Cognitive Behavioural Therapists' Experiences of Working Remotely With Language Interpreters

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Abstract

In the United Kingdom, approximately one million people cannot speak English well enough to access therapy in English. If there is no shared language used by both the client and therapist, then individuals require access to an interpreter so that they receive an equitable service. Research highlights the anxiety and pressures that working with an interpreter can bring for professionals. In light of the Coronavirus pandemic and increased remote working, this research aimed to explore the experience and perspectives of cognitive behavioural therapists working with language interpreters remotely. Semi-structured interviews were conducted with eighteen participants who were asked about their experience of working with interpreters remotely. Data was analysed using Braun and Clarke's six phases of reflexive thematic analysis (Braun & Clarke, 2019; Braun & Clarke, 2006). The analysis resulted in five main themes being constructed: the system doesn't make it easier; therapist values of inclusive and self-reflective practice; working in a culturally sensitive way; the powerful role of the interpreter and remote therapy – different landscape, different journey. In total, 17 subthemes were created. Findings offer an understanding of how working with an interpreter impacts CBT ways of working. The findings draw attention to the impact of the organisational context where therapists work. The results also offer an insight into the relationship dynamics when introducing a third person in a remote setting as opposed to the traditional client-therapist dyad. Findings are considered in relation to competencies and therapeutic skills. Training and learning needs are highlighted, along with service level implications.

Keywords: interpreters, interpreter-mediated therapy, cognitive behaviour therapy, remote therapy, qualitative, mental health

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Frequently Used Acronyms

Frequently used acronyms are listed below in Table 1 to aid the reader.

Table 1

Frequently Used Acronyms

Acronym	Phrase related to the abbreviation
BABCP	The British Association for Behavioural and Cognitive Psychotherapies
BAME	Black, Asian and Minority Ethnic
CA-CBT	Culturally Adapted Cognitive Behaviour Therapy
CBT	Cognitive Behaviour Therapy
CS-CBT	Culturally Sensitive Cognitive Behaviour Therapy
COVID-19	Coronavirus Disease 2019
EU	European Union
IAPT	Improving Access to Psychological Therapies (Renamed "Talking Therapies" on 16th January 2023)
LiCBT	Low-Intensity Cognitive Behaviour Therapy
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
PWP	Psychological Wellbeing Practitioner
UK	United Kingdom

Introduction Chapter

Chapter Overview

This introductory chapter begins by providing an overview of the topic, including an introduction to Cognitive Behavioural Therapy (CBT). It will discuss key aspects of working with clients who have limited spoken English, such as guidelines about working with an interpreter. The chapter highlights the impact of the Coronavirus (COVID-19) pandemic and the increase in remote working. This chapter then provides a further in-depth exploration of the literature and will discuss the stages of the systematic qualitative literature review surrounding therapists' experiences of working with interpreters. This will situate the current study and identify a gap in the literature. The chapter concludes with a rationale for the present research and the aims of the study as broadly derived from the systematic review.

Introduction to The Topic

This study explored therapists' experiences working with interpreters remotely to deliver CBT. An interpreter is recommended when working with clients with limited spoken English (Tribe, 2009). There appears to be only one study that has explicitly investigated the experiences of CBT therapists working with interpreters (Tutani et al., 2018). This study did not explore the remote aspect of therapeutic work and predominately interviewed Psychological Wellbeing Practitioners (PWPs). This highlighted a gap in the research. In light of the COVID-19 pandemic and initiatives around increased remote working, this research explored the experience and perspectives of CBT therapists working with interpreters remotely. This is important because research has shown that clinicians are concerned about working remotely (Turner et al., 2018). A better understanding could help identify barriers to working with interpreters in mental health settings and consider ways to

overcome these issues. It also offers insight into perspectives about increasing digital and remote ways of working. It is hoped that insight into how CBT is practised when working with an interpreter will highlight support needs and lay the foundation for potential training.

Terminology

Before this chapter presents the background literature, it will define terminology. This study focuses on working with interpreters. A spoken language interpreter translates what is said into meaningful language, whereas a translator converts written words between two languages. The task of an interpreter in the therapeutic context is to support communicative autonomy. This is defined as "the capacity of each party in an encounter to be responsible for and in control of his or her own communication" (García-Beyaert, 2015). The terms "patients" and "clients" have been used interchangeably throughout this thesis to refer to those receiving therapy. Furthermore, non-English speaking and limited spoken English are terms that are used interchangeably to refer to those who require the assistance of a language interpreter for therapy.

People who live in the United Kingdom (UK) and do not speak English or have limited spoken English may have come to the UK as a refugee, asylum seeker or migrant. The United Nations Convention Relating to the Status of Refugees (UNHCR) defines a refugee as an individual who has fled their country because there is a risk to their safety due to human rights violations or persecution and as such has a right to international protection. Refugees may have fled from war, violence, poverty or the consequences of natural disaster. The 1951 Refugee Convention states the legal definition of a refugee as someone who is "unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion" (UNHCR., 1951, p.3). The term asylum-seeker is largely a bureaucratic

term used to describe a person who has also left their country and searching for protection from persecution and human rights violations but has not yet been legally recognised as a refugee. They might be waiting for the home office's decision on their asylum claim. There is no legal definition of the term migrant, but migrants are people living outside their country of origin who are not refugees or asylum seekers. Migrants may decide to move to a new country, not because of persecution or threat but to improve their lives, such as to unite with family or have a better possibility of finding employment. Migrants can normally return home if they wish to do so.

The terms “culture”, “ethnicity”, and “race” are regularly used as if they were wholly interchangeable (Naeem et al., 2019). Culture is a common term but there is a great deal of uncertainty about what this word and phenomenon refers to (Naeem et al., 2019). One way of looking at culture is that it refers to a “group’s thoughts, experiences, and patterns of behaviour and its concepts, values and assumptions about life that guide behaviour and how those evolve with contact with other cultures” (Jandt, 2017). Culture is not static and is a constant process that evolves. Davidson and Patel (2009) argue that the term culture refers to an invisible norm of “whiteness” and therefore when talking about culture in clinical psychology, this is usually referring to the “other” (p.77). Although this thesis uses the word “culture” for ease of reference, it is acknowledged that individual experience and perspectives will underpin definitions. This study does not claim that culture and ethnicity are synonymous (Betancourt & López, 1993). Ethnicity has been described as “a group of people who have shared ancestry, heritage, culture and customs” (Perepa, 2019, p.13), as well as shared language, region of origin and religion (Markus, 2008). Ethnicity is a broader social construct than race. For example, “people who have migrated to the UK from other countries may still relate their ethnic identity to their country of origin, whereas their offspring, whilst

sharing similar physical characteristics, may identify themselves as having a different ethnicity" (Naz et al., 2019, p.3).

The term Black, Asian and Minority Ethnic (BAME) is imperfect and does not fully capture the cultural, racial, political, and social disparities that exist within and between ethnic groups. This term is used in this thesis when it mirrors the cited literature. For example, Improving Access to Psychological Therapies (IAPT) service outcome reports and positive practice guides produced by the British Association for Behavioural and Cognitive Psychotherapies (BABCP) adopt the acronym BAME (Beck et al., 2019).

The term "IAPT" is used throughout this thesis because it was the service that several participants worked in at the time of interviewing. However, on the 16th of January 2023, it was renamed "Talking Therapies". Finally, dyadic therapy refers to the therapeutic relationship between the therapist and the client. In contrast, the triad refers to the presence of an interpreter as the third person within this relationship.

Background

Current Context

The UK is increasingly becoming more culturally and ethnically diverse. This is partly due to a rise in the level of immigration in the UK. There is an increasing number of individuals who are displaced around the world. For example, Ukrainian refugees who fled Russian invasion; Afghanistan refugees who fled the Taliban and Syrian refugees who fled civil war. In the year ending June 2022, there were 63,089 asylum applications in the UK (Home Office, 2022). This was 77% more than in 2019 but considerably lower than other countries such as Germany and France. In the year ending June 2022, the main countries of

nationality claiming asylum in the UK were Iraq, Afghanistan, Syria, and Sudan (Sturge, 2022).

The Census collects information on the main languages spoken in the UK. In the 2021 Census, 1.8% of people (1,041,000) could not speak English well or at all. In the Census, more than 90% of people reported English as their main language (Office for National Statistics, 2022). However, the Census question forces multilingual individuals to select just one language as their "main language". It is unclear if this refers to someone's first language, preferred language or the one used most frequently. Polish was the most commonly spoken language after English. The other main languages spoken include; Romanian, Panjabi, Urdu, Portuguese, Spanish and Arabic. The largest increase from the 2011 Census was people who specified Romanian as their main language (Office for National Statistics, 2022).

Political Context

Prior to Brexit, free movement rules gave European Union (EU) citizens the right to live and work in the UK without requiring permission. Since Brexit, EU citizens migrating to the UK are subject to more restrictive immigration rules. Individuals moving to the UK from EU or non-EU countries to live or work require a visa or to claim asylum.

Individuals must apply for asylum to stay in the UK as a refugee. They must be physically in the UK to claim asylum, often this means arriving to the UK through irregular means such as crossing the English Channel in small boats. A person who claims asylum has the legal right to remain in the UK while their application is considered. Initially, individuals are offered a meeting with an immigration officer to screen for eligibility. An asylum interview is offered if the Home Office deems the claim suitable. The asylum process is complex and a time of long-lasting hardship (Mann & Fazil, 2006; Masocha & Simpson, 2012). During this time, there can be risk of homelessness, destitution and/or living in poor

living conditions. Studies report that asylum seekers have a negative experience of the Home Office (Liebling et al., 2014). Souter (2011) criticised the asylum system process due to a "culture of disbelief", which refers to the widespread assumptions that large numbers of asylum claims are unfounded or dishonest (p.48). Therefore, to prevent "abuses of the system" there is an increased risk that an asylum seeker might be denied refugee status (Souter, 2011, p.48). If refugee status is not granted, asylum seekers may be refused and might be able to appeal their case. Within the UK, asylum seekers are entitled to free healthcare but are not permitted to work, apart from in exceptional circumstances (UK Goverment, 2014).

In April 2022, the "Nationality and Borders bill" was passed which aims to deter irregular entry into the UK. This has been described as the "biggest overhaul of our asylum system in decades" (UK Government, 2022). The UNHCR believe that this act will penalise most refugees seeking asylum. The migration and economic development partnership is an asylum arrangement allowing the UK to send some people to Rwanda who would otherwise claim asylum in the UK. The Government stated that the intention is to stop people entering the UK by irregular means, but alternative safer routes have not been offered. This bill is highly controversial and as of March 2023 no one has been removed to Rwanda due to ongoing legal action. The "Illegal Immigration bill" was introduced by the UK Government in March 2023 and proposes that individuals who arrive in the UK by irregular means will be detained and removed from the country. McCann (2023) expresses concerns that the bill attempts to dehumanise people and would deny refugees safety, protection, and a fair hearing.

Public Narratives

Public narratives that surround immigration and refugees are often framed as polarised. Narratives may focus on a perceived threat to security, culture and resources to a

more positive narrative that highlights the benefits of economic growth and cultural diversity. An increase in expressed hostility and xenophobia towards immigrants was reported in the UK (Peterie & Neil, 2020) at a time that perhaps was exacerbated as the UK left the EU. During the EU referendum campaign, coverage of immigration within the media almost tripled (Moore & Ramsay, 2017) and was largely negative. Central to Brexit was implementing tighter borders with expressions to "take back control" of Britain's borders (Abbas, 2020). There was an increase in far right campaigns against multiculturalism which meant that issues of immigration, "refugee crisis" and terrorism were conflated and encouraged resentment towards racialized communities (Abbas, 2020).

Coronavirus

This thesis was carried out between 2020 – 2023 during and post-pandemic. The pandemic impacted people's mental health and access to psychological support. In 2019/20, there was a major outbreak of COVID-19 across the world (Paules et al., 2020). To prevent COVID-19 cases and deaths, most governments called for countries to go into "lockdown". In the UK, a nationwide lockdown was announced on the 23rd March 2020 and the public were instructed to stay at home. In the UK, mortality from COVID-19 was highest in older adults, those with low incomes, and those from racialized groups (Barr et al., 2020; Hayward et al., 2021), highlighting fundamental health inequalities (Nazroo, 2003).

Refugees and asylum seekers rely heavily on charities and lockdown negatively impacted the provision offered including interpreting and translation support services (Paton et al., 2020). The pandemic was a difficult time and lockdown exacerbated the social isolation and feelings of loneliness experienced by many asylum seekers and refugees (Paton et al., 2020; Reehal et al., 2019). There are calls to further explore the impact the pandemic had on the mental health and wellbeing of the population in the UK (Douglas et al., 2020).

The lockdown may have exacerbated symptoms among those with pre-existing mental health difficulties and increased the risk of developing new symptoms among those who did not. In the UK, the COVID-19 vaccination roll-out programme was predominantly carried out through healthcare services. Many migrants were not vaccinated due to a perceived lack of entitlement to healthcare, fear of cost and poor understanding of the systems which is often compounded by language barriers (Gardner, 2021; Nellums et al., 2018).

Cognitive Behavioural Therapy

Inequalities accessing healthcare for refugees and people from diverse ethnic backgrounds is also an ongoing concern regarding mental healthcare services, including access to therapy. In the UK, the availability of therapy such as psychodynamic psychotherapy, family/ systemic therapies and CBT has expanded. The National Institute for Health and Care Excellence (NICE) guidelines for common mental health problems recommends CBT (NICE., 2011) and this approach is widely used. This section will discuss the characteristics of CBT, the evidence base, a critique and introduce culturally inclusive CBT.

"Cognitive Behaviour Therapy" is an umbrella term encompassing a range of approaches and drawing on multiple theories and applications (Chadwick et al., 1996; Moloney & Kelly, 2004). The origins of CBT draw from learning theory, laboratory-based cognitive psychology, aspects of psychodynamic theory and clinical experience (Beck & Weishaar, 1989). The cognitive model was originally developed following studies conducted by Beck (Beck, 1964;1963) to explain the psychological processes in depression (Knapp & Beck, 2008). Beck et al. (1979) define CBT as "an active, directive, time-limited, structured approach. . . based on an underlying theoretical rationale that an individual's affect and behaviour are largely determined by the way in which he structures the world" (p. 3).

Newer forms of CBT have evolved such as mindfulness-based cognitive therapy, dialectical behaviour therapy, acceptance and commitment therapy (ACT) and compassion focused therapy (CFT). Over time, there has been an increased focus on the individual's relationship to their experience rather than the content of the experience itself.

Characteristics of Cognitive Behavioural Therapy

CBT focuses on the here and now and is based on the idea that cognitive processes are fundamental in the cause and treatment of someone's distress (Westbrook et al., 2011). The basic premise is that how someone perceives the world or situation impacts their emotions, behaviours and physiology. These four elements are all interconnected and can keep a problem maintained (Greenberger & Padesky, 1995; Padesky, 1994).

CBT is a collaborative approach that works toward a shared understanding with the client by sharing formulations. Gathering feedback and providing summaries are core parts of CBT to enable a shared understanding (Westbrook et al., 2011). Kuyken et al. (2008) differentiated between three levels of formulation: descriptive, cross-sectional and longitudinal. The descriptive level breaks the client's experience into thoughts, emotions, behaviours and physiology (Kuyken et al., 2011). A cross-sectional formulation identifies triggers, responses and maintenance cycles. A longitudinal formulation incorporates both descriptive and cross-sectional levels and a developmental history that link to the presenting issues and incorporates core beliefs, assumptions and early experiences (Kuyken et al., 2011).

Interventions target the cognitive or behavioural components of the formulation. In essence, CBT aims to offer a problem-focused space to enable the client to reframe or challenge "unhelpful" beliefs and behaviours. For example, a cognitive intervention such as guided discovery means that the therapist would use Socratic questioning to help the client understand the idiosyncratic meaning of situations and to consider alternative perspectives.

Behavioural interventions include behavioural activation, graded exposure, and behavioural experiments. Sessions are structured, time-limited and brief, with six to twenty sessions offered with the onus on the client to complete homework in between sessions (Westbrook et al., 2011).

Evidence-Base for Cognitive Behavioural Therapy

CBT has built its credibility from numerous data from randomised control trials (RCTs) whereby those in a treatment group receiving CBT have a reduction in symptoms that is significantly better than the control group. CBT has proven to be effective for various presentations for example, anxiety disorders (Hofmann & Smits, 2008), eating disorders (Hay et al., 2009) and chronic pain (Glombiewski et al., 2010). Butler et al. (2006) reviewed 16 meta-analyses which found support for the efficacy of CBT for a wide range of psychological disorders. Hofmann et al. (2012) provided a comprehensive evaluation of all contemporary meta-analyses examining the evidence base for the efficacy of CBT. Importantly for the present study, a limitation was that studies did not always report on the outcome for specific subgroups, such as people from minoritised communities. Furthermore, clients with limited spoken English are often underrepresented in research studies.

Critique of Cognitive Behavioural Therapy

Despite CBT being dominant in many clinical settings and well founded in clinical outcome research, it is subject to criticism. Indeed, the literature suggests that only about half of CBT clients will have a reduction in symptoms, even under ideal research conditions (Moore et al., 2012; NHS Digital, 2018; Pybis et al., 2017; Richards et al., 2016). The term ‘evidence-based’ therapy is often associated with CBT and standardised or scripted ways of working which does not address the needs of individual patients (Shedler, 2018).

Treatment progress has been stagnating and this lack of improvement can too readily be attributed to a failure of motivation or lack of psychological insight on the client's part (Smail, 2001). For many years the prevailing narrative has located mental health issues as being within the individual and the response has been to offer medical interventions. This can leave the individual with a sense of failure and feelings of isolation and stigmatisation. Whilst these feelings may impact everyone, they are further compounded by an individual's life context, particularly those disfranchised by disadvantages such as chronic illness, poverty or discrimination.

The discourse that anxiety and depression are viewed as an individual's problems may also have political consequences. Politicians may avoid taking action in politically contentious areas that would redistribute wealth and focus on structural inequalities (Knight & Thomas, 2019). Patel (2003) draws attention to the inextricable links between an individual's life and the historical, social and political context that shape it. The power, threat, meaning framework offers an alternative perspective to psychiatric diagnosis and highlights the impact of wider social factors on emotional distress and disempowerment (Johnstone & Boyle, 2018).

The literature draws attention to methodological issues applying RCTs to therapy research (Guy et al., 2012; Watts, 2018). NICE relies on a biomedical approach to mental health. It seeks to establish efficacy, i.e. "the measurable effects of specific interventions" (Nathan et al., 2000, p.964), rather than effectiveness, "whether treatments are feasible and have measurable beneficial effects across broad populations and in real-world settings" (Nathan et al., 2000, p.965). It is important to highlight the economic gains of RCTs as for many conditions, CBT is the recommended treatment in the NICE guidelines. The impact of this has been an increase in CBT practitioners and fewer long-term therapies offered by

highly trained, experienced yet more expensive therapists. This also leads to a reduction in patient choice in the National Health Service (NHS).

Critics have doubted the underpinning theoretical concepts of CBT and argue that it does not adequately provide a framework to understand the client's holistic life experience. Moloney and Kelly (2004) challenge the concept of cognitive processes and the relationship between cognition and emotions. For example, although people who are depressed may make negative comments more frequently than people who are not depressed, this could be attributed to the effect of aversive conditions. Therefore some people are more readily able to access negative or pessimistic beliefs. Moloney and Kelly (2004) and Sue and Sue (1999) draw attention to CBT's ethnocentric worldview that is based on assumptions about how clients' function, relate to others and understand the causes of their difficulties. CBT is premised upon a Western worldview of prioritising analysis, scrutiny and modification of thinking (Moloney & Kelly, 2004).

Culturally Inclusive Cognitive Behavioural Therapy

The field of psychology needs to question and scrutinise its clinical application of theory that is embedded in western ideology if it is to foster anti-discrimination and equal opportunities (Patel, 2003). The research on CBT has mainly focused on White western populations and in recent years, there has been increasing recognition of the need to examine if CBT is effective for people from racialized communities and refugee groups (Hinton & Patel, 2017). Within the CBT field, there has been increasing awareness of considering the client's cultural background when formulating (Beck, 2016; Persons et al., 2001) and adapting therapy to ensure that every individual can benefit from evidence-based therapy. Cultural adaptation of CBT can be defined as "making adjustments in how therapy is

delivered, through the acquisition of awareness, knowledge, and skills related to a given culture, without compromising on the theoretical underpinning of CBT" (Naeem et al., 2010).

The BABCP BAME positive practice guide highlights the role of culturally adapted CBT when working with refugees and asylum seekers (Beck et al., 2019). Beck et al. (2019) argue that therapists should be prepared to use a flexible approach when using CBT protocols and hold realistic expectations about the limits of applying mental health models developed for one culture to another.

Many terms, often used interchangeably, have emerged to demonstrate how professionals may work with cultural diversity and differences. These terms include cultural awareness, cultural sensitivity, cultural appropriateness, cultural humility and cultural competence. Beck (2016) distinguishes between culturally adapted CBT and culturally sensitive CBT. Although these terms are often used interchangeably in the literature, Beck defines culturally sensitive CBT (CS-CBT) as CBT adapted by therapists to include conversations around ethnicity and culture (Beck, 2016). They suggest that therapists should be confident to challenge their own assumptions, effectively deliver interventions and work from the client's frame of reference (Beck, 2016; Naz et al., 2019). Beck (2016) highlights the importance of therapists being comfortable and skilled at asking questions and following the client's agenda. However, asking clients about culture or addressing issues around race can be difficult for therapists (Beck et al., 2019; Naz et al., 2019). The authors suggest that this could be due to a lack of confidence, concerns about offending the person or making a mistake (Naz et al., 2019).

Beck (2016) defines culturally adapted CBT (CA-CBT) as CBT that has been adapted for specific groups for specific disorders. CA-CBT incorporates cultural values and uses culturally specific language, metaphors and examples. There may also be greater emphasis on

the client's context such as migration history or economic situation. There is an increasing body of literature evidencing the benefits of culturally adapted forms of CBT (Phiri et al., 2023; Silveus et al., 2023). Examples of CA-CBT include an adaptation of the behavioural activation approach for Muslim communities (Mir et al., 2015) and CA-CBT for Afghan refugees in Europe (Kananian et al., 2021). Additionally, CA-CBT has been associated with decreased treatment dropout rates (Naeem et al., 2021; Rathod et al., 2013).

Therapeutic Drift

The label of "CBT" is no guarantee of what will be delivered or the ability of the therapist to deliver it (Waller & Turner, 2016). There are CBT frameworks that describe the activities required to be brought together in order to carry out CBT effectively and in line with best practice (Roth & Pilling, 2007). However, CBT may not be delivered in the way it was designed to be for several reasons such as poor training (Paskell, 2013) or therapist drift (Waller, 2009).

Therapist drift can be defined as a failure to deliver treatments that practitioners have been trained in or a failure to deliver them adequately, even when resources are available (Waller & Turner, 2016). This results in clients receiving treatment that deviates from the evidence-base. For example, therapists often avoid exposure-based interventions for anxiety (Hipol & Deacon, 2013) because these are perceived to be challenging to the client (as well as to therapists). Although drift has been considered as problematic, there might be some instances where drift is necessary or indeed beneficial (Roscoe, 2020). The pressure on services might mean that there is pressure to apply CBT rigidly and discharge the patient (Roscoe, 2020). With the growing popularity of the third-wave therapies such as CFT and ACT, perhaps therapists are working in a more integrative way (Roscoe, 2020). This raises the question of the boundaries of CBT. Continuing to focus on evidence-based treatment

might keep the field stuck in an era of packages and protocols and perhaps the focus should be on the processes underlying CBT (Hayes & Hofmann, 2017). More recently, there has been the development of process-based CBT and idiographic methods which move away from protocol driven CBT (Hayes & Hofmann, 2017; Hofmann & Hayes, 2019).

Cognitive Behavioural Therapists

This study recruited participants who were BABCP accredited CBT therapists. Following CBT training, professionals can apply for provisional accreditation with the BABCP. After 12 months of being awarded provisional accreditation, they can apply for full accreditation. To maintain accreditation, professionals are required to commit to the ongoing requirements for CBT through a yearly declaration. Professionals can also be called to audit to provide evidence that they are meeting the accreditation standards. The criterion for accreditation includes being in supervised CBT practice in the UK. The BABCP defines being in CBT practice as "at least 50% of your psychotherapeutic practice must be acceptable forms of CBT" (BABCP, 2022). This can be in a range of formats such as face-to-face, online, telephone or group work. However, "CBT therapist" is not a protected title and therapists do not need to be accredited, trained, or receiving supervision from someone who understands CBT to be offering CBT to clients.

Improving Access to Psychological Therapies

In England, most psychological support is provided by the NHS, which includes primary care services like IAPT, secondary care community mental health services, specialist services, inpatient services and crisis support. Other support is offered via charities, the voluntary sector or privately. CBT therapists work across these settings but are perhaps mainly clustered within IAPT services. IAPT has recently changed its name to "NHS Talking

Therapies" (Clark & Whittington, 2023). However, IAPT has been used throughout this thesis as it was the service name during recruitment and interviewing.

History of Improving Access to Psychological Therapies

IAPT is a key provider of psychological therapy for adults within the NHS. The IAPT programme was introduced following Layard et al's. (2006) report that highlighted the social and economic cost of people suffering from anxiety and depression and advised that evidence-based psychological therapy should be offered. The key initiative of IAPT was to enable greater access to psychological therapies for the whole community by offering psychological interventions approved by NICE guidelines. Researchers and economists argued that IAPT would pay for itself due to the benefits of improved mental health on employment rates, work productivity and reducing public costs such as welfare benefits and physical health costs (Clark et al., 2009). In 2006, the Department of Health funded two pilot sites to collect data and inform the national rollout (Clark et al., 2009). This large-scale initiative for the provision of psychological therapies was launched in 2008. By 2017, around 7,000 therapists were trained and IAPT treated approximately half a million people per year (Clark, 2018). Based on NICE guidelines, CBT was the therapy of choice due to the evidence-base and the model fit into time-limited and pressured services.

Current Working of Improving Access to Psychological Therapies

Individuals can self-refer or be referred to the service. The severity of the client's symptoms is measured at referral as a baseline using a minimum data set (MDS) and at each appointment to monitor the effectiveness of treatment. IAPT obtains this clinical outcome data which is placed in the public domain.

A key organising feature of IAPT is delivery in accordance with a stepped care model (Clark, 2018). In line with NICE guidelines around the presenting problem, the first step is regarded as watchful waiting by which symptoms of low mood and/or anxiety are monitored by a General Practitioner (GP). At Step 2, individuals could be offered psychoeducational courses or low intensity CBT sessions (LiCBT) with a PWP to target mild to moderate symptoms. PWPs are trained to a standardized curriculum and competency framework (Richards & Whyte, 2011). If the client presents with moderate to severe symptoms, they may have sessions with a Step 3 high intensity therapist. Aside from CBT, therapists in IAPT services may offer other therapy including Interpersonal Therapy (IPT), counselling for depression (CfD) and/or Eye movement desensitization reprocessing (EMDR). Individuals experiencing enduring or severe symptoms may require support at Step 4 and require more intensive therapeutic interventions in secondary care support. They may also require risk management and an external referral would be made to secondary care. Finally, Step 5 would provide support for people at risk of harm or neglect. This includes inpatient stays and/or crisis support.

Critique of Improving Access to Psychological Therapies

Some CBT training courses have been specifically developed for the IAPT programme which is far from the CBT developed by Beck (1970). Within IAPT, trainee CBT therapists are taught to offer treatment based on a diagnosis followed by the relevant protocol (Binnie, 2015). However, transdiagnostic and formulation driven therapy is advocated as protocol informed work may overlook issues (Persons et al., 2021). Woolfe (2010) and Binnie (2015) outline how therapy becomes diluted when the focus is on diagnosis and manualised treatments. Services are stretched and NHS Trusts and Clinical Commissioning Groups (CCGs) impose session limits that do not always adhere to NICE guidelines.

Moreover, around 60% of clients who access IAPT complete a course of treatment, meaning that around 40% drop out (NHS Digital., 2022). This raises the question about why so many leave therapy, and how this can be addressed (Davis et al., 2020).

Barriers to Improving Access to Psychological Therapies

Mental health services have a duty to ensure equality of opportunity for different groups. People from all areas of the community should have a chance to benefit from psychological therapies. Positive practice guidelines (Beck et al., 2019) draw attention to the lower uptake of IAPT services by BAME communities and offer guidance about ways to enhance inclusivity. Individuals can face barriers to seeking mental health treatment (Memon et al., 2016; Williams et al., 2022) and have poorer outcomes when they do (Ahmad et al., 2022; Baker, 2020). These inequalities are a cause for concern for clinicians, policy makers, service providers and the psychological profession as a whole.

Bhavsar et al. (2021) reported that people residing in the UK for less than 10 years are less likely to engage in IAPT services compared to those born in the UK. The suggested reasons for these inequalities include stigma related to mental health, difference in symptom expression, differences in expectations, lack of awareness, cultural differences in help seeking and immigration status (Colucci et al., 2012; Satinsky et al., 2019). Anxiety and depression could be considered as western medical conceptions and a barrier might be differences in cultural and religious interpretations of mental health problems. Loewenthal et al. (2012) highlight how the Somali community conceptualised depression as being indistinguishable from everyday struggles.

Another barrier to accessing mental health support is not being fluent in English (Loewenthal et al., 2012; Walsh, 2020). Individuals who do not speak English are in a difficult situation whereby they might need help but can neither understand the language of

the helpers nor make themselves understood in their own language. Non-English speaking people might be denied services, not fully informed or given a limited service (Loewenthal et al., 2012; Patel, 2003). Barron et al. (2010) explored the perspectives of members from Pakistani, Bangladeshi and Chinese communities regarding primary health care interpreting provisions. The findings indicate that members of these communities were unaware of the provisions for healthcare professionals to arrange interpreting for their primary health care appointments. Within mental health services, verbal communication between the clinician and patient is essential to offer effective assessment and treatment. Furthermore, mental healthcare professionals are encouraged to strive to provide culturally competent care (Benuto et al., 2018). One element of this is to offer the use of a professional interpreter to facilitate communication and improve quality treatment. Interpreters allow for equal access to mental health care and facilitate conversations to help clinicians and patients communicate with each other (Tribe, 2009).

Remote Working

The pandemic required mental health services to adapt and remotely deliver psychological treatments, thus creating both opportunities and barriers. Before the COVID-19 pandemic, there had been a move towards increased telephone therapies for PWPs in IAPT (Turner et al., 2018), whereas high intensity therapy had usually been delivered face-to-face. Due to the COVID-19 pandemic, remote delivery of CBT became essential. High intensity interventions include internet-videoconferencing delivered CBT or telephone-delivered CBT (Matsumoto et al., 2018; Vogel et al., 2014).

