

**The role of interpreters in accessing psychological support and developing
relationships in mental health and Deafness**

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Section	Abstract	Text	References	Appendices & Tables
Thesis	274	-	-	-
Literature Review	200	7791	2452	3069
Research Paper	149	8310	2094	2904
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Abstract

The Deaf population are vulnerable to experiencing mental health difficulties. A qualitative meta-synthesis, reported in section one of this thesis, sought to explore the experiences of deaf individuals who access mental health services and clinicians who provide those services. The synthesis considered the personal, social, communicative, service and professional factors that influence service accessibility for deaf people. It contends that current provision of mental health services does not meet client need. Consequently, the review considers how access to sign language interpreters, education, and collaboration between deaf clients, interpreters and mental health services are instrumental in generating change and improving access.

In a further exploration of the experience of mental health care for deaf people, the research paper, reported in section two of the current thesis, examined the role of the British Sign Language (BSL) interpreter in the communication of compassion and development of therapeutic relationships between a mental health clinician and their deaf client. Findings identified that the therapeutic process relies on collaboration, continuity and trust between all individuals; The existence and nurturing of a 'triangle of care' between client, clinician and interpreter leads to stronger therapeutic relationships and better therapeutic outcomes. The research concluded that interpreters must be viewed as part of the clinical team and be supported in their role. Deaf clients must be involved in service development, and clinicians must be willing to improve their knowledge and adapt their practice.

The critical appraisal, reported in section three of the current thesis, allowed an opportunity to reflect on personal and professional learning, the research process and results. The importance of reflexivity in qualitative research was considered, alongside research strengths and limitations.

Declaration

This thesis records research undertaken in partial fulfilment of the requirements for the Doctorate in Clinical Psychology at Lancaster University. The work presented here is the author's own, except where due reference is made. The work has not been submitted for any academic award elsewhere.

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Section One: Systematic Literature Review

**The experience of accessing mental health care for the Deaf
population: A systematic meta-synthesis.**

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Abstract

There is a growing body of mental health and Deafness research. Literature has identified deaf individuals as more likely to experience mental health difficulties than their hearing counterparts, but less likely to receive appropriate support. The aim of this paper was to conduct a systematic review of the literature, synthesising the experiences of deaf individuals who access mental health services and clinicians who provide it. Meta-synthesis methodology was utilised to review findings from 9 articles. Three overarching themes were generated that encompassed the experience of mental health care for the deaf population, and factors that facilitate or hinder access: (1) Personal /Social considerations (2) Communication (3) Service/Professional conduct. Findings have practice and future research implications. This review adds further weight to the argument that current provision of mental health care does not meet the needs of the deaf population. Collaboration and education are highlighted as instrumental in generating change in the provision of support for this group.

Keywords: Mental health; Deafness; Access; Qualitative; Meta-synthesis

Highlights

- A novel meta-synthesis in the mental health and Deafness field.
- Experiences of mental health service access for deaf people are synthesised.
- Stigma, communication and professional/service inflexibility hinder accessibility.
- Education and collaboration are instrumental in promoting change.

Around 5% of the world's population have hearing loss to a disabling degree (World Health Organisation; WHO, 2015). In the United Kingdom alone, around 11 million individuals suffer from some form of hearing loss, and over 900,000 of those are severely or profoundly deaf (Action on Hearing Loss, 2016). Deafness can have an impact on functional, social, emotional and economic aspects of life, leaving individuals vulnerable to isolation and other challenges (FDP, 2009). Deaf with a capital D refers to a group who are culturally and linguistically unique. Deaf (with a capital D) individuals are often pre-lingually deaf, have a strong Deaf identity and use their country's equivalent of sign language to communicate (Berke, 2016; Sign Health, 2017). In contrast, deaf with a lowercase d describes or identifies anyone with a severe hearing problem (Young & Rogers, 2011). Research participants included in the current review were predominantly from Deaf communities across the globe. The current review will use the terminology, including D/deaf, as appropriate and as reported in literature.

Individuals who are deaf face many challenges communicating with the world around them. From infancy, deaf children's communication is influenced by whether they are encouraged to develop signed and/or spoken language. Boothroyd, Geers and Moog (1991) noted that profoundly deaf children acquire oral language skills at around half the rate of their hearing counterparts. However, literature evidences that infants exposed to sign language by their parents acquire it on an equivalent timetable akin to hearing children's acquisition of spoken languages (Meier, 2000; Morgan & Woll, 2002; Petitto et al., 2001), and even earlier in some cases (Bonvillian & Folven, 1993; Goodwyn & Acredolo, 1993). There is therefore a benefit in deaf individuals being encouraged to develop sign, alongside other communication, in order to better communicate their needs. Carter and Mireles (2016) considered that those in the Deaf community may be victims of 'audism'; they are discriminated against due to their communicative preferences and how this contrasts with

the audio centric nature of society. They theorised that deaf individuals can become isolated by such experiences, and that having a stigmatised identity can lead to negative affective states. This theory links to literature that identifies deaf children who struggle to be understood by those around them as four times more likely to experience mental health difficulties in later life (Fellinger, Holzinger, Sattel, Laucht & Goldberg, 2009).

Good mental health is important to our wellbeing and it is therefore vitally important that deaf people are well supported. A comprehensive survey conducted by the World Federation of the Deaf (WFD; Kuenburg & Fellinger, 2011) sought perspectives of Deaf leaders across 44 countries regarding health challenges for the Deaf community across the globe. It was reported by 65% of respondents that deaf people in their country have more difficulties with their health than hearing people, with the most commonly reported problems being mental health difficulties. Fellinger, Holzinger and Pollard (2012) conducted a literature review discussing factors that influence the mental health of deaf people, alongside prevalent disorders in this group and treatment. They noted a discrepancy between the incidence of mental health difficulties in the Deaf population and their access to mental health care. The review noted the communication barriers present in mainstream mental health services, and considered the benefit of specialist services for deaf clients. However, as specialist services serve a minority group and require specially trained clinicians, they are few in number. Research therefore must focus on exploring the barriers that exist within mainstream mental health services and to identify changes that could improve accessibility to these services for deaf people.

The WFD global survey reported that 82% of respondents felt that deaf people in their country faced considerable difficulties when attempting to access health care support and information (Kuenburg & Fellinger, 2011), often due to communication barriers. Deaf

people often have to acquire the writing system of their countries' spoken language (Richardson & Woodley, 2001), due to sign language not having a written equivalent. However, developing literacy in a second language can be challenging. Deaf people do not have the same advantages as bilingual individuals, who may have already learned to read and write in their first language, and can use those methods to learn another language (Mahoney, 2013). Such challenges can cause reading literacy levels in the deaf to be lower than their hearing counterparts (Kyle & Cain, 2015; Wauters, Van Bon & Tellings, 2006). Pollard (1998) considered how lower literacy links to a 'fund of information deficit' - a limited knowledge base in comparison to the general population, despite having average IQ and educational attainment. Literacy issues can influence accessibility to health information resources, meaning the health knowledge of deaf people is often more limited than the general population. Haricharan, Heap, Coomans and London's (2013) case study of the experience of a Deaf woman in South Africa highlighted how people's dignity and human rights are violated when they are unable to access health care and information. Lack of access can impact well-being, and an individual's understanding of when and how to seek support from services for psychological difficulties.

Due to communication difficulties, deaf individuals often feel deterred from seeking support (Hulme and Powell, 2014; Legeay & Saillard, 2013; McKee et al., 2011; Mweri, 2017). For individuals who persevere with services, the risk of being misdiagnosed increases substantially (Chatzidamianos, 2015), due to a lack of appropriately trained clinicians, assessment tools and Deaf awareness. Deaf awareness means having an understanding of the culture, history and issues of this group (Sign Health, 2016). However, literature has found that such awareness and the ability to work with deaf individuals is often lacking within mainstream health care services (Iezzoni, O'Day, Killeen & Harker, 2004; Leigh & Pollard, 2011; Smeijers & Pfau, 2009). Service appointment booking

systems and processes may rely on conversation over the telephone or in person, making them largely inaccessible (British Deaf Association, 2014). When individuals are seen by a professional, there is also often a lack of understanding of appropriate communication methods. They may assume that in lieu of speech, written communication is appropriate, unaware of literacy issues in the Deaf population (Iezzoni et al., 2004).

Existing literature illustrates that deaf people are vulnerable to mental health difficulties, but may experience challenges when trying to access support. The European Society of Mental Health and Deafness emphasise that the Deaf community are a neglected population who experience similar issues accessing support for mental health difficulties, regardless of where they reside in the world (Du Feu & Chovaz, 2014). Research therefore must explore these issues and consider what needs to change, in order to improve outcomes for deaf people.

Present Study

The current review aims to explore the experience of access to mental health services for deaf people. A particularly relevant field of health care for the Deaf community, the review will synthesise themes generated from the accounts of both clients and clinicians.

Qualitative data is valuable, as it provides a representative account of how a person experiences a phenomenon (Atieno, 2009). The review is novel in its approach and focus, and acts as a natural progression from previous literature reviews in the general field of the Deaf population's experience of health care.

Three published literature reviews hold relevance to the current systematic review. Kuenburg, Fellingner and Fellingner (2015) conducted a non-systematic, mixed methods review comprised of research published from 2000 to 2015. The review considered aspects

of deaf people's access to general health care and their health knowledge. There was no synthesis of data or themes; commonalities between papers was collated and reported, but no further interpretations were made. Findings were presented in two sections: challenges in accessing health care, and examples of how access could be improved. Communication was found to be the most considerable barrier to accessing health care, and results indicated that deaf people are at risk of marginalisation. The review suggested that understanding the communicative preferences of deaf people (e.g. use of interpreters, text phones) could improve access. The Keunberg et al. review provided a comprehensive summary of the global experience of health care for deaf people, before considering the need for improved awareness and service provision.

Scheier (2009) also conducted a non-systematic literature review that considered barriers to general health care for people with hearing loss. A summary of the literature identified that mainstream services and professionals often misunderstand the needs and abilities of D/deaf people, and require greater Deaf awareness. Communication was also noted as the main barrier to health care, similarly to the Keunberg et al. (2015) review. Both reviews stated a need for education of mainstream services regarding Deaf culture and the effects of deafness, in the hope that this may lead to improved support. Both reviews provided broad and useful, albeit non-systematic summaries of the current situation for deaf individuals in relation to health care across the globe.

The Fellingner, Holzinger and Pollard (2012) review provided a broad overview of the mental health of deaf people, and barriers to care. Their review was comprehensive in its summary of the factors affecting the mental health of deaf people, prevalent disorders in the population, and management and treatment. Implications considered communication as a barrier to care, and the lack of access which deaf people have to health information, and

subsequently, care. The review highlighted deaf people as more vulnerable to experiencing mental health difficulties, but less likely to receive support.

More focused reviews in this area could assist the development of a fuller understanding of the experience of mental health care for deaf people and the barriers that exist. Broad reviews are beneficial in providing an overview of a topic, however focused reviews are also necessary to provide a more comprehensive understanding of a phenomena or experience. Gopalakrishnan and Ganeshkumar (2013) identified systematic reviews and meta-analysis as the best sources of evidence for evidence based practice, making pertinent information concisely available to decision makers. Focusing the current review on mental health care access therefore allows for the identification of specific issues and barriers relevant to that experience, alongside the consideration of clinical implications and service improvements that can improve client outcomes.

The current review therefore aims to complement the positions presented in previous reviews, while enhancing the discussion through the completion of a novel synthesis with a more specific focus. The qualitative experiences of deaf clients and mainstream clinicians will aid the identification of influential factors related to mental health care access, and guide consideration of implications and service developments that will improve both access and client outcomes. No such review of qualitative data currently exists in this field, new research has been published since the publication of the previous reviews, and only one paper in the current review (Steinberg, Sullivan and Loew, 1998) was included in previous reviews. The aims of this review therefore are: (1) to develop an understanding of the current experience of and barriers to mental health care for deaf people and (2) to consider how support for this group could be improved.

Methods

Design

Meta-synthesis methodology was utilised due to its efficacy reviewing and combining qualitative literature (Campbell et al., 2003). Articles were evaluated using the metaethnographic approach originally described by Noblit and Hare (1988), which has since been further developed (Atkins, Lewin, Smith, Engel, Fretheim & Volmink, 2008; Walshe & Downe, 2005). A specific research question was chosen, before characteristics of the chosen papers were gathered and the papers were read in order to identify main concepts. Relationships between the concepts arising from different papers were considered, and common or recurring concepts were identified. The studies were translated into one another, and the translations were then synthesised, which was an iterative process. Relationships between the studies appeared to be reciprocal, from which an interpretation of the experience could be developed.

The researcher held the epistemological stance of objective realism (Kearney, 1988): collectively shared understandings shape our view of the world. The analytic approach chosen for the review fit well with that stance, as it sought to examine commonalities and discrepancies between themes derived from accounts, to develop a collective understanding of an experience.

Inclusion and Exclusion Criteria

Articles included in the review met the following criteria:

- (1) Employed a qualitative methodology
- (2) Published in English

- (3) Involved D/deaf individuals, or those involved in their care as research participants
- (4) Focused on access and/or facilitators and barriers to mental health care, or identified mental health care as a primary focus of research
- (5) Presented findings thematically or narratively
- (6) Mixed methods were only included if the qualitative results were reported separately

An over inclusive search strategy was employed, due to the limited volume of literature within the research field. Most initial papers did not meet inclusion criteria. Abstracts and full texts of remaining papers were examined for eligibility. Although a process had been agreed in the case of disagreements between reviewers, this did not occur. The flow diagram in Figure 1 illustrates the screening and selection process, resulting in nine papers being included as appropriate to include in the current review.

Figure 1 here

Search Strategy and Selection Criteria

The current review followed ENTREQ guidelines for reporting of data (Tong, Flemming, McInnes, Oliver & Craig, 2012). Systematic searches of the following databases was conducted from November 2016- January 2017: Web of Science, PsycINFO, MEDLINE, CINAHL and Google Scholar. Articles that met inclusion criteria were also reviewed for reference citations that database searches may have overlooked. Search terms covered four

domains: (1) Qualitative methodology; (2) Population; (3) Service; (4) Content of lived experience. Table 1 includes search terms used for the PsycINFO database search.

Table 1 Here

Quality Assessment

The quality of reporting in included studies was assessed using the Consolidated Criteria for Reporting Qualitative Research checklist (COREQ; Tong, Sainsbury & Craig, 2007). The presence or absence of reporting for 32 items on the COREQ checklist was assessed by the chief researcher. Scores were then reviewed by an independent peer, who had degree level knowledge of research methodology and there was 100% agreement with the appraisal. As the topic represented an understudied area, it was decided that papers with methodological limitations would not be excluded as this may have resulted in the loss of important data. Participant accounts were still relevant, and including all available data would ensure representative themes and interpretations.

Results

Characteristics and quality of included studies

Nine papers were identified that met inclusion criteria and none excluded on the basis of quality assessments. Characteristics of included articles are summarised in Table 2 and have a study number which they will henceforth be referred to by.

Table 2 here

The quality across studies varied considerably in relation to the three domains assessed by COREQ (Domain 1: Research team and reflexivity; Domain 2: Research design; Domain 3: Analysis and findings; Table 3).

Table 3 here

Overall, the reporting quality of the literature was moderate, ranging between 14 and 24 (out of a potential 32; Table 4). Reporting on items relating to the research team and reflexivity was poor across all studies. Limitations included minimal descriptions of the research team, reflexivity, and participant feedback.

Table 4 here

Articles included in the current review were published between 1998 and 2016, from Europe, North America, Canada and Australia. Five studies interviewed service users ^{1, 3, 4, 6, 7}, two interviewed service providers ^{2, 9}, while two interviewed both service users and providers ^{5, 8}. One study used Grounded Theory for analysis ¹, while the remaining eight

studies used Thematic Analysis ²⁻⁹. Three studies utilised either a mixed methods design, or used findings from a quantitative survey to shape their topic guide questions ^{1, 2, 8}. The substantial focus on qualitative methods and/or use of quantitative methods to aid the qualitative aspect of the research justifies inclusion in the review.

Four studies collected data using interviews ^{1-3, 6}, two used focus groups ^{5, 9}, and three using either interviews or focus groups ^{4, 7, 8}. All focused on aspects of mental health access for individuals who were D/deaf either as a primary focus or within the wider scope of health care access.

Synthesis Summary

Through the meta-synthesis process, three key themes were generated:

1. Social and personal fears and considerations
2. Communication
3. Service and Professional conduct

The steps of the synthesis are illustrated in Table 5.

Table 5 here

The meta-synthesis identified the multi-level processes which influence accessibility to mental health care. Deaf individuals must fight intrapersonal fears and considerations prior to accessing support, before attempting to overcome interpersonal challenges regarding

communication with services. Wider processes relating to service and professional conduct also impact on accessibility.

It was important to consider how to integrate ‘first-order constructs’ of original themes and quotes alongside ‘second-order interpretations’ from the original studies with ‘third-order interpretations’, where new interpretations are offered (Britten et al., 2002). Study and data integrity was retained by using direct quotes and the terminology included in the original papers. Hence, some examples will refer to D/deaf or a variation of the lower or uppercase “d”, dependent on their participant set, or ambiguity regarding whether they are referring to the Deaf community, or deaf people in general.

Social and Personal Considerations. Social and personal considerations were an integral aspect of the meta-synthesis. Several recurring themes in the literature could be combined under this concept, regarding the person’s own fears, and the response of society. An internal conflict between seeking support for difficulties and the fears of exposure to the community generated experiences of stigma for individuals.

Seven studies ^{1,3-8} explored the concepts of fearing exposure and protecting confidentiality. Individuals feared being ‘found out’ if they accessed services, discussing the insular nature of the community: “The deaf community is like a family. One thing can spread to everyone, and all the world knows about it” ⁷. Exposure could lead to a tarnished reputation, “People still gossip about my mental illness... People never forget...”¹, or people viewing them differently, “My kids, they see me as a strong woman, a strong mother... So if I tell them I am depressed, that would be in opposition to that. That’s how I feel, so I don’t show them that”³. The potential stigma from the community was a strong barrier to sharing difficulties and seeking support. There was a sense that feared outcomes sat at the forefront of people's minds, and dealing with difficulties while being part of such a

small community was overwhelming, like “living in a fishbowl”³. Accessing support was seen as risky due to the likelihood of confidentiality being compromised: “In principle everybody knows everybody. There would be a chance of meeting one’s psychologist at a party.”⁶.

Concepts of stigma and fear of exposure further linked to a belief that the Deaf community lack health awareness and understanding. Five studies^{2-5,7-8} discussed how the Deaf community is limited in its understanding due to a lack of awareness of and access to mental health information: “They have never learned about mental health issues. They don’t have access to the media like hearing people do”⁴. The concept of feeling disadvantaged in comparison to hearing counterparts was corroborated: “We typically learn things that are happening in the world *after* the wider community hears about it... Deaf people don’t have access to all the same information that the wider community does”³. The disadvantage of being unable to access information or education was evident:

Things that are out there in the hearing community are not out there in the Deaf community... just that whole thought of having it [depression, identified as] an illness versus something that you personally created or caused, that’s not something that is understood out there yet in the Deaf community.³

There was a sense of the Deaf community being an afterthought, or not considered by those developing health information or support services. Lack of access to health information could invariably lead to the development of false or stigmatising beliefs. A double stigma can therefore exist for a deaf person with mental health difficulties, as they feel torn between two worlds:

As a deaf person, I have found that people draw away from me. So I'm between deaf people without mental illness and hearing people with mental illness. It's a tough place to be. The deaf population...don't understand the mental illness. But, if they go to the larger community, they understand the mental illness but not being deaf.⁴

Four studies^{1,3,4,7} reflected to some degree the stigma that exists; in particular, the experience of internal stigma from the community when mental health difficulties were disclosed. One study theorised that the lack of role models alongside a lack of accessible information allowed stigma to develop: "I needed a leader in ASL, but there was no model there... I needed someone like me to show up. Someone who had lived it... but there was no one"¹. An absence of visible peers and understanding can make the experience of mental health difficulties overwhelming, stigmatising and isolating.

