, 'That also might  
286 mean what I've just said doctor but it could also mean this as well. If  
287 you want me to clarify I will or do you want to ask another question to  
288 clarify yourself?' so I will probably look into it a bit more deeper, so it's  
289 helped me understand that a bit better. But I just find it fascinating  
290 how people's minds work and how they jump from topic to topic and  
291 talk about whatever they're talking about and really believe that what  
292 they're saying is real. Yeah it fascinates me. So whereas before it was  
293 negative now I actually find it's a real positive.
- 294 I A complete switch is that how you've found it? And has working in  
295 mental health affected you on a personal level?
- 296 P4 No I don't think so. No, not that I've recognised, whether my family  
297 have said anything or think anything I don't know. They have said the  
298 whole signing, the whole interpreting has affected me personally  
299 because when I'm trying to explain something I will actually verbalise  
300 how I would sign it and BSL is a different structure to English, so I'll say  
301 in my head a completely normal grammatical sentence and the family  
302 just look at me and go, 'What are you talking about?' And that  
303 sometimes causes a row because like, 'What do you mean what am I  
304 talking about? I've just said, da- da- da- this time I've said it right,' and  
305 they're like, 'No you didn't say that the first time.' 'Yes I did!' 'No you  
306 didn't.' And then they say 'No what you actually said was blah-blah,'  
307 and I'm like oh no I've just signed it that way.' So yeah but I don't think  
308 that's mental health I think that's just generally because general BSL as  
309 when I'm talking I use my hands which annoys the family.
- 310 I Just because it's become second nature to you.
- 311 P4 It does and I find if I'm struggling to verbalise something then I will  
312 sign it to myself, to sign it to myself makes it clear before I speak it.
- 313 I It helps with that processing?
- 314 P4 Yes especially with spelling. So I suppose it's changed in that way.

- 
- 315 I That's interesting. And what do you like the least about working in  
316 inpatient mental health?
- 317 P4 In general or just about interpreting?
- 318 I Both.
- 319 P4 I don't think there's anything I dislike about the actual interpreting,  
320 what I don't like is staff that don't sign. I find that quite rude. Now I  
321 know the staff shortages so they have to use bank staff and everything  
322 else but I just find that I think if you're working on a deaf unit you  
323 should have the language and that potentially could put me out of a  
324 job but I still think it's rude and you do get bank staff in there that just  
325 talk, and I know that's when we come into it and we'll translate so the  
326 patients know what the bank staff are talking about but then when  
327 they sign back to say something we're voicing over and you've got  
328 staff that just totally ignore you and walk out and don't realise you're  
329 voicing over what a patient's saying and they just ignore you. So that is  
330 frustrating. But I don't know whether that would happen anywhere...I  
331 don't suppose it would really would it because if the patient was  
332 talking they'd be talking direct to them. But no as actually interpreting  
333 on an inpatient no I don't think there's anything I dislike, for me  
334 personally anyway.
- 335 I What do you like the most about working in inpatient mental health?
- 336 P4 The patients, yeah the characters of the patients, the things they  
337 come out with, things that they say, what they do, how they behave,  
338 the body language, it's just fascinating. It makes me laugh. It confuses  
339 me, makes me question, 'Really is that what you said?' because all my  
340 training is you take all the signing, you work it all out and you put it  
341 into some sort of order, obviously with mental health it's completely  
342 different that's not my job, that's the doctor's job to put it into order.  
343 So it's a complete switch around for me but no with the patients.
- 344 I And are there any other comments that you'd like to make about  
345 being on the ward, anything we haven't covered today?
- 346 P4 Can't think of anything no. What like?
- 

? interpreter  
more aware  
of the  
dynamic  
between  
deaf and  
hearing

changing  
role of  
interpreter  
- no longer  
assigning  
order

Communication  
Specialist

347 I I don't know any other experiences that you've had that you think  
348 might be relevant to the emotional impact of working on the ward?