Recent research suggests that remote CBT results in equivalent outcomes compared to traditional face-to-face treatment across a number of common mental health disorders such as generalised anxiety disorder (Théberge-Lapointe et al., 2015; Trenoska Basile et al., 2022);

obsessive compulsive disorder (Wootton, 2016); panic disorder (Efron & Wootton, 2021); post-traumatic stress disorder (PTSD) (Sijbrandij et al., 2016) and somatic disorders (Carlbring et al., 2018). Studies have shown how treatment for CBT can be adapted for delivery online and guidance has been published, i.e. for social anxiety (Warnock-Parkes et al., 2020), PTSD (Wild et al., 2020) and psychosis (Kopelovich & Turkington, 2021). It is possible, because of the potential benefits, that this way of working continues post-COVID (Békés & Aafjes-van Doorn, 2020; Warnock-Parkes et al., 2020). Skilbeck et al. (2020) argue the importance of integrating video conferencing into IAPT routine practice. They highlight evidence that trauma-focused video CBT can be as effective as face-to-face therapy and therefore is an essential mode of service provision.

During the pandemic, therapists suddenly faced with different working practices were presented with opportunities but also confronted by challenges. Therapy via video allows for a real time interaction and offers a range of benefits such as remote access and time and cost savings (Simpson, 2009). Most therapists have little training in providing video therapy and many believe that therapy via video is less effective than face-to-face (Topooco et al., 2017). Therapists report concerns about the impact of online therapy on the therapeutic alliance (Connolly et al., 2020). There is some debate in the literature about if an adequate working alliance can be formed between therapist and client when therapy is delivered remotely (Norwood et al., 2018). The BABCP provided guidance and a series of webinars for psychological professionals during COVID-19 regarding remote working. These webinars addressed challenges and offered ways of adapting when working remotely. Therapists' attitudes towards therapy via videoconferencing tends to increase positively with usage (Connolly et al., 2020).

Interpreters

This section focuses on spoken language interpreters. In most mental health services, language is fundamental as it is the instrument through which clients reveal their inner world. Language is often privileged over an embodied experience of how we express ourselves. The mother tongue or L1 is the "language of attachment and early significant intimate relationships and, as such, part of basic, early developmental experiences" (Tannenbaum & Har, 2020, p.884). Research highlights greater emotionality embedded in the first language compared with later acquired or learnt languages. The LX refers to any language learnt after the age at which the first language(s) was acquired, to any level of proficiency (Dewaele, 2018). If therapy is offered in a language that the client acquired or learnt later in life, it is likely that the emotional communication will be different compared with therapy in one's first language (Dewaele & Nakano, 2013). Research highlights how speaking in acquired or learnt languages can sometimes be a tool to avoid painful emotions (Tannenbaum & Har, 2020).

In some cases, clients are matched with a therapist who speaks the same language. If there is no shared language used by both the patient and therapist, the therapist will need to work with a trained spoken language interpreter (Costa, 2022b). Although some clients prefer to have friends and family members interpret for them (Alexander et al., 2004), using family and friends as interpreters is not recommended (Hadziabdic et al., 2014). There are several reasons why this is not recommended. For example, clients may feel uncomfortable talking about their thoughts and feelings in front of family and friends. The client may be experiencing difficulties related to people close to them. Furthermore, there are ethical considerations such as family members omitting information due to their own beliefs in what it right for their family member. There is also the risk of traffickers posing as family

members or friends. Therefore, it is recommended that practitioners collaborate with interpreters to ensure access to services and quality of care for clients who do not speak the language of their host country (Costa & Briggs, 2014; Tribe & Lane, 2009; Tribe & Thompson, 2011).

Interpreting agencies offer translation and interpreting services and may support both private and public sectors. Interpreters often work in a range of settings such as medical appointments, social services visits, ambulance callouts and psychological therapy sessions. Professional and trained interpreters work to professional and ethical standards. Formal qualifications such as a diploma in public service interpreting and experience are preferred but not always essential and therefore some interpreting agencies employ untrained interpreters.

Models of Interpreting

There are different approaches to interpreting. Proximate interpreting refers to when the interpreter is physically present, whereas in remote interpreting, the interpreter works from a distance such as via video or telephone. Simultaneous interpreting refers to when an interpreter translates during the conversation, thus a word or two behind, whereas in sequential interpreting, the interpreter waits for a pause and then interprets what has been spoken.

There are also different models of interpreting including “black box”, psychotherapeutic, cultural broker and advocate (Tribe & Morrissey, 2004). The “black box” or linguistic model emphasises the role of the interpreter is strictly verbatim translation. The psychotherapeutic or constructivist model emphasises the importance of conveying the meaning of words. The cultural broker model or cultural mediation emphasises the interpreter's role in offering relevant cultural information. It suggests that communication

goes beyond language skills and often requires more, such as knowledge about the cultural background. The cultural broker role can also involve interpreters normalising therapy which may be particularly useful for people from cultures in which therapy is unfamiliar or stigmatised. It is important to highlight the ethical issues of working with interpreters as cultural mediators. For example, an interpreter may not always the expert in a culture and if the interpreter adopts this role, it may change the dynamics and information may get missed. Finally, the advocate model is when the interpreter serves as an advocate for a client.

Working with Interpreters

Working with interpreters is necessary to prioritise the voices of people who are racialized or not fluent in English. Working positively with interpreters is part of anti-oppressive and anti-racism practice. This includes deliberate action to provide equal opportunities on an individual and systemic level. Allies recognise the privilege they hold and take responsibility of changing society patterns of injustice (Williams et al., 2022). Being an ally requires being motivated by values of inclusion, sharing power and having meaningful relationships.

There is little empirical evidence that evaluates the effectiveness of therapy outcomes with an interpreter. The majority of research has focused on trauma-focused therapy and concluded that treatment outcomes are similar with or without interpreters (D'Ardenne et al., 2007; Lambert & Alhassoon, 2015; Schulz et al., 2006). Qualitative research has explored the experience of working with interpreters in mental health services. Staff often find this work anxiety provoking and challenging (Gerskowitch, 2018; Raval & Smith, 2003; Scott, 2014; Tutani et al., 2018). Furthermore, it seems that only few therapists within IAPT are willing to work with interpreters which can have a detrimental impact on how long a client waits for

therapy (Costa, 2022b). Beverley Costa highlighted her concerns in the Cambridge Core blog in February 2022 stating,

> I was recently contacted by an IAPT service that wanted to reduce the number of patients spending over a year on their waiting lists. All the patients needed a spoken language interpreter to access therapy. I assumed that the service was having trouble finding suitable interpreters. But I was wrong. What they couldn't find were therapists within their service who were prepared to work with an interpreter. Many therapists are not keen to work with an interpreter. Many don't even believe it is possible to deliver therapy effectively via an interpreter. But often therapists, frequently dealing with competing demands, may just assume that someone else will do it (Costa, 2022a).

It is unclear if therapists were given a choice not to work with interpreters. Nevertheless, this highlights how people who require a spoken language interpreter are being denied access and equity of support. Costa (2022a) highlights how this does not seem right for a service called "Improving Access to Psychological Therapies". Following this blog, an implementation paper was published to provide detailed guidance for CBT therapists. Costa (2022b) draws attention to the assets and benefits of working with an interpreter and suggests how it can enhance the therapeutic experience, provide a greater sense of containment, a collaborative relationship and time to reflect while an interpreter renders translations. In recent changes to their "Minimum Training Standards", BABCP (2021) now recommends that clinicians should be able to demonstrate skills in working with interpreters.

Guidelines for Working With an Interpreter

The British Psychological Society (BPS) offer good practice guidelines for working with interpreters and recommend that all psychologists receive training (Tribe & Thompson, 2017). The guidance highlights practical issues that may arise such as booking the same interpreter for each session. More recently, Costa's (2022b) paper draws on existing evidence along with clinical wisdom to highlight practical implementations for interpreter-mediated CBT (Costa, 2022b). This consultation guide provides a framework with case studies from a CBT perspective and draws attention to challenges that may arise and how to problem solve them. Costa (2022b) highlights that therapists need to take a more active stance in therapy and draws attention to power dynamics and transparency when working in a triad. For example, making sure everything everyone says is translated and that the therapist does what they say they will do. Costa (2022b) highlights six areas to consider: preparation; meta-communication; boundaries; managing three-way relationships; working with interpreters remotely and offering support to interpreters. Each area will be briefly discussed in turn.

The first area is preparation for interpreter-mediated therapy, which involves booking an interpreter, having an initial meeting, and delicately declining the offer of interpretation from family members. Some services may have a small pool of in-house interpreters and therefore direct contact can be made. In other services, the therapist or administration team might book an interpreter. Costa (2022b) states that gathering information about the interpreting service and asking about quality control measures is useful. It is recommended that the therapist arranges a pre-meeting to provide a space to discuss the working methods of CBT, and certain therapist behaviours such as allowing silences (Costa, 2022b). Time spent on preparation and de-briefing may contribute to the interpreter feeling valued, respected and helps build a collaborative relationship. Other authors also recognise the importance of

setting the frame of therapy and establishing a working contract that covers confidentiality, responsibilities, and boundaries (O'Hara & Akinsulure-Smith, 2011; Tribe & Morrissey, 2004).

The second area includes the rules of communication (Costa, 2022b). The therapist should be transparent and set ground rules about communication. For example, asking for everything that everyone says to be interpreted. It is also important to talk about aspects of communication. For example, requesting that everyone speaks in short chunks or might have to repeat themselves. Costa (2022b) highlights that if the therapist does not take an active stance, they may lose control of the communication and, consequently, of the session.

Guidelines often recommend that the interpreter uses the first person when translating (Tribe, 2005). Bot (2005) suggests that interpreters speaking in the first person, "for" or "as" their client is rooted in European-American norms of communication whereby if someone shares another person's criticism, the criticism comes from the original speaker not the person reporting it. This idea may not be relevant to individuals from some cultures as highlighted by Bot (2005) in this Arabic proverb, "The one who repeats an insult is the one insulting you" (p. 240). Here, it is the person reporting who is responsible for what is said.

The third area highlighted by Costa (2022b) is managing boundaries. This includes safeguarding issues or managing requests from clients. It can be helpful to consider how interpreters arrive and leave appointments and discuss what happens if the interpreter and client encounter each other outside the therapy sessions. The fourth consideration is managing the three-way relationship (Costa, 2022b). Therapists need to be aware of the dynamics in the room and their own thoughts and feelings that may arise such as feeling excluded. Supervision and self-reflexivity can help the therapist reflect on these relational dynamics and complexities.

The fifth area is pertinent to this thesis as it highlights issues of working with interpreters remotely. Technology is not always reliable and communication issues might arise in a remote context (Costa, 2022b). The British Psychological Society offer guidelines for working with interpreters remotely (BPS, 2020; Tribe & Thompson, 2022). Although, telephone interpreting has its benefits such as confidentiality and practicalities, BPS guidelines recommend using video rather than telephone interpreting where possible. Video allows for visual cues which may help determine meaning. Preparation is key and it is recommended that guidance is provided for clients before a video appointment. Instructions on using an online platform in a range of languages can be found at www. burc.org/how-to-use-zoom-in-different-languages/. The Royal College of Speech and Language Therapists (2020) also produced guidelines for working with interpreters remotely. They provide a checklist of issues to consider before, during and after a session.

The final consideration proposed by Costa (2022b) is offering support for interpreters. This is essential as often the work can be emotionally charged. The therapist should offer an initial brief about the session and a debrief at the end.

Meta- Synthesis of the Literature

Background

A qualitative systematic review explored experiences of working with interpreters in healthcare (Brisset et al., 2013). This review included the perspectives of staff, patients and interpreters and identified three main themes; interpreters' roles; difficulties, and communication characteristics. In the limitations of the review, the authors highlight how it would have been useful to distinguish mental health and physical health settings (Brisset et

al., 2013). This current literature review aims to present a meta-synthesis of the qualitative literature exploring therapists' experiences of working with interpreters. This is important due to the unique nature of mental health services, such as therapy sessions and conversations around heightened emotive issues. The question guiding this review is: "How do therapists' experience working with an interpreter?" This review focused on professional, spoken language interpreters only.

Method

Design

A qualitative methodology was deemed to be most appropriate, with particular consideration for nuanced meanings. There are various approaches to synthesising qualitative research (Campbell et al., 2011). For this review, a meta-synthesis was conducted to synthesise data of studies from qualitative research (Campbell et al., 2011). Thematic synthesis was chosen to synthesise the studies (Thomas & Harden, 2008) which involves interpretation of data, and emphasises commonalities and discrepancies across accounts through context rather than multiple realities.

The literature review was guided by Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) (Moher et al., 2010). The author carried out all the aspects of this literature review alone, but themes and literature were reflected on with research supervisors and an author of one of the papers. A pre-registered protocol of this review is accessible at the Prospective Register for Systematic Reviews (PROSPERO) website (registration number: CRD42023388036).

Search Strategy

Four electronic databases (APA PsycINFO, CINHAL Ultimate, MEDLINE Ultimate and APA PsychARTICLES) were accessed via the University of Essex EBSCO host platform in December 2022. No limits were applied to the searches. Results were imported into the reference management software Zotero 5.0. Additional hand searches were completed to search for any additional relevant literature.

Individual searches of keywords and synonyms were searched before combining using the "Search with AND" tool within the EBSCOhost platform. The following terms were searched for in any field: ["Therapist*" OR "Psychotherapist*" OR "Psychologist*" OR "Counsel*" OR "PWP*"] AND ["experienc*" OR "perspective*" OR "perception*" OR "phenomen*" OR "attitude*"] AND ["interpret*"] AND ["qualitative*" OR "mixed"]. See table 2 for an overview of the database search.

Table 2

Searches for Each Database

Search number	Search terms	Databases: APA PsycINFO, CINHAL Complete, MEDLINE and APA PsychARTICLES
1	"Therapist*" OR "Psychotherapist*" OR "Psychologist*" OR "Counsel*" OR "PWP"	964,263
2	"experienc*" OR "perspective*" OR "perception*" OR "phenomen*" OR "attitude*"	6,617,959
3	"interpret*"	930,860
4	"qualitative*" OR "mixed"	1,446,512
5	Search #1 AND #2 AND #3 AND #4	4,260

Inclusion and Exclusion Criteria

Studies included in this review were guided by the following inclusion criteria: (a) reported on therapist experiences of working with interpreters; (b) used qualitative or mixed methods for data collection and analysis where qualitative findings could be extracted; (c) published in a peer reviewed journal and (d) written in English. Therapists were defined as those working in the context of mental health and included a range of professionals including mental health practitioners, psychologists and counsellors. Qualitative analysis was defined by a form of in-depth analysis. The decision to only include studies published in peer reviewed journals was made to ensure that only studies of adequate quality were included. Qualitative methods were defined as interviews or focus groups.

Studies were excluded if they did not sufficiently report on the perspectives of therapists. If studies explored a mix of participants' experiences, then studies were excluded if therapist experiences were not distinctly reported separate to other participants. Studies were excluded if the therapists were not talking about the experience of therapeutic work; for example, a paper that explored clinicians' experiences working with an interpreter to conduct cognitive assessments was excluded (e.g. Haralambous et al., 2018). If studies explored experiences broadly such as working with refugees, then studies were excluded if therapists' experiences of working with interpreters were not distinctly reported (e.g. Schweitzer et al., 2015). Single case studies were excluded as they did not include intersubjective analysis (e.g. Mofrad & Webster, 2012). No time frame restrictions were applied, and all sources were searched.

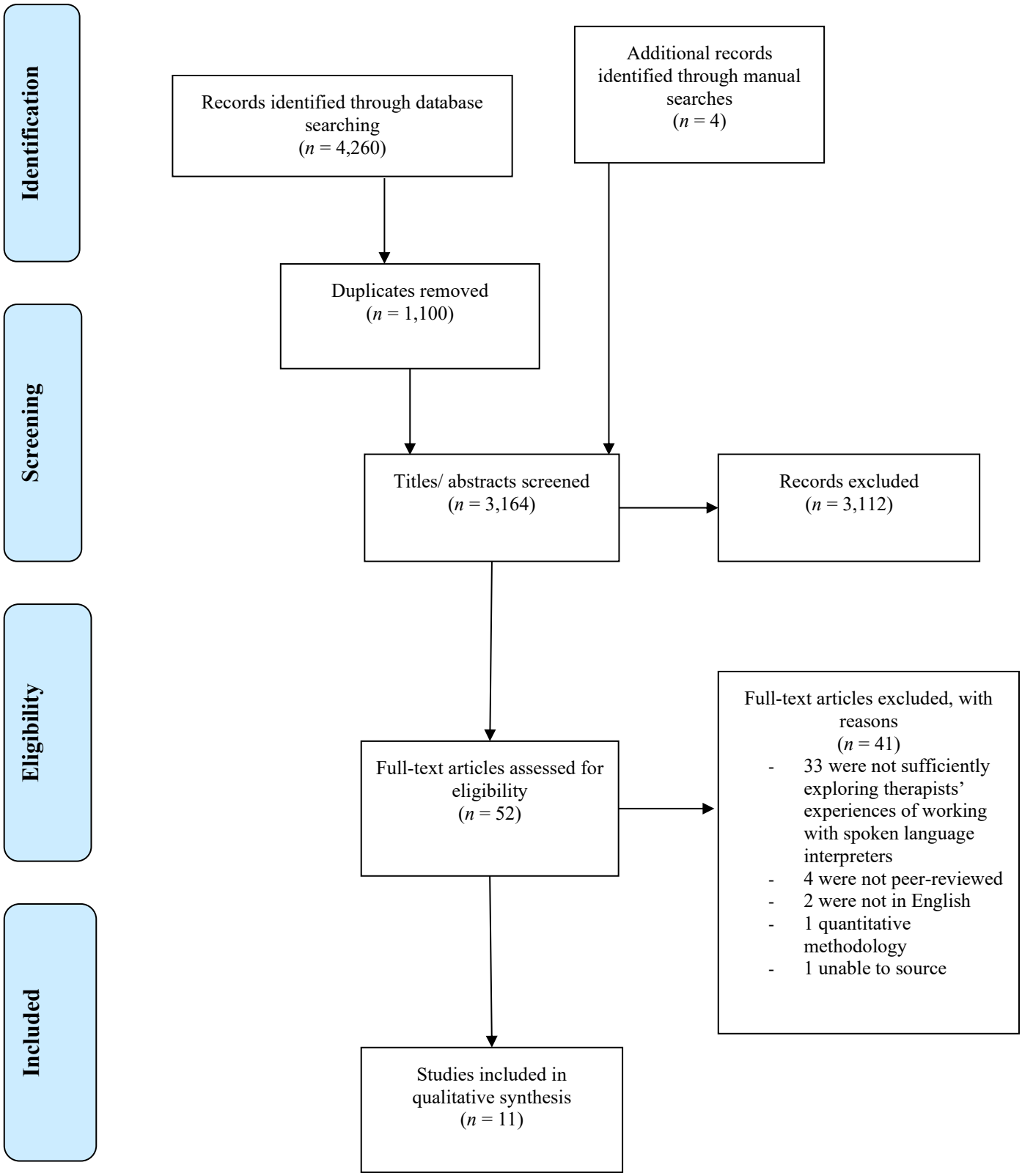
Study Selection

A total of 4,260 records were identified through electronic database searching. Additional hand searches were completed, and four additional relevant studies were found. Articles were downloaded to reference software and 1,100 duplicates were removed. The remaining 3,164 titles and abstracts were read and screened in line with the criteria stipulated. If it was unclear from the titles or abstract, the full details were retrieved and read in full along with studies that were deemed relevant to allow for further assessment of eligibility. Overall, 3,112 studies did not meet the criteria and were excluded. The full text was sourced from the remaining 52 studies that were eligible or if further information was needed to assess eligibility. The reference lists and citation searches of eligible studies were also examined for any relevant additional papers. Finally, the authors of theses or dissertation work were emailed to request any relevant soon to be published work. Figure 1 highlights the PRISMA flow diagram demonstrating the steps followed from the initial search to the final

included studies. Eleven studies met all criteria and were included in the review (Becher & Wieling, 2015; Gerskowitch & Tribe, 2021; Gryesten et al., 2021; Hagan et al., 2020; Khawaja & Stein, 2016; Kuay et al., 2015; Miller et al., 2005; Pugh & Vetere, 2009; Raval & Smith, 2003; Tutani et al., 2018; Yakushko, 2010)

Figure 1

PRISMA Flow Diagram of the Article Selection Process



Quality Assessment

There is a lack of consensus about how to assess quality in qualitative research and the extent that quality assessment is applicable (Finlayson & Dixon, 2008; Spencer et al., 2004). This is partly due to unclear definitions of what quality means in qualitative research (Finlayson & Dixon, 2008). However, a quality appraisal was conducted to determine the strengths, weaknesses, trustworthiness and credibility of the studies. The Critical Appraisal Skills Programme (CASP, 2022) checklist for qualitative research is recommended by the Cochrane Collaboration. It is the most commonly used tool within health-related qualitative research (Long et al., 2020). The CASP (2022) includes ten questions about areas of the study's quality including the study aims, methodology, design, recruitment, data collection, ethics, analysis, interpretation and implications. Each article was quality appraised in line with the CASP checklist and classified using "yes", "can't tell" or "no" responses (See Appendix A for the CASP appraisal results). No studies were excluded because there is no widely accepted method for excluding qualitative studies (Dixon-Woods et al., 2006; Garside, 2014). However, the quality assessment informed the thematic synthesis and assisted in exploring the contribution of the studies.

Synthesis

The meta-synthesis of this review was guided by thematic synthesis which is a well-established approach to qualitative research that explores and identifies patterns within the data (Thomas & Harden, 2008). Thematic synthesis allowed for themes to be identified by the individual studies but also for the author to generate new common themes across the qualitative studies (Thomas & Harden, 2008).

Firstly, the studies were read so that the researcher could become familiar with their content and start to identify the main concepts. Information from each study was collated; see a summary in Table 3. Secondly, the author narrative text was coded line-by-line by hand in the margin of the paper with respect to meaning and context (excluding participant quotes, unless author narratives were ambiguous). Text that focused on interpreters' or patients' experiences were not coded as they were not the focus of this literature review. As the focus was on the qualitative findings and author interpretations, both the results and discussion sections of the studies were coded. Each article was coded using both a deductive and inductive approach which initiated the process of translating concepts between articles. The codes applied to one study were applied to others. A new code was made if there were no prior codes applicable.

Next, codes were typed into a Microsoft Excel spreadsheet to allow for organisation of codes to develop initial descriptive themes. These initial codes were checked for consistency and collapsed where multiple codes were deemed to explain the same concept. Then, codes were organised into a hierarchical structure of descriptive themes, which remained close to the original findings from the studies (See Appendix B for an example of codes). Finally, the researcher formulated analytical themes and subthemes. Analytical themes were developed by going beyond the descriptive themes to synthesise and interpret the data in a way which provided answers to the review question. Table 4 highlights the cross-comparison of studies.

Reflexivity

To acknowledge my personal perspective, reflections throughout this thesis are presented in the first person. I have personal experience of working with spoken language interpreters while working as a therapist in IAPT services and I am particularly curious to

learn about other staff experiences. My experiences will have influenced how the data has been interpreted and presented within this review. To improve the credibility of the meta-synthesis, I kept a reflexive log and discussed themes from my reflexive log with peers and research supervisors. This is further discussed in the Methods and Discussion chapters.

Results of the Meta-Synthesis

The study characteristics in the selected articles will be discussed, followed by a quality appraisal of the studies and then a discussion of the identified themes.

Study Characteristics

The 11 studies included in the review were from various countries including the UK, Denmark, Australia, United States (US) and South Africa. The earliest of the studies was dated 2003 and the most recently published was in 2021. The sample size ranged from 3 to 15 with a total of 99 therapists (72 females) across the studies. Staff roles varied from psychologists, psychotherapists, family therapists, psychiatrists and social workers who worked in a variety of settings including community services, hospitals and specialist services. Some studies did not report socio-demographic characteristics. Across the four studies (Gryesten et al., 2021; Khawaja & Stein, 2016; Miller et al., 2005; Raval & Smith, 2003) that reported participants' age, it ranged from 27 to at least 55 years. Across the eight studies (Becher & Wieling, 2015; Gerskowitch & Tribe, 2021; Gryesten et al., 2021; Khawaja & Stein, 2016; Kuay et al., 2015; Raval & Smith, 2003; Tutani et al., 2018; Yakushko, 2010) that stated staff clinical experience, it ranged from at least 1 year to 30 years.

Ten studies focused on the experience of working with adult clients whereas one included families and children (Raval & Smith, 2003). Most studies explored experiences of

working with professional interpreters who had received training and were booked through an agency. Whereas, two studies spoke about on-site staff interpreters (Becher & Wieling, 2015) or ad hoc interpreters (Hagan et al., 2020). Most studies explored experiences working in person apart from two studies that also discussed working with interpreters via telephone (Khawaja & Stein, 2016; Kuay et al., 2015).

Three studies explored the experiences of therapists and interpreters (Becher & Wieling, 2015; Gryesten et al., 2021; Miller et al., 2005). Therapists' experiences were deemed to be adequately distinctly reported in these studies hence their inclusion.

Quality Appraisal

The CASP research tool was utilised to quality appraise the studies. None of the articles were assessed to be of high quality because of a lack of information regarding the relationship between researchers and participants or lack of details about ethical approval and/or considerations. All 11 studies were categorised as moderate quality.

All articles stated clear aims, although there was variability in reporting of the importance and relevance of the research. All studies used appropriate qualitative methodology to address the research aims including grounded theory (Kuay et al., 2015), thematic analysis (Becher & Wieling, 2015; Hagan et al., 2020; Khawaja & Stein, 2016; Miller et al., 2005; Tutani et al., 2018) and types of phenomenological analysis (Gerskowitch & Tribe, 2021; Gryesten et al., 2021; Pugh & Vetere, 2009; Raval & Smith, 2003; Yakushko, 2010). There was a range in the reporting of participant demographic information. Only four studies included participants' age (Gryesten et al., 2021; Khawaja & Stein, 2016; Miller et al., 2005; Raval & Smith, 2003) and only four studies included participants' ethnicity (Khawaja & Stein, 2016; Pugh & Vetere, 2009; Raval & Smith, 2003; Tutani et al., 2018).

All studies used semi-structured interviews and reported the setting for data collection. Whilst one study reported their full interview schedule (Becher & Wieling, 2015), 10 only gave vague details about the interview content (Gerskowitch & Tribe, 2021; Gryesten et al., 2021; Hagan et al., 2020; Khawaja & Stein, 2016; Kuay et al., 2015; Miller et al., 2005; Pugh & Vetere, 2009; Raval & Smith, 2003; Tutani et al., 2018; Yakushko, 2010). Six studies included brief reflective accounts (Becher & Wieling, 2015; Gerskowitch & Tribe, 2021; Gryesten et al., 2021; Khawaja & Stein, 2016; Raval & Smith, 2003; Yakushko, 2010) but the researcher's role, influence on analysis and reflexivity were rarely discussed in detail. There were limitations to studies that had an absence of author reflexivity (Hagan et al., 2020; Kuay et al., 2015; Miller et al., 2005; Pugh & Vetere, 2009; Tutani et al., 2018).

There was wide variety in the reporting of ethical issues. Five articles made no reference to ethical approval or considerations (Becher & Wieling, 2015; Miller et al., 2005; Pugh & Vetere, 2009; Raval & Smith, 2003; Yakushko, 2010). These articles were rated "can't tell" on the CASP checklist for ethical considerations as opposed to "no" as there is not enough information to know if this has been considered. Three articles simply stated the study had ethical approval (Gerskowitch & Tribe, 2021; Khawaja & Stein, 2016; Tutani et al., 2018) and three provided some further details of ethical considerations (Gryesten et al., 2021; Hagan et al., 2020; Kuay et al., 2015).

All studies provided descriptions of the analysis used and clearly presented findings with the use of supportive quotations. Some studies featured rather descriptive analysis which could indicate under-developed themes (Braun et al., 2022). These descriptive themes consisted of domain summaries, e.g. "Challenges" and "Skills" (Khawaja & Stein, 2016) rather than shared meanings within themes, e.g. "The most powerful thing is the system" (Gerskowitch & Tribe, 2021). All the studies clearly presented the findings and discussed

them in relation to policy and the wider literature. Two studies did not report the strengths and limitations of the study (Becher & Wieling, 2015; Raval & Smith, 2003).

Table 3

Summary of the Articles Identified in the Literature Review

Authors, year & location	Setting	Data analysis	Participants	Main themes
Becher and Wieling (2015) US	Hospitals, private practices, and community-based clinics	Ethnographic TA	7 clinicians (4 female)	Interpreters speaking out, The relationship matters, Who has the power?
Gerskowitch and Tribe (2021) UK	IAPT and secondary care psychology service	IPA	10 psychologists and psychotherapists (6 females)	The most powerful thing is the system, The knotty question of power, Dyadic and triadic alliances
Gryesten et al. (2021) Denmark	Adult MH services	IPA	3 psychologists (3 female)	The relationship between patient and interpreter, The interpreters influence on formation of alliance between psychologist and patient, The collaboration between psychologist and interpreter
Hagan et al. (2020) South Africa	Hospitals	TA	7 psychiatrists (5 female)	Miscommunication and difficulties, The language barrier, Age, culture and gender, Staff as interpreters
Khawaja and Stein (2016) Australia	Community clinic	Grounded theory	7 practitioners (4 female)	Challenges, Skills

Authors, year & location	Setting	Data analysis	Participants	Main themes
Kuay et al. (2015) Australia	Survivors of Torture Service	TA	10 clinicians (8 female)	Comparison with existing guidelines – briefing, gender matching, religion matching. Specific issues – advocacy, empathy, roles.
Miller et al. (2005) US	Refugee MH clinics	Inductive coding	15 therapists (10 female)	Therapeutic alliance and complex emotional reactions
Pugh and Vetere (2009) UK	Adult MH services	IPA	10 MH professionals (7 female)	The empathic dialogues, changes in empathic communication, the effects of shared cultures and cultural differences, opportunities for the interpreter to enrich the professional's understanding
Raval and Smith (2003) UK	Child and Adolescent MH Service (CAMHS)	IPA	9 MH practitioners (8 female)	The process of communication through translation, The impact of translation on the therapeutic style, The difficulty of establishing a co-worker alliance
Tutani et al. (2018) UK	IAPT	TA	13 therapists (11 female)	Negotiating three-way interaction, Challenges in communicating empathy, Establishing a shared understanding, Creative collaboration with interpreters
Yakushko (2010) US	Hospitals and community-based clinics	Phenomenological	8 psychotherapists (6 female)	Personality and training

Note. TA = Thematic Analysis; IPA = Interpretative phenomenological analysis; MH = Mental Health; IAPT = Improving Access to Psychological Therapies.