Individuals reported frustration at the lack of accessible support for them. Four studies^{3-5, 8} explored the concept of resilience and the often unhelpful coping strategies developed in order to manage symptoms: "I eat and sleep, eat and sleep... I watch a lot of TV... it helps me to forget... it's the only thing"³. Strategies had been developed in response to feeling abandoned by services. Linking back to fear, health information and awareness, a participant in one study illustrated how individuals in the Deaf community can lack awareness of beneficial interventions: "Realising how treatment could help would have helped me. Before, I thought, what's it for, what's the point?"¹. Increased knowledge could not only break barriers of stigma and fear, but allow individuals to seek support when they need it, rather than reaching crisis point. There was a sense however that individuals felt neglected by services, left to fend for themselves:

Deaf people will always find their way around the barriers they encounter. They always have done and always will do, but in today's world there shouldn't be any barriers.⁸

Deaf people should not have to rely on their resilience in place of appropriate support. Education is therefore vital to improving attitudes, access and outcomes for deaf people.

Communication. Theme two captured how communication is a vital component to the accessibility of mental health services. All studies explored the concept of miscommunication; individuals discussed how the fear of being misunderstood promoted fear and led to avoidance of support:

Even if I were just asking for directions at the information desk [of a psychiatric hospital], miscommunication could lead to my being committed mistakenly... I don't want to go there, even for a visit!⁷

The literature emphasised the lack of communicative ease for deaf people, and the worry of miscommunication and negative outcomes. The communication barrier between deaf clients and hearing clinicians was evident in all studies. Clinicians expressed frustration at their inability to communicate with clients: "If I want to talk to her, I have to write things down and she is very frustrated, she keeps trying to tell me things that I half understand and it's just very frustrating"⁹. Due to literacy limitations, written communication may not be the most appropriate communicative method for this group. One clinician theorised that "many deaf people lack English skills. They are ashamed to write"⁷. This account, however, appeared to place the blame for lack of communicative flexibility with the client.

An important component for communication in eight studies^{1, 3-9} was use of or accessibility to interpreters. For many individuals, interpreters are a vital intermediary to

ensure their needs are properly communicated. Some cannot access therapeutic interventions without them: “I wanted to join a support group...But they rejected me because of difficulties related to sign language interpretation” ⁶. Others emphasised the inequality of access in comparison to their hearing counterparts: “The Deaf always have to wait...people who are hearing can go straight away and have access to services. It isn’t fair...” ⁸, while staff lacked awareness of how to obtain an interpreter: “I wasn’t even aware that we could book interpreters... I don’t know where to book them through.” ⁹. Although literature has noted that interpreters improve communication, services lack awareness of how their role and utilisation could improve access. One study noted that the existing small pool of interpreters is also a barrier to access, as it provokes client anxiety around confidentiality:

I didn’t want to use an interpreter from the centre where I usually book one from because I use that centre in connection with my work. I wanted to keep things separate. I know that interpreters have a duty of confidentiality, but it would always be in the back of my mind... ⁶

Keeping portions of their lives confidential and separate was important to individuals. The literature emphasised the need for interpreters and other communicative technology to be more accessible, in order to provide individuals with more options.

Two studies ^{5,6} considered relationships that develop between client and clinician when seeking mental health support, and whether the presence of an interpreter is a potential barrier to access. Some respondents felt that direct communication with a deaf clinician would be more appropriate: “A third person in the room changes the dynamic. With direct communication there would be more time addressing real issues” ⁵. However, this is not always a possibility in current services. The importance of good rapport and working

relationships was emphasised: “The chemistry between us was poor...I don’t want to repeat myself and I don’t want to feel misunderstood”⁶. One respondent in the same study gave an example of what a positive triad relationship could look like:

The psychologist was really talented. The sign language interpreter ensured that the conversation flowed throughout. It meant a lot to me that I had the same interpreter with me for all my sessions...we could read and understand each other, and didn’t need to begin from scratch each time.⁶

Such relationships can clearly work and have positive effects. Understanding the role of the interpreter in mental health settings therefore is an important area for future research to improve accessibility of mental health services. Accounts identified that interpreters play a role in making services accessible, but how that role influences the therapeutic process must be better understood.

Three studies^{3, 5, 8} considered how communicative technology may improve access: minimising barriers in relation to both communication with and distance from services. Alongside online information and education resources, technology can also revolutionise therapy: “We prefer not to participate in [counselling] with an interpreter, [so] we would consider [driving 3 hours] to meet a signing therapist and then do all other sessions from the comfort of our home [via video conferencing]”⁵. Technology can improve accessibility by providing options to both clients and clinicians. However, one study considered the potential shortcomings of technological advances, limiting social interaction: “In the old days the deaf community was a strong community...that is the downside to technology – they don’t seem together like that anymore”⁸. The literature emphasised the importance for technology to be viewed as a facilitative communication aid, rather than a replacement to traditional services and methods. Clients must be supported in having knowledge of and

access to communicative facilitators that increase their options and allow them to communicate their needs.

Service and Professional Barriers. The final theme encompassed service and professional conduct that can impact on the accessibility of mental health care. Deaf awareness was noted in all studies, with some respondents sharing experience of seeking support from clinicians who lacked understanding: “Services don’t understand Deaf culture at all...as a Deaf person, I am constantly educating the people I get services from.”³. One study particularly highlighted the need for clinicians to understand how facial/body gestures may be interpreted: “Some staff have negative attitudes, bad facial expressions...this triggers clients to blow up...they need training on how to use better facial expressions”¹. Sign language is a language of its own, with intricacies and nuances, while the deaf experience itself is full of unique challenges. Professionals, therefore, require some awareness of this. The literature emphasised the need for clinicians to have skills “in deafness *and* mental health, and the interplay between the two, in order to properly assess and treat”². The need for such skills explained why many respondents preferred a deaf clinician: “A Deaf counsellor knows the language, the culture; knows what deafness means...is like me”⁷. The literature observed that such skill was currently lacking in mainstream services and hearing clinicians. This was evidenced by the responses of staff who lacked deaf awareness and confidence treating and assessing this group: “I’m not really sure if I could reliably assess whether someone was appropriate to be hospitalised – because with disordered thinking, you’d be looking at their speech as well wouldn’t you?”⁹. Even some interpreters were found to lack experience and awareness: “Many interpreters working in mental health settings do not have enough background in mental health. They are not able to see the subtle nuances...”⁵. The need for “training and cascading skills”² was emphasised, to better prepare clinicians

and interpreters to work with deaf individuals. Synthesis of data illustrated that current services feel they lack appropriate skills to support deaf people.

The view of respondents towards services and professionals was predominantly negative. Perceptions of services as restrictive, stigmatised and unhelpful were common: “From a Deaf person’s point of view, they [jail and mental hospital] are the same” ⁷. Individuals desired flexible services, between session check-ins, peer support and longer term treatment; these do not however often fit with the structure of current services. Although specialist services were more highly regarded, accessibility barriers existed for these: “There is no full Deaf support group...there is a respite programme, but it cannot adequately serve the Deaf population” ⁴, “There are not enough services in the whole state” ¹. Specialist services were valued for the “... range of therapeutic approaches available” ², which contrasted with the experience of restrictive mainstream services. As the likelihood of more specialist services being developed is limited, these views provoke consideration of what mainstream services could learn from specialist services.

Liaison between services was a recurring theme; communication between services and the willingness to share information, knowledge and skills was questioned. One study reported reservations regarding joint working:

There is an expectation that the team will become involved with the person in the community, in some cases in a joint way with the specialist service, but it’s not an easy alliance...some of that must be about our lack of skills, knowledge which creates a reluctance, and maybe the experts thinking that we should be comfortable. ⁹

Staff feel unsure of their role in supporting this population, emphasising the need for improvement of awareness and skills. The importance of liaison was emphasised by studies

that discussed geographical barriers to mental health care access. A large percentage of respondents in one study reported that families “found travelling to appointments difficult”

². If an individual is being seen by numerous, geographically spaced services, “CMHT is dislocated from services working on a day-to-day basis with clients” ⁹ which can cause issues if those services are not communicating. Overall, there was a sense that staff feel deskilled and uncertain of how to provide good support, while clients feel let down:

The whole [healthcare] system is not prepared to meet the needs of the hearing impaired. Children who are born deaf today are offered a CI [cochlear implant] operation, and the system thinks that there are no more hearing impaired people left. The fewer deaf and hard-of-hearing people there are, the less attractive it becomes to develop a system that can be used. ⁶

Viewing deafness purely as a medical issue, without consideration of the culture and community that exist within that, further exclude this population, making them less likely to seek support for mental health difficulties.

Discussion

The purpose of this review was to synthesise the experience of accessing mental health care for deaf people. A literature search identified a lack of qualitative research in this area. The meta-synthesis identified three overarching themes that highlighted the personal/social, communicative and service challenges that influence accessibility to mental health care.

A concept within the theme of personal and social considerations was fear of stigma that can occur as part of a minority community. Confidentiality and stigma are pertinent worries for deaf people with mental health difficulties (Scheier, 2009), however,

metasynthesis findings emphasised fear of stigma from the Deaf community itself. Respondents spoke of their hesitancy seeking support due to the 'grapevine', and fear of how the community would respond. Deaf individuals hold the perception that being diagnosed with mental health difficulties reflects badly on the community (Jones, 2002). Mental health education for deaf people could be beneficial in decreasing stigma and increasing understanding. There must, however, be consideration regarding who should conduct this education, and if possible, deaf clinicians should be utilised. Such individuals can act as 'role models', modelling positive attitudes, perspectives and collaborative working relationships with services (Deaf Unity, 2013). Educational and anti-stigma campaigns have mixed results in their ability to improve knowledge and attitudes (Smith, 2013), and Smith has posited whether there is the need for the development of new approaches in addressing mental health stigma. Future research will be vital in investigating potential interventions, and providing a robust evidence base that encourages services and clinicians to utilise these interventions to improve stigma amongst the Deaf community and wider society towards this group.

The challenges faced by the Deaf community in accessing health information and mental health resources may exacerbate stigmatising attitudes and limited knowledge. Elmonds, Ridd, Sutherland, Allsop, Alexander and Kyle (2015) conducted a study on the current health knowledge of the signing Deaf community and found that individuals could not access basic health information. They did, however, have greater awareness of campaigns associated with visual promotions. These findings link to Pollard's (1998) research on the health literacy of deaf individuals, and how this limits their ability to access written literature. Limited literacy, alongside an abundance of health information not available in a suitable communicative mode, can lead to negative perceptions and attitudes. In contrast, research conducted with hearing populations has found that those

who have more information about mental illness are less stigmatising (Corrigan & Penn, 1999). Corrigan et al. (2001) considered three methods of altering stigmatising attitudes: Education, contact and protest. Griffiths, Carron-Arthur, Parsons and Reid's (2014) meta-analysis of research evidenced that education and contact provide particularly positive results in decreasing stigma. The meta-synthesis therefore evidenced the need for education to improve deaf people's knowledge of mental health symptoms, diagnoses and potential treatments.

Current health promotions and resources worldwide are largely inaccessible to deaf people (Munoz, Bradham & Nelson, 2011; Napier & Kidd, 2013). Those developing resources must reach out to the Deaf community directly, seek to collaborate and use the groups' expertise. Giving deaf individuals the opportunity to aid development of resources would make them feel included, increase their familiarity and trust of healthcare professionals and services, which in turn could improve outcomes and lead to better allocated resources (Foot et al., 2014). Future research therefore could explore how health information could be made most accessible to deaf people. Their perspectives, alongside that of services, would be beneficial to the creation of resources that are fit for purpose.

Meta- synthesis findings evidenced the importance of facilitating communication with deaf people (Du Feu, 2017). Results correlated with existing literature; however, although previous research has identified communication as an issue to accessibility, little has been done to address this or action positive change. Interpreters have been noted as facilitators to communication; they bridge 'the communicative chasm between mental health workers and clients when they do not share a common language' (Miletic et al., 2006) and bridge the gap between cultures (Dean & Pollard, 2005). Current review findings noted however that staff still do not understand the role of the interpreter. Interpreters are,

therefore, not routinely made accessible to deaf individuals, which concurred with previous research (Ubido, 2002). This lack of understanding continues to be a barrier to communication. Future research must clarify the interpreter role and its influence on therapeutic processes and outcomes, in order to provide evidence of the need for more interpreters to be trained and utilised by services.

Deaf individuals also seemed unsure regarding the presence of interpreters; noting fears around confidentiality and the impact of a third person in a communication. However, meta-synthesis findings indicated that interpreters do influence clinical care and aid communication. These findings link to previous research which noted that the presence of interpreters is linked to improved clinical care, greater health information and accessibility (Henning et al., 2011; Moreland, Ritley, & Romano, 2011). However, regardless of their benefit, there are only approximately 7,500 sign language interpreters working across nearly 40 European countries (Wheatley & de Wit, 2014). Education and contact can decrease stigmatising attitudes (Corrigan et al., 2001); mental health services should therefore consider how they can collaborate with interpreter services and the Deaf community, to develop services that are prepared to work in collaboration and work flexibly to meet client need. Involving clients and interpreters in service and resource development will improve understanding of roles, increase familiarity and confidence working in collaboration, leading to more positive outcomes for deaf individuals.

The potential uses and benefit of technology was considered in the meta-synthesis. ‘Telehealth’ is the provision of video conferencing technology to facilitate mental health care (Wilson & Schild, 2009). Video relay services are already available in the USA, with pilot programmes conducted in the UK (Ladner, 2010). They provide access to interpreters via video link, so that sessions can go ahead even if an interpreter is not geographically

available. The use of technology has been hailed as a means of alleviating barriers to mental health care access (Wilson & Wells, 2009). However, the meta-synthesis findings highlighted the importance of technology facilitating communication and education, rather than replacing interaction and increasing isolation. Future research should explore the value of technology, seeking perspectives of both the Deaf community and services. This in turn can provide understanding that will assist the development of services and interventions that utilise technology in the most beneficial way.

Clinical Implications

The review has clinical implications for mainstream mental health services and the clinicians that work within these. As evidenced in the meta-synthesis, current mental health care provision is not serving the Deaf population sufficiently. Although considered a ‘minority’ group, 360 million people worldwide have disabling hearing loss (WHO, 2015). Metasynthesis findings indicated that current mainstream services do not meet client need and demand for services continues to grow. While deaf people have difficulty communicating with mainstream services (Chaveiro, Porto, & Barbosa, 2009; Pereira & Fortes, 2010; Smeijers & Pfau, 2009), specialist services have been praised for having trained staff, including interpreters, who have the necessary skills to work with and support deaf individuals (Psychological Professions Network, 2014). In theory, these services are ideal for deaf people, however such services are sparse, and the number of Deaf clinicians is limited (Gutman & Pollard, 1999). Collaboration between mainstream and specialist services is therefore vital to good services provision (Department Of Health, 2005), aiding the provision of appropriate support and increasing mainstream clinicians’ Deaf awareness and confidence working with deaf individuals (Salter, Swanwick & Pearson, 2017). However, the metasynthesis findings highlighted hesitance in relation to collaboration,

liaison and sharing of skills and resources. Future research must explore relationships between mainstream and specialist services, and the barriers that prevent collaboration. Case studies could evidence the benefit of collaboration, and promote the need for service developments. Services that are willing to learn from one another and work together may subsequently provide better outcomes for clients.

A lack of Deaf awareness was found to influence accessibility of mental health services and clinicians noted feeling that they lacked the skills to work with this group. Education could assist clinicians to understand how to communicate with deaf people, feel confident and able to recognise and respond to different means of communication (Action on Hearing Loss, 2015). However, it is important to consider whether a clinician's clinical skills should make them capable of working with deaf people regardless. In the case of clinical psychologists, considerable teaching is given regarding the importance of inclusivity and developing therapeutic relationships (British Psychological Society, 2015). Clinicians therefore must be proactive, and use their clinical skills to adapt their practice, in order to facilitate communication and interventions with this group. They should not feel unable or reluctant to work with this group due to a lack of appropriate training; results have highlighted that much of the adaptations required to facilitate communication require good clinical judgement and a willingness to collaborate, rather than specific skills. Deaf awareness training should be seen as a means of further improving understanding and skills, and services should consider how they are encouraging and supporting clinicians to feel confident in their clinical skills and ability to adapt practice.

Research influences both service and policy development, through the generation of a robust evidence base. In turn, evidence based policy impacts of health status and provision (Brownson, Chrigui & Stamatakis, 2009). The current review sought to amplify the voice of

the Deaf community and highlight current provision and accessibility of mental health care. However, researchers and services must go further to collaborate with and include the Deaf community in the research, development and implementation of resources and services designed to support them. There is a push toward greater patient and public involvement in research and service development (NICE, 2013). Collaboration would increase familiarity between the Deaf community and hearing services, clinicians and researchers. Mistrust is a common concept in work with marginalised groups (George, Duran & Norris, 2014), and involving them in the creation of services could improve this. Those in the Deaf community have a unique experience of mental health care; utilising and valuing their insight will evidence the need for change and provide suggestions of how best to shape future policy and services.

Policy and guidelines set out basic rights and standards of individuals, emphasising their rights to information and services (Action on Hearing Loss, 2015; Citizens Advice, 2010), and stating that those with disabilities must not be discriminated against by health care providers (Equality and Human Rights Commission, 2017; Waddington & Lawson, 2009). However, research has shown that such services are not routinely provided (National Association of the Deaf, 2016), or adjustments made to accommodate people have been reactive and substandard (Action on Hearing Loss, 2006). The current meta-synthesis also suggests that a systemic issue within health care services may exist in relation to adherence to guidance. Mental health clinical guidance exists (American Psychological Association, 2017; NICE, 2017) to assist clinicians in performing their roles ethically and providing appropriate treatment. There is also policy and guidance that exists to protect rights of deaf people, and educate clinicians on how to work with deaf people and interpreters (Miletic et al., 2006; NRCPD, 2012). Bauer (2002) conducted a review of the degree to which clinical guidance is implemented in practice. From 41 studies, adequate adherence was only

reported in 27% of studies. His research emphasised that guidelines are not often followed, and that the true challenge is the development of interventions and guidance that can be followed in clinical practice. Services and clinicians must therefore take responsibility to act in accordance with guidance. Future research should explore why adherence to guidance is poor, and what needs to change in order to improve adherence. It may be that guidance and policy is currently developed by groups that lack understanding of relevant issues to this client group. Guidance developed in collaboration between services and clients could be more comprehensive, useful and easy to follow.