349 P4 I had a funny experience when I first started here, actually that's just  
350 come back to mind, it was a male patient, quite a large gentleman that  
351 was losing his temper and needed to, not necessarily...he was  
352 restrained, held either side by staff and it was one hearing staff and  
353 one deaf staff. Hearing staff could sign but obviously he was holding  
354 the patient's arms so all hands were...So I was there waiting to sign  
355 what was going on and everything. Well they were all bent over, bent  
356 forward because that's the way the patient was holding, so they were  
357 all bent forward, so I sort of leant forward and down to sign. The  
358 hearing nurse said, all he said was, 'Floor,' so I got down on the floor  
359 ready to sign to the deaf staff and the hearing staff went, 'I meant...'  
360 and said the staff's member and what he meant was floor as in get the  
361 patient to the floor. So I dropped down on my hands and knees on the  
362 floor, and I just went, 'Oh!' So I stood back up. The moment had gone,  
363 I thought I'd made the situation worse because obviously the patient  
364 wasn't on the floor and he was still wriggling so in the end they took  
365 him to his bedroom and sat him on his bed. Things were sorted and  
366 everything else but then obviously after I'd had a debrief and I said,  
367 'Look I need to talk to you about that incident did I make it worse?'  
368 and he went, 'No you didn't, in fairness I don't think we would have  
369 got him to the floor.' And I went, 'It's not unusual for me to be in  
370 funny positions, I've done interpreting for people with false feet and  
371 stuff, I've had my socks and shoes off and we've measured feet and  
372 everything,' I said, 'So when you said floor I just went okay, I went  
373 down on the floor so I could see the other deaf staff clearer because  
374 then I'd be looking up at him and he could see me clearer.' And he  
375 went, 'No actually what I should have said was the staff's name, floor,  
376 so I knew he meant him.' So we had a bit of a giggle but obviously I  
377 felt a bit thick and a bit stupid.

378 I But from the sounds of it that was quite an easy mistake in that  
379 situation.

380 P4 I think it was.

381 I If you didn't know who the command was for.

Difficulty  
in  
communicating  
during  
restraint

Importance  
of clear  
communication

382 P4 Yeah and he did say, 'I could have said, Blah, floor,' so I knew he  
383 meant the staff. I said but obviously it was just the way I got on my  
384 hands and knees and you just went, 'I meant...' and he said the guy's  
385 name.

386 I I'm guessing as well like in a ward situation where sometimes things  
387 can be quite fast paced sometimes you don't have that same time to  
388 clarify things that you would have in other settings.

389 P4 No you don't. and it was quite a quick thing because the guy was  
390 kicking off. They'd got both arms, which was why then I got concerned  
391 like oh God I made it worse because they didn't get to the floor. And  
392 he went, 'No,' he said, 'In fairness because of the size of him and  
393 everything and the way he was fighting so I don't think we would have  
394 actually got him to the floor. So no you didn't.' so I was like, 'Oh okay,  
395 just remember that next time, do you mean me? Who do you mean  
396 the floor? What do you mean?' So obviously that was a bit of a  
397 learning bit for me.

398 I I'm sure it was also a learning experience for the hearing staff member  
399 as well.

400 P4 Yeah. That was a bit of a funny thing.

401 I Any other comments you want to make?

402 P4 No I can't think of any but I'll probably go out and go I could have said  
403 that.

404 I That's absolutely fine. And so if you don't mind I've got some  
405 questions to ask you regarding socio-demographics but this part is  
406 completely optional so you don't have to answer any of the questions  
407 if you don't want to. So how old are you?

408 P4 53.

409 I And what gender do you identify as?

410 P4 Female.

411 I And what ethnicity do you identify as?

*Having to  
react  
quickly*

*Interpreting  
and  
restraints*

412 P4 White British.

413 I And what training have you had with regards to interpreting?

414 P4 I'm a qualified interpreter so I've got my degree and I've also done  
415 mental health training as well.

416 I That was my next question. So what training have you had with  
417 regards to mental health, so you said you've been on a couple of  
418 courses?