Table 4

Cross Comparison of Studies by Subthemes

Studies	The influence of the interpreter on the therapeutic relationship dynamics		The role of the interpreter	
	Trust and collaboration within the triadic alliance	Negotiation of power	Trusting the interpreter with communication	Bridging the cultural gap
Becher & Wieling (2015)	*	*	*	*
Gerskowitch & Tribe (2021)	*	*	*	*
Gryesten et al. (2021)	*	*	*	*
Hagan et al. (2020)	*		*	*
Khawaja & Stein (2016)	*			*
Kuay et al. (2015)	*		*	*
Miller et al. (2005)	*	*	*	*
Pugh & Vetere (2009)	*		*	*
Raval & Smith (2003)	*	*	*	*
Tutani et al. (2018)	*	*	*	*
Yakushko (2010)	*			*

Thematic Synthesis

The findings from the 11 studies were synthesised. Two main themes and four subthemes were generated; the influence of the interpreter on the therapeutic relationship dynamics (main theme); trust and collaboration within the triadic alliance (subtheme); negotiation of power (subtheme); the role of the interpreter (main theme); trusting the interpreter with translation (subtheme) and bridging the cultural gap (subtheme). Each of these themes will now be discussed in turn. A summary of the themes is presented in Table 5.

Table 5

Summary of Themes Generated From Thematic Meta-Synthesis

Main theme	Subthemes
The influence of the interpreter on the therapeutic relationship dynamics	Trust and collaboration within the triadic alliance
	Negotiation of power
The role of the interpreter	Trusting the interpreter with communication
	Bridging the cultural gap

The Influence of the Interpreter on the Therapeutic Relationship Dynamics.

Across all the studies the presence of a third person was identified as having an impact on the dynamics of the therapeutic relationship. Although therapists perceived the work of interpreters as vital, it nevertheless affected how the therapist-client therapeutic alliance was established and managed.

Trust and Collaboration Within the Triadic Alliance. A central theme apparent across all 11 studies was the importance of the therapeutic alliance. The therapeutic alliance refers to the working relationship between therapist and client. It connotes a collaborative relationship based on trust and shared commitment. This is central to therapy, regardless of the theoretical orientation of the therapist (Wampold & Imel, 2015). Several author narratives discussed the impact of an interpreter's presence on this traditionally two-person alliance. The presence of an interpreter introduces complexity into the dynamics and might be seen as "an intrusion onto, or dilution of, this important dynamic" (Gerskowitch & Tribe, 2021, p.308). Moreover, "a potential obstacle to genuine therapeutic contact with the client" (Miller et al., 2005, p.30). Building an alliance with the client via an interpreter could be a "daunting process" (Hagan et al., 2020, p.9). Therapists might have to put "extra effort into building and maintaining rapport" (Khawaja & Stein, 2016, p.467). One way of doing this was through non-verbal attempts as highlighted by author narratives, "Participants drew upon their ability to demonstrate empathy non-verbally in attempts to match what they could not communicate verbally" (Tutani et al., 2018, p.9). Ultimately, the alliance between client and therapist "felt weaker compared to those clients with whom they communicate directly" (Pugh & Vetere, 2009, p.314).

The importance of a trusting working alliance between the therapist and interpreter was also a key element. If this trust was established, the therapist was more confident working collaboratively with the interpreter rather than simply managing the relationship. Indeed, the interpreter was sometimes viewed as an integral part of the three-way relationship as they "can function as an allied or a support" (Gryesten et al., 2021, p.5). Furthermore, "Participants were adamant that the strength of their clinical help was only as potent as how well they could work together with an interpreter" (Yakushko, 2010, p.451).

Additionally, the alliance between the client and interpreter was considered essential for clients to feel supported and accepted. It was largely seen as vital to consistently work with the same interpreter to create a safe and trusting relationship so that the client felt able to "share her trauma with *two* individuals" (Miller et al., 2005, p. 30). The therapist expected the interpreter to take an "affectively attuned position" to allow for this relationship to develop (Gryesten et al., 2021, p.7). Author narratives highlighted how the client may build a stronger alliance with the interpreter because they view the interpreter as the "empathic member of the triad" (Pugh & Vetere, 2009, p.314).

Some author narratives reflected on the impact on the relationship in relation to the modality of the therapist, "the more psychodynamically orientated participants described the emotional impact on the interpreter as part of the transference process" (Raval & Smith, 2003, p.13).

Negotiation of Power. A subtheme across several papers was the implicit power differential between the clinician and interpreter. This was connected to the quality of the relationship. Both therapists and interpreters hold power in the therapy sessions. However, due to formal education and mental health expertise, therapists were seen as having "greater authority and prestige" (Becher & Wieling, 2015, p. 455). Often the clinician was "a white professional authority figure" (Raval & Smith, 2003, p.13) and there was a perceived professional hierarchy whereby interpreters were in a position of limited power. Therapists might feel "guilt and shame about the perceived position of privilege" they held in the therapy room (Gerskowitch & Tribe, 2021, p.309). However, when therapists felt that interpreters were a "too-powerful interpreter" (Becher & Wieling, 2015, p.455), this could impact the relationship and increase the clinician's desire to "manage and control the interpreter" (Becher & Wieling, 2015, p.454). Powerlessness in interpreter-mediated sessions can invoke a range of emotional reactions, for instance, feeling "excluded" (Tutani et al.,

2018, p.9), feeling "self-conscious" (Miller et al., 2005, p.33) or even "competitive" (Miller et al., 2005, p.32).

The Role of the Interpreter. This theme describes the ambiguity of the role of the interpreter and was often conceptualised as fluctuating on a continuum. This continuum ranges from a functional role of direct verbatim translation to that of a more active role of cultural mediator or broker. Perspectives appeared to vary according to clinical settings and therapists' expectations. For some therapists, the interpreter's presence was a necessary intrusion, whilst for others the interpreter was central to facilitating the therapy.

Trusting the Interpreter With Communication. On a functional level, the interpreter's role is to translate, and this can be viewed as one end of the continuum. Some authors noted that the interpreter's role is "strictly within the role of language translation" (Becher & Wieling, 2015, p.454) and therefore interpreters are an "instrument that unobtrusively facilitates communication between therapist and client" (Miller et al., 2005, p.30). Thus, the interpreter is seen as an "unfortunate necessity" (Miller et al., 2005, p.30) and can be viewed as "ancillary and interchangeable" (Becher & Wieling, 2015, p.455). They are "expected to aim for a kind of invisibility during the session" (Miller et al., 2005, p.30) and narratives state that therapists view "the neutral interpreter as the ideal interpreter" (Gryesten et al., 2021, p.6).

Studies highlighted the importance of the communication process and how interpreters were relied upon and trusted to ensure information was conveyed accurately. The meaning of words might be changed during the translation process from one language to another and words may not convey the accurate or complete meaning of words. Authors reported how therapists can feel uncertainty about what had been said, anxiety about the level of accuracy and if interpreters were omitting details. Hagan et al. (2020) capture this: "the interpreter and patient might have a long conversation, but the interpreter only communicates

short phrases back to the clinician" (p.4). This could impact the relationship as the therapist might "shift their attention away from empathising with the client and focus more on evaluating the accuracy of the interpretations made" (Pugh & Vetere, 2009, p. 313). Raval and Smith (2003) described the process of communication as "taking longer, becoming slower and losing its momentum" (p.13).

In addition to the translation of the content of the messages, the way in which these messages were communicated could also be lost. Author narratives highlight how therapists might "repeat a patient's phrase to empathise with a patient and the interpreter would not understand the necessity of this" (Kuay et al., 2015, p.285). Pugh and Vetere (2009) stated there was a "loss of other subtle aspects of spoken dialogues such as the manner in which statements are expressed" (p.313). Thus, working with interpreters may compromise common factor skills such as reflection and empathy. Furthermore, a loss of verbal communication might result in a loss of what the client may be feeling or experiencing making clients "harder to read" (Pugh & Vetere, 2009, p.316). Good practice such as pre-briefing was recognised as important across studies to help manage communication issues.

Some authors highlight how interpreters can "cross a line if they interfere with what she (Psychologist) perceives as her treatment" (Gryesten et al., 2021). Author narratives emphasise how "there seemed to be a contradiction in the participant's wish for interpreters to be more forthcoming with their views, when at the same time the interpreter's views were seen as an intrusion on the work" (Raval & Smith, 2003, p.20).

Bridging the Cultural Gap. Narratives expressed that most therapists preferred an interpreter that provided a broad range of skills. However, therapists wanted to maintain the professional integrity of their therapeutic role and were mindful of their professional responsibilities. Author narratives suggest that the extent that the therapist empowered the interpreter to work beyond the functional role of translating words may be dependent on the

relationship and level of trust, “clinicians repeatedly discussed the role of relationship in trusting interpreters to go outside the traditional language translation role” (Becher & Wieling, 2015, p.454). In addition to the relationship, empowerment could also be impacted by the service context as when they felt “pressured by the system, they seemed to express a preference for an interpreter role to be one of pure translator” (Gerskowitch & Tribe, 2021, p.308).

Studies highlighted that the role of an interpreter was understood in more relational ways. A competent interpreter was sometimes described as those who were able to exceed the role of simply translating words and “capable of achieving affective attunement” (Gryesten et al., 2021, p.7). Tutani et al. (2018) highlighted how some therapists experienced the interpreter “assuming a role as a co-therapist” (p.9). Therefore, the interpreter could be seen as an “integral part of a three-person alliance” (Miller et al., 2005, p.30).

Often when there is a language barrier, there are also cultural differences between therapist and client. Miller et al. (2005) highlights some of the barriers faced by clients accessing mental health support “clients who come from cultures in which therapy is unfamiliar or viewed negatively” (p.31). Often interpreters will be the first point of access to support and their views on therapy can greatly shape the treatment clients receive.

Therapists who consider that an interpreter has a role beyond the verbal translation of words may view the interpreter’s role as one of a cultural broker or mediator. This role bridges the gap between therapist and client as the interpreter uses their cultural literacy to provide culturally relevant information to facilitate effective communication. The therapist might find it difficult to “catch the finer nuances” in the conversation due to the cultural or symbolic nature of communication (Hagan et al., 2020, p.7). Findings emphasise how the interpreter can help therapists understand the context of the client’s experience by providing cultural meanings, norms and sharing their own interpretations. Author narratives highlight

the importance of "culturally safe, sensitive and competent assessment and intervention" (Khawaja & Stein, 2016, p.469). Pugh and Vetere (2009) highlighted that working with interpreters can help gain a richer understanding of the client's difficulties as "cultural understanding helped participants to contextualise personal difficulties" (p.315). Some therapists explained how they sought advice from interpreters when addressing sensitive topics such as female genital mutilation (Yakushko, 2010, p.452). Tutani et al. (2018) describes how a shared understanding can be gained as interpreters have the "ability to communicate concepts in a culturally relevant way" (p.11).

In addition to matching language dialect, religion, ethnicity and/or cultural identity matching could also be deemed helpful for the client. The interpreter could "help the patient feel more comfortable as the interpreter's appearance and mannerisms could have a positive effect of reminding the patient of their country" (Khawaja & Stein, 2016, p.284). Given this, interpreters were seen as having "roles beyond interpreting including cultural consultancy and advocacy" (Kuay et al., 2015, p.286). However, it is important to acknowledge that just because the interpreter and client share the same language, this does not mean that they share the same culture. Moreover, they may be "socio-political tensions" between client and interpreter cultural groups (Pugh & Vetere, 2009, p.315)

Discussion

This meta-synthesis of 11 qualitative studies is the first to review the literature pertaining to therapists' experiences of working with interpreters and consequently provides valuable insight into this experience. In comparison to the systematic review by Brisset et al. (2013) the present literature review focused only on therapist experiences and included seven studies that were published after 2013.

The findings highlight how therapists perceive the impact of an interpreter and how this will affect the therapeutic alliance and power dynamics within the triad. The literature

review points to the importance of the triadic relationship and how the client and therapist might individually experience the relationship with the interpreter. It also highlights the nuance and complexity of the three-way dynamic. This draws attention to the benefits of therapists and interpreters building relationships with each other. Studies highlight the negotiation of power in this dynamic. The interpreter holds power in terms of enabling communication and can add or detract from any part of the conversation without the awareness of the therapist and client. This is compounded by the fact that the therapist holds the clinical responsibility for the session but may feel anxious or undermined if unsure as to what the interpreter is saying.

The findings suggest that therapists held multiple perspectives on the role of the interpreter which ranged from the interpreter providing functional support to one of co-therapist. Therapists' perspectives may be based on expectations in different clinical settings, clinical experience, theoretical orientation and/or the relationship they have with the interpreter. The findings draw attention to the benefits of therapists and interpreters building trusting collaborative relationships where roles are discussed and clarified. The therapist's responsibility is to manage any tension in establishing clear professional boundaries to ensure safe practice but needs to work with sensitivity and flexibility to effectively facilitate the therapeutic process between all members of the triad. Therapists will be aware that interpreters may be refugees and asylum seekers and might have their own history of trauma similar to the client. Given the nature of therapeutic work, it is important to recognise the psychological wellbeing of the interpreter. Training, support and supervision is recommended to enable therapists to confidently meet the challenges inherent in this work. This may depend on the therapist and their theoretical orientation.

Limitations

The limitations need to be considered when interpreting the findings of this review. This review only included peer-reviewed studies published in English. Therefore, eligible non-English and theses studies may have been missed and could have influenced the themes generated. In addition, although the peer review process is meant to ensure rigid methodology, there may be bias in what gets published (King et al., 2018). This review is subject to the limitations of the reviewed studies. This meta-synthesis only looked at the experiences of staff and therefore only provides a partial picture. The perceptions of interpreters and clients would also add to the current understanding of lived experience. Therapists who took part in this research may have done so because they experienced this work as complex or challenging which could bias the data. Many of the studies had small samples and included a mix of participants. Different therapeutic modalities such as psychoanalytical or CBT deserve their own discussion.

Rationale for the Current Research

Provision in mental health services to support clients who require an interpreter for therapeutic purposes is well established and founded on the principle that clients should be able to access therapy in their preferred language. Given this, the majority of therapists will be required to work with interpreters. However, only 11 studies were eligible for inclusion in the meta-synthesis which indicates the lack of research that exists exploring therapists' experiences of working with interpreters. Furthermore, only four were UK studies that looked at this experience within the NHS context. Working therapeutically across languages is a substantial topic and one that is worthy of attention.

Qualitative research can provide valuable insight into the experiences of therapists, their attitudes, beliefs, challenges and needs. This in turn, could help therapists feel validated and increase their willingness to work with interpreters. Research highlights that clinicians

acquire knowledge and understanding from their practical experience as well as the research literature (Malterud, 2001). They also develop skills from continuing professional development, training and supervision. Further research could also reveal insights that can help inform services and improve service level support.

The COVID-19 pandemic drastically impacted professional working practices. Many appointments were cancelled, rearranged, moved online or via the telephone. This included interpreting work (Di Braccio, 2020; Goldberg, 2020). In the present meta-synthesis, although two studies discussed use of telephone interpreters, no studies looked at the experience of working remotely or via video. In light of this, qualitative research exploring therapists' experiences of working with interpreters remotely is valuable. Remote delivery of therapeutic provision is now increasingly embedded into standard practice and this research will contribute to the understanding of how this is experienced and managed by therapists in practice. Working remotely adds another complexity to the work with an interpreter and therefore important to explore.

CBT therapists are an important and significant part of what the NHS currently offers. CBT therapists offer evidence-based treatment which is prioritised within mental health services in the UK. There is uncertainty about how the modality and training of the therapist impacts working with an interpreter such as adapting formulation, interventions, and style of questioning. There appears to be only one study that has explicitly investigated the experiences of cognitive behavioural therapists working with interpreters (Tutani et al., 2018). However, this study did not explore the remote aspect of therapeutic work and predominately interviewed Psychological Wellbeing Practitioners. More recently, the ability to work with interpreters has recently been acknowledged in the BABCP minimum training standards and core curriculum (BABCP, 2021). The focus on CBT therapists, working from

the same theoretical framework, principles of practice and professional accreditation regulations provides a cohesive group. This focus allows for more specificity in the findings.

It is anticipated that this study will facilitate a better understanding of how CBT therapists may adjust their practice to work remotely with an interpreter. Identifying potential barriers and challenges will enable reflection on how any issues can be addressed and any potential implications for the delivery of CBT interventions. It is hoped that the findings generated from this research study will help identify how therapeutic services can become more inclusive, effective and responsive to client needs. It is also anticipated that they will highlight areas for further exploration and lay the foundation for tailored training and support.

Aims and Objectives

In light of the gaps in the literature, the research aim for this study is to explore therapists' experiences of working with interpreters remotely. It is hoped that the research findings will inform services about how to improve efficacy and equity. The research questions are "How do CBT therapists experience working with interpreters remotely?", "What are the barriers and facilitators when working with interpreters remotely?" and "How do therapists adapt CBT and the process of therapy when working with an interpreter remotely?".

Chapter Summary

This chapter has introduced an overview of the topic including the current context and an overview of CBT. The chapter has outlined the research literature on working with interpreters and concluded with a rationale and aims for the present research study.

Methods Chapter

Chapter Overview

This chapter will outline how the study was conducted. The chapter will begin by presenting the research design and philosophical considerations which underpin and frame the chosen method for data analysis. It will discuss ontological and epistemological positions and provide a rationale for the method chosen. It will detail the research process by discussing ethical considerations, participant sample, recruitment, data collection, data analysis and dissemination.

Research Design

There is no single accepted research method suitable for all research questions and each method will have its own strengths and weaknesses (Schulze, 2003). The selection of the method adopted will depend on the ontological, epistemological and methodological perspectives. The majority of research in the Cognitive Behavioural Therapy (CBT) literature adopts a positivism paradigm. Positivism views reality as universal, objective, and quantifiable and adopts quantitative methods to prove or disprove a hypothesis through statistical testing (Ponterotto, 2005). Positivist research demonstrates the clinical effectiveness of CBT. However, this research study aims to explore and address subjective experience using a qualitative methodology.

This study adopts a qualitative approach to explore interpreter-facilitated CBT from the perspective of therapists working with interpreters remotely. A qualitative research design was chosen as it allows for a level of detail which explores individual interpretations and meanings in context (Barker et al., 2015; Murray & Chamberlain, 1999). Interpreter-facilitated therapy process is complex, as are the dynamics that arise in the triadic therapy relationship. Therefore, using a qualitative method allows for preservation of this complexity

and richness of data. Within qualitative research, methodologies aim to explore the meaning a participant attributes to an experience (Willig, 2013).

Research Paradigm

Research paradigms consist of interrelated theoretical and philosophical assumptions and beliefs (Kuhn, 2012; O'Reilly & Kiyimba, 2015; Ponterotto, 2005) which frame and guide the researcher in their work. Theoretical frameworks include ontological positions referring to the nature of reality and being. Braun and Clarke (2022) simplify ontology as "*what* it is that we think we can know" (p.166). Epistemological positions concern the theory of knowledge and theorises *how* we think we can know something. These positions impact the methodology adopted and how the issues are researched (Anfara Jr & Mertz, 2014; Ponterotto, 2005). Researchers highlight the importance of explicitly discussing the theoretical framework adopted to ensure that the underlying assumptions directing the research are clear (Creswell & Clark, 2017; Willig, 2013). The underlying assumptions of this research study will be outlined in the following paragraphs.

Ontology is concerned with the philosophical study of the nature of reality and can be understood as existing on a continuum between two opposing perspectives of realism and relativism (Braun & Clarke, 2022). Realism or naïve realism assumes that a knowable reality exists, and that the world is as it appears. Realism argues that there is one objective reality which exists independently of people's understanding or beliefs (Ormston et al., 2014). This approach is often associated with traditional science and dominant ways of thinking in the western world; whereas relativism maintains that existence has multiple constructed realities and there is no one reality that takes precedence and can claim to represent the truth. Relativism assumes that reality is dependent on the ways we come to know it; it is a product of interaction and therefore intertwined with the research process. There are also theories that sit between these two perspectives, such as critical realism. This ontological approach

acknowledges that reality and representations of reality are not the same thing. There is an assumption that there is an external reality that is independent of the human mind. Critical realism offers a contextualised version of realism and recognises how experiences of reality are shaped by social context such as culture and language. Maxwell (2012) states "language doesn't simply put labels on cross-culturally uniform reality that we all share. The world as we perceive it and therefore live in it is structured by our concepts" (p.9). Researchers working within a critical realist ontology accept that there is a material reality. Ontologically, critical realism maintains that there is a reality that exists which can be interpreted in multiple different ways, and which we can only come to know partially. Therefore, this reality can only be measured imperfectly. Rennie (2007) suggests that realist assumptions reduce individuals down to biology and behaviour. Relativism recognises the role of language, culture and wider context; whereas critical realism offers a middle ground which provides a position that retains a concept of truth but recognises that human representations shape how we know and experience this (Braun & Clarke, 2022).

Epistemological positions flow on from ontological positions. In considering an epistemological position, frameworks differ in what counts as valid knowledge and how we generate this knowledge. Braun and Clarke (2022) highlight three main epistemological positions which very broadly map onto the above ontological positions. Firstly, (post) positivism maps onto realism and assumes objective, unbiased data collection to acquire a single truth. Post-positivism maintains the assumption that there is one objective truth and principles such as causation, predictability and falsification influence the field. Researchers acknowledge the influences of context and seek to control for subjective factors. Secondly, constructionism or interpretivism map onto relativism and see the world as interlinked to the social world. Constructionism suggests that what we know of the world is produced through systems of meaning or discourses. Thirdly, contextualism maps onto a critical realist position.

Contextualism emphasises the importance of social and cultural contexts. It assumes a sense of truth but emphasises that humans cannot be meaningfully studied in isolation from the context they live in. Contextualism highlights that the researchers' values shape the knowledge they produce (Madill et al., 2000).

Methodology follows on from epistemological positions (Ormston et al., 2014) which can be quantitative and qualitative. Although methodological stances do not have predetermined positions, quantitative research is often closer to realist and post-positivist positions; whereas qualitative positions are closer to relativism and constructionist positions. This study was interested in lived experiences of therapists embedded in context and therefore the research adopted a critical realist ontology with a contextualist epistemology.

Thematic Analysis

Thematic analysis has been traced back to the early twentieth century (Joffe, 2011), and until recently has been relatively poorly understood. There are many different versions of thematic analysis and the history of the method is unclear (Javadi & Zarea, 2016). Thematic analysis is a method that explores meanings at a pattern level across a data set. Considerable contribution from Braun and Clarke's (2006) publication has led to enlightenment and subsequent increasing interest of thematic analysis. However, Braun and Clarke acknowledged that this 2006 paper left aspects of thematic analysis unclear and therefore subsequent publications have aimed to address issues and misconceptions (Braun & Clarke, 2019; Braun & Clarke, 2021). This has resulted in their contemporary approach which they termed reflexive thematic analysis (Braun & Clarke, 2019).

The chosen methodology for this research project is reflexive thematic analysis (Braun & Clarke, 2006, 2019). When considering the appropriate research methodology for this study, other qualitative methods such as interpretative phenomenological analysis (IPA) and grounded theory were reviewed. These methods differ to thematic analysis as they are

tied to set theoretical assumptions and specific guidelines. Reflexive thematic analysis does not have fixed epistemological positions and is a theoretically flexible method which can be applied to a range of research questions (Braun & Clarke, 2006). Thematic analysis is a widely used method in qualitative research which involves looking for patterns of experience that are important to the topic area (Braun & Clarke, 2006, 2019, 2022). Thematic analysis is also an accessible way to develop findings that can be widely communicated which is important in order to have an impact on practice and policy. Thematic analysis can be used to analyse a range of qualitative data such as interviews, focus groups and surveys (Braun & Clarke, 2006, 2019). Within reflexive thematic analysis, it is suggested that the researcher is clear about the explicit decisions they make during analysis and provide clarity about the process (Braun & Clarke, 2019, 2022). This is important as the ontological and epistemological assumptions frame the interpretation of the data and inform how meaning is theorised (Willig, 2012). Reflexive thematic analysis allows for a deeper exploration, it recognises subjectivities and emphasises the role of reflexivity (Braun & Clarke, 2019).

As described above, the researcher subscribes to a critical realist ontology and contextualist epistemology. In addition to the study's theoretical position, the researcher should clarify what will count as a theme in the data analysis process. Braun and Clarke (2006) highlight the importance of retaining flexibility when deciding what counts as a theme. For this research study, it was deemed appropriate that a theme would capture patterns in the data that said something important in relation to the research question. Braun and Clarke (2006, 2019, 2022) also suggest that the researcher should decide on the approach they will adopt to identify themes. In inductive coding, the researcher takes a bottom-up approach, noting thoughts while reading the data. This method is not driven by theoretical interest of the researcher. In contrast, a theoretical approach can be used, in which the analysis is driven by theory derived from previous literature. For this study, an inductive

approach was deemed most appropriate to allow for themes to be rooted in the data. Although inductive analysis is data driven, Braun and Clarke (2019, 2022) highlight that the researcher's theoretical assumptions and personal experiences will impact the analysis.

A further consideration for reflexive thematic analysis is to decide the level at which the themes are to be identified. Themes can be identified on a semantic level or latent level. At a semantic level, themes are identified within the explicit meanings of what has been said. Whereas, at a latent level, themes are identified by examining underlying meanings, assumptions or ideas (Braun & Clarke, 2006, 2019). A critical realist position enables the data to be coded at both the semantic and latent level (Joffe, 2011). Therefore, any item could be double coded in accordance with semantic and latent meaning interpreted by the researcher.

Ethical Considerations

Ethical Approval

Ethical approval was granted by the University of Essex ethics committee on the 23rd August 2021 (See Appendix C). Recruitment commenced following the ethics approval in September 2021. During this research project, all activities adhered to the British Psychological Society's (BPS) Code of Ethics and Conduct (BPS, 2021).

Consent and Anonymity

Prior to gaining consent, potential participants were provided with a participant information sheet (See Appendix D) which outlined an overview of the research project. Participants were made aware that interviews were recorded, and that they could withdraw from the study prior to data analysis taking place. Written informed consent (See Appendix E) was gained prior to the interview.

Participants' personal information such as names and contact details along with the audio-recordings and transcripts were stored confidentially on the University's secure online cloud storage. Participants were allocated ID numbers throughout data analysis and then pseudonyms throughout the write-up of the research.

Participants were also given the opportunity to read the initial findings of the study and comment on the themes. Six participants provided written consent for their written feedback to be included in the write-up of this study. Any distinguishable information, such as place of work, was either disguised or removed from the write-up of the study and transcripts.

Participants' Safety

Potential risks to participants of physical or psychological harm were considered. It was anticipated that participating in this study would not cause any additional emotional distress that staff encounter in everyday work. Therapists have access to professional on-going supervision as part of their regular practice. However, there was a perceived potential risk that the interview questions regarding the therapist's experience of delivering CBT remotely with an interpreter may cause some self-criticism or negative self-evaluation which could lead to feelings of stress or anxiety. To minimise this, participants were reminded that they could terminate or have a break from the interview at any time. If participants did experience any distress the researchers planned to offer a follow-up meeting, signpost them to support services and encourage them to speak to their supervisor. No participants explicitly identified any distress at the time of interview. Some participants reported positive experiences in that the interview process enabled them to reflect on their clinical work.

Impact on the Researcher

It was recognised that the interview process could impact the researcher due to participants sharing examples of trauma-focused work and/or their own difficulties. This was managed by utilising research supervision and keeping a reflexive log.

Participants

Sample Size

There is debate about the recommended ‘sample size' to use within qualitative research. Braun and Clarke recommend 10-20 participants as a suitable sample size for thematic analysis for a professional doctorate course. However, they highlight that the decision about sample size should be shaped by the data's richness and complexity but also in line with practicalities (Braun & Clarke, 2021b). In total, 18 participants were recruited; one for a pilot interview and then a further 17 took part. The pilot interview was included in the analysis. The sample was homogenous in terms of participants having similar training and clinical work. The sample was heterogenous in demographic characteristics such as age, gender, ethnicity and years of experience.

Inclusion Criteria

The inclusion criteria for this study were that therapists were accredited with the British Association for Behavioural and Cognitive Psychotherapies (BABCP) and had at least one experience of working with an interpreter remotely. The BABCP is the accrediting body for CBT therapists in England. Therapists could have provisional or full accreditation. Participants may also hold other accreditations. Participants may work in private practice, within the National Health Service (NHS) and/ or third-party organisations. They may currently be on leave of absence, i.e., maternity leave.

Exclusion Criteria

Individuals who were not registered with the BABCP were not eligible for the study. In addition, participants who had not worked with an interpreter remotely were not eligible for the study.

Participant Details

In total, 18 participants took part in the study. All therapists included in the study met the inclusion criteria. See the results chapter for further details of participant characteristics.

Recruitment

Following ethical approval, participants were recruited via a range of methods. An overview of the study was posted on social media accounts (Twitter, Linkedin, Facebook). The researcher also shared the study through word of mouth. The researcher contacted known researchers working in a similar field. A research poster (See Appendix F) was used to advertise the study. The research poster and social media posts included the researcher's contact details. Recruitment also took place via a poster at the BABCP Annual Conference in July 2022 (See Appendix G). As part of the recruitment strategy, participants were offered the chance to be entered into a lottery whereby one participant would win a £25 Amazon voucher. This strategy was adopted to encourage and express gratitude to participants. However, it was deemed that this would not be the main reason that individuals would participate, and they could choose to opt-out of the lottery. It was requested that potential participants made contact if they were interested in taking part. Once an individual expressed interest, participant information sheets were provided via email. The information sheet outlined the study, what was involved, information concerning storage of data, confidentiality and what would happen to the data once analysed. If the potential participants were still interested, they were sent some basic questions to screen for suitability, they were offered a

phone call to answer any questions and to arrange a date for interview. Participants signed and returned the consent form prior to the interview. All interviews took place online via Zoom. The researcher was in her private home in a confidential setting when carrying out interviews.

Data Collection

Semi-structured interviews were used to explore therapists' experiences. This method allows for rich data and therefore semi-structured interviews are a popular method of collecting qualitative data (Murray & Chamberlain, 1999). This semi-structured approach allows for consistency between interviews as well as flexibility to tailor the questions. This is deemed an appropriate method of data collection for thematic analysis (Braun & Clarke, 2006, 2022). The materials used for data collection and the process of conducting the interviews is outlined in the following paragraphs.