Strengths and Limitations of the review

Meta-syntheses have been criticised due to the potential for loss of original findings and limited generalisability (Thorne, Jensen, Kearney, Noblit, & Sandelowski, 2004). However, the current review retained original study interpretations and themes, while expanding on their ideas. A representative account of the experience of accessing mental health care for the participants in the included studies was generated. However, the challenge of gathering a true global perspective must be noted, due to the limited geographical scope of the papers included in the current review, and within the wider literature. Papers included in the current review considered experiences from Europe, North America and Australia. It must therefore be noted that the experiences of deaf people in other parts of the world may differ from the accounts presented in the current review. It may actually be that people's experiences in other parts of the world could be worse than those reported in the current review, as the areas covered by the current review have at least some systems in place for provision of care. However, further research would be required to evidence whether such a speculation has any credible basis.

Noblit and Hare (1988) explained that the drive of conducting a meta-synthesis must be to construct accurate interpretative translations. Valuing experiences from studies across the globe generated a representative account, and allowed for the consideration of future improvements that are generalisable. Atkins et al. (2008) noted how research methodology and synthesis can be influenced by the researcher. The reviewer had no prior experience with this group and remained reflective throughout the process, which minimised bias.

The sample included in the current review was small, but illustrated the lack of literature in this research field and allowed for greater focus on the data. Broader literature reviews have been favoured in this field in place of focused systematic reviews. However, the current review explored an important issue for this group and valued their experience in order to promote the need for change. Reporting quality of included studies varied; however none were excluded on the basis of the COREQ assessment as all participant data was valuable to the analysis. Juni, Altman and Egger (2001) debated the inclusion studies with lower reporting quality of lower, but noted that excluding studies due to quality could omit valuable data.

Conclusion

In conclusion, the systematic review and meta-synthesis of the qualitative literature identified key themes relating to the experience of accessing mental health care for deaf people. Findings highlighted factors that facilitate or hinder access, including fear of stigma, ability to communicate and Deaf awareness. The literature emphasised that the experience of seeking support for mental health difficulties across the world remains a negative one for many deaf individuals, due to social, personal, communicative and service limitations. The need for collaboration and education are highlighted to be instrumental in generating change in the provision of support for this group.

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Note: * This study is included in the systematic review.

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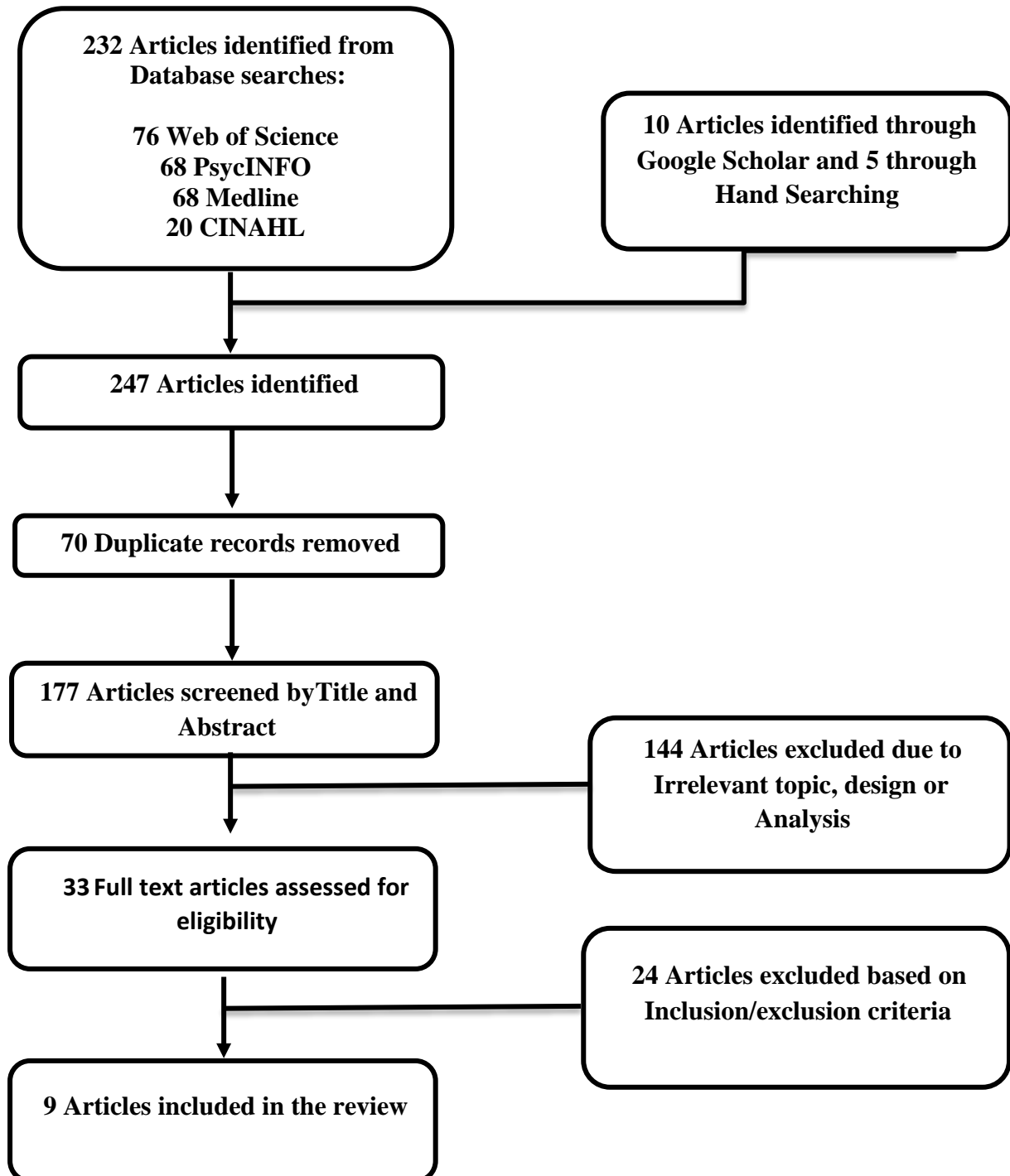
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Figures

Figure 1. Flowchart of search process



TablesTable 1. Search terms included in PsycINFO database search (3rd January 2017)

Population	Design	Service	Content
Deaf*	Qualitative*	CMHT*	Access*
Hearing Disorders	Interview*	Primary care*	Barrier*
Hearing Loss	Focus Group*	Mental health services*	Facilitator*
Deafness	Self-report	Psychology	Provision
deaf	Qualitative Research	Community mental health	Experience*
	Observation Methods*		Perception
			Attitude*
			View*

Table 2. Characteristics of included studies

Ref	Authors	Research Question	Country	Participants	Data Collection	Analysis
(1)	Anderson, Wolf Craig and Ziedonis (2016)	To explore the experiences of Deaf people accessing support for trauma and psychological difficulties.	USA	16 service user participants: 13 Female, 3 Male.	One 45 minute semi-structured interview in ASL.	Grounded Theory
(2)	Beresford, Clarke and Greco (2010)	To explore views of referrers to specialist mental health services on the current quality and access to mental health support for Deaf children.	UK	11 service provider participants: 7 teachers from specialist schools, 2 local education authority team members, 1 social worker and 1 community paediatrician.	One semi-structured interview, lasting between 40 – 90 minutes.	Thematic Analysis
(3)	Bone (2013)	To explore the Deaf experience in locating assessment and intervention support following a diagnosis of depression.	Canada	6 service user participants.	Up to 2 semi-structured interviews; lasting around 2 hours.	Thematic Analysis
(4)	Cabral, Muhr and Savageau (2013)	To better understand the experiences of Deaf and hard of hearing individuals accessing mental health services.	USA	12 service user participants. Focus group completed with 4 individuals, and 8 individual interviews.	One initial interview. Then, either: 1 hour focus group or 45 min semi-structured interview	Thematic Analysis
(5)	Horton, Chul Kim and Mills (2012)	To investigate mental health services in New York; consider barriers and required changes.	USA	9 participants: 5 service users and 4 service providers.	One 2 hour focus group.	Thematic Analysis
(6)	Skot, Jeppesen, Mellentin and Elklit (2016)	To explore barriers faced by Deaf and hard of hearing individuals accessing psychological services following large scale disasters or personal traumas.	Denmark	9 service user participants: 2 male, 7 female.	One semi-structured interview lasting between 1-2 hours.	Thematic Analysis
(7)	Steinberg, Sullivan and Loew (1998)	To explore experiences, knowledge and beliefs about mental illness and providers held by a group of Deaf adults.	USA	54 service user participants: 31 female and 23 male.	Individual and group semi-structured interviews	Thematic Analysis
(8)	Terry, Le and Nguyen (2016)	To explore health awareness and access to services for Deaf people in Australia.	Australia	21 service user participants: 13 female and 8 male. 10 took part in a focus group and 11 in one on one interviews.	One focus group lasting between 30-90 minutes or a one on one interview lasting 30-90 minutes.	Thematic Analysis
(9)	Thomas, Cromwell and Miller (2006)	To identify and explore issues providing services for Deaf people with mental health problems, from the perspective of community mental health teams (CMHT's).	UK	8 focus groups conducted with service providers; each with 5-15 participants. Specific numbers not specified.	One focus group lasting 1 hour.	Thematic Analysis

Table 3. Quality of nine included studies, assessed by COREQ

Reporting Criteria	No of studies reporting each criteria	Studies reporting each criteria
Domain 1: Research team and reflexivity		
Interviewer or facilitator identified	6	1 - 3, 7 - 9
Credentials	4	3, 7, 8, 9
Occupation	1	1
Gender	8	1 – 5, 7 - 9
Experience and training	2	4, 8
Relationship established before study start	4	1, 2, 4, 6
Participant knowledge of interviewer	0	
Interviewer Characteristics	4	3, 4, 6, 8
Domain 2: Research Design		
Methodological orientation and theory	9	1 – 9
Participant sampling method	9	1 – 9
Method of approach	9	1 – 9
Sample size	8	1 – 8
Number or reasons for non-participation	3	2, 3, 8
Setting of data collection	7	2, 3, 5 - 9
Presence of non-participants	6	1, 3 – 6, 8
Description of sample	6	1 – 3, 6 - 8
Interview guide	8	1, 3 – 9
Repeat interviews	4	2, 3, 5, 9
Audio or visual recording	6	1, 2, 4 – 6, 9
Field notes	3	2 – 4
Duration	6	1 – 6
Data (or theoretical) saturation	1	3
Transcripts returned to participants	1	3
Domain 3: Analysis and Findings		
Number of data coders	4	2, 5, 6, 9
Description of coding tree	5	1, 3, 4, 5, 9
Derivation of themes	9	1 – 9
Use of software	7	1, 2, 4, 5, 7 - 9
Participants' feedback or member checking	0	
Participant quotations provided	9	1 – 9
Data and findings consistent	9	1 – 9
Clarity of major themes	8	1 – 6, 8, 9
Clarity of minor themes	5	1 – 3, 5, 6

Table 4. COREQ domain and total scores

Study	Reference (year)	Domain 1 (8)	Domain 2 (15)	Domain 3 (10)	Total (32)
1	Anderson, Wolf Craig and Ziedonis (2016)	4	9	7	20
2	Beresford, Clarke and Greco (2010)	3	11	7	21
3	Bone (2013)	4	15	6	24
4	Cabral, Muhr and Savageu (2013)	4	9	6	19
5	Horton, Chul, Kim and Mills (2012)	1	10	8	19
6	Skot, Jeppesen, Melletin and Elkit (2016)	2	10	6	18
7	Steinberg, Sullivan and Lowe (1998)	3	7	4	14
8	Terry, Le and Nguyen (2016)	5	8	5	18
9	Thomas, Cromwell and Millar (2006)	3	7	7	17

Table 5. Process of meta-synthesis

Key concepts from original studies	Second-order interpretations	Third-order interpretations	Meta-synthesis final themes
Stigma/Conditional belonging ^{1,3,4,7,8}	(A) Awareness of a 'grapevine'	(D) Deaf people carry out a 'cost benefit' analysis of help seeking, weighing up the benefit of support with the stigmatised response from community	Social and personal fears and considerations
Confidentiality ^{1,3,4,6}	(B) Challenges of being part of a small community		
	(C) lack of health information leads to stigma	(F) Consideration of how to protect confidentiality – mindful of 'small community' – influence on attending services with Deaf clinicians	
Lack of role models ^{1,3,4,7}	(E) Desire to 'keep things separate'	(H) Hiding illness to protect reputation – feeling alone in their situation.	
	(G) No deaf people 'like them' – mental illness hidden	(I) Double stigma – Deaf with a mental illness – stuck in the middle, left out of both Deaf and hearing communities	
Resilience/Coping ^{3,4}	(J) Deaf people develop own coping strategies – look after themselves	(K) Deaf people fear/feel services will not be supportive, so try and develop own methods of coping	

Interpreters^{1, 3-9}	(L) Interpreters help communication...clients and clinicians have reservations	(M) Lack of clarity of interpreter role and how it influences interactions between client and clinician. Seen as potential threat to confidentiality for clients/ role for clinicians.	Communication
Triad relationship^{5,6,9}	(N) Existence of a triad – client, clinician and interpreter – in this communication, whether this is good or bad.	(O) Deaf people and clinicians feel unsure about how the communication changes with interpreter presence, extent to which they should be considered part of the process.	
Communicative flexibility/use of technology¹⁻⁹	(P) Clients value flexibility, but clinicians struggle to achieve this.	(Q) Flexibility is important to facilitate communication, however can be difficult in mainstream services with structures and processes. Service processes held above needs of clients.	
	(R) Technology may facilitate communication – increases options	(S) Potential benefit of technology must be considered alongside drawbacks. Ensure technology used as a facilitator, rather than replacement.	
Deaf awareness/Staff skill^{1,2,5,6,9}	(T) Deaf awareness and clinician confidence influence accessibility to services	(U) Clinicians responsible for adapting practice/ seeking knowledge to improve accessibility of services for deaf people. Existing skills should be encouraged/developed alongside additional training.	Service and professional conduct
Flexibility of mainstream services/Liaison with specialist services^{1,2,4,6,7,9}	(V) Services struggle to collaborate which impacts on accessibility and outcomes for deaf clients	(W) Importance of liaison, services sharing resources and learning from each other. Fill the gaps through collaboration.	

Appendix

Notes for Contributors for the target journal: Clinical Psychology Review

Language (usage and editing services)

Please write your text in good English (American or British usage is accepted, but not a mixture of these). Authors who feel their English language manuscript may require editing to eliminate possible grammatical or spelling errors and to conform to correct scientific English may wish to use the English Language Editing service available from Elsevier's WebShop.

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Article structure

Manuscripts should be prepared according to the guidelines set forth in the Publication Manual of the American Psychological Association (6th ed., 2009). Of note, section headings should not be numbered.

Manuscripts should ordinarily not exceed 50 pages, *including* references and tabular material. Exceptions may be made with prior approval of the Editor in Chief. Manuscript length can often be managed through the judicious use of appendices. In general the References section should be limited to citations actually discussed in the text. References to articles solely included in meta-analyses should be included in an appendix, which will appear in the on line version of the paper but not in the print copy. Similarly, extensive Tables describing study characteristics, containing material published elsewhere, or presenting formulas and other technical material should also be included in an appendix. Authors can direct readers to the appendices in appropriate places in the text.

It is authors' responsibility to ensure their reviews are comprehensive and as up to date as possible (at least through the prior calendar year) so the data are still current at the time of publication. Authors are referred to the PRISMA Guidelines (<http://www.prismastatement.org/statement.htm>) for guidance in conducting reviews and preparing manuscripts. Adherence to the Guidelines is not required, but is recommended to enhance quality of submissions and impact of published papers on the field.

Appendices

If there is more than one appendix, they should be identified as A, B, etc. Formulae and equations in appendices should be given separate numbering: Eq. (A.1), Eq. (A.2), etc.; in a subsequent appendix, Eq. (B.1) and so on. Similarly for tables and figures: Table A.1; Fig. A.1, etc.

Abstract

A concise and factual abstract is required (not exceeding 200 words). This should be typed on a separate page following the title page. The abstract should state briefly the purpose of the research, the principal results and major conclusions. An abstract is often presented separate from the article, so it must be able to stand alone. References should therefore be avoided, but if essential, they must be cited in full, without reference to the reference list.

Graphical abstract

Although a graphical abstract is optional, its use is encouraged as it draws more attention to the online article. The graphical abstract should summarize the contents of the article in a concise, pictorial form designed to capture the attention of a wide readership. Graphical abstracts should be submitted as a separate file in the online submission system. Image size: Please provide an image with a minimum of 531×1328 pixels (h \times w) or proportionally more. The image should be readable at a size of 5×13 cm using a regular screen resolution of 96 dpi. Preferred file types: TIFF, EPS, PDF or MS Office files. You can view Example Graphical Abstracts on our information site.

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Immediately after the abstract, provide a maximum of 6 keywords, using American spelling and avoiding general and plural terms and multiple concepts (avoid, for example, 'and', 'of'). Be sparing with abbreviations: only abbreviations firmly established in the field may be eligible. These keywords will be used for indexing purposes.

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Define abbreviations that are not standard in this field in a footnote to be placed on the first page of the article. Such abbreviations that are unavoidable in the abstract must be defined at their first mention there, as well as in the footnote. Ensure consistency of abbreviations throughout the article.

Acknowledgements

Collate acknowledgements in a separate section at the end of the article before the references and do not, therefore, include them on the title page, as a footnote to the title or otherwise. List here those individuals who provided help during the research (e.g., providing language help, writing assistance or proof reading the article, etc.).

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Footnotes should be used sparingly. Number them consecutively throughout the article.

Many word processors can build footnotes into the text, and this feature may be used.

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Please submit tables as editable text and not as images. Tables can be placed either next to the relevant text in the article, or on separate page(s) at the end. Number tables consecutively in accordance with their appearance in the text and place any table notes below the table body. Be sparing in the use of tables and ensure that the data presented in them do not duplicate results described elsewhere in the article. Please avoid using vertical rules and shading in table cells.

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Citation in text

Please ensure that every reference cited in the text is also present in the reference list (and vice versa). Any references cited in the abstract must be given in full. Unpublished results and personal communications are not recommended in the reference list, but may be mentioned in the text. If these references are included in the reference list they should follow the standard reference style of the journal and should include a substitution of the publication date with either 'Unpublished results' or 'Personal communication'. Citation of a reference as 'in press' implies that the item has been accepted for publication.

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As a minimum, the full URL should be given and the date when the reference was last accessed. Any further information, if known (DOI, author names, dates, reference to a source publication, etc.), should also be given. Web references can be listed separately (e.g., after the reference list) under a different heading if desired, or can be included in the reference list.

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Reference to a book: Strunk, W., Jr., & White, E. B. (1979). *The elements of style*. (3rd ed.). New York: Macmillan, (Chapter 4).

Reference to a chapter in an edited book: Mettam, G. R., & Adams, L. B. (1994). How to prepare an electronic version of your article. In B.S. Jones, & R. Z. Smith (Eds.), *Introduction to the electronic age* (pp. 281-304). New York: E-Publishing Inc.

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Section Two: Research Paper

Mental health and Deafness: Interpreters' perspectives on compassion and the development of the therapeutic alliance.

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Doctorate in Clinical Psychology

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Abstract

Objectives: The research aims to explore the role of the British Sign Language (BSL) interpreter in the communication of compassion and development of therapeutic relationships between a mental health clinician and their deaf client.

Method: Seven BSL interpreters were interviewed. Interpretative Phenomenological Analysis led to the generation of two key themes: nurturing the triangle of care and developing shared understandings.