419 P4 I've been on a couple of weekend and day courses, various places. So  
420 it's about three.

421 I Who are they run by?

422 P4 One is by the agency that provide the interpreters for here. The other  
423 one was for a company in Worcester, I think twice actually, twice in  
424 Worcester, the same company was running two slightly different  
425 levels of mental health, so I've done those.

426 I Great.

427 P4 Is it other training or is it just relating to this?

428 I Related to mental health that's fine. So thank you for taking part in  
429 this study and please could you contact me within two weeks if you  
430 change your mind and wish to withdraw from part of the study or all  
431 of the study.

432 P4 Okay thank you.

433

## Appendix I – Development of Superordinate Themes

### IPA Emergent Themes – “Jamie”

Emergent Themes	Original Transcript
Internalised difficulties/reasons (lines 23-26)	P4: My first experience to mental health hospital inpatient was the old building yeah it frightened me to death, I never came back for however many number of years. Yeah well out of my league. I think it was when I was newly qualified, not over-confident but thinking well okay I'm qualified let's have a go. Well I had a go, didn't like it, never went back again.
Self-esteem/questioning self (lines 35-48; lines 65-70)	<p>I: So I'm curious so you had the experience before and then thought no and didn't go back so what changed in terms of them coming back to the ward when it moved?</p> <p>P4: My own confidence. I remember somebody saying to me getting your qualification interpreter's degree was like passing your test, you've got your badge, you've got your licence, you've passed, same as your driving, you get your driving licence but then you go out and you learn to drive. The same with interpreting. You get your interpreter's badge to say you're safe, go out and learn to interpret now. And I think I started in that bit too early before I'd had that time to learn.</p> <p>I: To learn a bit more.</p> <p>P4: Yeah and be comfortable with saying, 'I've missed that, sorry can you repeat that?' interrupting a big dynamic if you're in a meeting so it was just having that confidence to know my own skills....</p> <p>I: ...so it was the dynamics, dealing with lots of people being in the meeting room as well and getting used to that?</p> <p>P4: And I think it was just their status, like the doctors, professionals, social workers, yeah it just threw me.</p> <p>I: Was it quite intimidating?</p> <p>P4: Yes. That's probably a better word. I totally felt inadequate.</p>
Not showing emotions	P4: No. I can't remember a time where I have been distressed or upset or anything, no, not even when we've had like the bad days a few years ago we had some patients that were quite challenging, behaviour challenging. No, they have like a good support here; they're always so like do you need to sit down, do you need to talk to me? But no I felt, I must have a