Materials

Materials used for recruitment included an advert and participant information sheet. Materials used for data collection included a demographics questionnaire (See Appendix H) and semi-structured interview schedule (See Appendix I). The demographic questionnaire asked about basic participant information, including age, sex, ethnicity and experience. The interview schedule was designed following a literature review and in conjunction with the researcher's supervisors. The schedule comprised open questions and attempted to be free from assumption. It was flexible to allow each participant to discuss their experiences in depth, thus encouraging perspectives to be revealed that are not normally documented (Burman et al., 1994).

Following ethical approval, a pilot interview was conducted to ensure questions provided the opportunity to gain detailed data related to the research question. The participant

was also asked for feedback on the interview process. This pilot interview was reviewed with a research supervisor, and it was agreed to add a prompt question about the experience of working in a culturally sensitive way.

All interviews were recorded with the participant's consent. Interviews were recorded using a digital voice recorder (Olympus DS-9000) and the Zoom record function. Both ways of recording were used to ensure there was no loss of data from technology errors or low battery. Additionally, the researcher aimed to utilise the auto-transcribe function but was unsure how accurate this would be. Following each interview, the recording files were immediately saved onto a password-protected laptop accessible only to the researcher. The original recording stored on the digital voice recorder was then destroyed.

Interview Procedure

As interviews were remote, the signed consent form was requested via email prior to the interview along with the demographic questionnaire. Participants were encouraged to keep a copy of the signed consent form for their own records. Participants were asked to complete some demographic questions which included the extent of their relevant experience. Interviews were conducted online via Zoom at a time that was convenient. Initially, participants were provided space to ask questions or express any concerns regarding the study. Then the researcher gave an overview of the process and provided information on the nature of the types of questions that would be asked. Participants were reminded about the confidentiality and anonymity policy as outlined in the participant information sheet. Participants were informed that they could end the interview at any time and withdraw from the study. Additionally, participants were reminded they could have a break during the interview.

All interviews were carried out by the researcher. Interviews were conducted in private settings on a one-to-one basis. Semi-structured interviews were conducted with 18

participants between November 2021 – September 2022. Interviews were recorded. The order of the interview questions varied depending on the flow of conversation and areas the participants discussed. The researcher tried to hold in mind data quality during the interview process and summarised and paraphrased to confirm or clarify the meaning (Roller & Lavrakas, 2015). Following the interview, participants were asked if they had any questions or any comments they would like to make. Participants were also asked if they would like a summary of the results and if they would like to be entered in a lottery to win a £25 Amazon voucher. One participant opted out of the lottery. Once recruitment ended, the remaining 17 were entered into the lottery; one participant was chosen at random and offered the voucher.

Project Development

In consideration of the pandemic, the initial project aim was to interview CBT therapists who had worked with interpreters online through video conferencing such as MS Teams or Zoom. Although telephone interpreting is not recommended for psychology work (Tribe & Thompson, 2017), it became clear that some services only offered interpreter work over the telephone due to the service set up. Furthermore, some potential participants highlighted that clients with limited spoken English were less able to access resources such as Wi-Fi, computer and webcam to have a video session. Therefore, the project was adapted to include all remote ways of working (both video and telephone).

After the pilot interview, the researcher noted that culturally sensitive CBT was an important topic and central to the experience of working with an interpreter and non-English speaking clients. A slight adjustment to the topic guide was made to include this as a prompt as it felt central to therapists' experiences.

Data Analysis

Interviews were audio-recorded and transcribed. Identifying material was removed or disguised. Transcript notations included all words, long pauses and laughter as suggested by (Braun & Clarke, 2013) (See Appendix J for transcription notation system). The transcripts were stored on the University Cloud and a password-protected laptop accessible only to the researcher and research supervisors. Data was managed using NVivo Version 12. NVivo is a qualitative data analysis software package that helps organise data.

Process of Coding and Developing Themes

The data-set was analysed using reflexive thematic analysis and the (Braun & Clarke, 2006, 2022) six stage process was used as a guide to analysis. To help ensure research rigour, the process of coding and theme development is documented below. The six phases are reported here in sequential order, however, the analysis was not a linear process and the researcher moved back and forward through the phases (Braun & Clarke, 2021).

The first phase involved initial engagement with the data, video and audio–recordings were watched and listened by the researcher alongside transcripts to check accuracy and to allow the researcher to become familiarised and immersed with the data (Braun & Clarke, 2006). The researcher also read and re-read the transcripts and noted preliminary observations of potentially interesting ideas (See Appendix K). The researcher recorded thoughts and feelings in a reflexive log.

Secondly, initial codes were generated and grouped which involved labelling data that was relevant or of interest related to the research question. Codes aimed to produce a brief shorthand descriptive or interpretive label for a piece of data. Codes were identified by working line-by-line through the transcripts. Each transcript was coded systematically before moving onto the next transcript. Initially, the majority of coding was semantic and stayed close to the participants' own experience. As the process developed, latent coding also took

place. Codes were recorded in NVivo (See Appendix L for an example of codes). To ensure this process was comprehensive, the researcher revisited interviews over time and codes were added to and refined. This was a slow process and the researcher repeatedly stepped away from coding and returned to it in a different frame of mind. During this phase, key features became noticeable along with similarities and differences across the data.

A research supervisor also independently coded one interview and these were cross-referenced to note any differences in perspectives. The aim of this was not to reach a consensus but to explore multiple assumptions and interpretations of the data. Initially, the researcher noticed a tendency to focus on the negative elements of the interviews and the difficulties faced. This likely came from the researcher's identification with participants struggles. The researcher kept a reflective journal which allowed her to notice this pattern and code areas of strength and therapist skill.

Phase three allowed for codes to be collated into potential themes. Due to the constant retuning of codes and themes, the researcher found it helpful to save different versions of the NVivo coding process. The researcher searched for patterns across the dataset. Codes were grouped to develop initial themes that reflected the data. During this process, the researcher found it useful to print the code book from NVivo and physically group codes (See Appendix M). The analysis of the data was a recursive process whereby the researcher moved back and forth through the six phases (Braun & Clarke, 2006). Themes were produced by organising codes around commonalities or central ideas. In total, this resulted in seven potential themes.

In the fourth stage, themes were reviewed. The researcher took a break from data analysis and returned with a fresh and open mind. This stage involved ensuring that themes supported the coded data across the data set. It also involved revisiting the table of themes to refine themes and subthemes. During this phase, there was a constant revisiting of the transcripts and initial codes.

The fifth phase of conducting thematic analysis was to refine, define and name the themes. Braun and Clarke (2006) highlight that "Names need to be concise, punchy and immediately give the reader a sense of what the theme is about" (p. 23). At this stage, the researcher reviewed feedback from her supervisors and themes were sent to participants who were invited to comment on the findings.

Finally, in phase six, the final results section was produced using quotes from the transcripts. As with previous phases, this was a recursive process whereby codes and themes evolved over the course of the analysis, as did the write-up.

Dissemination

All participants wished to receive a summary of the research findings and will be sent a copy of the final thesis. Provisional findings were presented in a poster at the BABCP annual conference in July 2022. The study was also presented at the University of Essex Staff Student Research Conference in June 2023. It is anticipated that at least one paper will be submitted for publication in an academic journal. It is hoped that this research will also inform positive practice guidelines and training for CBT therapists. It is anticipated that a poster with the final findings will be submitted for presentation at the BABCP annual conference in 2024.

Quality

This study was undertaken with a commitment to ensuring credible and rigorous results. Although there is not a definitive set of guidelines to quality check qualitative research (Long et al., 2020; Meyrick, 2006), a number of guidelines have been identified (Fossey et al., 2002; Tracy, 2010). Yardley (2017) recommends a framework for evaluating qualitative research. This framework highlights four components: "sensitivity to context",

"commitment and rigour", "transparency and coherence", and "impact and importance". The researcher was mindful of these principles during the research process.

The researcher was sensitive to context by asking open questions during the interview and undertaking a literature review. Additionally, the researcher considered the impact of her position and balance of power in the interviewing process. Yardley (2000) argues that sensitivity can be achieved by searching for data that contradicts emerging themes. The researcher held this in mind during analysis and sought out unexpected observations and considered how these differed to other themes. Commitment and rigour were demonstrated during the process through attentiveness, prolonged data analysis and sensitivity towards the data. Transparency and coherence have been demonstrated through a detailed account of the research process, explicit decision-making processes, and continuous reflexivity. Thematic analysis as a research method allows for a systematic and transparent process. The researcher documented and kept an audit trail of how the research was conducted on NVivo software. The researcher also took pictures of theme development that took place by hand. The impact and importance are further essential components to evaluate in qualitative research. This research study has reported important findings. It is hoped that these findings will improve therapeutic practice as well as contribute to the developing body of research. Further evaluation of this research is considered in the discussion chapter.

Member Reflections

This study invited input from participants during the process of analysing data. The term "member validation" or "member checks" refers to "taking findings back to the field and determining whether the participants recognise them as true or accurate" (Lindlof & Taylor, 2011, p.279). This suggests a true reality which the researcher is checking they got correct. Instead, the current study used "member reflections" to offer further opportunity for reflection, elaboration and collaboration with participants (Tracy, 2010). It was hoped that

this might contribute to a richer and deeper analysis. Themes were shared with participants, and they were given an opportunity for comments, ask questions or critique. This was also helpful to learn if participants found the themes meaningful and understandable. This is further discussed in the results chapter.

Reflectivity

Research is not objective and is improved when participants' and researcher's subjectivity is acknowledged (Braun & Clarke, 2006, 2019, 2022). Reflexive thematic analysis calls for ongoing reflection during the research process and "the researcher's reflective and thoughtful engagement with their data and their reflexive and thoughtful engagement with the analytic process" (Braun & Clarke, 2019, p.594). Reflexivity encourages the researcher to be self-aware and reflect on the ways their own history, training, values, experiences, beliefs and feelings are implicated in the research (Willig, 2013). Findings from the research are inevitably impacted by these factors and it is important to consider how these various factors have influenced the research.

Situating the Researcher

Braun and Clarke (2022) postulate that researchers should develop awareness of their own personal positionings and state that research "cannot be a value-neutral activity" (p.14). Therefore, it is crucial to acknowledge the researcher's personal position, values, privileges and perspectives as inherent to the research. Based on this intention, I have decided to situate myself and introduce my own personal positioning. Due to the epistemological position of this research and in recognition of its subjective nature, I will sometimes write in the first person as a way of acknowledging the relevance of self in co-constructing research throughout this thesis. To complement this approach, I will also write in the third person for the intended audience who perhaps are more familiar with traditional academic writing such

as academics and clinicians (Roth, 2005). The epistemological position influences all aspects of the research (Carter & Little, 2007). In this research, a critical realist ontology and contextualist epistemology was adopted.

I am a White, British female. I have always lived in England, and I only speak English. I have an English and Irish heritage and I acknowledge that my values and beliefs will have been shaped by my family's history and my personal and professional experiences. An appreciation of these values and beliefs is helpful as it offers me a lens to understand my engagement with and response to the research process. It also serves as a reflexive mechanism to ensure that my research maintains its focus on the participants and the research aims.

As a therapist, I recognise our shared experience as human beings, for example the need for belonging and fulfilment that is so often expressed in therapy. I also acknowledge the importance of honouring the uniqueness of the individual. As a CBT therapist often working with clients with complex needs, I have questioned how the CBT model can effectively help such clients. I wondered about the usefulness of therapy more generally and started to build a narrative about who and when it "worked" for people. Working in mental health services led me to question how we apply models and concepts with individuals who may hold different worldviews to the ones held by services. This has led me to re-evaluate and broaden my understanding of CBT and I wonder if this is something experienced by other CBT therapists. This has generated an interest in this topic.

I started my clinical doctorate training in 2020 during the Coronavirus (COVID-19) pandemic. Prior to this, my main experience was working in Improving Access to Psychological Therapies (IAPT) where I worked as a Psychological Wellbeing Practitioner (PWP) and then a CBT therapist. I also worked as a CBT therapist for a digital company. I have clinical experience working with interpreters to deliver CBT and experience of remote

CBT, although I do not have experience of delivering CBT with an interpreter remotely. I acknowledge that my clinical experience will have shaped this research as it would be impossible to detach this experience. In an attempt to be as transparent as possible, I kept a reflective log during the research process including the recruitment and interview stages. Extracts from this log are presented in Appendix N. I have reflected on my own assumptions at interview level and at the level of data analysis. This will be further discussed in the discussion chapter of this thesis.

The literature draws attention to the researcher's position within qualitative research, due to the direct role in data collection and analysis. In particular, if the researcher is an "insider" or "outsider" of the group being studied (Dwyer & Buckle, 2009). Insider researchers share characteristics or experiences with participants (Dwyer & Buckle, 2009). As previously mentioned, I trained as a CBT therapist and worked for the NHS before and during the pandemic. Therefore, I feel I have some insider perspectives as I share some characteristics with participants, such as similar training, awareness of service demands and awareness of the CBT model and protocols. My insider role status may allow participants to open up more with me so that there is a greater richness to the data collected (Dwyer & Buckle, 2009).

The outsider is the researcher who is not a member of the group they are studying. I am now employed as a Trainee Clinical Psychologist and for this project have been in a position of the researcher. I have worked with an interpreter a number of times, but I have not worked remotely with an interpreter. Therefore, I also hold some "outsider" perspectives. Holding these outsider perspectives in mind, I have paid close attention to when I have misunderstood or been unsure about the meaning of something. I found it useful to acknowledge that I was not in a binary position of "insider" or "outsider" and to appreciate my nuanced and multi-layered position (Dwyer & Buckle, 2009).

Chapter Summary

This chapter discussed the research design selected for this study. It discussed ethical considerations, data collection and data analysis stages of the project. The next chapter will discuss the results of the analysis.

Results Chapter

Chapter Overview

This chapter presents the results from the semi-structured interviews that took place with 18 participants who self-selected for interview. The study sample is presented followed by the themes and subthemes generated from the reflexive thematic analysis. Verbatim extracts are used to illustrate and support the researcher's interpretations. Pseudonyms are used throughout, and any potentially identifiable information has been redacted to preserve anonymity. This chapter concludes with details of member reflections.

Participant Characteristics

The recruitment phase lasted between September 2021 and September 2022. In total, 26 people expressed interest in the research; however, six did not respond to further contact and, two did not meet the inclusion criteria. In total, 18 participants were interviewed between November 2021 and September 2022. All interviews were carried out via Zoom using both audio and video functions. The length of interviews ranged from 45 minutes to 85 minutes and on average were 64 minutes.

Research participants' ages ranged from 29-56 years with a mean age of 41 years. There were 12 females and six males. To ensure anonymity, participants' ethnicity has been grouped into White (including White Other) and people from diverse ethnic groups. There were 10 White participants and eight participants from diverse ethnic groups. The length of time participants had worked as a cognitive behavioural therapists ranged from 8 months to 20 years with an average length of 5 years, and 4 months. There were 10 participants who spoke only English whereas eight had mixed abilities in other languages. Languages spoken included Chinese, Shona, Arabic, Punjabi, German and French. Some participants reported that although they were not fluent, they had some reasonable knowledge or were able to

partially understand languages including Spanish, Bulgarian, Hindi and Czech. Three participants mentioned that they had experience delivering CBT in a language other than English. See table 6 for a summary of participants' characteristics. Age and ethnicity are not shown in the table to prevent any participants being individually identified. Pseudonyms have been chosen so that they do not reveal the ethnicity or cultural background of participants. The researcher did not adopt numbers or initials as it was felt that this would feel impersonal and make it harder for readers to follow the narratives.

Participants experience of interpreter-mediated CBT ranged from one case to over 320 cases. There were five participants who had only worked with an interpreter over the telephone and not via video, whereas two participants had only worked with an interpreter via video and not the telephone. Participants were also asked if they had received any training in working with interpreters. Twelve participants reported that they had not received any training. Although, two reported that they had done some self-directed study and one reported that working with interpreters had been discussed in team meetings informally. Six reported that they attended a workshop or that they had received some training about working with interpreters.

During the research process, the majority of participants (11) were currently working in improving access to psychological therapies (IAPT), four were working in other National Health Service's (NHS) contexts such as refugee-specific services or secondary care services and three were working in private practice. Although seven participants were not working in IAPT at the time of interview, four of them reflected on previous experience working in IAPT during the interviews. In total, 15 participants had some experience working in IAPT as a CBT Therapist. Some of those who were currently working in IAPT, mentioned that they had previously worked in other services such as specific trauma services or services for refugees and asylum seekers.

All participants were British Association of Behavioural and Cognitive Psychotherapies (BABCP) accredited CBT Therapists. Some had provisional accreditation, and some were fully accredited. There were three trainee clinical psychologists, at least three participants worked in higher education and, at least two participants were working as senior clinicians. At least five participants mentioned that they had worked as a Psychological Wellbeing Practitioner (PWP) in the past. Some participants were also trained in other therapeutic models such as Interpersonal Therapy (IPT), Eye Movement Desensitization Reprocessing (EMDR), Dynamic Interpersonal Therapy (DIT) and/or counselling with British Association for Counselling and Psychotherapy (BACP) accreditation. All participants spoke about their experience of working with adult clients. None of the participants spoke about working with children, families, or group work.

Table 6

Summary of Participants' Characteristics

Pseudonym	Years/months experience as a CBT Therapist	Total number of interpreter-mediated clients (F2F or remote)	Total number of interpreter-mediated clients remotely (via video or phone)
Mo	2 years	5	3
Ross	8 months	1	1
Mia	3 years	50+	12
Reuben	6 years	25	2
Kim	3.5 years	1	1
Ellie	1.5 years	15	5
Grace	4 years	20	4
Ciara	3 years	5	1
Ali	4 years	10	5
Mark	2 years	1	1
Lily	3 years	100+	32+
Josh	5 years	10	3
Maxine	10 years	20 +	1
Carol	9 years	5	3
Stephen	20 years	320 +	160 +
Maeve	9 years	100+	50
Erica	1.5 years	2	2
Nina	10 years	25	25

Note. F2F= face to face.

Thematic Analysis

Upon completion of the interviews, audio-recordings were transcribed and reflexive thematic analysis (Braun & Clarke, 2019) was used to develop themes. Due to the project's critical realist ontology and contextualist epistemology, the process will certainly have been influenced by the assumptions and theoretical orientations of the researcher. Therefore, the analysis represents one way of constructing the participants' subjective experiences. Measures were taken to ensure a thorough analysis of the data and ensure rigour (See Methods Chapter). Overall, five main themes and 17 subthemes were extracted. Table 7 shows an overview of the themes and corresponding subthemes.

The findings highlight some of the differences and similarities between the experience of telephone and video sessions. Throughout the interviews, some participants switched between talking about telephone and online sessions and, where possible, this has been made clear in the write up. However, it is worth noting that sometimes participants were drawing from their more general experience rather than specific situations.

Table 7

Themes and Subthemes Developed From Reflexive Thematic Analysis

Main themes	Subthemes
The system doesn't make things easier	Working with interpreters increases anxiety about meeting demands of the system
	Mismatch between service provision and the needs of the client
	"A bitter taste in your mouth"
Therapist values of inclusive and self-reflective practice	Working with interpreters remotely widens access to communities
	Offering choice can be empowering
	A willingness to learn and reflect
Working in a culturally sensitive way	One size doesn't fit all
	It's the meaning that matters
	Where are the boundaries of CBT?
	Therapist flexibility
The powerful role of the interpreter	The interpreter as a source of cultural knowledge
	Uncertainty about what was being communicated
	Competing for power - "I'm in charge here"
	The dynamics of interaction
Remote working: different landscape, different journey	Anxiety about creating a safe environment
	Benefits and new opportunities
	Reduced interpersonal cues

Themes and Subthemes

Theme 1: The System Doesn't Make Things Easier

This first theme permeates throughout all the themes in this chapter. Participants spoke about the "system" they worked in. This encompassed the NHS, local services, and the wider political and social economic context. Participants spoke about how the system and context of therapy delivery closely influenced their experiences of working with interpreters remotely. This theme captures how most therapists felt under pressure in the organisation they worked in. Participants spoke about time pressures, service targets, additional administration processes and constant service change. Participants reflected on the restrictions of the system which sometimes meant that the needs of the individuals could not always be met. The use of language to describe working with interpreters reflected how this work could be seen as a burden. The interviews also highlighted how the pressures of the service could transform into anger towards clients.

Working With Interpreters Increases Anxiety About Meeting Demands of the System. Participants spoke about how they felt pressurised and anxious. Working with an interpreter generated additional work and participants were concerned that they did not have sufficient time to explore the client's issues in the depth required. However, they were still expected to meet organisational targets. Josh explained "it can be really interesting work. It is just making all of the adjustments to make it somewhat meaningful. When it is more difficult, it is often down to time pressures and practical challenges which is really unfortunate". Furthermore, Mo stated:

> If I had an extra ten sessions, I could explore that, and build on that with them, but we have targets to meet. So again, there is that therapist desire to speed things along. That is why I really want to just get on with it.

Mo comments on how he felt constrained by the number of sessions available within the IAPT service he worked in. These time constraints limited the therapist's ability to gain a full conceptualisation of the client's difficulties. This experience appeared to generate feelings of disempowerment and a lack of agency. Due to the time pressure and desire to "speed things along", the client's emotional experience or therapeutic relationship might be adversely affected.

Interpreter sessions require more time and consequently it is harder to schedule them into the diary. For instance, Ciara explained:

> Oh I really don't want to work with an interpreter but it's not about the interpreter. It's about the practical constraints of needing to allow extra time for the sessions, which sounds really awful ((laughs)) But it's just more of a practical issue.

Ciara's comment about sounding "awful" may allude to a potential threat to the participant's sense of self as a competent, compassionate and caring therapist. The impact of the time limited context also seemed to have an impact on doing the work "properly".

> I'm going to have to just find time to do it elsewhere which means working after my normal hours, so that's all part of that heart sink thing as well. It's not really about working with that kind of client or working with an interpreter, it's more about the fact that it feels like it's not (.) You don't actually have the time, you don't get given the time for what you need in order to do those appointments and to do them properly. (Erica)

For Erica, the longer session and extra work involved with working with an interpreter accentuated her stress in an already stressful job. This additional stress appeared common to most participants although Ciara and Erica felt it important to clarify that this "heart sink" feeling was "not about the interpreter" or client as individuals. Rather this stress arose in response to the additional work and time involved and the pressure to meet service

demands. This pressure was particularly evident for participants working in the NHS within IAPT services who were subject to changing and competing demands. For example, Mark stated, “Now, it's all recovery rates, a little while ago it was the waiting list, so, it's whatever the commissioners are not happy with, that’s kind of getting filtered down”. Mo commented, “I know that if I wanted extra time, I would get it but then that pressure of if you want extra time, you need to get recovery, something needs to work”. However, there were conflicting views between the service and within participants about what “recovery” meant, Carol stated “he obviously was anxious, low about leaving his country as well, so recovering wasn’t going to be the aim, it’s not always the aim for every patient”. Mark reflected “my goal is, it’s not necessarily recovery. I suppose then, having some improvement and having a positive experience of therapy so that they can then come back again if they need to”.

Erica commented on the pressure to meet contacts in her service “even if you allow that extra 30 minutes, then that means that's going to have a knock-on effect in terms of how many other contacts you can fit into the week”. These quotes offer insight into how the landscape of therapeutic services is often characterised by continual change, competing resources and targets. It is interesting to notice the rather dehumanised language used here by Erica as clients become “contacts” to be processed. This may be an expression of how participants in IAPT services internalise working practices, thus enabling them to navigate and manage a demanding environment. Interestingly, some therapists working in services outside of IAPT did not talk about this pressure and those that did, commented on how it was not a problem, “we're very lucky in that we're really small and quite an unusual team and we tend to fly under the radar in terms of KPIs and outcomes”. (Maeve)

Participants spoke about how working with an interpreter remotely added elements to their work that felt more of an emotional strain than clients who they saw face to face or who did not require an interpreter. Several therapists commented on how exhausting and tiring

they found the work, “It also can be quite tiring so I only tend to do one a day if I am working with interpreters” (Reuben). Josh echoed this stating “Personally, I find it a bit more stressful almost, I kind of feel it in my body a bit more with a telephone interpreter session”. In an already pressured system, interpreter work could cause additional “anxiety”, “stress” and felt “exhausting”. The work felt like a significant challenge and could leave participants experiencing a sense of being stuck and overwhelmed. Ali explained, “You’re looking at complex PTSD, refugees, genocide. Really complex presentations”. Some participants spoke about their efforts to prevent unfavourable effects of stress and burnout for themselves and allow time to “switch off”.

> I will make sure there's at least a half an hour break around it, each side. It might mean that, that squishes up some of my other contacts, which are a bit more back-to-back, but I've noticed if I don't do that, I really don't have enough time to switch off from the interpreter bits of it and the weight of that session (Lily)

Mismatch Between Service Provision and the Needs of the Client. Participants spoke about service restrictions which impacted their clinical work. In particular, participants reported that cognitive behavioural therapy (CBT) is tailored to fit the system rather than to meet the needs of the individuals accessing therapy. Therapists may attempt to adjust their practice, but the service is not always flexible enough to accommodate this. Some participants spoke about how rigidly adhering to CBT models and protocols came from the demands of the service. Ciara highlighted this top down pressure, “having our service manager in our heads saying, how many sessions are you offering this person, and can we offer them these sessions for this, and what happened to the health anxiety treatment?” This quote from Ciara captures a sense that the diagnostic labels such as “health anxiety” can be experienced as restrictive and reductionist. This feels important to then consider the context of broader social and political agenda to treatment, that services are predominantly embedded

in a medical model approach. Participants expressed their frustration about their desire to prioritise the needs of their clients, but this often felt unachievable. Working with an interpreter remotely meant that participants had to make decisions on what was realistic in their working context.

Participants spoke about the complex issues that clients may bring, and highlighted that clients not suited to IAPT may not have access to a provision of care within the NHS. Josh reported, “Often, if you have had experience as a refugee, you are getting told no all the time. You are not welcome, we cannot work with you, you are not right for us, we cannot give you this”. Due to the complexity of the client’s psychological and/or social needs, sometimes participants spoke about referring people out of IAPT. However, this could be distressing for the therapist and potentially lead to moral distress.

> It never feels that comfortable saying to someone, I know you've just spoken to me for an hour, but actually we are not the right service and you need to go over here. That never feels comfortable, and I think that feels more difficult, particularly because if you know that someone's got to work with an interpreter in order to access a service, there's that issue about they can't necessarily access all of the same services that other people can. (Erica)

This mismatch in service provision with client needs was often due to ongoing systemic issues. Mo described:

> If they are going through poverty, or they are not sure they will be sent back soon, or they are incredibly isolated at the moment or they have no money. All these things where all you can do is refer on and hope for the best.

The comment to “hope for the best” seems to encapsulate a sense of resignation regarding the system’s failure to provide adequate service provision, as well as a sense of the therapist’s personal powerlessness. Furthermore, there was a sense of frustration towards

service provision that appears ineffectual in reaching out and enabling non-English speaking clients to actively engage with services. Nina reported how outreach work "needs to be embedded within the organisation, whether it be therapy or whatever, really embedded into the service agreements, to say that we're going to be engaging and reaching out. It's time that mainstream services did that."

"A Bitter Taste in Your Mouth". Throughout the interviews, some of the reflections and language used highlighted the sense that working with interpreters and immigrant communities was perceived as a burden. Participants felt pressured to perform and conflicted in their practice. They were aware of their desire to meet the needs of current clients whilst at the same time feeling pressurised by waiting lists. This balancing act of service demands added to participants' stress and frustrations, "when people are not turning up to sessions, you just think I know I have got people that are coming through and it is taking up to 5 or 6 six months and it is not fair really" (Kim). Furthermore, Mia commented,

> I know how expensive the interpreter session is, and sometimes for people especially from certain countries they don't have a really strong sense about time so they may show up late or they may not just show up. And the NHS still needs to pay for the very expensive interpreter sessions… Just makes you feel you know "why don't you appreciate this kind of opportunities when the whole country you know, when other people are still starving and you're not using that." And its completely gone wasted. So, I guess that can, because it happens quite a lot especially with let's see, refugee, asylum seeker groups and they really make you have a bitter taste in your mouth when you think about how these resources can be used somewhere else.

The comments from Kim and Mia highlight how the pressures of the service can sometimes transform into anger towards the clients. It also highlights their frustration of the unfairness of the system when there are limited resources available. The non-attendance or

lateness is fully located as the problem which exists in the client and these participants do not consider how the service or wider systems may play a role. These clients are seen as burdensome. This may reflect the therapists' stress to meet organisational targets but also a lack of awareness of the struggles experienced by their clients and an unwillingness to reflect on their practice. These comments may also reflect some of the wider public discourses about migrant communities as a burden and/or threat and that these individuals should be grateful.

Some participants spoke about issues such as a lack of diversity and language skill within their workforce. Kim, a therapist who only spoke English, suggested an alternative to working with interpreters is for bilingual therapists to work with these clients, she stated "it is great that we can do it (interpreter work) this way but it is a lot more complicated and it would be easier obviously if there were therapists that were native speakers". Kim talks about a conflict between what she believes she is expected to do which is to support non-English speaking clients and a belief that this work would be better facilitated by bilingual therapists. Nina highlights her views on skilling up the workforce and having a workforce who speak a range of languages so that language skills can be utilised rather than relying on interpreting services.

> Unfortunately, we are reliant on these interpreters, but it's not the ideal therapy. It's almost like drawing a short straw if you like…. I guess what I'm saying is that it should be done infrequently. Right now, it's being relied on. Interpreting services should not be relied on for therapeutic services... sometimes you have skill levels in [large city], but you haven't got them in more white areas (Nina)

This comment of "drawing a short straw" highlights the perceived disadvantage that clients may face if they require an interpreter. Interestingly, some participants were fluent in other languages and had experience of delivering therapy in their first language. Ali said "hearing one case after the other just got too much for me and certain things hit home

because of the cultural similarities and then… yeah, just it wasn't great for my mental health". Ali talked about her experience and how she stopped offering therapy in her first language as it became too much. This indicates that it can be problematic to expect bilingual therapists to take on all this work. It also highlights the emotional impact that this work might have on interpreters and raises questions about how the system supports bilingual therapists and interpreters.

Some participants spoke about how clients requiring an interpreter may be disproportionately allocated to staff from diverse ethnic backgrounds. Although this is not the participants' direct experience, it highlights another perceived unfairness in the system.