Results: The therapeutic process and communication of compassion rely on collaboration, continuity and trust. Individuals must seek to develop a 'triangle of care', which can aid therapeutic relationships to thrive.

Conclusion: Interpreters need to be viewed as part of the clinical team and have access to supervision in order to fulfil their role. Clinicians must be willing to adapt practice and seek to improve their knowledge and Deaf awareness. Deaf people should also be included in service development and evaluation.

Keywords: Therapeutic alliance; Mental Health; Deafness; Interpreters; Qualitative

The World Health Organisation (2015) states that 360 million people worldwide suffer from disabling hearing loss. Around 70 million of those consider their country's variation of sign language as their mother tongue (World Federation of the Deaf, 2016). Sign language is a manual mode of communication with no written equivalent, and there are as many as 137 sign languages worldwide (Lewis, Simons & Fennig, 2013). Although sign languages are gradually being recognised as languages in their own right (Stiles, 2003; Danish Sign Language Council, 2015), progress is slow and society continues to struggle to communicate with this group. Sign language interpreters are therefore important figures in facilitating communication between deaf and hearing populations (Du Feu & Chovaz, 2014). Their presence can assist deaf individuals in various aspects of life, such as accessing support for psychological difficulties, by assisting them to communicate their needs.

Mental Health and Deafness

Deaf with a capital D refers to individuals who belong to a community with a unique cultural and linguistic identity (Action on Hearing Loss, 2015). It is this group that primarily consider a variation of sign language as their first language, using it as their main form of communication (Berke, 2016). In contrast, deaf with a lowercase d refers to an individual's inability to hear (Young & Rogers, 2011).

Deaf people are at greater risk of mental health difficulties than their hearing counterparts (Fellinger et al., 2012). Moores (1996) found that deafness was a more significant risk factor for mental health difficulties if the child came from a hearing family, rather than a deaf family. This could be attributed to decreased family acceptance and communication (du Feu & Fergusson, 2003) and slower acquisition of language (Gentili & Holwell, 2011). Deaf individuals generally learn language later, with less consistent and useful experiences in their early life and into their schooling years than their hearing

counterparts (Briggle, 2005). Pollard (1998) considered that deaf individuals experience an information deficit, having less knowledge due to an inability to access the same information as the general population. In relation to health care, the Deaf community have limited access to educational campaigns and communications (Tamaskar et al., 2000; McKee, Barnett, Block & Pearson, 2011), leading to lower health knowledge (Wollin & Elder, 2003; Zazove, 2009; Pollard & Barnett, 2009). Limited understanding can consequently influence an individual's ability to know when or how to seek support. For many in the Deaf community, this may mean they do not receive support for psychological difficulties until their symptoms have increased in severity (Fellinger, Holzinger & Pollard, 2012).

Estimates of incidence rates and diagnosis of mental health difficulties in deaf people are often based on 'extrapolation of general population statistics, combined with incidence data on hearing loss' (Marschark & Spencer, 2011, p.216). Diagnoses of deaf and hearing psychiatric inpatients differ considerably: in the deaf population, more impulse control and developmental disorders are reported (Landsberger and Diaz, 2010), alongside fewer psychotic and substance abuse related disorders (Black & Glickman, 2006). Research has also indicated a relationship between being deaf and a prolonged admission to hospital (Timmermans, 1989; Appleford, 2003). The Timmermans study reported a discrepancy between an average 148 day stay in a psychiatric unit in Flanders for a hearing patient, with a 19.5 years average stay for deaf patients. The historical importance of this reference is considerable, to highlight the scale of this problem in the past. Recent research, however, indicates that extended inpatient stays remain an issue for deaf people (Baines, Patterson & Austen, 2010) and communication issues may be one reason for this. In specific cases, inpatient admission may be necessary or even the only available treatment option. The epidemiology of mental health difficulties in the deaf is complex (Griggs, 2004), and Baines et al. (2010) identified a shortage of community based services that meet patient need, failing

to provide resources such as interpreters that decrease miscommunication and improve service provision.

Access to services

Access to services remains a key issue for this population. Fellingner et al. (2012) identified a discrepancy between the proportion of mental health difficulties in deaf people, and access to support. Sign-language interpreters are not routinely sought or provided, making services largely inaccessible to individuals who communicate primarily in sign (Sign health, 2016). Early evidence by Schlesinger and Meadows (1972) suggested that many clinicians in mainstream services will have limited to no familiarity with deaf people. Seeing a deaf person for the first time may leave them feeling unskilled. They may react with shock and not understand the need for an interpreter, leading to a breakdown in communication. This response appears to remain true today (Du Feu, 2017). Deaf individuals can feel discouraged by such experiences, raising questions regarding the number of individuals not receiving appropriate support, or avoiding services completely, due to communication issues.

Specialist services that provide inpatient and outpatient services with trained staff who have skills to support deaf individuals do exist (Beresford, Clarke & Greco, 2010). However, these services are often inaccessible due to barriers such as geography and funding (Horton, Chul Kim & Mills, 2012; British Deaf Association, 2014). For example, only four such services exist in the UK, in London, Manchester, Birmingham and Belfast. Accessibility is a postcode lottery, with no services in Scotland or Wales. In America, despite the Disabilities Act requiring services to provide effective communication and support to aid accessibility, many services fail to provide interpreters (American Psychological Association, 2013), indicating a potentially recurring issue across the globe.

Sign Language Interpreters

Literature has evidenced that the Deaf community are vulnerable to mental health difficulties, yet encounter considerable challenges when attempting to seek support. A vital communicative facilitator are sign language interpreters. Du Feu and Chovaz (2014) noted that 'Interpreting is much more than translating. It is a complex process and a bridge between two cultures' (p.141). Interpreters not only communicate dialogue from one language to another, they mediate cultures and assist interlocutors to develop an understanding of one another. Information gathering and relationship building in an individual's own language is also beneficial and minimises the occurrence of qualitative distortions (Farooq & Fear, 2003).

Although the benefits of interpreters are considered in the literature, the role of the interpreter continues to be misunderstood. A narrative review of health literature indicated that a coherent understanding of an interpreter's function in a healthcare setting is lacking (Sleptsova, Hofer, Morina & Langewitz, 2014). Misunderstanding the interpreter's function can cause services to not utilise their expertise, leading to less accessible services. The 'Sick Of It' report (Sign Health, 2016) evaluated service accessibility for the Deaf community and found that 70% of deaf people who had not seen their doctor recently had wanted to, but were unable to attend an appointment because an interpreter was not provided. Optimal communication, fewer misunderstandings and greater patient satisfaction and outcomes occur when professional interpreters are utilised in services (Flores, 2005), and there can be serious implications for individuals' mental health when they are not. Research therefore needs to explore the interpreter role in mental health settings, to explore their function and the benefit of their presence on interventions and outcomes.

Psychological therapy is often a beneficial intervention for individuals with mental health difficulties. An essential component of psychological therapy is the therapeutic

alliance that is developed between client and clinician (Wright & Davis, 1994). In the case of a deaf client, an interpreter would be part of the therapeutic process, facilitating communication between the client and clinician. There is a body of literature that evidences the benefit of positive therapeutic relationships and the impact of these on health and therapy related outcomes (Hovarth, Del Re, Fluckiger & Symonds, 2011; Kelley, Kraft-Todd, Schapira, Kossowsky, & Riess, 2014). However, there is a lack of research that explores how therapeutic relationships develop in an interpreter mediated communication. Literature has indicated that therapeutic relationships are beneficial to client outcomes. It is therefore important for research to explore how such relationships develop when interpreters are involved in the process. Such findings would provide insight into how mainstream services need to work alongside interpreters, for improved outcomes for the Deaf community.

Compassion

A key component in the development of therapeutic relationships is the presence and communication of compassion. Compassion is described as the sympathetic concern felt for another individual (Goetz, Keltner & Simon-Thomas, 2010). Research with hearing populations has identified touch (Goetz et al., 2010) and voice (Simon-Thomas, Keltner, Sauter, Sinicropi-Yao & Abrahmson, 2009) as two facilitators to the communication of compassion. However, there is currently no literature that considers the communication of compassion in a sign language interpreter facilitated therapeutic relationship, where voice and touch are not traditionally displayed. Research with spoken language interpreters has indicated that positive relationships can be developed and compassion communicated through a unique process where all three individuals work as a 'triad' (Robertson, 2014), rather than viewing the interpreter as an outsider to the therapeutic process. This is an important concept

to explore further in research with sign language interpreters, as such processes may improve accessibility to support and outcomes for deaf clients.

The current study therefore aimed to gain the experiences of interpreters working in mental health settings. Their accounts would illustrate how the therapeutic process operates between a client, clinician and interpreter. Research objectives were to explore:

1. The role of BSL interpreters in mental health settings and the development of therapeutic relationships.
2. The barriers and facilitators to the development of therapeutic relationships.
3. How compassion is communicated in a BSL interpreter mediated relationship

Method

Design

The current study was reported in adherence to ENTREQ guidelines (Tong, Flemming, McInnes, Oliver & Craig, 2012). Interpretative Phenomenological Analysis (IPA) was the chosen methodological approach due to its principles of understanding lived experience and making sense of individual meaning and interpretation (Pietkiewicz & Smith, 2014, p.7). A double hermeneutic exists in IPA: participants make sense of their own world, while the researcher tries to make sense of the participant's sense of the world (Smith & Osborn, 2003).

Participants

Qualified BSL interpreters over 18 years old were invited to participate. All were registered with either The National Registers of Communication Professionals working with Deaf and Deafblind People (NRCPD) and/or Association of Sign Language Interpreters (ASLI).

Seven participants took part in the study, six women and one man. Participant demographics are available in Table 1. Pseudonyms were utilised to protect participant confidentiality. The sample is representative of the profession demographic, in which around 83% of registered or trainee BSL interpreters are female (Mapson, 2014).

Table 1 here

Procedure

The recruitment strategy included online advertisement on twitter, advertisement on the ASLI and NRCPD websites and forums, and a recruitment email that was sent to members of ASLI via a gatekeeper. A snowballing process was also utilised; individuals with awareness of the research disseminated details to their networks.

A participant information sheet was sent to individuals who had expressed interest in the study, and interviews arranged at their convenience. Interviews were audio recorded and subsequently transcribed, lasting between 55 - 85 minutes. The interview was semistructured, conducted with reference to a topic guide (Table 2) which maintained interview focus, while allowing the researcher to probe for further elaboration when appropriate. Three interviews were conducted via Skype video, two via Skype audio and two via telephone.

Table 2 here

A debrief sheet was sent to participants following the interview, containing details of organisations they could contact for support if necessary. Transcripts and documents were uploaded onto a secure server hosted by Lancaster University who are a registered data controller.

Ethics

All study procedures and materials were reviewed and approved by the Faculty of Health and Medicine Research Ethics Committee (FHMREC) at Lancaster University, U.K. The research was developed with reference to the Helsinki Declaration (World Medical Association, 2013) and the Data Protection Act (1998). The confidentiality of participants and protection of sensitive data was paramount. Signed consent forms were stored separately from other research documents and transcripts were anonymised. Audio recordings were deleted once the transcription was considered to be an accurate representation of the interview.

Data Analysis

Analysis followed IPA guidelines detailed by Smith, Flowers & Larkin (2009); as advised for samples larger than six, emergent themes were developed for each transcript before the emergent themes were compared across all transcripts. Accounts were homogenous; no disconfirmatory codes were noted, but experiences of participants altered the understanding and coding of overarching themes. Final themes were reviewed to ensure there was a balanced representation of each participant's experience.

Results

Analysis generated two superordinate themes: (1) Nurturing the triangle of care and (2) Developing a shared understanding. Superordinate and subordinate themes are presented in Table 3.

Table 3 here

Nurturing the triangle of care: “We were an equal triad”

The first superordinate theme represents the importance of collaboration and trust, to nurture a ‘triangle of care’: a therapeutic relationship encompassing all individuals that allows for the facilitation of communication.

Communication. Participants reported BSL as: “an emotive language full of visual metaphor and imagery” (Lucy, p.9). Interpreters hold an important role in facilitating communication: “We are effectively channelling those people in the room... it is going through us... it’s a complex process that we do have an important part of” (Paula, p.4). Interpreters engage in an interpretative process, processing and mediating the communication for language and cultural differences. They influence how the client and clinician relate to and understand one another.

Interpreters reflected on minimising potential bias by ensuring they communicate ‘truth’: “It’s about communicating what you see and how it’s being said, rather than trying to make sense...there is never an ideal translation, there is always a departure from the original”

(Lucy, p.4). Having an awareness of this departure, and sharing this with the clinician and client nurtures the triangle of care. Interpreters are a bridge between the client and clinician, allowing the client to be heard, and providing important context for clinicians: “I can’t always explain what it is, but I can make sure the clinician is aware of it, in the way they might have been aware of themselves with a hearing client” (Katie, p.5). Katie’s account highlights the process of teamwork which helps the triangle of care to function.

Unlike therapeutic relationships between hearing individuals, the triangle created between client, clinician and interpreter does not rely on voice. Lucy noted, “they mention voice, and what I think they should have is dialogue... voice is just the mechanism through which language is conveyed. The important bit is the language you use” (p.10). Lucy emphasised that meaning can be conveyed even in the absence of traditional mechanisms. Clients and clinicians find alternative methods of connecting: “Deaf people can communicate an awful lot with a look or a gesture, movement kind of thing. They don’t actually have to articulate an awful lot” (Karen, p.2). There was a sense that individuals paid greater attention to other methods of communication in lieu of voice: “emotional range is just as present in sign as it is in spoken language... You can see, feel and hear it” (Tom, p.9). Openness assists the communication of compassion in the triangle of care. Interpreters have a unique role:

If the clinician is conveying compassion through their use of language, I can convey that in sign. It's also not just about signing and your hands...our facial expressions, how we sit or stand... It's being silent if the clinician is being silent... averting your gaze, or sometimes gazing. I don't quite know how I do it, but I think I can communicate compassion across quite well...it's a very subtle process. (Sally, p.4)

However, clinicians also show compassion through “eye contact, nodding, gesturing towards the person... being culturally sensitive” (Lucy, p.9). Tom concurred, feeling that

compassion is communicated “Through the natural expressions and body language of the client and the clinician...And through me...being careful to portray their sense of meaning or understanding” (p.9). Equal contribution therefore facilitates the communication of compassion. Interpreters reflected on stepping back when there is no dialogue:

When there is silence, I don’t look at anybody... it gives them that breathing space, and allows them to look at the clinician, to gain something from them, a sense of something like compassion or connect with one another (Sally, p.5).

To nurture the triangle, clients and clinicians must be able to develop their own rapport rather than relying on connection through the interpreter. Each individual has a role in both the development of the triangle and communication of compassion.

Trust and the balance of power. Trust was a prominent theme in all accounts. Lucy viewed it as vital in nurturing the triangle of care:

Trust is hugely important, and goes in all directions... It’s very important for the interpreter to build that relationship with the clinician, so the client can then do that.

The Deaf person has to trust the interpreter before they can trust the therapist (p.4).

Her account indicated the intricate process of developing trust between three people; Tom concurred, noting that “managing [rapport] between three people can be tricky” (p.8).

Tom’s quote suggests that interpreters are attuned to clinical processes important to the development of relationships that would not necessarily be expected of them. Trust can foster equality, as illustrated by Sally: “We were an equal triad, and each person was as valuable as the other” (p.5). Equality in the triangle subsequently aids the development of therapeutic relationships.

Intrinsically linked to concepts of trust and equality was the delicate balance of power. Interpreters reflected on their power: “[We] are the key to communication. There’s something about reflecting on the process of communication in these situations, your role within that, and how everything influences one another” (Paula, p.3)). Paula’s account indicated the importance of interpreters having an awareness of power dynamics. Sally discussed being “the type who will get the whole story in the waiting room” from a client. She reflected:

I need to kind of separate/distance that. I explain, we should have that communication between the three of us...to ensure that we're all entering the room on an equal footing, and there isn't any existing rapport or alignment” (p.6).

Sally understood the likelihood that the client may align with her as the interpreter at the expense of the clinician, due to their shared communication. Awareness of dynamics and emerging alignments is important in nurturing the triangle of care through equal interaction. It was considered vital that clinicians are able to take a position of power without alienating the client and interpreter. Katie shared a positive experience of how the triangle of care develops when a clinician has the confidence to use their power:

[The psychologist] makes a point of at the start of every session going to the client first and shaking their hand...there becomes a natural ease between them. He has awareness of the fact he can’t sign, and makes good use of the interpreter as a cofacilitator. But he is the one who leads, and challenges the client and I think they feel that in the room and come to respect him (p.8).

Her account identified the benefit of clinicians wielding power positively, helping to put individuals at ease, establishing roles and building trust. Lucy further considered how

positive use of power can assist clinicians to “work with an interpreter to ensure [they’ve] got the therapeutic control while getting the information [they] want” (p.3). Reflection on power dynamics is vital in building trust and nurturing the triangle of care.

Willingness to collaborate. Collaboration is vital to nurturing the triangle of care and aiding the therapeutic process:

It really aids the situation... I can concentrate on doing my job without the added challenge, and I think that preparation makes the situation as easy or natural as possible for the client, which helps them bond with the clinician better. (Paula, p.4)

Notice the use of the word ‘natural’: collaboration can lead to familiarity, which assists the development of relationships and therapeutic outcomes. Sally shared how a lack of collaboration impacts on dynamics: “... Things can feel very stilted. You're very aware of it and there's almost a kind of lack of flow between the three of you. It can really affect the dynamic... it doesn't feel as good or therapeutic” (p.4). Interpreting in a therapeutic environment is unlike interpreting in other fields; relationships developed can and do affect engagement with treatment and therapy outcomes. Sally further reflected on the difference a collaborative relationship has on the therapeutic process: “... it makes everything better. It even makes difficult conversations so much better” (p.4).

Karen’s experience of collaboration was largely negative: “My experience to date is overwhelmingly that we are not engaged with the clinician. No briefings or debriefings” (p.4). The purpose and benefit of preparation was emphasised: “... so that [you] understand what the clinician goals are... it’s vital to know where you are supposed to be pitching what you are seeing” (Tom, p.3). Preparation aids collaboration as it helps individuals share aims, as well as providing opportunity to notice and remedy therapeutic challenges:

I have a session coming up with psychometric tests, and I've actually met with the psychologist before and gone through the assessments. It gave me a chance to look at them and say that these will be really challenging and this is the reason why. (Paula, p.4)

Preparation allowed Paula to understand the clinician's session aims, and the clinician to learn that psychometric tests must be adapted for this group. Preparation aided collaboration, and subsequently the therapeutic process.

Alternatively, Fiona discussed reflecting on her own actions in order to be collaborative and assist the establishment of roles and nurturing of relationships:

I want to ensure I'm not intruding too much...if the Deaf person is discussing something difficult, I want them to engage with the psychologist so it feels like they are talking directly to them, rather than to me (p.5).

Interpreters reflected on the need for the client and clinician to develop rapport between themselves, and reflect on how to respond in order to assist this. They see collaboration as vital to the process, but indicate that clinicians do not seek to collaborate in the same way: "We can provide so much context, which would aid an assessment or the development of a relationship, but we are not always invited to share that... because they can't sign, they miss these enlightening things" (Sally, p.7). Interpreters not being utilised effectively can impact on collaboration and subsequently therapeutic relationships and outcomes.