Maintaining work/life boundaries (lines 139-152)	really thick skin, either that or I've got no emotion any more, I don't know. But no. I expect the closest I've ever come to actually having that sort of feeling was recently they had an elderly patient on the ward that was not well at all and I'd not long lost my Dad, but I think that was more because it was a personal experience to me that then the ward clerk asked me after if I needed to sit down and chat, if I was all right. But I was fine, walked in and got that, oh God, I don't think I can do this, but it was like no you're at work, you're not at home you're at work, so it was that segregation.
Human vs conduit interpreter (lines 154-163)	P4: Yeah and I was fine. But I suppose that's the closest I've ever come to it but I think you get hardened...I try not to show that side of it but I just try to stay as professional as you can do really. We are impartial and not to be seen to be showing anything really, even though we do. We're human we do take it on board but no we've got quite a good peer group. So I know if there has been something that really gets to me I know I can just give them like a text and it's like a group chat that we've got.
Coping strategy (lines 174-177)	P4: And again I think that's only come with being in the field for so long, I've just learnt how to disengage from it. It's like it's (participant name) at work, this is not (participant name) personal, it's like there's this barrier that I'm here to do, which makes me sound not empathetic but I am but I think it just keeps that professionalism.
Maintaining team boundaries (lines 217-221)	P4: ...I will admit it, I've even tiptoed into it myself where you do forget that you are not part...you are part of the team but you're not part of the team. And it's so easy to get your barriers and your lines blurred a little bit
Role of the interpreter (lines 223-232)	P4: And it can be quite a sensitive time that you're working with somebody, if you're working with the doctors or whoever and you've got the person that you're interpreting for and they're offloading their intimate thoughts and feelings and everything it can be quite emotional and upsetting for them that they're offloading things like that, and you do work very closely together but you still have to remember at the end of the day I just walk away it's the doctor then and the patient that's got to deal with it. So it's hard not to get sucked into that role of giving your opinion and your view, you think you're not here to do that.
Coping strategy – focus on linguistics rather than emotions (lines 233-245; lines 252-266)	I: And are you someone who's able to leave work at work, so when you leave the building are you able to switch off and forget about what you might have interpreted?  P4: I don't necessarily forget, I do, from leaving work and getting home, that time in the car I'll sometimes have a think about what's gone on in the day and I'll reassess and it's like, oh yes it's been a pretty good day today, or actually yeah we struggled with that today, why, why didn't that go as smooth as it could have been or why didn't it go as smooth as it has done? And that could be again the patient themselves not being fluent, it could be us, we could be just tired, I don't know, maybe the questions from the doctor wasn't coming across. So I'll do that in between leaving work and getting home. Nine

	<p>times out of ten I'll get home and that's it, house head back on...</p> <p>I: ...And your reflections in the car do they tend to be more about the linguistic process, like did I interpret this correct, or why wasn't that as flowing, or is it ever about the more emotional content of things that you might have interpreted?</p> <p>P4: It's probably more linguistic than emotional side. And I think that's just again because I don't take on the emotion. I might but it doesn't affect me as though I need to reassess that, I just think well I know where it's come from that will go soon and I'll get on with things. I do pick myself and go well was that the right choice of sign, or was that the right choice of word to use? But again that's something that's developed that I do less of than I did when I first started. So when I first was qualified I was very critical, very critical of myself and thinking well that wasn't very good, that didn't work, for various reasons. But again over the years it's like I've learnt not to take ownership, it's not always me that's wrong, like I said it could be the deaf person, it could be the other hearing person that I'm with, it could be a number of things. It could be just because it was raining and I got wet this morning or, everybody's moaning because they're all wet and what have you. So I have learnt again and I think that just comes with experience.</p>
<p>Changing role of interpreter in inpatient mental health (lines 335-343)</p>	<p>I: What do you like the most about working in inpatient mental health?</p> <p>P4: The patients, yeah the characters of the patients, the things they come out with, things that they say, what they do, how they behave, the body language, it's just fascinating. It makes me laugh. It confuses me, makes me question, 'Really is that what you said?' because all my training is you take all the signing, you work it all out and you put it into some sort of order, obviously with mental health it's completely different that's not my job, that's the doctor's job to put it into order. So it's a complete switch around for me...</p>

Internalised  
difficulties/reasons  
(lines 23-26)

Self-esteem/  
questioning self  
(lines 35-48; lines 65-  
70)

Human vs conduit  
interpreter (lines 154-  
163)

Changing role of  
interpreter in  
inpatient mental  
health (lines 335-343)

Role of the  
interpreter (lines 223-  
232)

Not showing  
emotions  
  
Maintaining work/life  
boundaries  
  
(lines 139-152)

Maintaining team  
boundaries (lines 217-  
221)

Coping strategy (lines  
174-177)

Coping strategy –  
focus on linguistics  
rather than emotions  
(lines 233-245; lines  
252-266)

PEOPLE FORGET  
THAT WE'RE  
HUMAN AS  
WELL

Internalised  
difficulties/reasons  
(lines 23-26)

Self-esteem/  
questioning self  
(lines 35-48; lines 65-  
70)

Human vs conduit  
interpreter (lines 154-  
163)