> some people apparently complained to the BABCP because they put people who require interpreters when there is not many translated materials, give those all to BAME staff, and then they complain that their recovery rates go down and they are unfairly treated. Because it is like 'Hang on a minute, I am working with clients where there are more challenges compared to people that do not get them (Maxine).

This quote echoes this idea that these clients are burdensome to work with. Within a target driven system, it also adds to a disadvantage for BAME therapists who are already a socially minoritized group. Some therapists reflected on a desire for the system to change to allow for in-house interpreters. It was felt that this would serve clients needs better than the current systems in place. As Grace explained

> interpreters who understand CBT a bit more, they would understand the measures, why you have to do what you do, maybe over time, they get to learn different models and understand how the sessions are structured … if you had people in house, they would know how it runs a bit more and you would get to know them a little bit more.

This comment highlights that the system is not set up in a way that allows therapists to build a relationship with interpreters.

Theme 2: Therapist Values of Inclusive and Self-Reflective Practice This theme was identified following therapists' reflections about the communities they served. Participants spoke about the importance of improving community engagement and providing equal access to psychological services to individuals who might otherwise be excluded or marginalized. Participants spoke about offering choice to clients and their own willingness to learn and be self-aware. This seemed to reflect their values and preferred ways of working.

Working With Interpreters Remotely Widens Access to Communities.

Participants reflected on the importance of inclusive practice and being able to offer support and empowerment to all those who seek psychological help. Reuben highlighted that "having people able to access therapy in their mother tongue is incredibly, incredibly important". Furthermore, Ellie reflects on what it might mean if therapists were not working with interpreters, "If it's not a part of your work at all, that probably indicates a wider problem. So yeah, I think it probably should be coming up in everyone's work at some point, in some form". Grace echoes this saying "It was so great that we could have an interpreter show up to every session and allow everyone in the area to access the service". This seemed to reflect the values therapists held about improving access to non-English speaking individuals that lived in the area that their service served.

Maeve spoke about how her service helped people set up with internet access during the pandemic to improve inclusivity of access to support "we've been buying dongles and sending them and then like, talking through the patient, how do we help them sort of get connected when they didn't have that connectivity." Mark also spoke about how remote working allowed for clients to have access to an interpreter which they otherwise may not have had access to. Mark worked face to face with the client and the interpreter joined the session remotely from another country, "there was no chance of us actually getting somebody in the room with us. It would have to be some form of remote".

Some participants reflected on how their values of inclusivity came from their own experience and background.

> the sort of question I would often ask is, if someone from my background or my community was accessing this service, how would they find it? And I think unfortunately a lot of the time it's not a great experience (Reuben)

This comment highlights how more needs to be done to reach and improve the experience for marginalised communities. Some participants spoke about the difficulties, frustrations and barriers in clients accessing support.

> They can't just pick up the phone and make a referral themselves. Straight away there's a barrier, if I can't even do that how am I going to talk to them? How are they going to help me if I can't pick up the phone and speak to somebody of my own language? (Nina)

Nina switches between "they" and "I" in her comment. This may reflect her own personal experience as she had explained that she had family members that required language support.

Offering Choice Can Be Empowering. Participants reflected that they felt offering choices to clients was important. This might be choice of mode of therapy, use of an interpreter, the choice to ask for a different interpreter and/or therapist from the same or different country of origin or religion.

Grace spoke about offering choice of the mode of therapy, "I just feel like in an ideal world, we give people the choice as to whether they are face to face or remote". Grace reflects that choice is only possible in an "ideal world" and continued to discuss the lack of choice during the COVID pandemic. Participants also discussed offering options when considering other intersections the client might hold such as physical health conditions. Kim stated, "when people have got physical health problems or nobody is able to take them to

their appointment, then actually video is very convenient". Offering choices may mirror therapists values around working collaboratively, which is a central part of CBT.

Ellie spoke about offering a choice of interpreter, "choice in who their interpreter is. I always try to check in with them, is that interpreter, do you feel comfortable with them?" Reuben and Ciara spoke about respecting the client's decision about which language to speak in.

> I would always leave the preference down to the client. I would always be wary about making an assumption because it can go either way in my experience. I've had some people make an explicit request to work with someone who speaks their language and that then can be facilitated, but I've also had explicit requests not to when there's concerns about confidentiality or stigma. (Reuben)

> He (the client) did actually speak decent English, so as the sessions went on, we needed the interpreter to intervene less and less. So, he would talk to me in English, and then if he would get stuck, he would say a question in Arabic, and then she (interpreter) would translate. (Ciara)

Ciara and Nina also highlight how therapists cannot assume that clients want to be matched with a therapist who speaks the same language or from a similar cultural background. Ciara explained, "we often assume clients would be happier with someone from their own language and background, but actually, that's not always the case". Nina gave an example of this "not all Sikh women, for example, want a therapist that is of their own culture. That presumption needs to be tackled because where there's been domestic violence or where they're in the same culture everybody knows one another".

A Willingness to Learn and Reflect. Due to the nature of the work with interpreters and at times cultural differences, participants spoke about how they valued the importance of

being curious in their work. Participants spoke about adopting an open and curious stance with the client "I think the only way you can navigate it is to gain more knowledge, but then also be open to that knowledge being incomplete" (Lily). Maeve spoke about treating the client as the expert and the importance of asking questions:

> Tell me about how your symptoms would be understood where you come from, you know, because I might have a generalized idea about kind of, you know, models of mental health in Iraq, but actually, what about you, in particular, like, what did your family really think about someone who's having flashbacks or, you know, hearing voices.

Some participants spoke about the importance of reflection around their own biases and assumptions. They spoke about how working with interpreters often brought up feelings and thoughts of their own which they wanted to reflect and learn from. However, sometimes the time and space for this was not provided. There was also a recognition that making mistakes was inevitable, but this was also a vehicle for personal and professional growth which they valued.

> almost a self-supervisor who comes up on my shoulder and sort of says well hang on that's a bit of an assumption there or that sounds like a bias activating there and I can sort of check what I'm doing and what I'm thinking and in a very sort of CBT way, do some self-practice, self-reflection. And I guess the other bit that's important is there's also something about, I don't know, accepting that I will make mistakes. I make plenty all the time but actually being able to acknowledge that and accept that and actually then being able when it happens to rectify it, so yeah I get things wrong and that's part of being human. (Reuben)

Some participants felt that their training on issues relating to difference was superficial and did not provide sufficient grounding for critical self-reflection. For some

therapists there was an awareness of wider cultural and societal shifts, and they experienced a nervousness in saying anything that might offend others.

> It's lip service. It doesn't get to the root of it. It doesn't give you any skill. It doesn't get you to reflect on your own biases. We go, you have your own biases. That's nice. What are they? How do they affect you in your therapy room and how are you going to overcome them? … I think with all the discrimination, all the movements and all the political and cultural dynamics are all shifting across the world generally, regardless of therapy. All the dynamics there I think have really played out in the therapy realm as well. And I think we definitely need some more training on it, but I also think that people are really scared to get things wrong. I'm really scared to insult people really scared to (Lily)

These quotes highlight how wider social discourses influenced individual therapy work. Some therapists were fearful of causing offence and consequently this impacted on their confidence. Some participants commented on the usefulness of being able to reflect on their work with interpreters during the research interview.

> hadn't really kind of thought about it a lot. I think it's just a good opportunity to reflect back on this case a little bit as well and just kind of think a little bit about what went well, what didn't go well, that kind of thing. Made me think a little bit about preparing for working with interpreters in the future (Mark)

There was an implication that there was limited space for reflection within the service they worked due to pressures.

Theme 3: Working in a Culturally Sensitive Way

This was a strong theme throughout the interviews. Participants spoke about being culturally aware and making adaptions to CBT when working with interpreters. They spoke

about an awareness of the wider context and sensitivity to factors such as culture, ethnicity and religion. Participants reflected on the importance of meaning making and the need to be flexible within a CBT way of working.

One Size Doesn't Fit All. Participants reflected on how concepts of CBT did not aways translate well. Participants reflected that CBT is underpinned by European-American values such as individualism, independence, and assertiveness. Mo reported that "CBT is a very westernised way of looking at therapy, it incorporates westernised values which does not always translate to clients from different parts of the world". If the client was from a culture with different values and experience to the therapist, they would need to aware and sensitive to these differences. Ross stated, "where I have worked with people from Asia and India before, I have had to be, I guess some of my assumptions, I have been aware of the completely different cultural opinions".

However, with some non-English speaking clients there was a shared understanding of concepts and mutual sense of how therapy might work. Mo explained, "I have had interpreter triages where they are French or Spanish, and it is easy because they know about mental health language, they can talk about their emotions. It fits the CBT model in some way".

Quotes demonstrate how there may be differences when working across cultures. There was recognition that the CBT model lends itself well to asking about culture. A key part of this work was around assessment, information gathering and formulation skills. Josh spoke about what he would ask during assessment and formulation sessions:

> thoughts about themselves, the world the future, or you are thinking about people's rules for life and core beliefs. That is all essentially people's culture. How you have learned to make sense of the world as a young person, what was your family like? What was your school like? What was your local area? What were the messages you

were getting? These are things that we should all be making space for and thinking about.

Josh highlights that the CBT model is flexible enough to work across cultures. There is a recognition that culture influences an individual's life experiences, belief systems and assumptions which is integral to CBT practice. Some participants spoke about CBT disorder-specific protocols and guidelines. They used diagnostic labels such as “PTSD” and spoke about the steps that they might follow in protocols. Maeve commented on how even though therapy needs to be adapted, some constructs still felt useful across cultures,

> there does seem to be such a kind of fidelity, like within the PTSD model, that it, it really kind of when it works, it really works just as well for refugees with complex trauma who might have completely different models of mental health.

Maeve highlights that there are universal diagnostic constructs even within “different models of mental health”.

It’s the Meaning That Matters. Some CBT terminology could not be directly translated into various languages. These complexities in language could cause confusion or misunderstanding. Maeve gave an example,

> in Arabic, the word for noise is interchangeable with the word for voice. So we always ask our patients, well, do you have voices? … And the patients always says yes and then it turns out, they're literally just talking about like the neighbours next door, you know, and it's a lot to disentangle.

Participants spoke about the role the interpreter has in translating meaning. Some participants spoke about how the meaning or idea was more important than the verbatim translation of words. Maeve explained, “we really rely on our interpreters to help translate ideas where maybe the idea does exist in that culture, but the language around it is quite

different". Carol reported that she informs the interpreter that she wants to "understand the gist of it, and don't translate verbatim, so not word-for-word, but give the context of what I'm asking in their language". This reliance on the interpreter to translate meaning could facilitate a sense of team work when it went well, as reflected by Lily:

> the best interpreters are the ones where they really do work as a team where they know that I don't know the culture, I don't know the language and they're going to have to not just interpret my words, but my intention as well. Considering why I'm asking this person this?

Furthermore, some participants reflected that enabling clients to understand key ideas took prominence over terminology. Reuben explained that it "depends on the mother tongue of the client. So sometimes it's more about not using the term itself, it's about conveying the idea". Stephen commented on how "meaning" felt particularly central to the CBT way of working "in CBT, the words are really important, meaning is really important. There's enough different meanings for 'depressed' in UK language".

Where are the Boundaries of CBT? This subtheme highlights the discourses surrounding how CBT is conceptualised and practised when working with interpreters remotely and with non-English speaking clients. For some participants they felt that the principles underpinning CBT were broad enough to embrace a range of approaches to meet the needs of clients. Other participants felt that the CBT model was compromised. For Grace, a space for the client to share their story was felt to be most helpful "Sometimes it felt a bit more like counselling in a way. It was just listening to someone, which I think was helpful in some ways, but it was not CBT. It was hard to be more structured with it". Although CBT is a broad umbrella, simply "just listening" does not fit with the CBT model. It is interesting that this participant equated this to counselling and this may reflect some of the assumptions CBT

therapists hold about therapeutic approaches. This may also reflect how listening and developing the relationship was given less emphasis or importance as specific techniques.

There was a sense that fitting clients into models would neglect the individual needs of the client and so adaption and flexibility was often seen as essential. Stephen commented, "I think we get slightly stuck in our Western frameworks. CBT has the capacity to adapt but if we apply it in a formulaic way according to the books, we often miss the context". Stephen seemed to suggest that CBT has to be more than scientific or theoretical in its approach. Rather it needed to be responsive to the context of an individual's life circumstances, history and experiences. Indeed, amongst the participants there was recognition of the importance of understanding a client's culture. Interestingly, Stephen commented on his perception of CBT which was broad and constantly evolving,

> If you're using cognitions in its broadest context and behaviours to change emotions, then it's CBT. And I think there's certainly a movement, if you look at the things that are happening at the BABCP conference, it's quite broad and CBT is going to take over everything from within.

This indicates that participants held differing perspectives as to what constitutes CBT, perhaps shaped by their initial training and subsequent clinical practice. The below quote from Lily reflects some of the reflections about the boundaries of CBT and how the system can impact the model "there's a big difference between what is cognitive behavioural psychotherapy and IAPT CBT. Sometimes I do one, sometimes I have to do the other ((laughs))."

Therapist Flexibility. Some participants spoke about fidelity to the CBT model and protocols. Whereas other participants reflected on their need to adapt and be flexible. For some, flexibility felt more comfortable than others depending on their experience and system they worked in.

The predefined protocols that had been taught during training were often difficult to translate into the reality of clinical practice. Participants reflected on the importance of using their intuition and clinical judgement, rather than solely relying on the current evidence-base.

Ciara reflected, “Got to be honest, wasn’t the best at sticking to the protocol. We did wander quite a lot. I think partly because he does not have the right to work in the UK and everything”. Ciara reflected on how the client’s status of not having a right to work in the UK impacted on the focus of the sessions which tended to centre on practical problem solving strategies, often moving away from the issues surrounding the client’s health anxiety. Ciara later commented “he just wanted support with some of the other stuff, so we just naturally drifted in that direction”. Quotes from participants suggest that CBT therapists have an awareness and understanding of wider systemic factors. Grace stated how “someone who needs an interpreter might be from a lower economic background, or they might have loads of health issues. There seems to be a lot of inequalities that are happening for those people”. These comments refer to the importance of CBT generic meta competencies and adapting interventions in response to the client.

Some therapists described greater flexibility within their work and working in a more integrative way. A transdiagnostic and idiosyncratic approach to therapy was described by some therapists. Carol explained, “I’m not afraid to do idiosyncratic formulations with people to follow what they bring in the session. I find it can be quite helpful because it’s really geared to the difficulties a person has”. Reuben highlights how he works to address and respond to the client’s individual needs:

> taking the same protocols that we would use with the majority service users, but it’s about those more case-by-case changes and arguably there is some literature saying that is what CBT was originally envisaged as, is that we are truly taking people with whatever they bring and they’re able to guide us.

The confidence to do this may be reflected in the years of experience the therapist had.

> There is not an ideal therapy sometimes. It is not a magic wand. You are trying to help someone express themselves and have a space where they can reflect and think. It is not always going to lead to change and that is okay. I play around with it if there are other services in the local area. But basically, I can do something where I explore the past more with them try and make sense of that in a CBT way. (Josh)

In the above example, Josh illustrates the multi-layered nature of clients' distress. He reveals how CBT can provide an alternative lens and provide a more in-depth way of making sense of distress.

CBT therapists spoke about simplifying therapy as one of the main adaptations when working with an interpreter remotely. Josh highlighted that "the idea that when 'things are complicated, go simpler', that is a CBT type mantra". Examples of this included keeping the formulation simple as Carol stated, "I've chosen to stick with a very basic CBT model sometimes, just a five-part model"; keeping techniques simple "I feel the simpler the technique is the better on the online video format" (Mia); using simplified explanations "simplifying the models a little bit if there was an interpreter, not overcomplicating it" (Grace). CBT interventions were also simplified, and often behavioural interventions were focused on rather than cognitive interventions. Lily explained, "We are going to get stabilisation. We are going to get structure. We're going to get kind of real routine stuff in place. And that has to be enough for now".

This simplification might reflect the loss of time when working with an interpreter. It also might reflect that clients who are not familiar with CBT or therapy might need time to focus on the basics of the model. Sessions may also be less structured. Agenda setting and

structure is a core part of the CTSR for CBT therapists. However, this structure was something modified to accommodate the needs of a three-way alliance.

> It is still trying to keep some of those same principles of helping people make sense of how their thoughts are affecting their mood and trying to learn through experience and behavioural change. But, yeah, in a less structured way. (Josh)

Although the term "integrative" therapy was not used by the participants, they spoke about ways that they are flexible and relying on their clinical judgement in their approach rather than strictly adopting a pure protocol or model. This may come from working in a formulation driven way, knowledge about third wave approaches, intuition, experience or relying on more general meta competency skills.

Theme 4: The Powerful Role of the Interpreter

Participants talked about a three-way therapeutic relationship with the interpreter and client. Participants spoke about the interpreter being an active member of the therapeutic relationship who was empowered to speak and offer information. Whereas at times some participants expressed a desire for the interpreter to be neutral and provide verbatim translation only. Most participants expressed that their expectations were for the interpreter to provide relevant information and convey meaning while the therapist kept power and control of the session. There were frustrations and uncertainty when the therapist felt like an outsider to the conversation. The additional presence of a third person in the virtual room can increase the pressure felt by the therapist.

The Interpreter as a Source of Cultural Knowledge. Participants spoke of ways that interpreters provided cultural knowledge. Therapists generally appreciated this and recognised that this was supportive for the client. Grace reported that "the interpreter would

know a lot more about the culture than I did, and they would be like, ‘Oh, in Turkey this is a thing’. They would be able to give me inside info and I would learn a lot more”.

Participants spoke about how interpreters could offer suggestions for cultural metaphors to help convey an idea, as Ellie explained, “they (interpreter) helped come up with metaphors that were appropriate for her culture”. Using culturally appropriate metaphors ensures that ideas are conveyed in a way that they are understood by the client. The interpreter also provided cultural information about some of the practical things like completing questionnaires.

> doing the work and social adjustment scale – asking people to rate from 0 to 8 the impact on different areas of life. She (interpreter) said that people in Sierra Leone don't use numbers like that. They only use it for counting, the amount of things, and money. They don't use it to rate stuff. (Mark)

These quotes highlight how the interpreter is more than someone who translates words and someone who can act as a cultural mediator. The interpreter could also offer cultural knowledge around risk,

> we had to be really careful how we asked about risk. But that was an insight provided by the interpreter. They do have their place in that sense. They can be really useful in terms of the cultural knowledge from new coming communities. (Nina)

Despite the usefulness of cultural information from the interpreter, at times this could feel inappropriate if it was felt that translation was inaccurate or inappropriate.

> I was asking the patient through the interpreter what their beliefs were about the fact that this other person that they knew had passed away and the interpreter said I'm really sorry can't ask that. I went, yes, you can. I need to know that because it's really important and she says in our culture, we really don't talk about death. And I'm going okay, but I need the patient to tell me that not you. (Lily)

It might be that this cultural information was useful, but the therapist alludes that this information remains a guide rather than an absolute and therefore the therapist has a responsibility to check understanding with the client. In addition to this, interpreters are also bringing their own culture and beliefs into the therapy space as Maxine explains,

> Interpreters are human as well and they are not therapists. They are coming from a particular viewpoint when you ask them a general question that is not about interpreting, you are getting what their views are from their family experience, so you have to be mindful of that.

Aside from the main role as communication and being a cultural mediator, sometimes the interpreter was viewed as someone with understanding of therapeutic concepts and skills.

> it's obviously always a little bit daunting because at the beginning you don't know what interpreter you are getting and sometimes you also rely on them that they have a very unconditional positive regard, no judgment or point of view. (Carol)

Uncertainty About What was Being Communicated. There were inconsistences and conflicts about what the participants expected from the interpreters; sometimes seeing the interpreter as a purely functional translator of words, other times as a co-therapist or cultural mediator. Participants spoke about the frustration when it felt that interpreters did not translate everything that was said by the client which left them with an uncertainty about what was being communicated. As Grace highlighted, "sometimes you can tell that they are interpreting everything, other times, the client would talk for minutes, and the interpreter would talk for maybe ten seconds, so you knew not everything was being translated". This uncertainty of what was being said could trigger some anxiety for therapists.

> they would have conversations back and forth, and I would have no idea until the interpreter would be like, 'Ooh, sorry. We were just talking about blah, blah, blah.' And I'm like, 'Okay, can we get back on track.' So, I know, for me, that sometimes I

> worry about if that were to happen again…you don't know if they're translating and it's taking a while, or if they're actually having a separate conversation. (Ciara)

Some therapists had poor expectations of interpreters. Ali stated, "interpreters are people who just translate information. So, I suppose, they don't know how to keep boundaries, they don't know how to communicate things properly".

In line with guidelines, some participants spoke about the importance of a pre-briefing with the interpreter to discuss expectations and help prepare the interpreter. As Carol stated, "My endeavour was to meet with the interpreter a few minutes before the session started to introduce myself properly and give a bit of insight about what I was about to do". Stephen explained how this preparation can help the sessions run more smoothly, "I would normally do 20 minutes preparation prior to seeing somebody, especially for the first time, even if the interpreter doesn't want to do that. Simply because you can iron out these sorts of things a little more".

Competing for Power - "I'm in Charge Here". Participants spoke about issues relating to power whereby some felt that they held power, others felt powerless, and some wanted to share power. The therapist was reliant on the interpreter and therefore the interpreter was seen as powerful. The therapist was competing for this power and control of the session as Maeve explained,

> There are some patients who develop a really strong rapport with the interpreters and will kind of turn and look only at the interpreter for the whole session, and you're there kind of craning your neck around going, 'I'm in charge here' ((laughs)), I promise.

The therapist can sometimes feel like they have lost control of the session and want to remind the client and interpreter that they are in charge or ask to be invited back into the conversation, Ellie reported "I have interrupted to say, 'I'm noticing this is going on for a

long time, would you be able to kind of let me back in'. Ali spoke about how she may need to be more active and assertive to keep control of the session, "I usually say can I just interrupt you here, kindly, and make sure that you are telling me what they're saying. So, yeah, I find I have to be a bit more firmer in sessions with the interpreters".

The interpreter can be the person that the client builds a relationship with which may leave therapists feeling disempowered and incompetent.

> A lot of the warmth, empathy, and a lot of that kind of stuff – a lot that was coming from the interpreter rather than from me. I was kind of a little bit lost, stuttering, and getting things wrong and muddled up. (Mark)

Furthermore, therapists spoke about feelings of exclusion and loss of power when there was a close relationship between the interpreter and the client.

> So, you find an interpreter and the patient talking like a tennis ball and it gets a bit nervous… anxious for me, because I don't want to interrupt them, but at the same time, I need to interrupt them because I don't know what they're saying. (Ali)

This image of a "tennis ball" going back and forth highlights the centrality of the interpreter and the client in the therapeutic exchange. This can generate anxiety for the therapist who may experience reluctance to interrupt whilst appreciating the necessity to be an active central participant in the triad whilst also holding clinical responsibility. Some participants also highlighted that some interpreters may have a lack of understanding of therapy and its collaborative nature which impacts the power dynamics. Ross said that "she (interpreter) sometimes refers to me as doctor or something like that. It is quite hard to bring it back to collaborating, so I feel she can sometimes be a little bit passive, submissive".

These quotes point to the importance of the therapist and interpreter establishing a collaborative working alliance where respective roles and responsibilities are clarified, understood, and respected. This approach has the potential to reduce any confusion or

misunderstanding that may adversely impact upon the therapeutic process. Maxine reflected that as the professional in the NHS, the therapist was the gatekeeper to services, “I am part of the NHS, I make the decisions about therapy, but I hope as much as possible to empower her. She can also leave therapy if it is not for her”. Some participants also reflected on how the remote element of the work impacted their sense of control in the session.

> I can't tell you what to do, because you're in your own home but you are also in my clinic, here like that and so we find it a little bit harder to kind of keep the patient's focus where it should be or their doorbell goes, or their flatmate walks through the room, or are they just yeah, there's a lot of picking up phones and doing something on the phone while they're in a session with us, which they wouldn't do in, in a clinic session. (Maeve)

The interpreter also had a powerful presence even when they were not in the virtual room. Mia explained

> interpreter just dropped out and left me and the patient staring at each other for five to ten minutes and the whole time you don’t really know … we can’t talk anyway, but we don’t want to leave because we don’t know when they are going to come back

The Dynamics of Interaction. This subtheme highlights how the therapeutic relationship is impacted when a third person joins the traditionally dyadic relationship. There were multiple layers to what impacted this relationship. Participants spoke about the additional third person, the remote aspect, the language barrier and the interpreter’s ability to be warm and empathetic.

A third person in the virtual room can make the relationship feel different as Mark said, “I think it changes the dynamic a little bit, it can make things harder to manage”. Participants spoke about how it can feel harder to build a rapport. As Ciara explained, “I just think we’re so used to therapy just being one-on-one that having that extra person in the

(virtual) room can feel a little bit harder to make that connection". This connection and rapport may take longer to form as Ross reflected, "I feel like our relationship is slowly coming along. I get the sense that it is slower than my English-speaking clients because of the language barrier and because of the technical problems we have had".

Sometimes participants relied on the interpreter for warmth and empathy. Lily stated, "when it comes to the empathy and the tone and the unconditional attention, the interpreter should be able to or one would hope the interpreter should be able to deliver that as well". However, Grace felt that this could be lacking from the interpreter:

> when they (interpreter) would say things back, you lose a lot of empathy in the room sometimes. Some interpreters seemed a bit rough. It just did not feel like a very safe environment sometimes. It did not feel really warm and empathic.

However, some therapists commented on how the interpreter matched their tone. Subsequently, this meant the therapist felt more optimistic about forming a relationship.

> she even tried to copy the tone of how things were said, which I really liked. I think small things like that, especially over the phone, make a difference. It did make me think, actually, that there could be possibilities for more options by working online or over the phone. (Maxine)

Developing a relationship or repairing a rupture might be harder remotely with an interpreter.

> obviously that would be hopefully repaired if it were visually, I could see what the interpreter was doing or I could share on my screen, or I would write down on a piece of paper. I could diagram rather than having to explain it verbally those kinds of aspects of it might repair some of that kind of disconnect or some of that alliance issue. But I don't have those options available to me. It does cause then at least my

> understanding would be that it does cause the alliance to grow weaker or just grow slower depending on where they're in the therapy treatment. (Lily).

The alliance and trust in the three-way relationship was particularly important for sensitive work around trauma. Therefore, having a consistent interpreter was seen as vital for the alliance

> you're not just suddenly going to just like, have some stranger in the room and carry on talking about your rape. So we do tend to kind of go to quite a lot of lengths to make sure that we can get the interpreter that can consistently, you know, be with the patient for the whole of that journey. (Maeve)

Theme 5: Remote Working: Different Landscape, Different Journey

For all participants, there was a move to remote working with the COVID pandemic. For some clients this meant either pausing, stopping therapy, or accessing support via the telephone or video. Participants were aware that remote delivery changed the therapeutic experience in a myriad of ways. For many participants, remote working continued but there were different perspectives about whether this was suitable for interpretation work. The remote element of working with interpreters added practical and relational complexities and the need for ongoing review and adjustments.

Anxiety About Creating a Safe Environment. Working remotely with an interpreter added anxiety about creating a safe environment particularly around trauma work. Some therapists mentioned that remote working did not feel like a good enough replacement for face-to-face therapy.

> I just felt a bit hopeless around the therapy, like, ‘We are just going to have to wait until this pandemic is over. I just do not see this being good therapy’. She had quite

> complex issues, it was already challenging doing it over the phone. She was elderly, and then the interpreter on top of that. I used to dread the appointments. (Grace)

Most participants commented on technology difficulties. Poor connection and access to technology can be barriers when working with interpreters remotely. Reuben explained, "poor connection and access to technology can present as difficulties for therapists and clients, I've had one or two instances where we had poor connection and that was, yeah tricky".

Some participants reflected on how they felt the interpreter had not been professional during the remote session.

> The interpreter was making a cup of tea in the background. I could definitely hear that. There was other noises, some things, even though I'd asked them a couple of times, are you as the interpreter in a confidential space? They were obviously not even though they said they were. (Lily)

> three-way telephone conference and that was disaster, yes, so, when they said something and they got delayed and the interpreter jumping in before the patient finished and it's just, yes, I don't know how we all survived that session, but it's very scary. (Mia)

This lack of control over a remote session reflects how working with interpreters remotely can feel "hopeless", disastrous and "scary" for therapists. Confidentiality and a confidential space were important for therapists. Reuben mentioned the importance of a safe environment for both the client and interpreter,

> a safe space where they can talk, somewhere where they won't be interrupted or somewhere they can really… yeah discuss what they need to discuss or want to

> discuss without fear of family overhearing. I think the same is true also with the interpreter.

Not being able to actually see interpreters and clients caused anxiety about who the interpreter might be or who they were with.

> if the interpreter's in the room, I do feel a bit more in control of the contextual element. I'm happier protecting the client, whereas if I don't quite know where the interpreter is, or if they're doing it briefly. I just want to know what they're doing, who else is there (Stephen)

There was also the uncertainty of the space the client was in and so more of a focus might be given to 'resettling' at the end of the therapy session. Ross stated "we will spend the last five minutes resettling, because I just do not know what her environment is like, what she is going back into".

Participants spoke about the importance of being able to see the client, particularly for trauma reprocessing work. Where possible, in face-to-face settings but otherwise, video was viewed as the next best thing.

> doing some assessment, stabilisation work on a telephone. Then before we actually went into doing any work on the trauma memory itself, we'd moved to face-to-face before doing that. It's not something I'm particularly comfortable doing purely on the telephone. I think it's something that should be done where you can actually see the person (Mark).

> the majority of our patients are very dissociative and we just felt we couldn't keep them clinically safe on the end of the phone not being able to see if they were dissociating while they were doing reliving (Maeve)

The anxiety about a safe environment included therapists own sense of containment. Some participants spoke about the support they received from colleagues to manage their feelings. However, due to the impact of the COVID pandemic and increased time working from home, adaptions to supporting each other changed.

> ordinarily, in the office, you sort of stumble out of a heavy session with the patient and just go into the staff room and whoever was there, you'd go, Oh, can I just tell you? Can I just tell you how that session, like, I just have to offload this that was so upsetting and you almost just process it quickly, again, with your colleague, and we realized that wasn't obviously happening in lockdown. So we had a buddy system where you were paired up, and each of you would have regular calls and instant messages throughout the day to be like, how was that session? (Maeve)

Benefits and New Opportunities. Although there were some concerns about remote working with interpreters, some therapists highlighted the benefits and their views on how technology offers more opportunities. Reuben stated, "I guess remote delivery has sort of really highlighted is it can be done, it can be safe, ethical and effective, but it improves access". Mo also reflected on a shift in perspectives that CBT can be done remotely with interpreters,

> I do not think it is going away. I think more and more people will say let's do video, let's do telephone. Pre-pandemic, I was taught that CBT workers do not do work over telephone unless there is a real big access issue around it. Or you have two sessions on the phone and then bring them in.