Importance of continuity. Continuity is important to nurturing the triangle of care. In therapy, clients see the same clinician throughout their input; participants felt that continuity of interpreter was also important: "I think continuity of interpreter is important, but that's not always something that we have... I think we make a difference anywhere and

aid communication, but it's particularly important in health. It's people's lives" (Karen, p.3). However, barriers to continuity exist: "We get booked up... months in advance" (Fiona, p.5). Sally considered service pressures: "Increased pressure. Such a pressure...If someone is getting different interpreters...or the clinician is less thoughtful, it can feel much more clinical and less beneficial" (p.4). Lack of continuity can destabilize the triangle and development of therapeutic relationships, impacting on client outcomes.

Another barrier to continuity is the increase of BSL interpretation services being provided by other agencies: "various spoken language agencies are dealing with BSL because they have won contracts" (Fiona, p.3). There was a sense that BSL interpreting in therapeutic settings is not understood or valued: "people see BSL interpreting as a lucrative business, so you have competing non specialist agencies trying to win contracts...eroding the service we are able to provide" (Karen, p.3). Participants reflected on how they felt this influenced client care: "With an increase in interpreters, I've seen a decrease in standards" (Lucy, p.13). Concern regarding diminishing quality and mainstream services failing to understand the value of interpreter services in therapy was common: "It's often a lack of awareness...with mainstream services, they don't know what to ask for" (Katie, p.3). This reality further limits consistent, quality care being provided to deaf people.

Developing a shared understanding: "We are not just the voice over"

The second superordinate theme represented factors that can affect the development of shared understandings between those in the triangle of care, and subsequently the development of therapeutic relationships.

Understanding the interpreter role. Participants felt strongly that the interpreter should be viewed as a co-facilitator in therapeutic settings: "The idea of having us just come

in and translate and add nothing more seems absurd...” (Lucy, p.6). However, participants spoke of feeling like a hindrance to the therapeutic process. Karen emphasised how interpreters struggle to defend their role can influence relationships with other professionals:

To be fair we are still a young profession... a lot of interpreters have not come from an academic background. So a lot of us don't know how to speak about what we do... if an interpreter's not able to articulate what we do/why we do it/why we should be seen as part of the team rather than an add on, actually, it's quite difficult for other professionals to get their head around (p.3).

Karen highlighted two issues: clinicians not understanding the complexities of the interpreter role, and interpreters not feeling confident. Interpreters feeling unable to defend their role due to not coming from an 'academic background' emphasises the power imbalance that can occur within health services. Such power imbalance can affect clients as well as interpreters. She further considered how service and clinician perspectives need to change in order for things to improve:

See interpreters as part of the team from the get go... they can't treat someone without us... We are a necessary evil, and it would be good to see people embrace that more and see us as part of the team (p.11).

Clinicians feeling deskilled. Intrinsically linked to the concept of misunderstanding the interpreter role is the idea presented by interpreters of clinicians' feeling deskilled by their presence:

A clinician...can often feel a bit disempowered because there is you as the interpreter and a deaf person, who share this language that they have no access to. They are relying solely on your interpretation to do their job (Fiona, p.5).

It may be that some culturally informed beliefs about role and place in society may affect the development of therapeutic relationships. Rather than being viewed as a facilitator, participants felt that they are viewed as “...a hindrance... [The clinician] can’t speak directly to their patient and they have to rely on a third person. I think some people can feel very precious about that” (Katie, p.2). Paula similarly found:

Feeling deskilled is a problem; not because it is the reality, but because it can sometimes be the clinician’s perspective. Having that perspective doesn’t then encourage collaboration, or the desire to work with the interpreter (p.7).

Individuals must have awareness of how their perspectives and biases influence the therapeutic process. Tom alternatively felt that clinicians’ feeling deskilled may relate to their inability to conduct their role in the way they are accustomed: “...they have all this training and knowledge to treat and assess and they can’t deliver it in the way that they have been doing for years” (p.7). Interpreters shared their perspectives as to why they do not feel welcomed in the therapeutic process by clinicians; some considered the possibility of clinician threat or clinician’s feeling deskilled by the need to adapt practice. While these are only the opinions of these interpreter participants, they do introduce interesting points for consideration and discussion.

Lack of Deaf awareness. Participants discussed the impact of clinicians lacking Deaf awareness or experience with an interpreter. Some clinicians “assume that you know the deaf person...that you’re some kind of keeper for [them]” (Fiona, p.3). Such assumptions can make both the interpreter and client feel misunderstood, hindering the development of therapeutic relationships. Sally similarly recalled: “...the clinician assumed I was the deaf person’s carer or relative...there was no awareness of my role whatsoever with regards to me being a professional” (p.3). Alternatively, Fiona discussed encountering a clinician with

level 1 BSL who tried to ‘make sense’, rather than portray client truth, evidencing that “Sometimes people with a little bit of knowledge are as dangerous as those without...they bring their own assumptions” (p.3). Clinicians must be willing to seek knowledge of Deaf culture and working with interpreters, alongside a willingness and confidence to adapt their practice. Paula educated a clinician in session, in order to nurture the triangle of care:

I’ll ask them to speak directly to the deaf person and give their eye gaze to them... if [looking at interpreter] is done too much, that’s when the risk of the relationship not developing really grows. The client will see a relationship developing between the interpreter and clinician, rather than with them (p.7).

A lack of Deaf awareness can be detrimental to therapeutic relationships and participants discussed how reflection on their part aided awareness and encouraged adaptation. Tom discussed the need for clinicians to understand the challenge of interpreting psychometric tests which aren’t normed for the Deaf population:

They’re English based, for a hearing population... if the questions don’t make a lot of sense to the Deaf person, they’ll allow me to move it round so it’s got a Deaf cultural slant on it, so they’ll still get the right response (p.5).

Working with a clinician who has an understanding of the need for adaptation makes the interpreter role easier. Interpreters’ insight can also be beneficial to clinicians’ awareness. Katie had a conversation with a clinical psychologist regarding psychometrics, “they’re not appropriate for deaf people. So as an interpreter, I have to turn round and say, well you can ask that question, but it won’t really work” (p.2). Deaf awareness, strong clinical skills and the confidence to adapt practice aids the development of shared understandings and stronger therapeutic relationships.

Importance of interpreter support. The facilitative role of the interpreter in the triangle of care was clearly defined; they channel and communicate dialogue, emotion and meaning. Participants discussed switching off from their own thoughts and emotions in the moment, though this appeared to sometimes be a challenge: “Our work is so varied. So you can plan as much as possible, but...things crop up that you don’t expect” (Fiona, p.2). Sally considered the impact on interpreters when they channel distressing content:

You’ve got to think about things like vicarious trauma... you can be in a situation where the deaf person has gone through a trauma, and so that can affect you. You never know until you go into the first appointment what it’s going to be (p.3).

Interpreters can undergo a double trauma as they watch a client ‘act out’ their trauma via BSL, and must then interpret that for the clinician. The role merits clinical supervision; however, provision of such support is not mandatory. Participant discussed seeking peer supervision: “...we talk about the language side of stuff, rather than the emotional or psychological impact of the work...we don’t know about that” (Paula, p.3). While they can consider the mechanisms of their role, there are emotional aspects with which they need support to explore. As noted by Katie, “...in a normal team, a clinician could just debrief to a colleague, however, we are often just left and have no one to share with” (Katie, p.6). Karen similarly felt: “...we are privy to some disturbing disclosures... There’s nowhere to put that when you get it” (p.11).

Participants discussed the benefit of receiving supervision from psychology colleagues. A clinical psychologist noticed that Sally required a space to explore the impact of her work: “[The client] started getting very upset, then so did I, and the psychologist involved said that they would talk to my employer, to set up space so that I could be properly supported. That was amazing!” (p.4). Her colleague noticing her need for support

highlights the positive impact of collaboration on therapeutic relationships. Paula similarly had a psychology colleague notice her need for support: “The stuff that’s going through me can be quite challenging, and that was brilliant that she recognised that this could have an impact on me, and therefore the interpreting and work” (p.2). Paula’s point is incredibly important; interpreters must be well supported so that they are fit to practice and not at risk of burnout. Otherwise, there may likely be a negative impact on therapeutic relationships and outcomes.

Discussion

Findings illustrated the complexity of the therapeutic process. Results demonstrated two superordinate themes: Nurturing the triangle of care and developing a shared understanding. The therapeutic process relies on communication, collaboration and trust from all individuals, and it is important for those in the triangle of care to develop shared understandings in order for relationships to thrive.

Nurturing the triangle of care

Although the communication of language relies on the interpreter, results highlighted that the communication of emotions such as compassion was a collaborative process in the form of ‘a triangle of care’. The concept of triangles in mental health care has previously been applied in bipolar disorder (Chatzidamianos et al., 2015), psychosis (Burbach, 2016), and immigrants (Falicov, 2007). However, the nature of the triangle here differs from the traditional client, clinician and relative structure, instead including the interpreter as an important contributor to the therapeutic process. Had relations been involved in the triangle (as is the expectation for hearing people), sessions would become group therapy. Therefore,

the triangle of care is unique in this setting, and highlights the different processes from the hearing population.

Compassion is the feeling that arises in witnessing another's suffering, and the subsequent desire we feel to help (Goetz et al., 2010). Results evidenced the collaborative communication of compassion in the triangle, and indicated that concepts and processes operating within hearing populations cannot be directly applied to deaf populations. Results evidenced that compassion can be communicated without touch and voice, which are considered key factors in hearing literature. Results highlight the importance of research, to understand therapeutic processes for deaf people and how these differ from the hearing population. Research can then aid the adaptation of services to meet client need.

Achieving a power balanced mental health service relies on collaboration, communication and equal partnership (Amering, Mikus and Steffan, 2012). Interpreters are an imperative part of the triangle of care for deaf people. Comprehension of both linguistic and non-verbal utterances are salient to prognosis (Zimanyi, 2012, p.108). It is therefore vital that clinicians engage with interpreters to gain a comprehensive picture. Effective communication with the client also requires the interpreter's input on how the client is communicating (Glickman, 2007). It is for such reasons that collaborative approaches are advocated (Mudakiri, 2003; De Bruin & Brugmans, 2006). Literature from the hearing population however has evidenced that although collaboration is encouraged in mental health settings, it does not regularly occur (Quealy-Berge & Caldwell, 2004; Fredheim, Danbolt, Haavet, Kjongsberg & Lein, 2011). Hearing literature has previously explored barriers to collaboration, considering professional attitudes and service obstacles (Chatzidamianos et al., 2015). However, no such research exists for the deaf. A gap in

literature therefore exists, and future research could explore barriers to collaboration in order to facilitate positive change.

Participants considered whether clinicians potentially feeling deskilled was in response to the interpreter presence, or change to the usual therapeutic process. Clinicians working with spoken language interpreters can feel powerless, feeling detached from a process they usually feel central to (Raval, 1996). It was felt in the results that clinicians were uneasy with the dynamics of a triangle of care and the need to adapt practice. This links to Pollard's (1994) explanation that clinicians do not use their full range of skills when working with deaf clients. Clinicians feeling confused or threatened in their role can be a potential threat to the therapeutic alliance (Cornes and Napier, 2005). Boness (2017) considered how psychologists may feel deskilled when working with a deaf client or interpreter. She emphasised the professional's ethical obligation to collaborate and adapt practice, but to also understand the role of the interpreter. Future research could investigate the issue of clinicians feeling deskilled in this process further, and how this influences therapeutic relationships.

Results emphasised that shared understandings of roles can aid collaboration. Preparation was considered key; it allowed interpreters to clarify their role which subsequently decreased clinician threat. It also provided clarification of the clinician role and aims. BSL interpreter best practice guidelines highlight briefing and debriefing with clinicians as vital, and facilitative to collaboration (ASLI, 2014). Interpreters are not only participants in communication, they wield considerable power to influence discourse (Metzger, 1995). Their contributions can be vital, and aid the progress of the therapeutic process. Leanza et al. (2014) stated that collaboration through mutual trust, understanding of role and how each individual contributes to each therapeutic task aids the development of

therapeutic relationships and evidences the value of the interpreter in the clinical team. Current results evidenced that such collaboration does not routinely occur in mainstream mental health services. Services must integrate interpreters into the clinical team and encourage contact, in order to develop understanding and working relationships.

Hearing literature has evidenced the value of continuity on outcomes in mental health settings (Hoertel, Limosin & Leleu, 2014; Newman, O'Reilly, Lee & Kennedy, 2015), and the research also identified continuity as influential to therapeutic relationships. However, the current study identified two prominent barriers to continuity: access to interpreters and a lack of quality assurance procedures. Interpreting in the mental health field is particularly challenging due to the communication of often complex information in an emotionally charged setting (RID, 2007). There is growing understanding of the influence of the interpreter's presence on the development and dynamics of therapeutic relationships. Literature evidences the need for continuity, and the impact it can have on both therapeutic relationships and patient outcomes. Although the NHS has produced principles emphasising the need for high quality interpretation, accessibility and timeliness (NHS, 2017), there are still issues with continuity and quality. The NHS is ultimately responsible for maintaining quality, even when interpreting contracts are outsourced. In house interpreters report directly to the NHS and are required to comply with rules as other members of staff do. Therefore, the current research raises the consideration that if the NHS formally recognises interpreters' contribution to the clinical process, which they cannot dispute, as evidenced by this and previous research, they must train them specifically and have them as equal partners in care.

Developing a shared understanding

A lack of deaf awareness was identified as a barrier to the development of therapeutic relationships. Leigh (2009) stated that therapists must have an awareness of cultural factors when working with deaf individuals. However, few professionals working in mainstream services understand deaf culture and history. Deaf clients are primarily assessed and treated in services designed for hearing clients and dominated by hearing professionals (Pollard, 1994; Glickman, 2007; Landsberger & Diaz, 2010). Only three participants in the research had worked alongside a Deaf clinician and all had varied experience of working with clinicians lacking Deaf awareness. Training for services and clinicians could be beneficial, but may be difficult to implement. Tribe and Thompson (2008) noted that even if training is not provided by their service, clinical psychologists should be seeking to continually learn and develop confidence through their continued professional development. Action on Hearing Loss (2016) have developed information sheets that can be easily disseminated, to improve service knowledge. Similarly, Gentili and Holwell (2017) developed an education module providing clinicians with an understanding of working with deaf people, and such resources could be easily utilised by mainstream services. Participants felt that deaf people do not expect perfection, but rather value a clinician and service who are aware of the limitations of their knowledge, and actively try to improve that.

Although deaf clients report greatest satisfaction with the clinical experience when a clinician can sign (Steinberg, Wiggins, Bermada & Sullivan, 2002), this is unlikely to occur in mainstream mental health services. Steinberg et al. (2002) emphasised that clinicians showing willingness to collaborate and educate themselves will reduce barriers to therapeutic relationships. A means of achieving this would be to involve deaf people and interpreters in service development, improvement and evaluation. Simpson and House

(2002) conducted a systematic review regarding user involvement in the development and evaluation of mental health services. They found that clients trusted services more and were more satisfied with the care received, while clinicians developed more positive attitudes towards the clients. Involving deaf clients in service development could therefore be beneficial in identifying their communicative preferences, evidencing the need for interpreters and improving collaboration and working relationships.

The final key finding from this research was the need for interpreters to be supported in their role. Dean and Pollard (2001; 2013) theorised that the interpreter role exists in a high demand and low control environment, leading to high levels of strain. Stressful environments increase the chance of burnout and research has linked burnout to heavy workload and limited support (Deville, Wright & Varker, 2009). These theories identify interpreters as high risk for experiencing burnout, and a group who could benefit from professional supervision. Participants felt that current supervision structures are not meeting interpreters' needs in helping them process both the technical aspects of their role, and the highly emotional content of their work. Participants in the current research considered the potential for such supervision to be facilitated by other clinicians, such as psychologists that the interpreters are working with. However, although such supervision may provide an appropriate space to explore the emotional content of the work, the interpreter would have to seek other supervision to consider technical aspects of their role.

Alternatively, there is therefore a growing body of literature that advocates for supervision for interpreters being conducted by interpreters. This would allow for interpreters to receive supervision around all aspects of their role at once. A framework to facilitate supervision and interpreter training has been developed by Dean and Pollard (2001), known as the Demand Control Schema. This framework highlights the spectrum of challenges in

interpreting work, encouraging the interpreter to learn and reflect upon how factors within their working environment affect them, their clients, and translations. 'Demands' of the role can be split into four categories: environmental, interpersonal, paralinguistic and intrapersonal. Use of such a framework in supervision would encompass the various challenges of the interpreter role, and allow them a space to reflect upon and learn from their experiences.

Literature from Dean and Pollard (2005; 2008) has emphasised the need for interpreters to be viewed as a practice profession, in order to recognise the importance of supporting them in the technical, interpersonal and intrapersonal aspects of their role. The interpreter role has technical aspects such as bilingualism and cultural knowledge, which is supplemented by the relational ability of the individual to develop relationships and make complex, social assessments and judgements (Pollard & Dean, 2008). As such, it would be beneficial for interpreters to receive comprehensive supervision, to assist them in fully understanding and fulfilling their role.

As stated by ASLI (2016) however, professional supervision is a relatively new concept for interpreters, and not mandatory. With regard to mental health clinicians, clinical psychologists particularly understand the benefit and influence of supervision (BPS, 2010), as it is key to the fulfilment of their role in an ethical manner. The profession is in a prime position within the NHS to advocate for the importance of clinical supervision for interpreters. In the absence of this, interpreters could be impacted by the work, and require formal support from the NHS, which puts additional strain on services. Clinical psychologists can also understand and highlight the benefit of supervision being conducted within the profession, to ensure that the supervisee is comprehensively supported in all aspects of their

role. Ensuring interpreters are supported via supervision will also benefit the development of therapeutic relationships and the therapeutic process.

Clinical Implications

This research has clinical relevance to therapeutic professionals in mental health settings, such as clinical psychologists. Clinicians may struggle with the adjustment and change associated with a triangle rather than dyad therapeutic relationship. Practitioner guidelines (HCPC, 2010) note that clinical psychologists must be able to work in partnership with other professionals for the needs of the client. Collaborative working may be an important factor in providing quality care for clients, inviting interpreters to be part of the therapeutic process and valuing their contributions alongside clinician skills. Li et al., (2017) noted that current guidance for working with interpreters tends to relegate the interpreter to the side-lines, rather than establishing them as an integral part of the process. The current study emphasised the importance of developing a triangle of care, with equal partnership amongst all individuals. Results from this study therefore provide evidence for the need to change guidance and establish the triangle of care as a viable and important process.

A key skill of clinical psychologists irrespective of the hearing status of their clients is formulation (British Psychological Society, 2014): an ability to integrate information to form an understanding of a client. Future research could explore how the process of formulation is completed in therapeutic work with deaf clients, and how much collaboration there is between the triangle of care in this process. Clinical psychologists need to understand clients' context and history to develop a representative formulation that can direct intervention. There must therefore be consideration with regard to how interpreters may facilitate this process. Interpreters are not merely 'mirror like language conduits' (Leigh & Pollard, 2011, p.217), but act as a bridge between cultures, assist understanding

and the development of relationships. Clinical psychologists should therefore consider their awareness of resources that will aid their work, and seek to utilise them.