I STILL WISH  
I KNEW WHERE  
TO STAND

Changing role of  
interpreter in  
inpatient mental  
health (lines 335-343)

Role of the  
interpreter (lines 223-  
232)

AS INTERPRETERS  
WE'RE NOT  
NECESSARILY  
LOOKED  
AFTER

Not showing  
emotions  
  
Maintaining work/life  
boundaries  
(lines 139-152)

Maintaining team  
boundaries (lines 217-  
221)

Coping strategy (lines  
174-177)

Coping strategy -  
focus on linguistics  
rather than emotions  
(lines 233-245; lines  
252-266)

## Appendix J – Allocation of Supporting Quotes per Theme

Emotions  
and  
professionalism

Human vs conduit  
interpreter (lines  
154-163)

P4: Yeah and I was fine. But I suppose that's the closest I've ever come to it but I think you get hardened...I try not to show that side of it but I just try to stay as professional as you can do really. We are impartial and not to be seen to be showing anything really, even though we do. We're human we do take it on board but no we've got quite a good peer group. So I know if there has been something that really gets to me I know I can just give them like a text and it's like a group chat that we've got.

Jamie p6 158-160

Maintaining  
professional p26  
boundaries (lines  
838-844)

P3: If there is a boundary between... you may not want to disclose things or offload how you really truly are feeling to members of staff on the ward, even if that's a psychologist, a counsellor, whoever else. If you are then next week interpreting for them and trying to look professional, you want somebody that's more impartial than that. So finding appropriate people that could do that is needed. Sam

Professionalism  
(lines 823-837)

P1: ...I just remember in that situation, the one with being hit with the stick, it was thinking "oh right I can't really react right now because I'm in a room full of professionals and I've got the contract with this job so I need to not react really to it". I kind of reacted with a bit of "oh God, are you okay? Ooh well that didn't go very well did it? Yeah" and then it was when I got to walk out the room and sit down somewhere, I had a little cry

Charlie p24 824-837

Maintaining  
professional  
boundaries  
(lines 1269-  
1277)

Charlie  
p.37

P1: I, I don't know. I suppose it's the professionalism I suppose, and also right I had to go back into ward review (laughing)

I: ...And then also it's knowing what support I'm, I'm actually allowed to get...

I: Yeah

P1: ...and from where. I don't know, I don't know who to talk to

I: Okay

P1: I could talk to, as I said my interpreter buddies but I don't know if I can access the psychologist here or I thought they were just here to see the patient and I don't. I think, I think there's a lot that's unclear is what I've learnt today (laughing)

I: Okay. Is that something that you would like clarified?

P1: Yeah, I think so. It's just knowing, and then, because I don't want to mess up or merge any boundaries so that's it, you know.

Professionalism  
(lines 625-651)

Charlie

627 -

633

used

p19

I: What, in an ideal world, what would you like support wise on the ward?

P1: It would be...I think it would be helpful to talk to the psychologists because I know the ones on the ward here know about working with interpreters and they know about working with deaf people. However, that might feel uncomfortable in ward reviews say, and I start interpreting something along a similar theme. That might suddenly be going, "oh gosh, ooh yeah I remember she told me before that that was a problem" so it would be nice to have somebody to talk to like a clinical supervision but they have to be, they can't just be any psychologist. They've got to be somebody who knows about deaf people and interpreter's roles. So if there was somebody like that. So I know that there are two psychologists on the ward. One that I see fairly regularly and one that I don't see fairly regularly...

I: Okay

P1: ...so maybe if we could access that person

I: The one that you don't see as regularly?

P1: Yeah. Yeah because they...because I'm assuming...you know...I don't know how comfortable I'd feel with "oh right, they're talking about a Mum who told them that they're a failure and stuff. Oh you know what that was my childhood as well. I was brought up to believe that I was a failure so do I want you to know that much about me as an interpreter?"

I: Yeah

P1: And is that professional? Is that appropriate?...