There were also reflections that remote working suits therapists and works well for them to work remotely.

> I think it suits me personally. There are many factors. Going into the office, there was always an issue with room booking. We do not have a big hub for mental health that

> we always have. You are always piggy backing off somebody else's open plan bit or room to do your notes. I do not miss faffing around with that at all and all the IT and tech issues. I am set up at home, and I think it is taking out so many things like that that were a headache, and now just having a system that works. (Ross)

Ross draws attention to the problems he faced pre-pandemic in the working environment with room space and IT issues. Consequently, this therapist views remote working as convenient as it provides an alternative to the inadequate NHS infrastructure that he worked in before the pandemic. All therapists spoke about a preference for video compared to telephone work. Josh reported, "in the pandemic, I have done interpreter therapy sessions over the telephone and over video. Over video is so much better in terms of the dynamic that can be formed and how it seemed to work". Furthermore, Mo commented, "the more I think about it, the more I feel better about doing interpretive clients online. I would say the CBT implementing techniques is a lot better online compared to telephone".

Reduced Interpersonal Cues. Participants touched on the lack of body language and eye contact when working remotely. Mia explained, "you miss all of that body language. And it's quite I guess robotic in a way and then sometimes when you talk and then maybe a little bit delayed and the patients don't know where to look". This comment highlights how remote working can feel less human and more "robotic". Therefore, participants had to work harder when working remotely.

> you have to work a bit harder, the three of you to find your kind of your cadence, like to find your kind of rhythm with kind of, and now the interpreter talks, and then I talk and then the patient talks and that I find it much easier to get to get into that rhythm that to and fro, whereas there's something about it being on a screen that everyone isn't quite sure who's going to talk next. (Maeve)

Participants commented on how it is difficult not knowing how questions are landing with the client if you do not speak the language or see the clients reaction.

> You can't see the person, you can't rely on any sort of body language or anything to sort of get some sense of how the person's receiving what you're saying, so yeah. I mean, I really don't like ((laughs)) (.) when I see that, if I see that I've got someone booked in it's with an interpreter, I'll be honest, I really don't like it. I'm like, 'Oh God'. (Erica)

Working on video means that the therapist can only see the clients and interpreters face and shoulders and therefore cues are likely to be missed. Stephen reported, "you communicate a lot with the lower part of your body and obviously you can only see the top. So sometimes you might lose some key information".

Participants also spoke about differences between telephone and online video sessions. Some spoke about the usefulness of seeing someone on video compared to lost visual cues via the phone. As Ellie states, "there's social cues of, 'I'm about to speak,' in some way, and it's easier to get everyone on board with that".

Although participants could not understand clients when they were speaking due to the language barrier, participants spoke about how they would pay attention to other cues.

> I was using just the idea of how quickly they're talking, because I guess I got an idea of how they're speaking and how their tones were, and I was using that as more of a guide to kind of prompt, if needed. So, sometimes the client would start speeding up a little bit, and I knew that was coming up in an area that would be tough, so I would ask in those moments to slow down, or to just check in with her emotional scale. (Ellie)

Due to a lack of body language and communication barriers, some participants spoke about how they might emphasise warmth and tone of voice to convey a sense of emotional connection. Ciara explained, “I was just trying to really emphasise the sound of my voice rather than the words, if that makes sense. Trying to make sure that I was sounding really warm and thoughtful and almost overdoing it”.

The participants also reflected on the difference when they are not in the same physical space together.

> If we’re in a room together there are subtle cues and things you can do sort of show the person you are there, even if it’s as simple as passing over a box of tissues and just sort of saying can I get you a glass of water and take your time. But some of that is missing I guess doing it online. (Reuben)

Member Reflections

Participants were given the opportunity to offer their thoughts and reflections on the research findings. Following analysis, all 18 participants were presented with the initial themes via email; six participants responded. All six provided written consent for quotes to be used in the write up.

The intention of member reflections was not to check the themes but to offer an opportunity for participants to reflect and provide feedback on them. However, of those who responded, all participants expressed that the analysis accurately reflected elements of their own experience that they could relate to. As Carol reported, “I can actually relate to many of the experiences you mention, even if I have not thought of it at the time of the interview”. Maeve stated that she felt the themes “captured the breadth and nuance of the issues”. Participants reflected that they related to “uncomfortable feelings”, “added pressure”, “loss of control” and “feeling stressed” and “exhausted”.

Some participants offered further clarification on themes, in particular around remote working. Carol reflected that the pandemic had changed her experience of working with interpreters, “before COVID, it was a bit easier to get an interpreter face to face. Nowadays, this is impossible. No one wants to travel anymore”. This comment highlights the necessity of this area of research. Moreover, Ross reflected, “I have to admit, remote delivery of interpreted therapy sessions often feels less likely you'll get good outcomes”. Whereas Mo shared that “doing the sessions from home makes clients feel safer, they are more likely to attend”. This echoes the contradictions in the difficulties and opportunities of working with an interpreter remotely that are captured in the themes.

Reading participants' reflections helped me understand what resonated with participants. It also offered insight into the experience of therapists reading quotes from the other participants. One participant drew attention to one quote which “came across as xenophobic and elitist”. This reflection helped me think about if the perceived burden of working with interpreters and immigrant communities as something that cannot be explicitly named in services. Reuben felt that this was what “people keep private”. The quote referred to here was a quote that I initially felt uncomfortable with and something I discussed with my supervisors. My supervisor highlighted the importance of including all facets of experience. It was felt that these comments bring to light some of those beliefs that colleagues may hold. However, I wanted to be mindful of how this information was presented and ensure that I included these quotes but situated the quotes in context.

Four of the participants reflected that they had found the themes “interesting” and all of them thanked me for sharing the themes. Mo commented that the process had provided him “a space to reflect on my own feelings towards working with this client group”.

Chapter Summary

This chapter detailed the findings of the analysis. These findings are expanded on in the discussion chapter by providing further interpretations with links to theory and existing research.

Discussion Chapter

Chapter Overview

This chapter provides a review and critical discussion of the current study's findings. This chapter will start by revisiting the research questions, summarising the main findings of the research and then will discuss how they relate to the existing body of literature. The clinical and research implications will be discussed, along with the strengths and limitations of the study. Finally, this chapter concludes with a reflective summary of the researcher's experience of completing the research.

Revisiting the Research Questions

Following the researcher's literature review, there appeared to be only one study that had explicitly investigated the experiences of Cognitive Behavioural therapists (CBT) with interpreters (Tutani et al., 2018). However, this study did not explore the remote aspect of therapeutic work and predominately interviewed Psychological Wellbeing Practitioners (PWPs). Given this, the researcher believes this is the first research study to qualitatively explore the experience of CBT therapists working with interpreters, specifically via remote access. This thesis builds on previous research, seeks to extend knowledge and offers a new perspective within the CBT modality. It recognises the increased remote working as a result of the Coronavirus (COVID-19) pandemic. Subsequently, it has been suggested that remote provision of therapy will be a substantial ongoing part of service delivery in mental health services (Nguyen et al., 2022). This makes this research topical and relevant. Furthermore, the ability to work with interpreters has recently been acknowledged in the British Association of Behavioural and Cognitive Psychotherapies (BABCP) minimum training standards and core curriculum (BABCP, 2021).

The research aim of this study was to explore the experience of CBT therapists working with interpreters remotely. Three research questions guided the research, (1) How do CBT therapists experience working with interpreters remotely? (2) What are the barriers and facilitators when working with interpreters remotely? (3) How do therapists adapt CBT and the process of therapy when working with an interpreter remotely?

Summary of Findings in Relation to Research Questions

Eighteen CBT therapists participated in the research. Fifteen worked in the National Health Service (NHS), 11 in primary care and four in secondary care. Three were working in private practice in the UK. The sample was diverse with respect to age, gender, ethnicity, languages spoken and experience. Five themes and 17 subthemes were generated from the reflexive thematic analysis (Braun & Clarke, 2006, 2022).

The initial research question asked; how do CBT therapists experience working with interpreters remotely? The key findings identified that the experience of working with an interpreter was perceived as valuable but was also associated with some difficulties and frustrations. Participants reflected on their values and expressed their commitment to inclusive practice, self-awareness and offering choice when working with clients with limited spoken English. They valued the knowledge and input the interpreter could provide around cultural information. These frustrations and difficulties appeared to arise from the therapists' attempts to effectively provide therapy within the systems, expectations and protocols integral to the working environment that was often experienced by participants as demanding and pressurised. Indeed, some participants expressed how they felt overwhelmed by the expectations of their working context and consequently working with an interpreter was experienced as an additional burden that could generate a "heart sink" moment.

When working with an interpreter, some participants expressed their preferred face-to-face work. Telephone therapy was least favoured and sometimes described as ethically

unsafe, particularly if the focus of the work was around trauma. Participants described how remote working was now embedded into their normal therapeutic practice post-pandemic. However, this approach added a layer of complexity that was described as emotionally draining and participants recognised how working remotely impacted on the time required to establish trust and rapport with both the interpreter and client.

Regarding the second research question, what are the barriers and facilitators when working with interpreters remotely? Participants often spoke about the complexities in working with interpreters. Facilitators and barriers were identified concerning building a trusting working relationship with the interpreter, differentiating roles and power dynamics. Issues were identified regarding the pressure of organisational targets, technology difficulties, reduced interpersonal cues and practical booking arrangements.

Regarding the third research question, how do therapists adapt CBT and the process of therapy when working with an interpreter remotely? Findings highlight the importance of working sensitively with cultural differences and how CBT could be adjusted to facilitate this. Participants talked about tailoring formulations, choice of interventions and working at an appropriate pace to clearly focus on the client's individual needs. They also spoke about how they may simplify formulations and interventions and take a more practical focus to the work. The extent that therapists could work flexibly appeared to depend on their organisational context and how broadly they defined "CBT". For those that held a broader perspective of CBT, there was a sense that therapists could use their professional judgement and experience to work in a flexible way. For those therapists who defined CBT more rigidly and worked in a more protocol driven way, deviation from prescribed ways of working could generate feelings of being incompetent, discomfort and anxiety. The findings will now be discussed in more detail in relation to existing literature and theory.

Main Findings in Relation to Previous Literature

The findings will now be explored in light of previous research. Themes mirror findings from previous studies, such as mixed views about the role of an interpreter; (Becher & Wieling, 2015; Miller et al., 2005; Tutani et al., 2018); issues relating to power (Becher & Wieling, 2015; Gerskowitch & Tribe, 2021; Raval & Smith, 2003); changes to the therapeutic relationship (Becher & Wieling, 2015; Gerskowitch & Tribe, 2021; Gryesten et al., 2021; Kuay et al., 2015; Miller et al., 2005; Tutani et al., 2018); challenges to communication (Hagan et al., 2020; Pugh & Vetere, 2009; Raval & Smith, 2003; Tutani et al., 2018) and the pressures to meet the demands of the system therapists work within, particularly in NHS settings (Erbil, 2015; Gerskowitch & Tribe, 2021). Findings also echo conclusions in previous studies about working remotely, such as challenges of reduced interpersonal cues (James et al., 2022; McBeath et al., 2020), fatigue (Shklarski et al., 2021) and navigating the virtual environment (James et al., 2022). Simultaneously, most therapists considered that remote working had been effective and considered that it was now an integral part of their professional practice.

This study supports existing BPS guidelines (Tribe & Thompson, 2017) and practical implementation guidelines for interpreter-mediated CBT (Costa, 2022b). It also contributes by further emphasising the importance of reflective practice at both practitioner and service provision level to support the development of services that are creative and flexible. The study draws attention to the importance of understanding the barriers experienced by non-English speaking clients and the reasons for engagement, disengagement and missed appointments. It highlights the need for service provision that is sensitive and responsive to clients' needs and that is able to be flexible and adaptable in meeting those needs, including access to a language interpreter.

This thesis offers a novel understanding of how working with an interpreter impacts how CBT may be conceptualised and delivered. The findings draw attention to the impact of the organisation where therapists work. The findings also offer an insight into the relational dynamics when introducing a third person in a remote setting as opposed to the traditional client-therapist dyad. The research highlights the importance of acknowledging that clients may be refugees or asylum seekers and as such, therapists need to work with self-awareness, cultural awareness and sensitivity to the client's history and their current circumstances.

Impact Upon CBT Ways of Working

The findings offer a novel insight into how the modality of CBT is impacted when working with an interpreter. Findings will be discussed in relation to core elements of therapeutic practice, such as common factor skills and model-specific behaviours. Participants often spoke about how working with an interpreter remotely could impact upon their ability to implement these skills and behaviours.

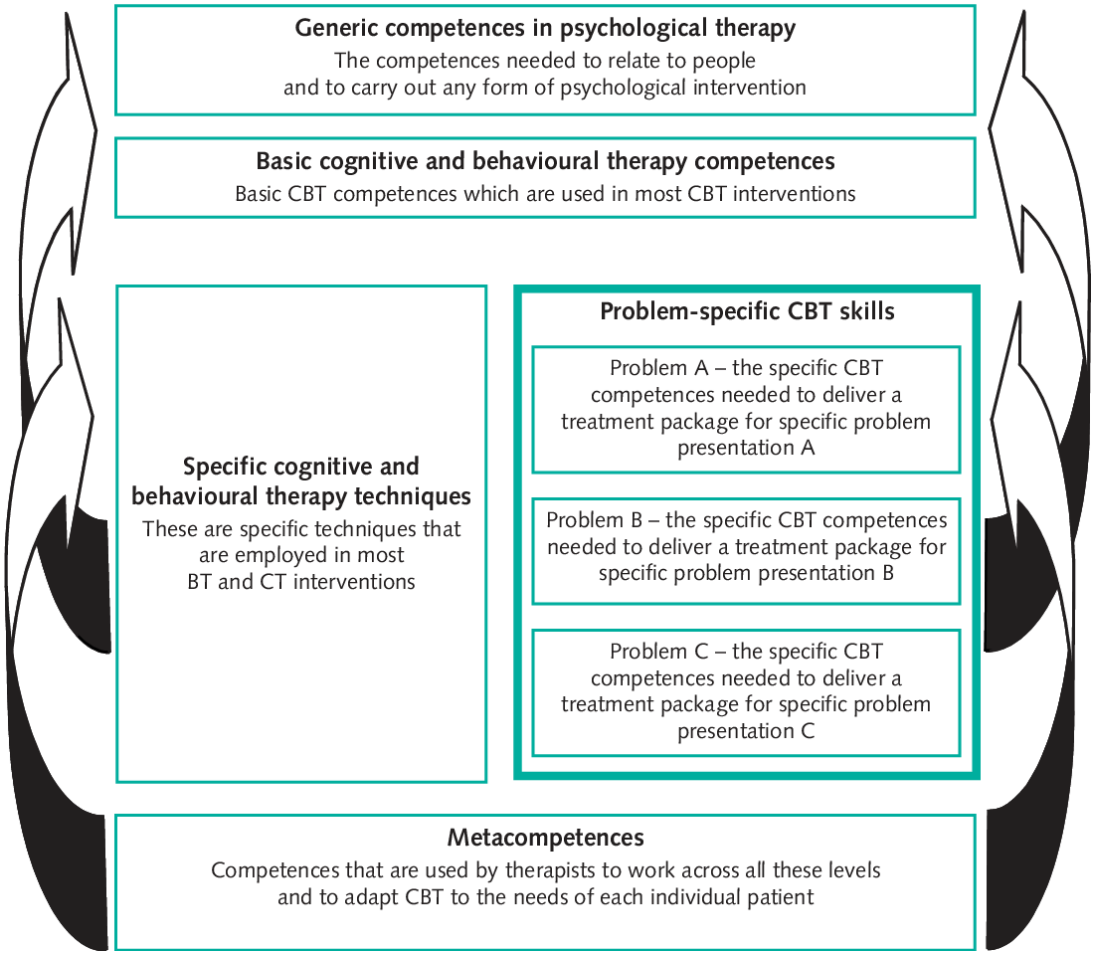
Broadly speaking, CBT competence can be defined as the degree to which a therapist demonstrates the knowledge and skills necessary to appropriately deliver CBT interventions in line with the current evidence-base of an individual client's presenting difficulties and with sensitivity to the client's needs and values (Barber et al., 2007; Kaslow, 2004). However, how CBT is conceptualised and practised is constantly emerging and evolving, and as such, what constitutes effective CBT is often subject to debate and disagreement (Muse et al., 2022). CBT has been adapted several times in an effort to tailor the approach to different contexts (Hayes & Hofmann, 2017). The ability to adapt has enabled CBT to maintain its foothold in the field (David et al., 2018).

The most comprehensive overview of CBT competence is Roth and Pilling's (2007) framework which describes the competencies that should be brought together to deliver CBT effectively founded on the principles of best practice. Competences were derived by looking

at therapeutic approaches with the strongest claims for evidence of efficacy and successful treatment model with associated treatment techniques. This was used to extract and collate therapist competences. Roth and Pilling (2007) argue that competences are needed to ensure good-quality CBT, monitor standards of practice, and facilitate the evaluation of trainee CBT therapists. This competence model for CBT identifies five domains; generic competences, basic cognitive and behavioural therapy competences, specific cognitive and behavioural therapy techniques, problem-specific competences and meta competences (see figure 2). The study findings highlight how these competencies were adapted or impacted.

Figure 2

Outline Model of CBT Competencies (Roth & Pilling, 2007, p.7)



Generic Competences. Generic competences refer to common features present across psychological therapies that are considered important to facilitating positive therapeutic outcomes (Roth & Pilling, 2007). All therapists, irrespective of training or orientation would be expected to have certain characteristics and skills. These are sometimes referred to as 'common factors' (Messer & Wampold, 2002; Wampold, 2015). Therapist characteristics include establishing and maintaining a trusting therapeutic alliance, empathy, warmth, authenticity, and the ability to work sensitively and manage therapeutic ruptures and endings. The therapist would also be expected to have knowledge of common mental health conditions and understand the importance of working with cultural sensitivity. Therapists would be expected to adhere to an ethical code of practice, recognise the limits of their competence and participate in regular clinical supervision. The findings are discussed in relation to generic competencies under the section about relationship dynamics later in this chapter.

Basic Cognitive and Behavioural Therapy Competences. Basic competences establish the context and structure for CBT interventions (Roth & Pilling, 2007). This includes understanding core CBT principles and orienting clients to the CBT model. The therapist would be expected to conceptualise the client's thoughts, physical symptoms, behaviours and emotions and how they interact to maintain problems and share this with the client. These competences also include agenda setting, homework setting and using summaries and feedback. These practices reflect the underlying philosophy of CBT that clients need to be active participants in their therapy.

The findings of this thesis highlighted how participants held differing perspectives on how CBT was conceptualised and delivered. Although CBT may be considered an umbrella term encompassing a number of approaches with contradictory epistemologies, it is often presented as one unified approach, which results in CBT gaining "power as a brand" (Watts, 2018, p.108). Although all participants had been trained in CBT, had the job title 'CBT

therapist' and were BABCP accredited, each will have their own experience and way of working. For some therapists within Improving Access to Psychological Therapy (IAPT), this meant adherence to diagnosis specific protocols.

Specific Cognitive and Behavioural Therapy Techniques. Specific cognitive and behavioural therapy techniques refer to the applied technical interventions associated with most forms of CBT (Roth & Pilling, 2007). This competency also recognises the importance of deriving a formulation which includes the development and maintenance of the client's difficulties. This provides a framework for the specific therapy techniques. The formulation is expected to be collaboratively discussed and shared with the client. CBT techniques include interventions such as self-monitoring, exposure technique or guided discovery. Different techniques would be deployed for each individual depending on the severity and nature of the presenting problem.

The study draws attention to how CBT therapists were mindful of selecting and modifying techniques and interventions that they felt would be appropriate when working with an interpreter. They also considered how interventions might be delivered and received via an online platform and their suitability when working with non-English speaking clients. Finding highlighted how therapists relied on the interpreter to accurately represent the client's experiences. Bruner (1974) draws attention to how meaning is created in human interaction and the importance of shared understanding. However, participants did not share the same language as the client and consequently could not understand the dialogue between the client and interpreter. For some, this generated uncomfortable feelings of uncertainty and exclusion. Participants identified the strategies they used to mitigate these feelings. For example, some participants described working at a slower pace and/or in shorter segments to support the interpreter in the translation process. This appeared to reduce the possibility of miscommunication and helped to confirm the therapist's sense of agency. Participants also

spoke about simplifying or modifying CBT interventions and this may point to the therapist's intention to minimise any misunderstanding within the triad. These findings resonate with studies that identified how therapists adjusted the therapy to a slower pace when working through an interpreter (Miller et al., 2005; Pugh & Vetere, 2009) and previous research which suggests therapists simplify interventions when working with interpreters (Mofrad & Webster, 2012).

Participants identified that many of the clients who required translation support often had presenting problems that centred on practical concerns, such as gaining refugee status and/or how to access a range of resources. This highlights how CBT can be shaped and adapted to meet client needs for example by selecting interventions focusing on behavioural techniques for example problem solving strategies. This echoes the findings by McPherson et al. (2020), who reviewed client experiences of various psychological therapies for depression. This review draws attention to the importance of therapists understanding the cultural and social context of clients' lives. This understanding can provide a foundation for discussion between the therapist and client whereby the client is encouraged to explore what they would find meaningful and helpful in the therapeutic process. This can facilitate shared decision-making and informed choices and consequently help tailor the therapy to meet individual client needs. Naeem et al. (2019) highlight that the CBT therapist's challenge is to work with cultural awareness and sensitivity, adapting the delivery of the therapy and the interventions used whilst maintaining CBT's core theoretical principles.

Problem-Specific Competences. Problem-specific competences refer to evidence-based disorder-specific protocols. They may be different ways that a disorder is conceptualised and thus there are different protocols for the same problem or disorder. For example, for depression, there is cognitive therapy (Beck et al., 1979) and behavioural activation (Jacobson et al., 1996; Martell et al., 2001). The delivery of these problem-specific

interventions will be predicated on the range of generic, basic, specific and meta competences. In this study, participants highlighted difficulties applying disorder-specific models in practice due to complexity and cultural adaptation. Adhering to the medical model sometimes meant that participants felt confined or limited in their approach.

Meta Competences. Meta competences establish the overarching skills needed to balance knowledge of protocols and delivery of interventions with being flexible and responsive to clients' needs. Roth and Pilling (2007) divide meta competencies into generic and CBT-specific areas. Generic meta competences are relevant to all therapies and reflect the ability of the therapist to use clinical judgement and be flexible, responsive and adaptive. CBT-specific meta competences refer to the therapist's ability to formulate, select and apply the most suitable CBT techniques and implement CBT in a way that is consistent with its philosophy. Roth and Pilling highlight how these competencies are more abstract than others and subsequently there is less evidence for their relevance and importance.

The findings of this thesis highlight how service demands, time pressures, organisational targets and the complexities of working within a triad remotely challenged therapists to re-evaluate how they select and apply CBT techniques and interventions. However, the findings also suggest that the overarching or generic meta competences of collaborative working, clinical judgement, adaptability, agenda setting and thoughtful, responsive therapeutic activities and interventions can be used effectively with working with interpreters.

Working in Pressured Systems

The research findings draw attention to the pressured, target-driven environments in which therapists worked. This was often characterised by stress, anxiety and frustration. This pressure necessitated that therapists had to make pragmatic decisions on how best to manage their workload, which sometimes meant prioritizing organisational protocols and

expectations. Protocol adherence is often prioritised in NHS settings (Sreenan, 2013), which could cause conflict for participants who felt that they needed to deviate from protocol or structure. This resonates with Erbil (2015), who explored the experiences of IAPT practitioners and found that service management did not acknowledge the extra time required to work with interpreters and 'clashed' with performance indicators around protocol-driven treatment. Some therapists found this more uncomfortable than others. This seems to reflect the prevailing political culture to use "pure" CBT and to prioritise adherence to protocols. However, research suggests that CBT guided by an individualised formulation produces outcomes that are equivalent or superior to the outcomes of CBT by a protocol (Persons & Hong, 2016). It appears evident that participants did not always feel they had the time or emotional energy to engage in a reflective process to examine their therapeutic work in depth or to reflect on how they might be impacted.

Relationship Dynamics Within Triadic Remote Working

Findings show that moving from the traditional dyadic to a triadic relationship changed the dynamics of the therapeutic encounter. Research consistently suggests that therapy of any orientation is an interpersonal endeavour in which the therapeutic relationship is of central importance (Messer & Wampold, 2002). The CBT therapeutic relationship has traditionally been seen as "necessary but not sufficient" (Beck et al., 1979, p.45). However, in recent years, interest in the role of the therapeutic relationship within CBT has increased. The focus has been on establishing an empathically attuned co-operative therapeutic relationship that is traditionally nurtured within a face-to-face encounter that helps to create a sense of psychological intimacy. However, remote therapy necessarily means that there is an absence of physical proximity. Sanders and Lehmann (2019) point to the importance of a therapeutic space that is relaxed and welcoming as a mechanism to support a sense of psychological safety and care.

For remote clients, it is impossible to be offered a comfortable chair, a warm room, water to drink. The client, therapist and interpreter may all be based in different geographical locations and only meet in a virtual space, often in three separate windows. This absence of physical proximity and care can potentially reinforce feelings of isolation, alienation and disconnection for the client. This is particularly relevant for clients who may already feel isolated by language barriers and lack of opportunities for social integration. It is also important to acknowledge how social-economic factors may impact on the client's experience of remote therapy. Clients with access to a private, quiet and comfortable space at home with reliable internet access are more likely to have a positive experience of remote therapy (Watson et al., 2022). However, those clients who have a relatively limited income such as refugees may not have access to a comfortable private and quiet space where they feel able to talk openly without feeling worried about being distracted or overheard. However, if clients do have access, some may benefit from saving time and the reduction of costs involved in attending a face-to-face appointment. Understanding the context of the client's life highlights the importance of forging a collaborative working alliance between the therapist and interpreter to provide a psychologically safe and productive therapeutic space.

During the pandemic, services moved to providing remote therapeutic support. Findings highlighted that therapists, clients and interpreters may have felt unprepared for telephone or video sessions. In particular, it took time to establish processes regarding how clients could consent from their home, confidentiality, what happens when technical difficulties occur, or helping the client create routines to ensure their emotional safety during and after the session. Therapists are aware that they are responsible for establishing working practices with interpreters. Findings revealed that participants in this study particularly appreciated working consistently with the same interpreter with an opportunity to meet before the session and to debrief at the end. It seems evident that establishing a collaborative

working alliance where ground rules were agreed was an important element in enabling the therapist to feel confident.

Findings also highlighted how therapists can feel anxious about working with traumatic experiences or issues in a virtual space, given the potential difficulties in ensuring client safety and emotional containment. Remote therapy means working with a limited physical image of the client and as such is unlikely to provide the necessary opportunities for the therapist or interpreter to accurately observe or read a client's non-verbal communication. This has the possibility for misunderstanding between all members of the triad. Zoumpouli (2020) draws attention to the importance of establishing a consistent, emotionally attuned presence in remote practice where difficulties in connection with clients, whether technological or interpersonal communication are acknowledged and discussed. Working remotely also raises questions about developing new organisational processes, for example different assessments protocols, the duration of therapeutic sessions and the role of interpreters.

Therapists are often aware of the inherent power dynamics in working with an interpreter in triad work and are mindful that they hold clinical accountability. It is interesting to note that although participants in this study recognised their responsibilities for managing the therapeutic process, participants tended to articulate how the session would be organised in general rather than specific terms. This may have signified a lack of relevant training or a reluctance to move into what could be perceived as a managerial rather than a collegial role. Although participants spoke about power dynamics inherent in the interaction with the interpreter, some may have found this differential uncomfortable. Indeed, wider issues relating to power imbalances and social inequalities and how these might impact on each member of the triad were often not acknowledged. This echoes Gerskowitch (2018) who

suggests that this avoidance may be due to discomfort, fear of causing offence or lack of confidence to address.

Patel (2003) identifies that several differences exist between the client, interpreter and therapist for example, social economic status, ethnicity, age, gender, political and religious beliefs. These differences will impact upon the triadic relationship and are likely to unconsciously play out in the therapeutic process. It is interesting to note that participants predominantly focused on technical or organisational pressures. Whilst it is easy to recognise how these immediate concerns took priority, it may also suggest a reluctance to address sensitive issues around inequality and difference.

Reflexivity

Self-awareness and reflexivity are often described as qualities associated with common factors and meta competencies. Historically, personal therapy is not prioritised for CBT therapists (Laireiter & Willutzki, 2003, 2005) and has often de-emphasized the impact of therapist qualities on client outcomes (Scott et al., 2021), although CBT does recognise the therapist in relation to the therapeutic process (Laireiter & Willutzki, 2005; Safran & Segal, 1996; Thwaites et al., 2014). It is therefore important for CBT therapists to become aware of their own thoughts, feelings and interpersonal pulls. Bennett-Levy et al. (2001) proposed "Self-practice/Self-reflection" (SP-SR) through which therapists use CBT techniques to gain a deeper understanding of themselves. The findings of this study highlight that reflection on personal bias and assumptions was important. There were varying degrees to which therapists had the ability to engage in this process. Furthermore, clients may present with complex needs, such as being survivors of trauma and/or torture if they are refugees or asylum seekers. Therapists working with traumatized clients are at increased risk of burnout, compassion fatigue and vicarious trauma (Iqbal, 2015). Previous research (Becher & Wieling, 2015) has highlighted the potential for interpreters to be affected by traumatic content that may arise in

therapy sessions. In this study, therapists spoke about offering space to de-brief with interpreters but again due to time pressures, this could be experienced as a source of stress.

The importance of reflective practice when working with clients is emphasized and echoes existing literature (Brooks, 2019). There were variations in self-awareness of personal judgment and exploration of where bias may have originated from. The use of SP-SR includes techniques such as downward arrowing which is recommended to help therapists uncover their beliefs which might influence unhelpful behaviours when working with refugees, asylum seekers and survivors of torture (Brooks, 2019).

Similar to Patel (2003), participants acknowledged numerous differences that may exist between the interpreter, client and therapist such as language, culture, religion, ethnicity, class, age and gender. Participants in this study highlighted the need to be culturally aware and often relied on the interpreter as a source of cultural information. Participants were mindful to adapt therapy to make it culturally sensitive, for example by carefully considering the use of non-verbal communication, language, metaphors, images and terminology.