Results also emphasised that clinical psychologists and other clinicians working therapeutically must seek to engage both clients and interpreters in the therapeutic process, working collaboratively and flexibly, to improve outcomes for deaf clients. Training for the profession prepares clinical psychologists to be proficient in different approaches, eclectic, flexible and client focused. Literature has explored the possibility of adapting approaches such as Dialectical Behavioural Therapy (DBT) for the Deaf population (O'Hearn, Pollard & Haynes, 2010), who can be at higher risk of suicidal ideation and personality difficulties. This approach seeks to facilitate ideological, behavioural, cognitive and emotional change, alongside encouraging acceptance. Their research noted that therapies can rely upon written materials and procedures, and described how such an approach can be adapted for this population through collaboration, consideration of client need and language nuances. Given the interpreters' substantial and rather undocumented participation in clinical practice, their involvement in the production of therapeutic materials and procedures could illuminate aspects of the clients' experience that are not readily available from other sources. It is therefore important for clinicians, clients and interpreters to work together, as such collaboration can aid adaptation and lead to more effective interventions and positive outcomes for deaf people.

Clinical psychologists value supervision as it ensures they are fit to practice and support clients (BPS, 2011). Findings identified that interpreters are asked to be part of the therapeutic process and hold and communicate emotional and challenging content without mandatory supervision. This not only puts the interpreter at risk, but could negatively impact on therapeutic relationships and client outcomes. Sign language interpretation is a

relatively new profession and therefore still fighting to evidence its value and establish its boundaries. Clinical psychologists could use their position to advocate for the importance of clinical supervision for all professionals engaged in this line of work, and support interpreters to gain the support they require in order to fulfil their role, using the potential impact on therapeutic relationships as a motivation.

Study Limitations and future research

IPA generally recruits small, homogenous samples (Smith et al., 2009). The current study's seven participants is an acceptable, albeit small sample. The recruitment strategy was comprehensive; it provided positive results early in recruitment, but attracted fewer participants as time progressed. Figures estimate the number of qualified BSL interpreters in the UK at around 800 (Murray, 2013). The inclusion criteria of having mental health interpreting experience may have made the recruitment pool considerably smaller.

The current research only gathered accounts from one part of the triangle of care. Lack of funding and challenges gaining ethical approval meant that accounts of deaf clients and hearing clinicians could not be gathered. Similar qualitative research could be conducted with these groups separately, to gather their experiences of therapeutic relationships. Results could then be triangulated and analysed. Alternatively, a longitudinal study could be conducted following the development of therapeutic relationships through a course of therapy with a clinician, client and interpreter. Session recordings could be analysed, alongside qualitative accounts from participants. This would allow a researcher to analyse the development of therapeutic relationships in action. It would also identify prominent facilitators and barriers to therapeutic relationships. It is acknowledged that this could be very difficult to organise, and would need consideration regarding how to minimise bias or influence. Such research could also have clinical implications for

interpreters, indicating whether it would be beneficial for them to have a mental health component in their training to aid their ability to work in this field.

Conclusion

The aim of this study was to gain an understanding of the BSL interpreter role in the development of therapeutic relationships, facilitative and disruptive factors, and how compassion is communicated. Results evidenced the potential for a triangle of care: a therapeutic relationship between client, clinician and interpreter. Collaboration, trust and continuity facilitate this triangle, whereas lack of Deaf awareness, role disclarity and clinician threat are barriers. Discussion considered service and professional implications, with reference to existing theory and literature. Interpreters have a unique role in the development of therapeutic relationships, and research has rarely before sought their perspectives. It is hoped that this study has contributed to the evidence base, and encouraged future research and discussion in the area.

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Tables

Table 1. Participant Demographics

Pseudonym	Gender	Years Qualified	Motivation	Experience: Mainstream/ Specialist
Fiona	F	15 years	Previous degree in linguistics	Mainly Specialist
Paula	F	10 years	Father worked with deaf individuals	Mainstream only
Tom	M	15 years	Interest in languages. BSL felt like second nature	Mainly Specialist
Lucy	F	16 years	Child of Deaf Adults (CODA)	Mainstream only
Sally	F	3 years	Night classes	Mainly Mainstream
Karen	F	16 years	Hearing problems as a child – interest in Deafness	Mainly Mainstream
Katie	F	10 years	Night Classes	Mainly Specialist

Table 2. Example of topics and prompts in topic guide

Interview Topic Guide	
Topics	Prompts
Introduction	I would like to ask you some questions about your experiences of being a BSL interpreter for a Deaf client accessing mental health services
Motivation and experience	What motivated you to become an interpreter? What is the biggest challenges of your role? What are the differences between work in mainstream and specialist services?
Therapeutic relationship	Can you tell me about your role in developing therapeutic relationships? Are you part of that relationship? What do you think is the hardest aspect of the three way communication for the client? Does your role change as therapy/input progresses?
Compassion	What do you think compassion means? Is this something you see/gain a sense of through the communications of a client and clinician? How can compassion be communicated in this situation? What do you feel your role is?
Looking to the future	What do you feel are the important factors in developing positive therapeutic relationships? How do you see the role of the interpreter changing in the future? Does it need to change? What can be learned from current experiences, in order to improve provision of care in the future?

Table 3. Superordinate and subordinate themes

Superordinate Themes	Sub ordinate Themes
“WE WERE AN EQUAL TRIAD”	Communication
Nurturing a triangle of care	Trust and Balance of Power
	Importance of Continuity
	Collaboration
“WE ARE NOT JUST THE VOICE OVER”	Understanding the interpreter role
Developing a shared understanding	Clinicians feeling deskilled
	Lack of Deaf awareness
	Importance of supporting interpreters

Appendices

Appendix A: Example of coding process for excerpt of Paula's transcript

Notes/ Interpretations	Transcript	Emerging Themes
Disclarity of role Reflecting on interpreters need 'going through me' Impact on interpreter = impact on work	P: I've also done lots of therapeutic work. Ongoing work, though I'm not always sure what/who the clinician was...clinical, or... I do particularly remember though a psychologist once at the end of a session saying to me that if I needed supervision, or a space to discuss the work content, to come to her. That was brilliant. The stuff that's going through me can be quite challenging, and that was brilliant that she recognised that this could have an impact on me, and therefore the interpreting and work. R: Am I right in thinking that you appreciated their reflection that you need to take care of yourself in order to do a good job?	Communication – complex process Importance of interpreter support
Development of rapport – keeping each other in mind	P: Yeah, that's right. I think that's the first time a professional had taken my...the impact on me into consideration. I thought that was really nice and it helped our rapport, as she was thinking of me as well.	Willingness to collaborate
Lack of preparation – impact on relationships	There have been other times though where that hasn't happened. A time when I didn't actually get prep or support was for a learning disability assessment I think. I went in and a lot of it I had to pause and ask what that meant or was for, the aims of that. And I think the lack of preparedness and hesitation impacted on the development of rapport between the client, clinician and me. I've had other experiences of being called on to the ward to interpret for someone being kept there. I had never met this person, didn't know their communication style or anything. Luckily they had a support worker who was able to give me some information, but even then, it was still really challenging because it was unpredictable. R: And do you feel that the unpredictability is a challenge of the work?	Lack of deaf awareness
Importance of context Awareness 'don't know what you're	P: Yes, definitely. You don't know what you're going into. Real lack of prep, and going into those scenarios can be practically, emotionally, linguistically challenging. When I started, I think I was naive and just thought about the language I would be translating.	Importance of interpreter support – impact of

going into' – added challenge of unknown	But it's much more than that, and you need to know that you will be able to deal with whatever you are going into. Not just for your sake, but the client and professional because you are the key to communication.	session content Communication
Interpreter plays key role in communication	R: Are there opportunities for you to seek supervision; from either other interpreters, or the clinicians/team you are working with?	
Lack of supervision r.e. emotional impact of work	P: Yeah, I think there is some research being done on this. We do sort of have peer supervision which can be quite helpful and I can go to my manager, and we have group supervision, with two nurses. They are all really helpful. I think with peer supervision though we talk about the language side of stuff, rather than the emotional or psychological impact of the work because we don't really know about that. We'd need someone to guide us a bit I suppose. It's only recently that people have started to talk about the job being difficult. It's not until you start stripping back your role in the room and you realise how much responsibility you have and what you take on, from both sides.	Importance of interpreter support - current processes not
Reflection on role		
Learning about therapeutic processes – reflection	R: Yeah, that makes sense. P: I mean, I've only started to learn about transference. Although i wouldn't recognise that is what happens when I'm sitting in a room, it's useful to think about afterwards and why certain feelings may have been present in the room or relationship. R: So there's something about reflecting on the process of communication in these situations, your role within that, and how everything influences one another? P: Exactly. I think that is a part missing from our training; it focused mainly on the language. It could have changed since I trained, but when you talk to other interpreters, we're all feeling the same things. R: Yes, and there's something to be said for needing support in order to do our job well. So in terms of understanding how to develop good therapeutic relationships, it sounds like greater consideration needs to be given to the interpreter in the relationship and their role.	Collaboration
Mental health training for interpreters?		
Vulnerable position for interpreter?		Communication Importance of interpreter

Appendix B: Final themes identified in the analysis with brief illustrative quotes

Superordinate and subordinate themes	Illustrative Quote(s)	Source
<i>Developing the triangle of care</i>	It's no longer just understanding sign but interpreting it into English. There's not always word for sign, sign for word equivalent. You're having to work on context and meaning, so that can be really challenging.	Paula, p.2
Communication (7)		
Trust and the balance of power (5)	Trust is hugely important and goes in all directions.	Lucy, p.4
Willingness to collaborate (7)	[A professional] who really understands your role as an interpreter. You come into the booking feeling well informed and you're put into the picture before anything starts.	Fiona, p.3
Importance of continuity (6)	I think it's important to have consistency and regularity...I prefer working more long term and continuously with a person, and you're involved as part of the care. It's not about 'helping', but making sure that they have access to ongoing care. I think continuity of interpreter is important, but that's not always something that we have.	Karen, p.3
<i>Developing a shared understanding</i>		
Understanding the interpreter role (7)	I'm there for language, to communicate. Cultural mediation, big time. A lot of guiding the clinician. It's not just about interpreting; there is so much more...	Katie, p.4
Clinicians feeling deskilled (7)	Being deskilled, or feeling deskilled. That they have all this training and knowledge to treat and assess and they can't deliver it in the way that they have been doing for years.	Tom, p.7
Lack of Deaf awareness (7)		
Supporting interpreters (5)	I mean in a normal team, a clinician could just debrief to a colleague, however, we are often just left and have no one to share with.	Katie, p.6

Appendix C: Notes for Contributors for the target journal: Journal of Clinical Psychology

Manuscript Preparation

Format. Manuscripts should contain each of the following elements in sequence: 1) Title page 2) Abstract 3) Text 4) Acknowledgments 5) References 6) Tables 7) Figures 8) Figure Legends 9) Permissions. Start each element on a new page. Because the *Journal of Clinical Psychology* utilizes an anonymous peer-review process, authors' names and affiliations should appear ONLY on the title page of the manuscript. Please submit the title page as a separate document within the attachment to facilitate the anonymous peer review process.

Style. Please follow the stylistic guidelines detailed in the *Publication Manual of the American Psychological Association, Sixth Edition*, available from the American Psychological Association, Washington, D.C. *Webster's New World Dictionary of American English, 3rd College Edition*, is the accepted source for spelling. Define unusual abbreviations at the first mention in the text. The text should be written in a uniform style, and its contents as submitted for consideration should be deemed by the author to be final and suitable for publication.

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Abstract. Abstracts are required for research articles, review articles, commentaries, and notes from the field. A structured abstract is required and should be 150 words or less. The headings that are required are:

Objective(s): Succinctly state the reason, aims or hypotheses of the study.

Method (or Design): Describe the sample (including size, gender and average age), setting, and research design of the study.

Results: Succinctly report the results that pertain to the expressed objective(s).

Conclusions: State the important conclusions and implications of the findings.

In addition, for systematic reviews and meta-analyses the following headings can be used, Context; Objective; Methods (data sources, data extraction); Results; Conclusion. For Clinical reviews: Context; Methods (evidence acquisition); Results (evidence synthesis); Conclusion.

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Final Revised Manuscript. A final version of your accepted manuscript should be submitted electronically, using the instructions for electronic submission detailed above.

Artwork Files. Figures should be provided in separate high-resolution EPS or TIFF files and should not be embedded in a Word document for best quality reproduction in the printed publication. Journal quality reproduction will require gray scale and color files at resolutions yielding approximately 300 ppi. Bitmapped line art should be submitted at resolutions yielding 600-1200 ppi. These resolutions refer to the output size of the file; if you anticipate that your images will be enlarged or reduced, resolutions should be adjusted accordingly. All print reproduction requires files for full-color images to be in a CMYK color space. If possible, ICC or ColorSync profiles of your output device should accompany all digital image submissions. All illustration files should be in TIFF or EPS (with preview) formats.

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Article Types

- **Research Articles.** Research articles may include quantitative or qualitative investigations, or single-case research. They should contain Introduction,

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- **Commentaries.** Occasionally, the editor will invite one or more individuals to write a commentary on a research report.
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Any possible conflict of interest, financial or otherwise, related to the submitted work must be clearly indicated in the manuscript and in a cover letter accompanying the submission.

Research performed on human participants must be accompanied by a statement of compliance with the Code of Ethics of the World Medical Association (Declaration of Helsinki) and the standards established by the author's Institutional Review Board and granting agency. Informed consent statements, if applicable, should be included with the manuscript stating that informed consent was obtained from the research participants after the nature of the experimental procedures was explained.

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Section Three:

Critical Appraisal

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Trainee Clinical Psychologist

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The aim of this critical appraisal is to reflect on the process of conducting the research project presented in section two of the current thesis. I will firstly consider how I chose the research topic, and the importance of reflexivity in qualitative research. I will consider my reflections on the research process and results, alongside the study's strengths and limitations. Finally, I will summarise the outcomes of this research and consider how future research can advance understanding in this field, in order to improve outcomes for deaf individuals.

The research aimed to explore BSL interpreters' perspectives on compassion and the development of the therapeutic alliance between a clinician and deaf client. My interest in this field stemmed from the completion of my Learning Disability placement during clinical psychology training. Working with this client group emphasised the importance of being able to adapt clinical practice, communicate effectively, and continually develop knowledge in order to work with vulnerable and marginalised groups. These lessons related to the HCPC standards of proficiency for practitioner psychologists (2015). While my placement experience aided my understanding of adapting practice for the Learning Disability population, it led me to reflect that we had not received teaching around working with other disabilities or sensory impairments. I became particularly interested in how a clinical psychologist would work with deaf individuals. A literature search highlighted this group as a marginalised minority who struggle to access mental health services (Keunberg, Fellingner & Fellingner, 2016). Literature indicated that those in the Deaf community have their own cultural identity and communicate in BSL (British Deaf Association, 2015). In order to engage in psychological therapy, a BSL interpreter is often required to facilitate communication between hearing clinicians who do not sign and deaf clients who do (Sign Health, 2015). I was interested in exploring how the presence of a third person in the therapeutic process influenced both the development of therapeutic alliances and the communication of compassion, both of which are vital components to successful

psychological intervention and positive outcomes (Ardito & Rabellino, 2011; Wampold, 2015). I felt this research would strengthen the evidence base for the need to adapt and improve services for deaf clients, including understanding and valuing the role of the interpreter. I also viewed it as a learning opportunity, to better understand this client group, the role of the BSL interpreter, and how to adapt my clinical practice to meet client need and encourage positive outcomes.

In order to gain a comprehensive understanding of how interpreters influence the development of therapeutic relationships, it was imperative to gather the accounts of interpreters themselves. Llewellyn-Jones and Lee (2013) noted that 'Interpreters are present in interactions to allow people who do not share a language to interact effectively' (p.57). Their role is unique, and their perspectives on facilitators and barriers to therapeutic relationships are vital. Previous literature has focused on perspectives of clients and clinicians regarding what influences accessibility to mental health support. Results from these studies, as synthesised in section one of the current thesis, emphasised the importance of the interpreter's presence, in order to improve accessibility and communication between client and clinician. I felt that gaining the experiences of interpreters would provide the greatest insight into this process, and sought their accounts by conducting semi-structured interviews. Data was analysed using Interpretative Phenomenological Analysis (IPA), which has an idiographic focus (Larkin & Thompson, 2012). I felt this was the most appropriate approach for this research because I sought to understand how interpreters make sense of and understand their role in the context of a mental health setting.

Research results evidenced that interpreters have a vital role in mental health settings. Their role should exist within a 'triangle of care', in which the client, clinician, and interpreter are equal contributors to the therapeutic process. This 'equal contribution' was

understood as all individuals aligning equally and working together, to make communication and the therapeutic process as natural as possible. The concept of the triangle of care concurred with research stating that an expectation of interpreter impartiality and neutrality in the therapeutic process is unrealistic (Hale, 2007). Equality of alignment should instead be encouraged, and can be facilitated through collaboration. Collaboration was identified as a key concept to both the development of therapeutic relationships and the communication of compassion. Continuity and trust facilitated the triangle, while clinicians' lack of Deaf awareness, disclarity of role and perceived threat to control were identified as barriers to the therapeutic relationship. Understanding each individual's role and adapting practice appropriately facilitated the triangle of care, leading to a triadic communication event where there is a shared situation and shared construction of meaning (Llewellyn-Jones & Lee, 2013). The outcome of this is the development of rapport and therapeutic relationships between all individuals. The study concluded that professionals such as clinical psychologists need to understand and value the interpreter role in providing therapeutic interventions. Without interpreters, clinicians cannot fulfil their role. All individuals must therefore be valued for the contribution they make to the therapeutic process and be willing to work together, in order to encourage positive outcomes for deaf individuals.

Reflexivity in qualitative research

Reflexivity is the awareness of how the research process and outcomes are influenced by the researcher (Haynes, 2012). Reflexivity is important in qualitative research, as all aspects of the research process are influenced by the researcher. As stated by Alvesson and Skoldberg (2000), interpretation and reflection are two key elements embedded in reflexive research. I felt that being reflexive throughout the research process was important due to the qualitative

nature of the thesis. I therefore kept a reflective journal, to remain aware of potential biases or influences on the research.

Reflections on the use of interviews for data collection

In designing my research project, I chose to interview BSL interpreters about their experiences. Interviews were conducted over telephone or Skype, due to the geographical spread of the participant pool. Participants felt these methods suited them, as it allowed the interview to be conducted outside working hours and from the location of their choosing. However, I noted in my reflective journal that although I had sought interpreter feedback on my recruitment materials, I had chosen the research design without their insight. At the beginning of the research I understood BSL to be a visual language, using gesture, facial expression and body language (British Sign, 2017). However, I had not considered whether it would be beneficial to be in the same room as participants. I conducted the majority of interviews via Skype, and noticed that participants would often sign alongside their speech, or visually demonstrate examples. As noted by a participant in the research, “some things just can’t be said in English”. On reflection, my lack of Deaf awareness and understanding of the complexities of BSL meant that I had not considered that seeing the participant when they were providing their accounts may have provided useful insight. The experience reflected a pertinent issue identified in my research: that interpreters’ insight was not being valued, and not being included in therapeutic/research processes from the beginning. It made me reflect upon the need to seek the expertise of the desired participant group in the research design stage, even in choosing the data collection method. In this case, however, I do not feel the research suffered as a result. My flexible and collaborative data collection allowed me to gather representative and comprehensive accounts.