Offering choices to clients was also described as important to respect the client's autonomy and encourage therapeutic engagement. This was centred around use of an interpreter or the choice to ask for a different interpreter and/or therapist who might be from the same or different country of origin or religion. This seems to reflect the participants' desire to work collaboratively and empower clients to have a voice in their therapy.

Clinical Implications

This section will discuss the clinical implications of the findings from this study. Therapists are required to work proficiently with interpreters (BABCP, 2021). In an increasingly diverse society, working with interpreters will remain a significant proportion of national budgets for therapy services. The NHS spent £66 million on translation and interpreting services in 2019/2020 (Inbox Translation, 2022). This is a substantial proportion

of national budgets. Consequently, it follows that there are significant clinical implications of the findings of this study. Training and learning needs are highlighted, along with service level implications.

Training and Support

Findings indicate that training to work with an interpreter is generally inadequate and would benefit from review and updating, This is particularly relevant in the context of rapid changes to service delivery since the pandemic. An experienced and well-trained workforce can help to reassure service users that the services they access will provide high quality care. To ensure that high standards of care are established and maintained it is important to provide on-going training to support the development of best practice and the awareness and implementation of current practice guidance (Costa, 2022b). This training might form part of the core CBT therapists' programme of study as well as a range of post-qualification professional development opportunities. It would seem self-evident that the drive towards a high standard of professional care should be supported by the development of an organisational clinical strategy in which translation and interpreting services are integrated into therapeutic provision.

In addition to identifying the benefits of professional study, the research also offers implications for individual learning and development via personal reflexivity, peer and individual supervision and activities to promote self-awareness. Participants often spoke about their interest or passion for working with different or marginalised groups. This supports Bassey and Melluish (2012) findings that CBT therapists' individual experiences and motivation to learn about culture are key contributors to developing 'cultural competence'. However, the competent therapist may not necessarily have explicit knowledge and/or experience of different cultures but instead is sensitive to clients' differing experiences and backgrounds and takes time to understand their clients' values and goals. In line with Mirdal

et al. (2012), this promotes a more egalitarian and collaborative therapeutic relationship whereby the therapist's intention is to enable the sharing of power between the therapist and client. The findings of this study highlight the importance of ongoing peer and service level professional conversations to evaluate, enable and embed best practice into therapeutic practice and provision.

Service Level Change

Findings indicate that CBT therapists tend to experience conflicting emotions in relation to working with interpreters. This points to the importance of support systems such as ongoing training, supervision and reflective practice being embedded into good practice guidelines. Findings highlight that a perceived demanding or supportive working environment influenced how they related to the interpreter. It was clear that the intensity of therapists' workload was crucial to the difficulties encountered. Participants working within an organisational context of funding pressures, rigid structures, and constant change experienced stress. This is particularly relevant in light of the high burnout and high staff turnover in IAPT services (Owen et al., 2021). To alleviate the pressures on therapists, services could offer more sessions or longer sessions for interpreter-mediated therapy. There could also be new ways of contracting and integrating interpreters into service provision thus facilitating opportunities for collaboration, for example via joint reflective practice activities for both therapists and interpreters. Whilst making changes to service provision is ultimately a political decision, without this commitment to systemic change, it is unlikely that these issues will be effectively addressed and resolved.

Addressing Barriers

During the interviews, some participants reflected on the systemic and social changes needed to support non-English speaking communities to address barriers that clients' face.

Whilst this reflection is essential, participants were aware that changes needed to be implemented. These changes ranged from revising referral processes to enable non-English speakers to access therapy more easily to assessing how CBT could be tailored to suit individual needs. Therapists would benefit from a deeper understanding of the stigma and discrimination that clients with limited spoken English may experience and how these impact upon their engagement with professional services. The therapist mustn't assume something is lacking in the client if CBT does not appear helpful or acceptable to the client. This points to the importance of working with service users to understand their perceptions and needs in order to develop a range of therapeutic and support services. However, these changes require time and organisational commitment and may be difficult to achieve in a pressurised environment with high staff turnover.

Some literature highlights that matching clients with therapists who speak the same language or from a similar culture is helpful as this allows clients to identify with individuals they perceive to be similar to them (Cabral & Smith, 2011; Festinger, 1954). However, it would be complex and difficult to accurately define what would constitute a "match" and whether this is always the most therapeutic option. A recommendation made by some participants was that recruitment could be targeted to increase the proportion of bilingual NHS CBT therapists. However, participants felt that it would also be vital that bilingual therapists had the choice as to the number of clients they supported using their language skills due to the increased pressure and emotional strain the work may add. The research findings highlight that assumptions cannot be made on client or therapist preferences. Furthermore, participants recognised the need for all therapists to be skilled to work with interpreters due to the vast number of languages and dialects and consequently should not be confined to a select few therapists. Another option would be the development of 'in-house' interpreters that could join training sessions and team meetings. This could be cost-effective, facilitate the

development of collaborative working relationships, and increase interpreters' understanding of therapy.

Directions for Future Research

A positivist stance would suggest that study findings naturally lead to a subsequent set of research questions. However, the critical realist stance taken throughout this thesis would recognise that any recommendations for future research would not be value-free. This thesis expands on research that highlights how therapists experience challenges in triadic work with an interpreter by looking at the context of remote working and the modality of CBT. One direction for future research could extend the ideas presented in this study by exploring different therapeutic orientations. Similarity, future research could extend the scope of organisational settings that work with interpreters as this is a little-researched aspect of this topic. This could include the use and provision of supervision as part of inclusive practice.

This study has only explored the experiences of therapists and future research could give attention to the experiences of clients and interpreters working within different therapeutic modalities and settings. Working with interpreters has recently been identified as a key competency on IAPT postgraduate training courses. Research could explore how equipped newly qualified therapists feel about working with interpreters in light of this training. Further research could be undertaken to explore help-seeking in non-English speaking individuals who may have additional barriers to accessing help. Research could review the effectiveness of community intervention. Services could consider how recovery is measured, which often relies on outcomes developed for specific populations and may not be generalisable. Recovery for everyone is different and may not always be captured by services. Craig (2008) challenges the notion of " recovery" and argues for a more collaborative, equal therapeutic relationship. In this way, clients are empowered to voice what recovery means for them, thus shaping the therapeutic work.

Wider Implications

Successive UK Governments have committed to providing universal health care to all, including migrants and refugees. How this translates into practice and policy is often a contested field. Some literature suggests that non-English speaking individuals who might be refugees have a greater need for political and social justice rather than psychological therapies (Summerfield, 1999; Turner et al., 2003). This includes improving the asylum and immigration system, access to legal advice and strategies to support social inclusion. However, providing psychological services that enable non-English speaking refugees and migrants to feel supported and empowered to cope with the issues they face is also valuable. The research indicates this can be achieved via culturally and linguistically informed therapeutic service provision. Sometimes, people with limited spoken English are considered marginalised, disadvantaged or 'hard to reach' groups. These terms may suggest that there is an inherent reluctance of these groups to be reached. Although there may be reasons that certain people do not engage with services, it could also be reframed as a reluctance of service providers to seek ways to understand and work with diverse groups in a meaningful way. This might look different to how services are currently operating. For example, people may express themselves through dance, art, poetry, prayer, and music (O'Brien & Charura, 2022). These therapeutic interventions are often less privileged in mental health services in the UK. Developing these services requires high-quality research, adequate funding, political will, and commitment.

Strengths and Limitations

The strengths and limitations of the research are discussed below. The research was evaluated using Tracy's "Eight Big Tent" criteria for excellent qualitative research" (Tracy, 2010). Each area has been discussed in turn, (1) worthy topic, (2) rich rigour, (3) sincerity,

(4) credibility, (5) resonance, (6) significant contribution, (7) ethics, and (8) meaningful coherence.

Worthy Topic

The study explored is a worthy topic, mainly due to its relevance and timeliness to current events such as immigration and increased remote working since the COVID-19 pandemic. Furthermore, working with interpreters is integral to the work of CBT therapists and is a regular part of their workload. Given this, the findings contribute to the literature on the experience of working as a CBT therapist. Some participants commented on the usefulness of the interview process as it allowed them to reflect on their clinical work and to identify their personal and professional values. For some participants, the interview process provided a space for them to contemplate their practice differently from what they might typically experience in supervision or with colleagues. It is hoped that this research will inform training schemes and services and raise awareness of the complexities and pressures experienced by therapists working within a CBT theoretical orientation.

Rich Rigour

The study has shown rigour as research decisions have been made explicitly throughout and were discussed within research supervision. Tracy (2010) argues that "demonstrations of rigor include the number and length of interviews, the appropriateness and breadth of the interview sample" (p.841). The sample size of 18 allowed for a range of experiences to be equally heard. The sample size is a noteworthy strength, particularly for recruiting staff who were considered key workers during the pandemic and subsequently experienced increased pressure and demand. The level of knowledge or experience working with an interpreter remotely was not pre-defined, meaning there was a varied range of experience within the sample. Furthermore, the services that therapists worked in were not

pre-determined and therefore invited therapists working in various settings. The sample was heterogeneous in many ways. There was diversity in ethnicity, age, gender, length of time working as a therapist and level of experience with interpreters. This highlights the strengths of the recruitment strategy. It allowed for broad and detailed representations of experience, thus a more representative knowledge of the broader population of therapists. However, purposeful sampling meant that the sample was self-selected. This could mean that therapists who struggled to work with interpreters or had a passion for this area were recruited. Some participants were currently working in or had worked in specific trauma services or services for refugees and asylum seekers. This could be viewed as a limitation due to a bias sample as perhaps those more in a 'middle ground' were not represented. A snowballing approach was used for recruitment. Social media and word of mouth were used primarily for recruitment; therefore, there would have been therapists who did not hear about this research project.

The method enabled an in-depth exploration of participants' experiences, and the flexibility of semi-structured interviews allowed for probing questions to be asked to gain a rich understanding while ensuring that core topics were asked about with every participant. Due to COVID-19, all interviews were conducted via Zoom as face-to-face interviews were not permitted. All participants agreed to using the video function, and most attended from home. This may have allowed participants to speak freely compared to if the interview took place in the work environment. This might have allowed participants to talk about the organisation they worked in, and the pressures they felt more openly. However, some elements may have been missing in the absence of face-to-face interactions. This research asked about experiences of working remotely and the interview was conducted remotely, so there may have been a bias towards people who liked working in this way or felt strongly about it. The timing of the interviews might indicate how staff felt following the pressures of the COVID pandemic.

Thematic analysis was deemed suitable to explore the subjective experiences of therapists. A supervisor coded an interview and these codes along with patterns in the data were discussed in the supervisory team. Furthermore, research supervisors read this thesis for coherence and quality. Member reflections allowed for participants to review themes and provide feedback which enabled allowed to add to data to make it richer and complete.

Sincerity

I have demonstrated sincerity by being transparent regarding my own experience, position, privileges and perspectives. To ensure transparency, I have been explicit about the steps of the analysis and decisions made throughout the research. I have kept an audit trail throughout. I had previously worked in the same team at the same time with four of the participants and although this meant a rapport had already been established before the interview, it may have biased how they responded to questions in the interview. Others who opted for an hour-long interview may have been a bias sample and attracted more socially confident or passionate people about the topic.

At times the answers given by participants indicated that they were responding to me as a clinician rather than a researcher. I was aware that some of my experiences working with interpreters was quite different to the participants. This highlighted to me that this could have increased the likelihood of making assumptions about participants as well as participants making assumtpions about my experience. Keeping a reflexive diary and writing a reflexive account enabled me to reflect on my own positioning in the research.

Credibility

Credibility has been demonstrated using member reflections. All participants were invited to comment on preliminary findings. Participants shared invaluable perspectives, which helped the researcher gauge the findings' resonance with members. This also helped

me consider if the research was meaningful and comprehensible. Codes and themes were also reflected on with my researcher's supervisors.

Regarding the reliability of the results, it is noted that another researcher may have had a different set of conversations even with the same participants and interview topic guide. Furthermore, in a qualitative analysis of semi-structured interviews, a different researcher could have produced a different, and equally valid, set of results even with the same transcripts. My insider/outsider position and experience as a CBT therapist working in an IAPT service and as a Trainee Clinical Psychologist working in secondary care psychology service will have inevitably influenced my analysis. These factors are not necessarily viewed as limitations and instead perhaps offer a unique position to understand the participants' experiences. The write-up of the findings included rich descriptions and the use of quotes to evidence themes.

The participants in this study were all BABCP accredited therapists, and those who did not hold accreditation were excluded. Although this exclusion criterion was applied to ensure that only therapists with sufficient training and experience of CBT were recruited, the exclusion may have inadvertently limited the transferability of the findings to those practising CBT without BABCP accreditation.

Resonance

During the analytic process, interviews and codes were discussed with the researcher's supervisors. Attempts to make findings transferable included a thorough description of the research methodology and the use of quotations. In terms of generalisability, the recruitment of staff was varied. To the researcher's knowledge, all 18 therapists worked in different services nationwide. Therefore, the findings could provide insights that could be useful in other contexts.

Significant Contribution

Given the study's findings, participants may feel validated. It is hoped that this thesis has valuably reframed some of the difficulties CBT therapists face along with ways services can support staff. The researcher attended the Annual BABCP conference in 2021 and 2022 to meet therapists and present a poster with an opportunity for recruitment. It is expected that the findings will be presented at a future conference.

Ethics

Completing this research required upholding stringent ethical processes and scientific rigour. Ethical approval was gained, and standards such as participant anonymity, confidentiality and protection from unnecessary risk were fulfilled. Research supervision was utilised to reflect on the use of quotes in the write-up. Member reflections highlighted the impact that some quotes may have had on participants. Participants were offered a space to reflect on the themes further. Consideration was given to how best to present the research and quotes to raise important issues.

Meaningful Coherence

Meaningful coherence refers to the “consistency, soundness, and rationality of a study” (Tracy & Hinrichs, 2017, p.9). The research aims and questions of the study are established as broadly derived from the systematic literature review. A qualitative design and reflexive thematic analysis suitably address the research questions. The analysis process has been audited and reviewed with research supervisors. Research supervisors and some participants have read this thesis to ensure it is coherent and meaningful to the reader.

Final Reflections

This section offers a personal reflection on the research process. I acknowledge that my clinical experiences, therapeutic training and life experiences will have inevitably

influenced how I approached this study, interpreted the interview transcripts and presented the final analysis. On reflection, I think one of the reasons I was drawn to this research topic was due to my own experiences of being misunderstood and isolated. The study gave me the opportunity to reflect on my experiences of working with an interpreter. In the stages of interviewing and the initial stages of analysing the transcripts, I found it difficult to disentangle myself from the participants' accounts as it mirrored some of my own experiences when I worked with interpreters. My clinical experience was also in IAPT services. I recognised many of the comments made by the participants relating to workload and the frustration of working within rigid systems. In recognition of this, I revisited the transcripts several times to try to be as balanced in my interpretation as possible. I felt that my clinical practice as a CBT therapist was important to this study. As someone with a shared understanding of delivering CBT, I felt I could frame the research questions to draw out the complexities of working with an interpreter from this orientation. If my previous clinical experience had been from a different theoretical orientation, I could have missed the tensions, subtleties, and nuances in the participants' responses. It is not surprising to me that the study highlighted how CBT therapists framed their CBT practice in different ways and how they adapted their practice to work with an interpreter. Indeed, I recognise the need for flexibility in working from a CBT orientation, and I can appreciate the importance of working holistically with a client. Working with an interpreter often necessitates a slower pace of working, but this brings with it more time for reflection and observation, thus supporting the formulation process.

The study also highlighted the value of being skilled at speaking more than one language. It was interesting to notice my reaction to this, and I recognised my own discomfort at not being skilled in another language. As an English speaker, I have enjoyed the benefits that arise from sharing one of the world's dominant languages, and I recognise

that at times I have taken this for granted. When I have worked with an interpreter, I have been aware of their fluency and skill in moving between two languages and realise how valuable this service is. I have also reflected on how frustrating it must be for clients with limited spoken English to engage in services.

Throughout the study, I reflected on my own attitudes and biases. I have been aware of news stories that focus on issues relating to immigration and refugees and the narratives that form around these news stories. I have wanted to develop my awareness, and I attended training events such as 'Working with refugees', 'Interpreter-mediated CBT', and 'A culturally inclusive approach'. Throughout this process, I have also started to challenge ideas embedded in western culture that emphasise individuality. I have also started to re-evaluate my ideas about the importance of connection and community. This awareness has helped me appreciate the different perspectives participants have expressed about their work and clients. Therapists are influenced by their life experiences, worldviews and belief systems. I noticed that some participants were concerned about not saying anything that might cause offence.

Working with an interpreter highlights power and powerlessness for everyone involved in this three-way interaction. This is a complex and sensitive issue and for the therapist who will be perceived as being in the most powerful role and may generate feelings of uncertainty. I acknowledge that I could have framed questions about how supervision or training helped therapists process their feelings about difference and power, and this may have provided an opportunity to explore participants' discomfort or concerns. If I were to extend this research, this would be an area to explore.

Undertaking the doctorate has enabled me to appreciate my growth as a therapist. Training as a CBT therapist gave me a clear grounding in working with clients. The evidence-based nature of CBT provided a sense of security that this approach was both effective and legitimate. I enjoyed the BABCP conferences and felt a sense of belonging and

shared understanding. While I am grateful for my IAPT experience and recognise its value, I realise that my practice has developed differently. Whilst interviewing CBT therapists for this research, I had to hold these feelings. I was aware of my own journey but also mindful of how I would have responded to questions a few years ago if it was answering the questions myself. I tried to approach the interviews with open-mindedness, sensitivity and a willingness to really hear the experiences of the therapists. It has been an interesting experience and I have felt both critical and defensive of CBT and sometimes felt torn between being both a therapist and researcher. Indeed, as a therapist, I could both sympathise and empathise with the participants. From the role of the researcher, I have I tried to look at the interviews from different perspectives. I was also aware that researchers who are themselves bilingual or from a different culture to me may have interpreted the interviews differently.

If I were to start this thesis again, there would be things I would do differently. For example, I would have liked to develop the topic guide in collaboration with therapists. Given the interpreter's impact on the therapist, I've often wondered if I should have included interpreters and clients in the recruitment process. On reflection, I also could have adopted some of my CBT skills to downward arrow in the interviews to uncover some of the meaning for example, when participants spoke about feeling under pressure, I could have explored this and asked what it would mean to them if they did not meet the demands of the system.

I noticed a sense of responsibility to do justice to the topic and the participants who have so generously agreed to be interviewed and share their experiences. I also recognise that I ultimately benefit from this research as it enables me to complete my thesis and hopefully gain employment as a clinical psychologist. My experience of the doctorate has enabled me to view therapy more holistically and to view CBT as part of this more inclusive approach. I

have welcomed the opportunity to work more flexibly and to embrace different ways of working.

Conclusion

To the best of my knowledge, this thesis is the first study to specifically explore the remote element of CBT therapists' experiences of working with interpreters. Working with interpreters is integral to the work of CBT therapists and is a regular part of their workload. The majority of the participants worked in an IAPT service and their experiences offer important insight into how the system therapists work in can impact their confidence and willingness to work with an interpreter. The findings build on existing literature and provide valuable insight into this experience. The study offers important contributions, particularly due to its relevance and timeliness to current events such as immigration and the COVID-19 pandemic.

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Appendices

Appendix A

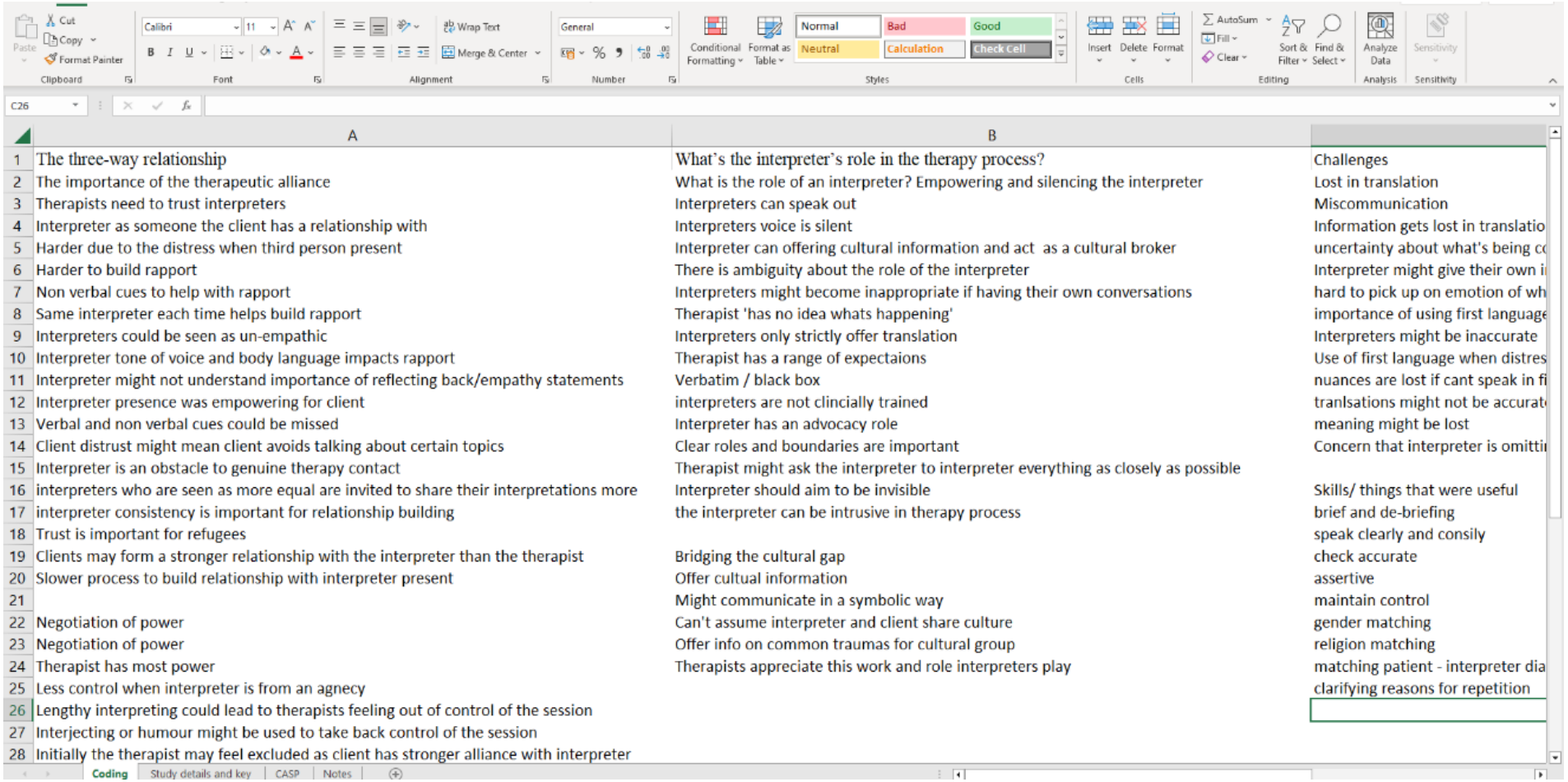
Quality Scoring of Articles Identified in the Literature Review

	Clear statement of aims	Qualitative methodology appropriate?	Research design appropriate?	Recruitment strategy appropriate?	Data collection appropriate?	Researcher-participant relationship considered?	Ethical issues considered?	Data analysis rigorous?	Clear summary of finding?	Value of research?	Total score
Becher and Wieling (2015)	2	2	2	2	2	2	1	2	2	2	19
Gerskowitch and Tribe (2021)	2	2	2	2	2	2	1	2	2	2	19
Gryesten et al. (2021)	2	2	2	2	2	1	2	2	2	2	19
Hagan et al. (2020)	2	2	2	2	2	1	2	2	2	2	19
Khawaja and Stein (2016)	2	2	2	2	2	1	1	2	2	2	18
Kuay et al. (2015)	2	2	1	2	2	1	1	2	2	2	17
Miller et al. (2005)	2	2	2	2	2	1	1	2	2	2	18
Pugh and Vetere (2009)	2	2	2	2	2	1	1	2	2	2	18
Raval and Smith (2003)	2	2	2	2	2	2	1	2	2	2	19
Tutani et al. (2018)	2	2	2	2	2	1	1	2	2	2	18
Yakushko (2010)	2	2	2	2	2	1	1	1	2	2	17

Note: 2 = yes; 1 = can't tell; 0 = no. Total score 20 = high quality; 16–19 moderate quality; ≤ 15 low quality

Appendix B

Example of Codes and Initial Grouping of Codes for Literature Review



	A	B	
1	The three-way relationship	What's the interpreter's role in the therapy process?	Challenges
2	The importance of the therapeutic alliance	What is the role of an interpreter? Empowering and silencing the interpreter	Lost in translation
3	Therapists need to trust interpreters	Interpreters can speak out	Miscommunication
4	Interpreter as someone the client has a relationship with	Interpreters voice is silent	Information gets lost in translatio
5	Harder due to the distress when third person present	Interpreter can offering cultural information and act as a cultural broker	uncertainty about what's being c
6	Harder to build rapport	There is ambiguity about the role of the interpreter	Interpreter might give their own i
7	Non verbal cues to help with rapport	Interpreters might become inappropriate if having their own conversations	hard to pick up on emotion of wh
8	Same interpreter each time helps build rapport	Therapist 'has no idea whats happening'	importance of using first language
9	Interpreters could be seen as un-empathic	Interpreters only strictly offer translation	Interpreters might be inaccurate
10	Interpreter tone of voice and body language impacts rapport	Therapist has a range of expectaions	Use of first language when distres
11	Interpreter might not understand importance of reflecting back/empathy statements	Verbatim / black box	nuances are lost if cant speak in fi
12	Interpreter presence was empowering for client	interpreters are not clincially trained	tranlsations might not be accurat
13	Verbal and non verbal cues could be missed	Interpreter has an advocacy role	meaning might be lost
14	Client distrust might mean client avoids talking about certain topics	Clear roles and boundaries are important	Concern that interpreter is omitti
15	Interpreter is an obstacle to genuine therapy contact	Therapist might ask the interpreter to interpreter everything as closely as possible	
16	interpreters who are seen as more equal are invited to share their interpretations more	Interpreter should aim to be invisible	Skills/ things that were useful
17	interpreter consistency is important for relationship building	the interpreter can be intrusive in therapy process	brief and de-briefing
18	Trust is important for refugees		speak clearly and consily
19	Clients may form a stronger relationship with the interpreter than the therapist	Bridging the cultural gap	check accurate
20	Slower process to build relationship with interpreter present	Offer cultual information	assertive
21		Might communicate in a symbolic way	maintain control
22	Negotiation of power	Can't assume interpreter and client share culture	gender matching
23	Negotiation of power	Offer info on common traumas for cultural group	religion matching
24	Therapist has most power	Therapists appreciate this work and role interpreters play	matching patient - interpreter dia
25	Less control when interpreter is from an agnecy		clarifying reasons for repetition
26	Lengthy interpreting could lead to therapists feeling out of control of the session		
27	Interjecting or humour might be used to take back control of the session		
28	Initially the therapist may feel excluded as client has stronger alliance with interpreter		

Appendix C
Ethical Approval

University of Essex

23/08/2021

Miss Jennifer Wardman-Browne

Health and Social Care

University of Essex

Dear Jennifer,

Ethics Committee Decision

Application: ETH2021-1407

I am writing to advise you that your research proposal entitled "Cognitive Behaviour Therapists' experiences of working with interpreters online" has been reviewed by the Ethics Sub Committee 2.

The Committee is content to give a favourable ethical opinion of the research. I am pleased, therefore, to tell you that your application has been granted ethical approval by the Committee.

Please note that this approval does not cover any future recruitment activities involving NHS Trusts directly, which would require the submission of an IRAS form for Health Research Authority Approval.

Please do not hesitate to contact me if you require any further information or have any queries.

Yours sincerely,

Aaron Wyllie

Appendix D

Participant Information Sheet

Title of Project: Cognitive Behaviour Therapists' experiences of working with interpreters remotely

Dear participant,
My name is Jenny Wardman-Browne. I am a Trainee Clinical Psychologist at the University of Essex on the clinical psychology doctorate. Before starting the doctorate, I worked in IAPT as a PWP and then a BABCP accredited CBT Therapist within Essex and Cambridgeshire. My email address is jwardm@essex.ac.uk.

I am currently carrying out a piece of research entitled, 'Cognitive Behaviour Therapists' experiences of working with interpreters remotely' under the supervision of Professor Susan McPherson.

Thank you for contacting me to express an interest in this research. Before you decide whether or not to take part, we would like you to know why the research is being done, and what it would involve for you. This information sheet provides you with information about the study and your rights as a participant. Please take the time to read this information sheet before making up your mind.

What is the purpose of the study?
This study is being carried out by the researcher as part of her Doctorate in Clinical Psychology and will form the basis of her thesis. We are investigating the experiences that CBT therapists have working with interpreters remotely.

Who can take part?
The study is recruiting BABCP accredited (provisionally or full) therapists who have at least one experience working with an interpreter remotely. The study is for clinicians working in the UK, working for the NHS or elsewhere. We are looking for the people who would kindly be willing to help us with our research and take part in an interview.

What would be involved?
The researcher will contact you after you receive this information sheet to see whether you would like to participate in the study and to ensure you meet the inclusion criteria. You will be asked some basic information about yourself, such as occupation and experience. It is possible that you may not be eligible to take part.

If you are eligible and wish to continue, you will be asked to read and sign a consent form and to email a signed copy back to the researcher. By signing the form, you are giving your consent to take part in the study.

Next you and the researcher will arrange a time convenient to for a one-off interview. This interview will be online (via Zoom or MS Teams) or if you would prefer, this could take place over the telephone.

The interview will last about 1 hour. The interviewer will ask about your experiences of working with interpreters when delivering CBT remotely. The researcher is interested in hearing about your own experiences from your point of view - there are no right or wrong answers. The interview will be carried out by the researcher, and it will be recorded on a voice recorder or using the Zoom recording function. If you are asked a question which you would prefer not to answer, you can just let the researcher know.

At the end of the interview your participation will be finished, and you will not be contacted again by the researcher (unless you would like to further discuss anything or receive a copy of the results of the study, in which case these will be emailed to you at a later date).

After the interview, the recording will be fully transcribed so that we have a written account of the interview. We will use this information to conduct analysis that will help us to identify themes that appear to be important to you and to other participants in the study.

What will I get out of participating?
Although the study will not offer you a direct benefit, we hope the information we get from the study will offer important insights into what the experience of delivering CBT with an interpreter remotely. This may help to inform training, guidelines, and supervision.

Do I have to take part?
Naturally, there is no obligation to take part in the study. It's entirely up to you. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form.

Can I change my mind?
If you change your mind once you've agreed to take part in the research, you can leave without having to give a reason or an explanation.

You are welcome to withdraw your information within two weeks of the interview. All you need to do is contact the researcher to let her know. If you withdraw ***before*** **or** ***up to two weeks*** *after* the interview, your information will be destroyed, and you will not be contacted again. If you choose to withdraw ***more than two weeks*** *after* the interview, you will not be contacted again, but your information will still be used for the study. This is because typing-up and analysing the interviews takes many hours, and so a lot of work would be lost if information was withdrawn at a later time. However, if you believe there is a strong reason why your information needs to be withdrawn after two weeks please contact the researcher or her supervisor to discuss further.

Will my taking part in this study be kept confidential?
Absolutely. All information collected will be kept securely and stored in line with the Data Protection Act 1998. A list may be kept linking participant numbers or pseudonyms to names, but this will be kept securely and will only be accessible by myself and my supervisors. Some word-for-word quotes from your interview may be used in the study report but any identifying details will be removed or replaced with false details. A copy of the information which we record about you, but not other participants, will be provided, free of charge, on request. The only circumstances under which confidentiality *would not apply* is if something you told the researcher made her concerned that you or someone else was at a high risk of serious harm. In the rare event of this happening, the researcher would tell you this was the case, and would let you know what action she would have to take.

Our legal basis for processing your personally identifying data is that you have consented to it. The data controller is the University of Essex. Essex University's Data Protection Officer can be contacted on dpo@essex.ac.uk.

Has this study been given ethical approval?
Yes. The study has been reviewed and approved as ethical by the University of Essex

Can I find out about the results of the study?
Yes. If you like, the researcher will send you a summary of the results at the end of the study. If you would like to see the full dissertation report, you can contact the researcher to request a copy.

Are expenses paid?
As interviews are online or on the telephone where possible, travel reimbursements are not possible. However, you will be offered to enter a lottery whereby you have chance to win a £25 Amazon voucher. The researcher will ask you if you wish to be entered into the lottery after interview. As the researcher

aims to recruit around 15 participants, if everyone wishes to enter, you will have a one in 15 chance of winning.

What happens if I have a concern or complaint?
If you have concerns or complaints about this study, please contact the primary researcher, Jenny Wardman-Browne and/or supervisor Susan McPherson (smcpher@essex.ac.uk).

If you are still concerned or feel your compliant has not been adequately addressed, please contact the University Research Governance Officer, Sarah Manning-Press (sarahm@essex.ac.uk) or HSC Research Director, Camille Cronin (camille.cronin@essex.ac.uk) who will advise you further.

What happens next?
The researcher will email you in about a week using the contact details you provided to ask you if you would like to take part. If you do not, simply let her know that you'd prefer not to be involved.

If you would like to take part or discuss further, the researcher will arrange a brief telephone call with you to collect some basic information and answer any questions you have. There is a possibility that you may not be eligible for this study. If eligible and you wish to go ahead, we will book a convenient time for an interview. You will then be asked to return a signed copy of the consent form before the time of the interview to jwardm@essex.ac.uk.

If you need to contact us in future, please contact me by emailing jwardm@essex.ac.uk or Professor Susan McPherson (smcpher@essex.ac.uk)

You are welcome to ask questions at any point.

If you do decide to take part, we suggest you keep this information sheet for future reference.

Best wishes,

Jenny Wardman-Browne
Trainee Clinical Psychologist
Department of Health and Social Care
University of Essex

Supervised by

Professor Susan McPherson
Department of Health and Social Care
University of Essex
Email: smcpher@essex.ac.uk

Appendix E

Consent Form

Dear participant,
This research is being carried out by Jenny Wardman-Browne under the supervision of Professor Susan McPherson.
Please read the participant information sheet before completing this consent form. If you have any questions about this form, or further questions about the study, please contact the researcher at jwardm@essex.ac.uk
We would be very grateful for your participation in this study
Best Wishes,
Jenny Wardman-Browne

Statement of Consent	**Yes/No**
Have you read the Participant Information Sheet?	
Have you had an opportunity to ask questions about the study?	
Have you received satisfactory answers to your questions?	
Have you received enough information about the study?	
Do you understand that you can leave the study at any time and without having to give a reason?	
Do you understand that you may withdraw your information from the study up to two weeks after the interview, but not after this time?	
Are you aware that the study has been approved by the University Research Ethics Committee?	
Are you aware that all information will be kept strictly confidential, except in the rare circumstances in which it is judged that you or someone else is at high risk of serious harm?	
Do you understand that the interview will be recorded?	
Do you understand how to make a complaint if need be?	
Do you understand that anonymised quotes from your interview may be used in the report of the study?	
Do you agree to participate in the research project, "Cognitive Behaviour Therapists' experiences of working with interpreters remotely", being carried out by Jenny Wardman-Browne	

.....
Participant's signature and date

.....
Participant's name [in capitals please]

.....
Researcher's signature and date

.....
Researcher's name [in capitals please]

Please keep a copy of this signed consent form for your own records and please email a copy to jwardm@essex.ac.uk any time before your interview

Appendix F

Recruitment Poster

University of Essex

ARE YOU A BABCP ACCREDITED CBT THERAPIST?

HAVE YOU HAD EXPERIENCE WORKING WITH INTERPRETERS REMOTELY TO DELIVER THERAPY?

WOULD YOU CONTRIBUTE TO A RESEARCH PROJECT?

My name is Jenny Wardman-Browne. I am a Trainee Clinical Psychologist and BABCP CBT Therapist. I would like to invite you to take part in a research study that aims to find out more about how therapists deliver CBT remotely while working with interpreters.

What is involved?

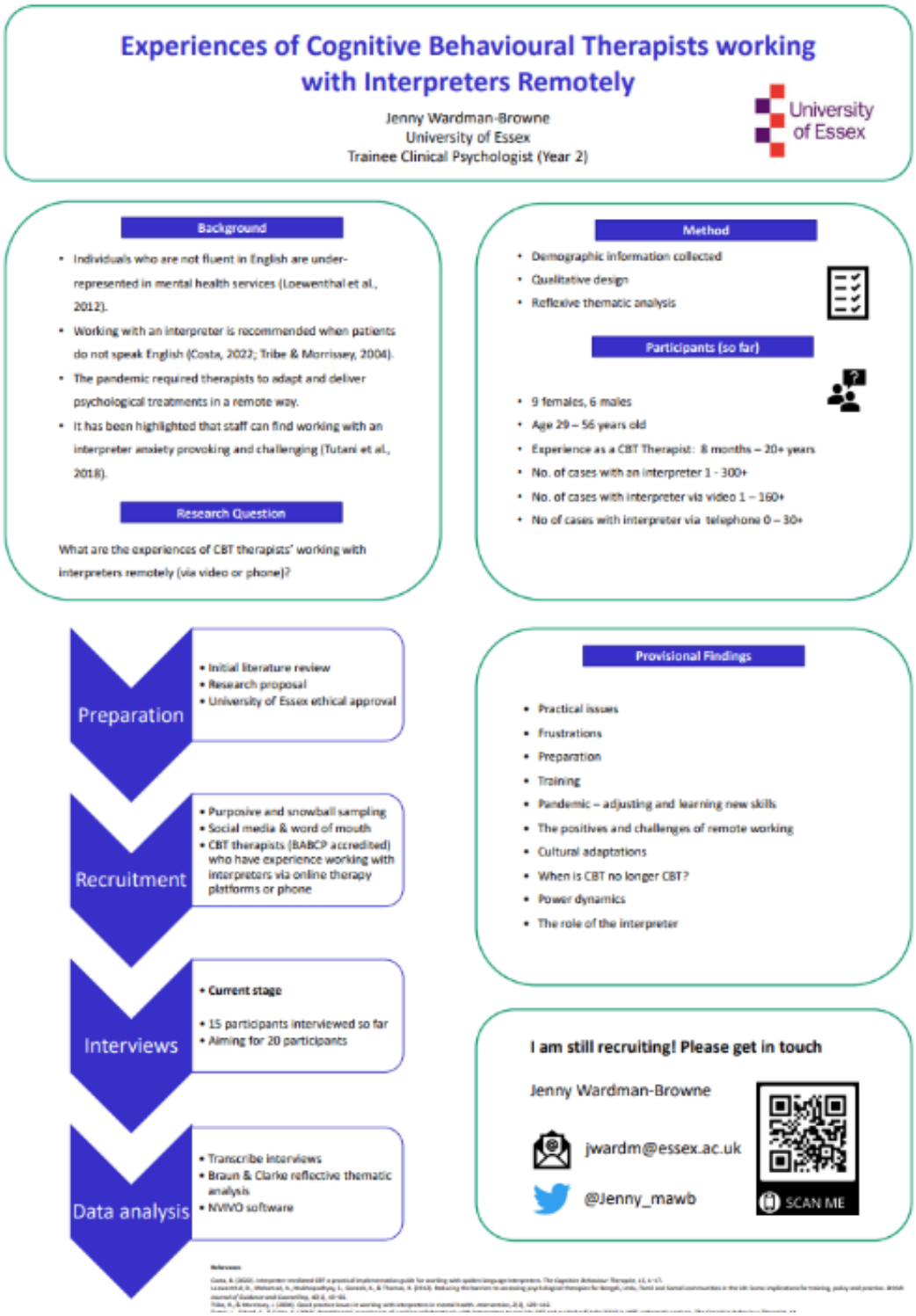
It would involve taking part in an interview with myself via an online platform or over the phone. If you would like to find out more, please send an email to me on jwardm@essex.ac.uk and you will be sent further details about the study

Thank you

ENTER LOTTERY TO WIN £25 AMAZON

Appendix G

Research Poster presented at Annual BABCP Conference 2022



Appendix H

Demographic Questionnaire

I wonder if you would be able to give me some brief details about yourself. If there is anything you would prefer not to answer, no problem, you can leave it blank.

Age:

Gender:

Ethnicity:

Job Title:

Employment Setting:

Number of months/years' experience as a CBT Therapist?

Number of cases assessed/treated with an interpreter?

Number of cases assessed/treated with an interpreter via video i.e. MS Teams/ Zoom/ Attend anywhere etc

Number of cases assessed/treated with an interpreter via telephone?

Do you speak any other languages apart from English yourself?

Have you had any training working with interpreters?

Contact email and mobile number:

Appendix I

Interview Topic Guide

Introduction

First of all, I would like to thank you for taking the time to talk to me. To start with, do you have any questions about the participant information sheet?

As you know, I am interested in learning about therapists' experiences of working with language interpreters, particularly delivering CBT. I have questions here might be useful to discuss, but most important are your experiences. There are no right or wrong answers. I am going to record the interview so that I can listen to what you have said at a later date. However, if you want to stop the interview or the recorder at any time you can. All the information you provide will be strictly confidential. Your name will not be mentioned in any reports arising from this study. Interview will last about an hour but feel free to let me know if you need a break at any time. If we lose connection, I will wait for you/ try and call you on your mobile. At end of interview there will be a chance to ask questions and we can de-brief.

Any questions – Ok to start?

Experience and training

- Using the demographic questionnaire - Can you start by telling me roughly how much experience you have had? Do you work much with interpreters at your place of work? *Why?* What training have you had in relation to working with an interpreter? *What did it cover? What course was it part of?*
- Do you feel your training prepared you adequately for interpreter-facilitated work? *What was missing?* Has the way in which you work with interpreters changed as you have gained more experience, and if so, how?

Therapy setting

- What's your experience of making arrangements? Can you tell me about the set up? *Do you work with the same interpreter throughout treatment? How is it booked? Do you meet beforehand?*
- Impact of COVID – *what happened to clients? How did you manage moving remotely?*
- Set-up for online CBT with interpreter – what did you do to set up?
- Ending/debrief with interpreter

Delivering of CBT

- How do you think working with an interpreter impacts the delivering of CBT if at all? *Adaptions?*
- Benefits/challenges of interpreter presence online – confidence and skill to do this
- Has working with an interpreter changed the way you think about delivering CBT? *Different with different presentations or protocols?*
- What are some of the challenges? Is there anything you think you could do as a clinician to improve your interpreter facilitated work? – *Working with someone from a different culture? How well does CBT translate? Power dynamics and relationship?*

- The impact of working with an interpreter online and your perception of therapy outcomes/ recovery rates?

Ending

- Are there any other thoughts, feelings or reflections that you would like to share that I haven't asked about? Any other questions that you'd like to ask me?

De-brief

- What was the experience of the interview like? Any parts that were of particular interest to you? Where these issues you had talked about / thought about much before?

- Inform interviewee of date up to when they can withdraw data (2 weeks from now) (Date)
- Would you like a copy of the results at the end of the study? YES / NO
- Thank you for you time
- Check if participants would like Amazon voucher and where should it be sent if they win

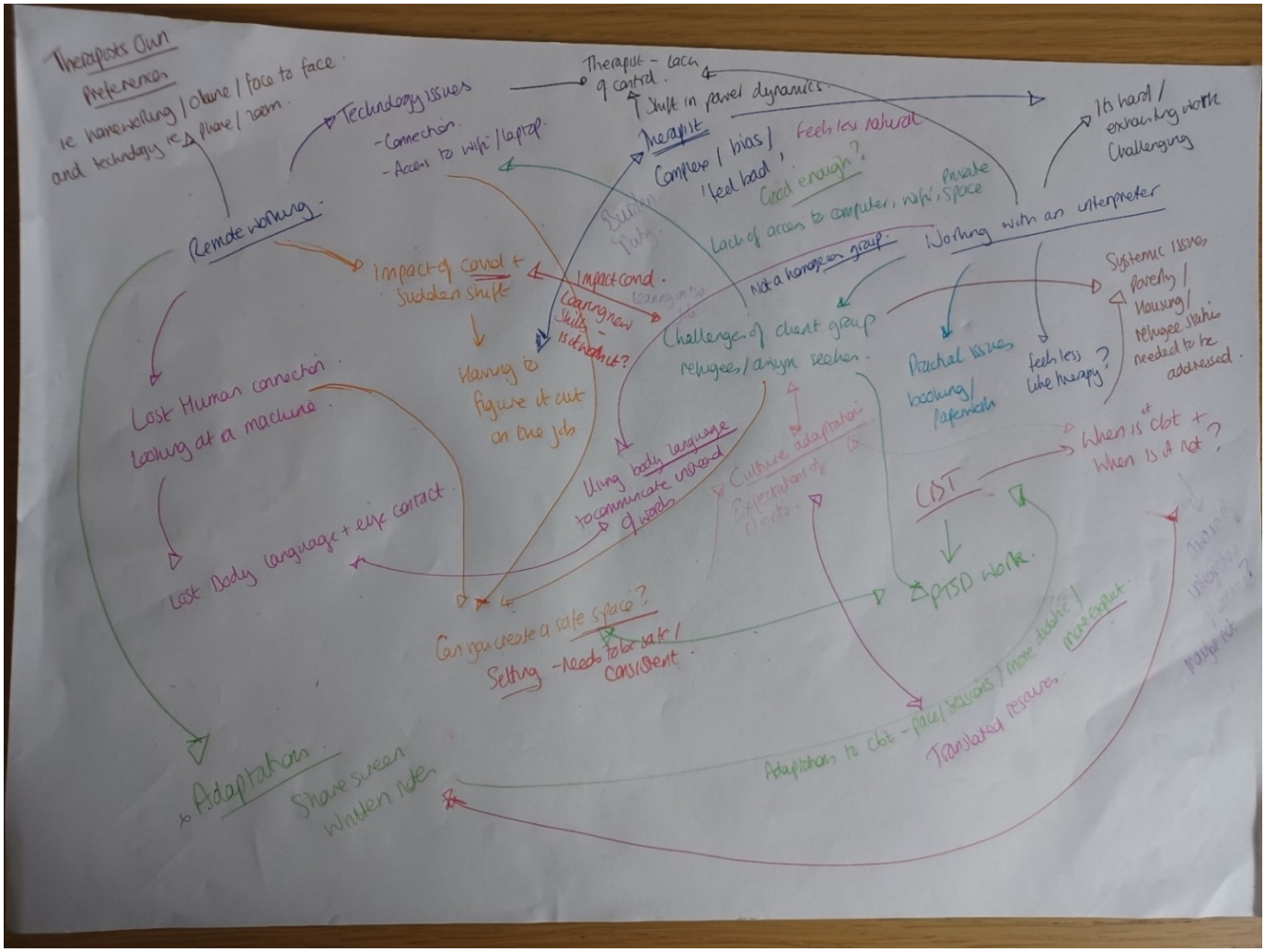
Appendix J

Transcription Notation System

Feature	Notation example
Laughing	((laughs))
Spoken Abbreviations	Do not use abbreviation if speaker does not, such as IAPT or BAME
Pause	((pause)) indicates a pause of a few seconds or more
Inaudible speech	(inaudible)
Reported speech	For example: I really don't like it. I'm like, 'Oh God'
Identifying information	Replacing information with square brackets, for example, London or Bristol might be replaced with[large city]
Removing parts from quotes	To indicate a missing part use …

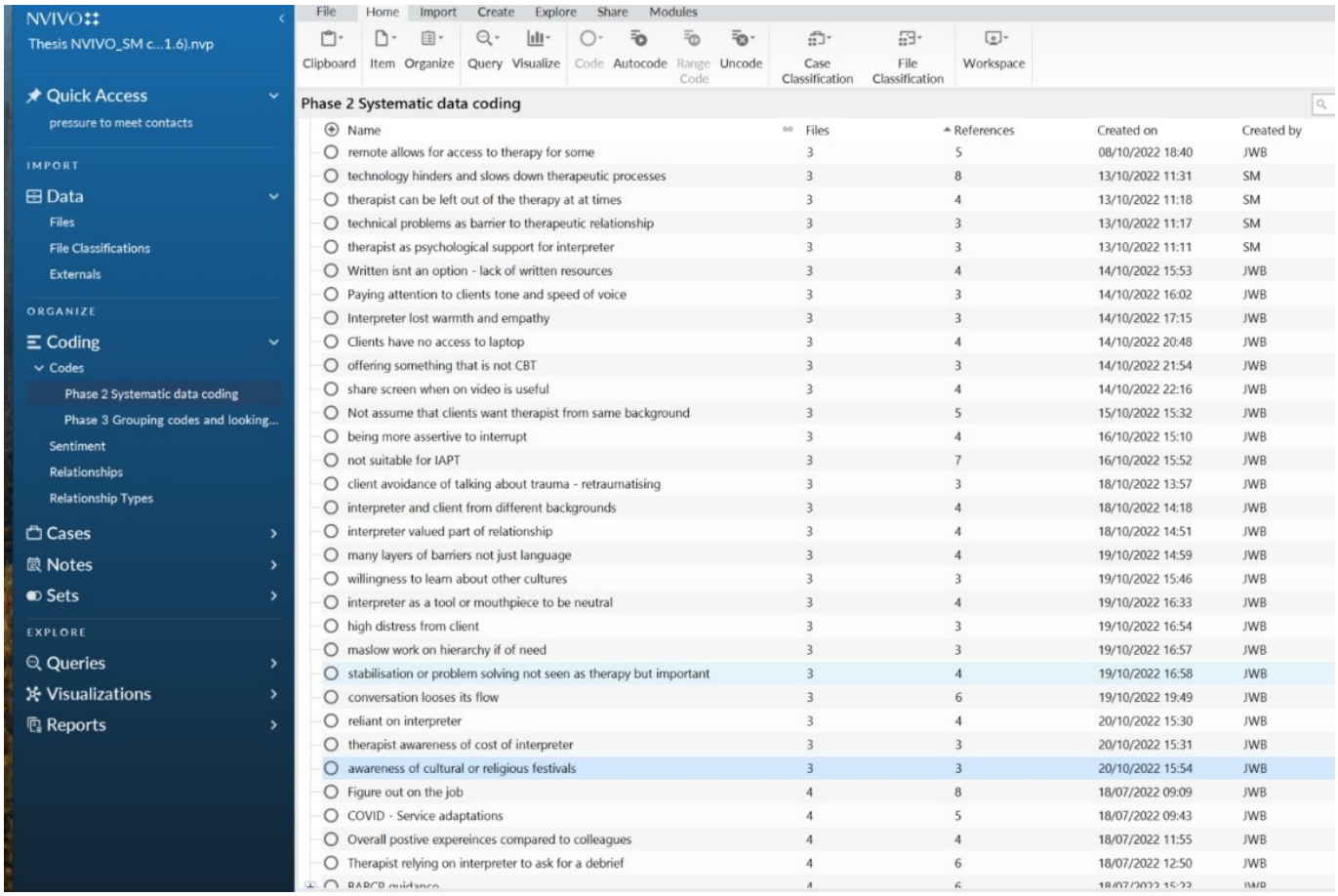
Appendix K

Extracts from Data Analysis Process Phase One (Familiarization)



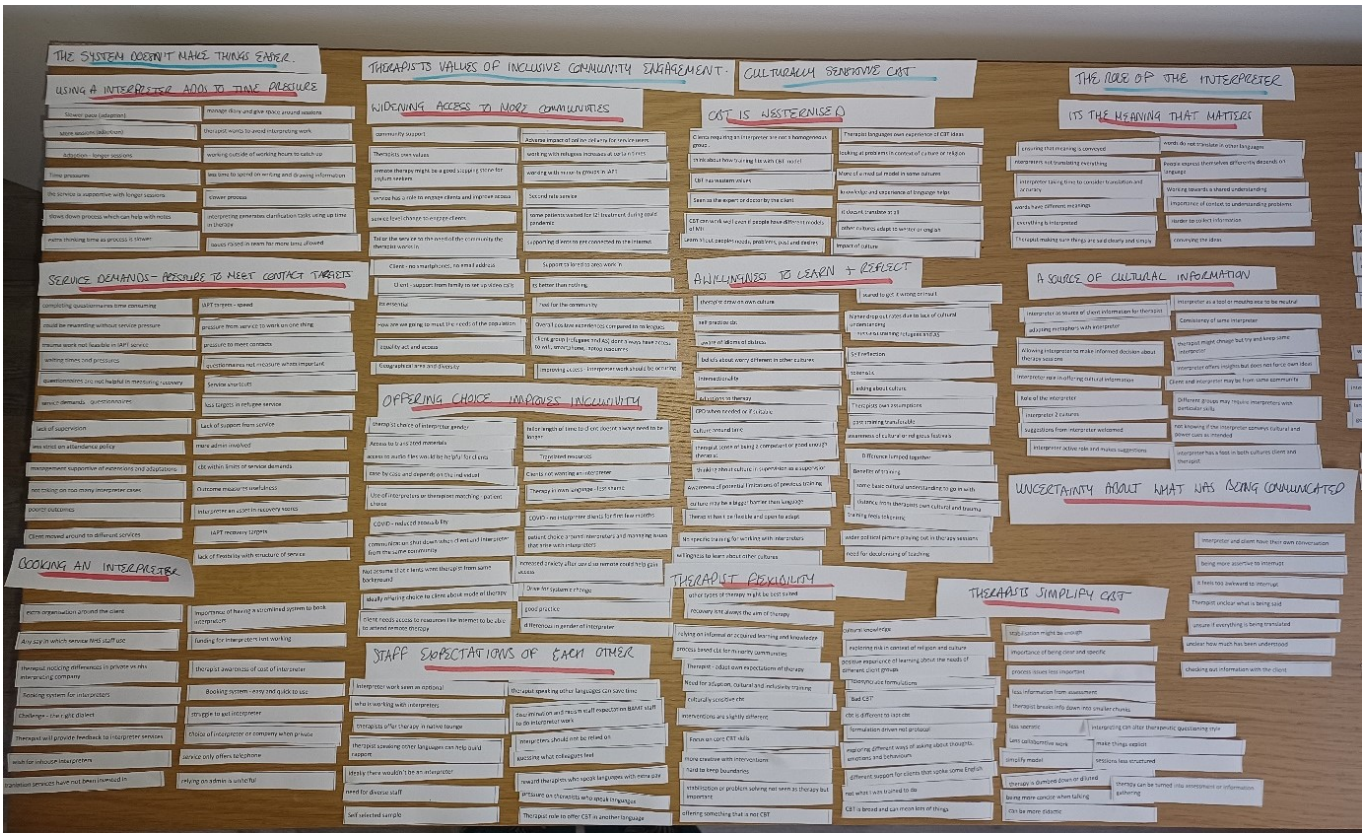
Appendix L

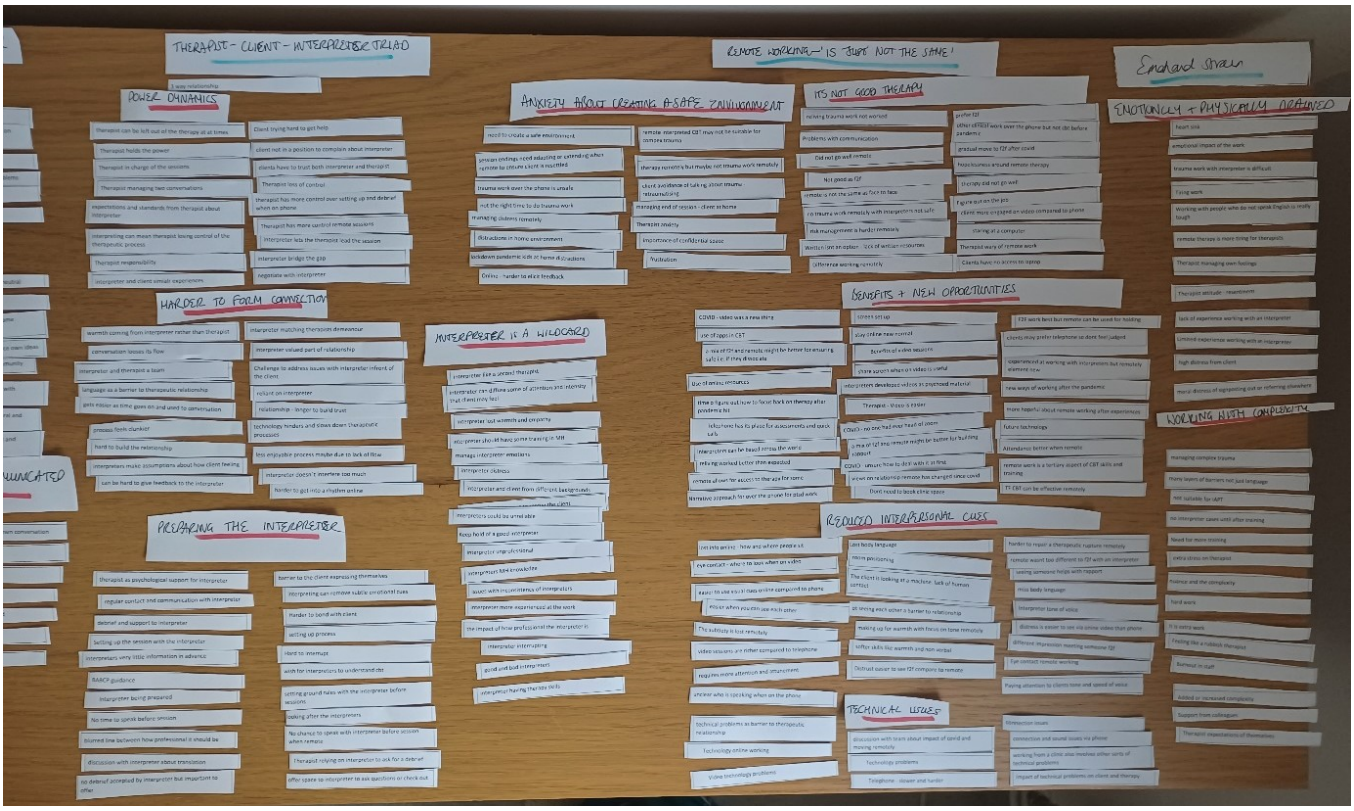
Extracts from Data Analysis Process Phase Two (Systematic Coding)



Appendix M

Extracts from Data Analysis Process Phase Three (Grouping/looking for themes)




THERAPIST - CLIENT - INTERPRETER TRIAD
POWER DYNAMICS
ANXIETY ABOUT CREATING A SAFE ENVIRONMENT
REMOTE WORKING - IS JUST NOT THE SAME!
IT'S NOT GOOD THERAPY
Embodied Strain
EMOTIONALLY + PHYSICALLY DRAINED
HARDER TO FORM CONNECTION
INTERPRETER IS A WILDCARD
BENEFITS + NEW OPPORTUNITIES
WORKING WITH COMPLEXITY
PREPARING THE INTERPRETER
REDUCED INTERPERSONAL CUES
TECHNICAL ISSUES

Appendix N
Extracts from Reflexive log

My training for working with an interpreter consisted of one lecture during my PWP training on a 'diversity' module. Since this lecture, I have recently attended a workshop on 'Interpreter-mediated CBT'. Reflecting back, I would describe my experiences of working with interpreters as mixed. I worked with people who were Deaf or who did not speak English. I struggled initially with how to set up appointments for clients and at times I felt a little awkward when collecting clients from the waiting room. I always tried to talk to the interpreter I was working with prior to a session and to debrief afterwards and I found this really helpful. I was aware of using supervision to talk through how to work with interpreters, but also to explore my own anxieties about working with non-English speakers so that I was able to interact with care and sensitivity to the context of these clients' lives. I noticed that I felt more confident when I was able to work with the same interpreter each time for a particular client and I felt we had a collaborative relationship. There were also times when I noticed that I felt frustrated. For example, when working with a client who described feeling depressed, the interpreter told her that he also had been depressed. I assumed that the interpreter was trying to express empathy, but I felt this disclosure was inappropriate and I thought it also shifted the dynamics of the interaction between the three of us. I also wondered what else the interpreter was disclosing. Reflecting back on these experiences, I realise that at times I felt anxious and I imagine that my experiences are not unique. I need to be mindful of not imposing my perceptions or experiences onto my research.

Reflecting on the first two interviews has made me very aware of the difficulties that therapists experience in the systems they are expected to work within. It was evident that therapists felt under pressure and this appeared to impact on their practice. It does feel to me

that clients are expected to fit into the system and adaptions are sometimes experienced as ‘heart sink’. I recognise this feeling of being under pressure and how therapists try to do the best they can in difficult circumstances. However, it also leaves me with a sense that there is such limited time and space to reflect on these issues and how they impact on clients.

I recognise the subjectiveness of the research process and I have spent a lot of time in internal dialogue wondering if my coding and themes were “right”. I have changed my mind and played with different wording and this has felt a creative process, but also at times frustrating. I have considered if others might identify different themes that might be more appropriate. I recognise that research is a process and it has been helpful to take breaks from analysis and return at a later date.