The decision to conduct semi-structured interviews with participants was considered in my reflective journal. I was aware of the potential power dynamics in an interview setting and how my aims and biases could influence data collection. I defined the interview purpose, topic guide, posed questions, explored concepts and terminated the conversation. There was the potential for an asymmetrical power relation, as the interview is primarily a one way dialogue. As the interviewer, I also held the monopoly of interpretation; I transcribed and analysed the data, reporting my understanding of how the participants understood their experience. Kvale (2003) considered methods of minimising interview power dynamics, including the 'platonic' interview where both interviewer and interviewee engage in discussion, asking questions and exploring concepts. On reflection, I feel I encouraged this approach in my interviews. I minimised my power by sharing my background and purpose with participants; I shared that I was relatively new to the field and sought their perspectives not only to illustrate a phenomenon, but also to aid my own understanding and knowledge. I encouraged participants to object, question or seek clarification if this was required. Latours (2000) indicated that this 'agnostic' approach encourages objectivity, by allowing 'objects to object'. The interview process was a strength of the research; my approach encouraged multifaceted discussion which led to a more collaborative and positive research experience.

Reflections on focusing on the interpreter perspective

Studies that are too ambitious in design or scope are more likely to fail (Dawson, 2009). Deciding that the research would seek the perspectives of interpreters therefore was felt to be a realistic and achievable choice. I had initially thought that gathering the experiences of all individuals involved in the triangle of care would be beneficial and would provide a comprehensive account of the therapeutic process. However, this was not feasible to

complete in the thesis process timeframe. There were also barriers that limited accessibility to deaf clients. As an individual who cannot sign, I would have required a BSL interpreter to assist me in interviewing deaf clients. My experience mirrored that of deaf people accessing services: I was unable to communicate with a group and therefore disadvantaged without an interpreter. The cost of acquiring an interpreter and challenges with arranging interviews to suit the availability of all individuals were barriers too considerable to overcome. I therefore influenced the study design since my inability to sign alienated the Deaf population as participants, without assistance from an interpreter. One of my supervisors is fluent in BSL, and so in an experiential setting we could have simulated supervision in which he only signed to me and I had to understand, learn and make progress. The implications, however, are considerable; although I was able to exclude this group for research purposes, they must continue to live with this challenge in communication.

Young and Hurt (2011) considered how to engage deaf individuals in research and noted that when a researcher cannot sign well enough, or at all, an interpreter is often required. However, they considered how the interview process could be disrupted by the presence of an interpreter. Their research emphasised the need for communicative flexibility and understanding of literacy, to successfully engage deaf individuals in research. The empirical paper discussed that future research could further understanding of the triangle of care by conducting research with clients, clinicians and interpreters. A longitudinal study which follows the therapeutic process between a client, clinician and interpreter could provide further insight into the development of therapeutic relationships and communication in this process. Reflection on the current thesis emphasises that in order for such research to be developed, there would need to be considerable thought regarding research design, data collection and analysis.

A brief literature search indicated that research rarely focuses solely on the perspective of the interpreter. Despite their important role, they are often perceived only as a communicative device and their opinions and experiences are overlooked. Research has been conducted exploring working with interpreters in mental health settings from the perspective of the hearing clinician (Waddell, 2016). Research has also explored the experiences of deaf individuals seeking support in mental health services (Steinberg, Sullivan & Loew, 1998), and how the perception of Deaf culture and the individual is influenced through the interpretation process (Napier, Young, Oram & Skinner, 2016). This research therefore sought to address inequality by focusing only on the experiences of the interpreters. I felt that this research would provide insight into the therapeutic process from the perspective of the interpreter, further developing the research field, and evidencing the need for education, understanding and service development.

The research recruited seven participants which, although is a small sample, is reasonable for IPA. The participant pool was limited; The National Registers of Communication Professionals working with Deaf and Deafblind People (NRCPD) reported around 1100 registered and trainee interpreters in the UK in recent years (BDA, 2017). Seeking those with experience working in mental health settings made the participant pool much smaller. I recognised that I entered this research as an outsider to the Deaf community, and so I attended a specialist unit to gain experience meeting deaf clients and interpreters prior to the recruitment phase. During recruitment, I reached out to the NRCPD, ALSI and fellow researchers in the field. However, if I was to conduct the research again, I would endeavour to build those links at an earlier stage as I could have utilised the expertise of these organisations and individuals more, to aid with research design and recruitment.

Reflections on results and implications for clinical psychology

The results of the empirical paper highlighted the importance of the interpreter role in facilitating communication and the development of therapeutic relationships. A key theme was the importance of collaboration, and the potential uncertainty of some clinicians to partake in this. On reflection, there was a sense through the research that interpreters felt that clinicians and services do not understand their role. Interpreters are crucial members of the professional team in mental health service delivery (Militec et al., 2006). Not only do they communicate between two languages, but they bridge the gap between different cultures and backgrounds (Dean & Pollard, 2005). Guidelines have been developed to assist clinicians with developing a greater understanding of the interpreter role and how to work with them, to make the therapeutic process easier for the client (Action on Hearing Loss, 2016). Emphasised in those guidelines is the need for preparation before a session: clinicians and interpreters having a discussion before a session to understand aims, each other's roles and perspectives, and adapt the room setup to aid collaboration and alignment amongst individuals. I noted in my reflective journal that these steps seemed obvious, and wondered why there would be barriers to collaboration in this situation. The results of the empirical study provided evidence reinforcing the importance of reflexivity, highlighting how a clinician's biases and fears can impact collaboration and their work.

Clinician threat was a concept considered in the research paper, as participants identified it in their opinions, as a potential barrier to collaboration and the development of relationships. Guidelines focused on working with interpreters noted that being dependant on another person to conduct an aspect of your role could leave psychologists feeling anxious or excluded from interactions (BPS, 2008). It may also be that clinicians who lack experience working with deaf individuals experience 'Shock-withdrawal-paralysis' (Schlesinger &

Meadow, 1972, p.213), wherein they freeze, withdraw from a situation or act inappropriately due to their surprise or feelings of uncertainty with regards to how best to react. Pollard (1994) subsequently conducted a study which provided empirical data to support the concept of 'Shock-withdrawal-paralysis'; In Rochester, New York, there is a large Deaf and Hard of hearing (HH) population, and yet his research indicated that access to and quality of public health care for this population remains poor. It was also theorised that the incidence of shock-withdrawal-paralysis may actually be increased by local clinician's awareness of the complexities of assessing and communicating with a deaf person. I reflected that there could be several potential explanations for why clinicians appear to interpreters to feel uncertain about working together, or to adapt practice, and it may be that further research could explore this further. While literature has identified that clinicians with little experience of working with this population may find it challenging, this emphasises the importance of utilising the interpreters' presence and knowledge, to make the process as natural as possible for all individuals. A clinician who seeks to utilise the skills of the interpreter, introduce themselves and their role, and promotes the development of a mutually respectful and collaborative relationship (Militec et al., 2006) will gain better outcomes. The research identified that this stance may not be routinely achieved currently by clinicians or within services. Greater awareness of the implications that a lack of collaboration can have on outcomes, and greater understanding of roles may begin to change this for the better.

I felt that the empirical research was of considerable relevance to clinical psychology. I was supported to develop a study which would be beneficial to the research field, while also providing useful considerations for the clinical psychology field. A key component to any interaction, particularly a therapeutic interaction, is the development of rapport between individuals (Leach, 2005). Rapport and the subsequent development of therapeutic relationships between client and clinician are vital in psychological intervention. Research

has evidenced the influence that a good relationship can have on therapeutic outcomes, often being as influential as the psychological approach used (Lambert & Barley, 2001).

Psychologists therefore should be interested in how the presence of an interpreter may influence that rapport and the development of those relationships.

The empirical research evidenced that therapeutic relationships can develop in interpreter mediated communications, if all individuals are willing to engage and collaborate. Glickman and Harvey (2008) considered how the importance of using interpreters in work with the Deaf community is well documented, and the ability to work with them should be a core competency of therapists. This research made me reflect on the lack of Deaf awareness training and education regarding working with interpreters in current clinical psychology training, and more widely in mental health services. However, this is also relevant to a section of the hearing population who do not speak English and require interpreters to aid communication. Both groups are being inadequately served by current mainstream services. Issues must be highlighted and the importance of access and interpreters must be emphasised, particularly in a time where there is vast movement of populations across the globe. However, even if education is not provided, psychologists should seek to continually develop their skills (Tribe and Thompson, 2008). The experience of conducting this research made me reflect upon the fact that in order to fulfil our role, we need as much information and context as possible to aid our clinical decision making process. This includes educating ourselves and seeking the support of interpreter colleagues who can provide vital context to our interactions with clients. It is hoped that the thesis evidences the need for attitudes to change and improvements to be made at personal, professional and service levels.

A reflection from the empirical research was the need for interpreters working in mental health settings to have access to clinical supervision. Supervision is a strand of clinical governance for professions working within health services (Care Quality Commission, 2010). For clinical psychologists, it is a process of 'relationship-based education and training that is case-focused' (Milne, 2007). It is a vital process in our continued professional development, to aid learning, encourage reflexivity and support our psychological wellbeing. Research participants relied on peer supervision in lieu of clinical supervision. However, they identified that they required the support of a professional such as a clinical psychologist to reflect on the emotional impact of their work. Two research participants had received supervision from a clinical psychologist and found it beneficial. Interpreters 'hold' the pain of a deaf individual, as they see it communicated and must then mediate and communicate it to the clinician. Literature has explored the concept of 'vicarious trauma' in this profession: the experience of empathic pain in relation to the pain experienced by someone else (Harvey, 2003). Dealing with emotional content without appropriate supervision and support is not only risky for the interpreter, but can negatively impact the therapeutic processes they facilitate and relationships they are part of.

I reflected on the importance of clinical psychologists considering how to protect all those involved in the therapeutic process. As a highly banded professional in the NHS, the clinical psychologist role has a managerial aspect. They must advocate for interpreters to receive clinical supervision, and be willing to share their knowledge and skills in exploring emotional content in a safe space. Completing this thesis taught me that clinical psychologists working with deaf people in mental health settings have a responsibility not only to the client, but the systems around them, including interpreters and relatives. Clinical psychologists must be willing and able to adapt their communication styles and methods to include others in client care if this is appropriate or requested. Clinical psychologists are expected to establish

and maintain a safe practice environment (HCPC, 2015). Collaboration, willingness to adapt practice, education, Deaf awareness and supporting interpreters to access supervision will aid the development of a safe and trusting therapeutic environment. A positive environment will subsequently increase the ability to develop the triangle of care, leading to better outcomes for deaf clients.

Conclusion

In summary, the completion of this thesis developed my reflexivity and increased my understanding of working with deaf individuals. Results emphasised the challenges faced by deaf individuals accessing support for mental health difficulties. The empirical paper evidenced the existence and importance of nurturing the triangle of care. Interpreters have a part to play in therapeutic relationships and cannot just be viewed as translators. I learned the importance of being a reflective practitioner, maintaining awareness of how my personal experiences and biases may influence my work and interactions with others. Clinical psychologists must be prepared and willing to adapt practice, educate themselves and work in collaboration with professionals and clients. Research is vital in evidencing the need for change; flexible services and collaborative clinicians will improve services and outcomes for deaf clients.

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Section Four: Ethics Section

Ethics Section

Laura Catherine Wedlock

Trainee Clinical Psychologist

Doctorate in Clinical Psychology

Lancaster University

Faculty of Health and Medicine Research Ethics Committee (FHMREC) Lancaster University

Application for Ethical Approval for Research involving direct contact with human participants

Instructions [for additional advice on completing this form, hover PC mouse over 'guidance']

1. Apply to the committee by submitting:

a. The University's **Stage 1 Self Assessment (part A only)** and the **Project Questionnaire**. These are available on the Research Support Office website:

[LU Ethics](#)

b. The completed application **FHMREC form**

c. Your full research proposal (background, literature review, methodology/methods, ethical considerations)

d. All accompanying research materials such as, but not limited to,

- 1) Advertising materials (posters, e-mails)
- 2) Letters/emails of invitation to participate
- 3) Participant information sheets
- 4) Consent forms
- 5) Questionnaires, surveys, demographic sheets
- 6) Interview schedules, interview question guides, focus group scripts
- 7) Debriefing sheets, resource lists

Please note that you DO NOT need to submit pre-existing handbooks or measures, which support your work, but which cannot be amended following ethical review. These should simply be referred to in your application form.

2. Submit all the materials electronically as a **SINGLE** email attachment in **PDF** format by the deadline date. **Before converting to PDF ensure all comments are hidden by going into 'Review' in the menu above then choosing *show markup>balloons>show all revisions in line*.**

3. Submit one collated and signed paper copy of the full application materials in time for the FHMREC meeting. If the applicant is a student, the paper copy of the application form must be signed by the Academic Supervisor.

4. Committee meeting dates and application submission dates are listed on the [FHMREC website](#). Applications must be submitted by the deadline date, to:



Prior to the FHMREC meeting you may be contacted by the lead reviewer for further clarification of your application.

5. Attend the committee meeting on the day that the application is considered, if required to do so.

1. Title of Project: Mental health and Deafness: Interpreters' perspectives on compassion and the development of and barriers to the therapeutic alliance between a clinician and their Deaf client

2. Name of applicant/researcher: Laura Catherine Wedlock

3. Type of study

- ☒ Includes *direct* involvement by human subjects.
- ☐ Involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants. Please complete the University Stage 1 Self Assessment part B. This is available on the Research Support Office website: [LU Ethics](#). Submit this, along with all project documentation, to Diane Hopkins.

4. If this is a student project, please indicate what type of project by marking the relevant box: (please note that UG and taught PG projects should complete **FHMREC form UG-tPG**, following the procedures set out on the [FHMREC website](#))

- PG Diploma ☐ Masters dissertation ☐ DClInPsy SRP ☐ PhD Thesis ☐ PhD Pall. Care ☐
- PhD Pub. Health ☐ PhD Org. Health & Well Being ☐ PhD Mental Health ☐ MD ☐
- ☐ DClInPsy Thesis ☒

Applicant Information

5. Appointment/position held by applicant and Division within FHM Trainee
Clinical Psychologists/Full time Student – DclInPsy

6. Contact information for applicant:

E-mail: [REDACTED] **Telephone:** [REDACTED]
(please give a number on which you can be contacted at short notice)

The Project

NOTE: In addition to completing this form you must submit a detailed research protocol and all supporting materials.

10. Summary of research protocol in lay terms (indicative maximum length 150 words):

The project aims to give voice to interpreters to talk about their views on therapeutic alliance in mental health practice. I want to understand their role in facilitating the development of a therapeutic relationship between a hearing clinician and a client who is Deaf. Compassion is a central feature of the development of a positive therapeutic relationship, and previous research with hearing people has evidenced how this can be communicated via touch and voice. There is however no research that considers how compassion is communicated to and understood by a Deaf client.

There are several research questions: What factors facilitate/rupture the development of a therapeutic relationship? How is compassion communicated between the primary clinician and Deaf client via a BSL interpreter? How do interpreters view their role in the development of a therapeutic relationship?

Gaining interpreter perspectives would provide a greater understanding of how compassion is communicated in the unique client-therapist-interpreter relationship. Interpreters would provide insight into how the situation could be improved, so that therapeutic relationships are more easily developed. It may also highlight potential areas for further research, training and consider how changes may improve accessibility of services, development of therapeutic relationships and procurement of positive outcomes for Deaf individuals.

11. Anticipated project dates (month and year only)

Start date: September 2016

End date May 2017

12. Please describe the sample of participants to be studied (including maximum & minimum number, age, gender):

The research aims to interview NRCPD registered interpreters, qualified in British Sign Language. Participants can be male or female and must be over 18 years of age. There is no maximum age cut off, participants are only required to be currently working or have worked with Deaf individuals accessing mental health services. With regards to sample size, qualitative research utilising considers the concept of 'saturation', the point at which no new themes or information is gathered from the data. Although this process can be helpful during data collection to identify when the researcher has the data they need to answer their research questions, it provides little guidance for estimating required sample sizes before conducting the research. Guest, Bunce and Johnson (2006) conducted an experiment investigating data saturation and found that this occurred within 12 interviews, although 'basic elements for meta themes were present as early as six interviews'. Therefore for the current research, a sample size between 6-12 participants will ensure a viable study.

13. How will participants be recruited and from where? Be as specific as possible.

The research will be advertised online, via twitter and on websites that are relevant to the intended participant group. Interpreter services and charities which work with interpreters will be contacted, so that the research may be advertised on their websites or social media accounts. Note that the chief researchers' professional social media accounts (e.g. twitter) will also be used. However, the chief researcher personal Facebook account will not be used. Participants will also be encouraged to spread the research to other interpreters they may know through word of mouth.

Interested parties will be able to contact the chief researcher directly, to express their interest in taking part. Gatekeepers will be asked to disseminate the study material to their mail groups.

14. What procedure is proposed for obtaining consent?

When participants contact the chief researcher to express interest in taking part, they will be sent an information sheet and consent form. Once they have read these over and had any remaining questions answered, they can return the signed consent form via email, post or give it to the chief researcher in person on the day of the interview. If participants choose to post the consent forms, self-addressed envelopes will be made available. Prior to interview, the chief researcher will go through the consent form with the participant again, and ensure they are aware of their right to withdraw up to 2 weeks following interview.

15. What discomfort (including psychological eg distressing or sensitive topics), inconvenience or danger could be caused by participation in the project? Please indicate plans to address these potential risks.

This is a qualitative study interviewing professionals about their views on their professional role. As such, the topic is not sensitive and should not provoke any negative feelings in the participants. If however a participant does become distressed during interview, the interview will be paused. Time will be taken to calm and reassure the participant, ensuring that they are aware of the confidentiality of their information and their right to withdraw if they feel they can no longer continue. If participants are happy to continue, the interview will resume and they will be reminded that they can take a break or stop at any time. A cooling down phase is included at the end of the interview so that the chief investigator will ensure that participants leave interview without any negative feeling.

16. What potential risks may exist for the researcher(s)? Please indicate plans to address such risks (for example, noting the support available to you; counselling considerations arising from the sensitive or distressing nature of the research/topic; details of the lone worker plan you will follow, and the steps you will take).

The LCFT lone worker policy will be considered with regards to the current research. The chief investigator will conduct interviews in person at Lancaster University or at the participant's place of work if possible. Proper sign in procedures will be followed in both environments, and the policy of visitors on site will be followed. If the interview cannot be conducted in person, the interview will instead be conducted via telephone or skype. There is no considerable risk to the chief researcher, but should emotionally difficult issues arise from the narratives of the participants, the chief researcher has access to a supervisory team which includes two experienced psychologists who have conducted research on the field and will provide support should this is required.

17. Whilst we do not generally expect direct benefits to participants as a result of this research, please state here any that result from completion of the study.

There will be no direct benefit to the participants of taking part in the study. However, they may find the interview to be a positive and interesting experience. Their data will assist a greater understanding of the therapeutic relationship, and how this can be improved in future. This will be made clear to the participants.

18. Details of any incentives/payments (including out-of-pocket expenses) made to participants:

Participants who travel to interview will be reimbursed up to the value of £20. They will be asked to make a note of their mileage, or to retain any public transport receipts.

19. Briefly describe your data collection and analysis methods, and the rationale for their use. Please include details of how the confidentiality and anonymity of participants will be ensured, and the limits to confidentiality.

Data will be collected via semi structured interview, which will last around an hour. An interview schedule will be used to facilitate discussion, and the interview will be recorded using a digital recording device. If it is necessary to use skype for interview, participants will be reminded that complete confidentiality cannot be ensured via this channel. Phone interviews will be suggested instead. When organising interviews, the most appropriate time and method will be discussed with the participant, to protect confidentiality as much as possible. If interviews are conducted within the participant's place of work, it will be discussed that while

Participants will be given a pseudonym which will replace their name in the typed transcript. Interviews will be typed into transcripts by the chief researcher only, and all identifying data will be removed for the purpose of the confidentiality. The only time in which confidentiality may be broken is if risk or safeguarding issues are identified during interview. In that case, the chief investigator will seek guidance from supervisors and address any issues in an appropriate manner. Participants will be reminded that direct quotations will be used in the research write up, but that their identity will be protected.

Data will be analysed using thematic analysis. This method identifies and analyses patterns within the data, leading to interpretations of aspects of the research topic (Braun & Clarke, 2006). It's theoretical freedom and flexibility allows for a rich, detailed and complex account of data to be created.

20. If relevant, describe the involvement of your target participant group in the design and conduct of your research.

This is a student project with no funding attached. As such, it has not been possible to involve a sign language interpreter in the design of the study. However, one of the research supervisors (Dr Gerasimos Chatzidamianos) is a sign language interpreter and provides input across all stages of the project. Also, Dr Rachel Lever is an experienced clinician who is a signer herself and has also worked with sign language interpreters in clinical settings. Her input has also been incorporated across all stages of the study.

21. What plan is in place for the storage of data (electronic, digital, paper, etc.)? Please ensure that your plans comply with the Data Protection Act 1998.

Transcription and analysis of the anonymised transcripts will take place on the University H drive via a virtual private network (VPN). At no time will files be downloaded onto PC or laptop hard drives. Any paper documents will be scanned and saved on to the University H drive. Hard copies of documents will then be destroyed. Data generated by student research (including electronic copies of consent forms and transcripts) are retained by Lancaster University for 10 years.

22. Will audio or video recording take place? ☐ no ☒ audio ☐ video

If yes, what arrangements have been made for audio/video data storage? At what point in the research will tapes/digital recordings/files be destroyed?

Audio files will be transferred to an encrypted portable memory drive. The files from this memory drive will then be transferred to a password protected H drive on Lancaster University's secure computer network. Digital audio files will then be deleted from the digital recorded and encrypted memory drive following transfer.

Lancaster University retains data generated by student research for 10 years. This includes consent forms, which contains participant names. This is the only personal data that will be retained following the studies completion. This data is stored electronically by Lancaster University in the long term. The data will be encrypted and transferred securely to the chief researcher's academic supervisor using ZendTo file transfer software. The DclinPsy programme has agreed that the academic supervisor should be the data custodian and therefore in charge of deleting data/study materials. They will save the files in a password protected file space on the University server. The Chief Investigator will send an email to the academic supervisor with the password for the encrypted files, the end date for the study and the year the data should be destroyed.

23. What are the plans for dissemination of findings from the research? If you are a student, include here your thesis.

This research is being conducted for the purpose of an empirical paper for a doctoral thesis. The findings will be shared within the university, with external markers, and with academic and field supervisors. The findings will also be submitted for peer reviewed publication and may also be presented at conferences and other training events.

24. What particular ethical considerations, not previously noted on this application, do you think there are in the proposed study? Are there any matters about which you wish to seek guidance from the FHMREC?

An ethical consideration for this research is the participants discussing their work, in which they facilitate the development of a therapeutic relationship and work to be completed by a therapist and client. The chief investigator must therefore ensure that participants do not share information that will break confidentiality. The interview schedule will include an emphatic note prior to the beginning of interview, asking participants to consider the questions asked in relation to their work in general. If they feel that a particular example may evidence their point, they will be asked to only provide the bare details and to change any names of individuals involved to protect confidentiality. However, it is still possible that participants share information that is confidential. As previously noted, all identifiable information will be removed from the transcripts.

Signatures:

Applicant [REDACTED]

Date: [REDACTED]

*Project Supervisor (if applicable): [REDACTED]

Date: [REDACTED]

*I have reviewed this application, and discussed it with the applicant. I confirm that the project methodology is appropriate. I am happy for this application to proceed to ethical review.

Stage 1 Self-Assessment Form (Part A) - for Research Students

(To be completed by the student together with the supervisor in all cases; send signed original to Research Support)

Student name and email: Laura Wedlock - [REDACTED]

Supervisor name: Dr Ian Fletcher Department: DCLinPsy

Title of project: Mental health and Deafness: Interpreters' perspectives on compassion and the development of and barriers to the therapeutic alliance between a clinician and their Deaf client.

Proposed funding source (if applicable): N/A

1. Please confirm that you have read the code of practice, '[Research Ethics at Lancaster: a code of practice](#)' and are willing to abide by it in relation to the current proposal? *If no, please provide explanation on separate page*

2. Does your research project involve non-human vertebrates, cephalopods or decapod crustaceans? *If yes, have you contacted the Ethical Review Process Committee (ERP) via the University Secretary ([REDACTED])?*

3a. Does your research project involve human participants i.e. including all types of interviews, questionnaires, focus groups, records relating to humans etc?

If yes, you must complete Part B unless your project is being reviewed by an ethics committee

3b. If the research involves human participants please confirm that portable devices (laptop, USB drive etc) will be encrypted where they are used for identifiable data

3c. If the research involves human participants, are any of the following relevant:

The involvement of vulnerable participants or groups, such as children, people with a learning disability or cognitive impairment, or persons in a dependent relationship

The sensitivity of the research topic e.g. the participants' sexual, political or legal behaviour, or their experience of violence, abuse or exploitation

The gender, ethnicity, language or cultural status of the participants

Deception, trickery or other procedures that may contravene participants' full and informed consent, without timely and appropriate debriefing, or activities that cause stress, humiliation, anxiety or the infliction of more than minimal pain

Access to records of personal or other confidential information, including genetic or other biological information, concerning identifiable individuals, without their knowledge or consent

The use of intrusive interventions, including the administration of drugs, or other treatments, excessive physical exertion, or techniques such as hypnotherapy, without the participants' knowledge or consent

Any other potential areas of ethical concern? (Please give brief description)

No other areas of ethical concern

4. Are any of the following potential areas of ethical concern relevant to your research?

Could the funding source be considered controversial?

Does the research involve lone working or travel to areas where researchers may be at risk (eg countries that the FCO advises against travelling to)? If yes give details.

Does the research involve the use of human cells or tissues other than those established in laboratory cultures?

Does the research involve non-human vertebrates?

If yes, has the University Secretary signified her approval?

Any other potential areas of ethical concern? (Please give brief description)

There may be lone working, but lone working policy and processes will be put in place to ensure researcher safety.
--

5. Please select **ONE** appropriate option for this project, take any action indicated below and in all cases **submit the fully signed original self-assessment to RSO.**

☐ **(a) Low risk, no potential concerns identified**

The research does **NOT** involve human participants, response to all parts of Q.4 is 'NO'.

No further action required once this signed form has been submitted to RSO ☐ **(b) Project will be reviewed by NHS ethics committee**

Part B/Stage 2 not usually required, liaise with RSO for further information. If Lancaster will be named as sponsor, contact RSO for details of the procedure

☐ **(c) Project will be reviewed by other external ethics committee**

Please contact RSO for details of the information to submit with this form

☒ **(d) Project routed to UREC via internal ethics committee**

SHM and Psychology only. Please follow specific guidance for your School or Department and submit this signed original self-assessment to RSO

☐ **(e) Potential ethical concerns, review by UREC required**

Potential ethical concerns requiring review by UREC, please contact RSO to register your intention to submit a [Stage 2](#) form and to discuss timescales

☐ **(f) Potential ethical concerns but considered low risk, (a)-(e) above not ticked**

Research involves human participants and/or response to one or more parts of Q.4 is 'YES' but ethical risk is considered low. Provide further information by completing [PART B](#) and submitting with this signed original PART A to RSO

Student signature: [redacted] Date: [redacted]

Supervisor signature: [redacted] Date: [redacted]

Head of Department (or delegated representative) Name: x [redacted]

Signature: [redacted] Date: [redacted]

.....

THE UNIVERSITY OF LANCASTER

PFACT project information and ethics questionnaire

(To be completed by the student together with their supervisor in all cases)

Name of student: **Laura Wedlock**

Name of supervisor: **Dr Ian Fletcher**

Project Title: **Mental health and Deafness: Interpreters' perspectives on compassion and the development of and barriers to the therapeutic alliance** FHM Division:
Doctorate in Clinical Psychology

1. General information

1.1 Have you, if relevant, discussed the project with:

☐ the Data Protection Officer?

☐ the Freedom of Information Officer?



N/A

(Please tick as appropriate.)

1.1 Does any of the intellectual property to be used in the research belong to a third party?

Y / N

1.2 Are you involved in any other activities that may result in a conflict of interest with this research?

Y / N

1.3 Will you be working with an NHS Trust?

Y / N

1.4 If yes to 1.3, what steps are you taking to obtain NHS approval?

N/A _____

1.5 If yes to 1.3, who will be named as sponsor of the project?

N/A _____

1.6 What consideration has been given to the health and safety requirements of the research?

All health and safety requirements will be carefully considered prior to the start of the research. Relevant processes and strategies will be implemented to ensure the research is conducted in a safe and ethical manner.

2. Information for insurance or commercial purposes

(Please put N/A where relevant, and provide details where the answer is yes.)

2.1 Will the research involve making a prototype?

Y / N / N/A

2.2 Will the research involve an aircraft or the aircraft industry?

Y / N / N/A

2.3 Will the research involve the nuclear industry?

Y / N / N/A

2.4 Will the research involve the specialist disposal of waste material?

Y / N / N/A

2.5 Do you intend to file a patent application on an invention that may relate in some way to the area of research in this proposal? If YES, contact Gavin Smith, Research and Enterprise Services Division. (ext. 93298)

Y / N / N/A 3. Ethical information

(Please confirm this research grant will be managed by you, the student and supervisor, in an ethically appropriate manner according to:

(a) the subject matter involved;

(b) the code of practice of the relevant funding body; and

(c) the code of ethics and procedures of the university.)

(Please put N/A where relevant)

- 3.1 Please tick to confirm that you are prepared to accept responsibility on behalf of the institution for your project in relation to the avoidance of plagiarism and fabrication of results.

✓

- 3.2 Please tick to confirm that you are prepared to accept responsibility on behalf of the institution for your project in relation to the observance of the rules for the exploitation of intellectual property.

✓

- 3.3 Please tick to confirm that you are prepared to accept responsibility on behalf of the institution for your project in relation to adherence to the university code of ethics.

✓

- 3.4 Will you give all staff and students involved in the project guidance on the ethical standards expected in the project in accordance with the university code of ethics?

Y / N / N/A

3.5 Will you take steps to ensure that all students and staff involved in the project will not be exposed to inappropriate situations when carrying out fieldwork?

Y / N / N/A

3.6 Is the establishment of a research ethics committee required as part of your collaboration? (This is a requirement for some large-scale European Commission funded projects, for example.)

Y / N / N/A

3.7 Does your research project involve human participants i.e. including all types of interviews, questionnaires, focus groups, records relating to humans, human tissue etc.?

Y / N / N/A

3.7.1 Will you take all necessary steps to obtain the voluntary and informed consent of the prospective participant(s) or, in the case of individual(s) not capable of giving informed consent, the permission of a legally authorised representative in accordance with applicable law?

Y / N / N/A

3.7.2 Will you take the necessary steps to find out the applicable law?

Y / N / N/A

3.7.3 Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications?

Y / N / N/A

3.7.4 Will you take appropriate action to ensure that the position under 3.7.1 – 3.7.3 are fully understood and acted on by staff or students connected with the project in accordance with the university ethics code of practice?

Y / N / N/A

3.13 Does your work involve animals? If yes you should specifically detail this in a submission to the Research Ethics Committee. The term animals shall be taken to include any vertebrate other than man.

3.13.1 Have you carefully considered alternatives to the use of animals in this project? If yes, give details.

Y / N / N/A

3.13.2 Will you use techniques that involve any of the following: any experimental or scientific procedure applied to an animal which may have the effect of causing that animal pain, suffering, distress, or lasting harm? If yes, these must be separately identified.

Y / N / N/A

Signature (student): [REDACTED] Date: [REDACTED]

Signature (supervisor): [REDACTED] Date: [REDACTED]

N.B. Do not submit this form without completing and attaching the Stage 1 self-assessment form.



Thesis Ethics Protocol

Mental health and Deafness: Interpreters' perspectives on compassion and the development of and barriers to the therapeutic alliance between a clinician and their Deaf client.

There are around 11 million people in the UK who suffer from some form of hearing loss. Over 900,000 of these individuals are severely or profoundly deaf (Action on Hearing Loss, 2015). Fellingner, Holzinger and Pollard (2012) conducted a review which noted that there are higher rates of mental health difficulties reported in the Deaf population. They found evidence of discrepancies between the level of mental health difficulties in the Deaf population and their access to appropriate health care and support. Deaf with a capital 'D' refers to a group of individuals who have a unique cultural and linguistic identity. There exists a principle that 'deaf' with a lower case 'd' refers to those who regard their hearing loss in medical terms; an audiological condition which has led them to be unable to hear (Young & Rogers, 2011). They do not actively associate with the deaf community. The use of d/Deaf in research indicates that there is no differentiation, and that all individuals are being referred to. Deaf individuals however have a strong deaf identity and use British Sign Language (BSL) to communicate (Berke, 2016). This visual mode of communication has no written equivalent, which can cause issue for professionals with no prior understanding of BSL.

Provision of mental health services for this group therefore has been and remains poor. Hulme and Powell (2014) noted that Deaf individuals are expected to approach

their GP as a first port of call for psychological issues, however up to 25% of Deaf individuals avoid their GP altogether. This is often due to difficulties communicating with services and clinicians (Chatzidamianos, 2013; Ringham, 2013), which often leads to Deaf individuals becoming discouraged. This raises worrying questions regarding how many Deaf individuals are not receiving the support they need.

For those who do manage to access mental health services, the experience becomes more challenging. This is due to the limited number of appropriately trained clinicians, the lack of Deaf awareness and the lack of assessment tools that are specifically designed for this population, which results in an increased risk for many Deaf people experiencing mental health problems being misdiagnosed (Chatzidamianos, 2013). In 2003, British Sign Language (BSL) was recognised as a language in its own right (Stiles, 2013), which some 101,000 Deaf individuals use (Royal Association for Deaf people, 2012). However services are often illequipped and lack clinicians who can communicate using BSL. Sign language interpreters are therefore a vital bridge between Deaf individuals and mental health service clinicians. They have the unique experience of being present in a situation which is usually protected and privately shared between clinician and client. They also have the responsibility to communicate vital information and convey specific feelings between the two parties, to assist in the development of a therapeutic alliance.

There are several specialist mental health services throughout the UK, in places such as London, Birmingham, Manchester and Belfast (Psychological Professions Network, 2014). These specialist services offer in-patient and out-patient services with trained staff, including interpreters, who have the necessary skills to work with and support Deaf individuals. In theory, these services are ideal for the Deaf, however there

are only a handful of such services spread across the country. Deaf individuals therefore must sometimes travel great distances in order to receive specialised support. There is also an issue with the ability for

Deaf individuals to access the appropriate level of support in certain parts of the country. Mainstream services are largely unable to meet the needs of Deaf individuals due to the lack of qualified interpreters in these settings. Deaf individuals therefore find themselves accessing a higher level service which may be inappropriate. There are BSL healthy Deaf minds services, which are similar to a mainstream IAPT service, however these services are commissioned on a trust to trust basis and so access for individuals varies across the country. Finally, while mainstream services have specialised services for specific problems, services created to support the Deaf cover all difficulties, often meaning that individuals with a variety of difficulties and severity are treated in the same environment. As a results, most Deaf individuals remain untreated in the community.

Research has explored the influence that a good therapeutic alliance can have on therapy outcomes (Horvarth, Del Re, Fluckiger & Symonds, 2011). But how is this alliance challenged when the clinician and client cannot communicate directly? And what factors could improve the development of such an alliance? These are the questions which the current research would hope to consider. Compassion has been described as the feeling which arises in witnessing another human's suffering, and the subsequent desire we feel to help them (Goetz, Keltner & Simon-Thomas, 2010). This concept is therefore important in the process of developing that therapeutic alliance. Research has indicated that touch (Goetz et al, 2010) and voice (Simon-Thomas, Keltner, Sauter, Sinicropi-Yao & Abrahmson, 2009) are two important platforms which enable secure attachments and cooperative relationships to be developed, and compassion to be

communicated. There is no literature which considers how compassion is communicated to and understood by a Deaf client in the absence of voice. Also, there is no research which considers if and how attachments are impacted when compassion is channelled manually and through facial markers, rather than verbally.

Interpreters gain information which could inform these questions through their experiences of mediating communication between Deaf clients and clinicians. They experience both sides of a relationship within mental health services and facilitate its development. Their experiences therefore are vital to gain in order to better understand what the needs of clients are, what clinicians can do to facilitate the development of positive relationships, and how services need to change in order to provide the necessary support for this demographic.

Relevance to clinical psychology and dissemination

This research area is relevant to clinical psychology because it highlights a population that psychology is currently failing to adequately support. Research in the field of mental health and Deafness remains relatively sparse, considering the size of the related population. Conducting qualitative research with interpreters is a novel approach and allows the opportunity to gain their unique experiences. It would be hoped that the data gained would assist a greater understanding of how compassion is communicated in these unique relationships. Interpreters would provide insight into how the situation could be improved, so that therapeutic relationships are more easily developed. Analysis may lead to consideration regarding the future training of psychologists. This may include potential adaptations to both training and the clinical psychology role, which would improve their ability to work with Deaf clients. It may also highlight potential areas for further research, training and consider how changes may improve accessibility

of services, development of therapeutic relationships and procurement of positive outcomes for Deaf individuals. Finally, the research may highlight the benefit of developing useful guidelines which could improve mainstream service provision. Findings may contribute to the development of guidelines for hearing clinicians on how to involve a BSL interpreter.

The chief researcher will aim to disseminate the findings of this research as widely as possible. The conclusions and service implications will be generalizable to all mental health services that may come into contact with Deaf individuals. Having a greater understanding of how a mediated therapeutic alliance can work and the benefit it may have may assist services in feeling more able to provide appropriate care and encourage Deaf individuals to reach out to their service if they require support.

Research question

The research intends to gain the perspectives of interpreters who have worked with Deaf individuals accessing mental health services. Their experiences and perspectives would provide an understanding of how compassion is communicated in an interpreter mediated therapeutic relationship. It will also highlight the barriers that exist for the development of such a relationship. The results of this research will assist consideration around how services and clinicians can adapt in order to improve access to mental health services and outcomes for individuals who are Deaf.

The research questions therefore are as follows:

- What are the factors that facilitate/rupture the development of a therapeutic relationship?

- How is compassion communicated by the primary clinician to and understood by a client who is Deaf via a BSL interpreter?
- How do interpreters view their role in the development of a therapeutic relationship?

Method

Design

The researcher will incorporate a qualitative approach, with the chief investigator conducting interviews face to face, via telephone or skype. An interview schedule will provide a semistructure to the interview process; directing discussion towards topic areas relevant to the research question, whilst also allowing for flexibility to explore avenues of conversation which may be relevant and insightful. The schedule was developed by considering the main research questions and expanding them to create discussion subtopics.

The data will be analysed using thematic analysis. This method identifies and analyses patterns within the data, leading to interpretation of aspects of the research topic (Braun & Clarke, 2006). Its theoretical freedom and flexibility will allow for a rich, detailed and complex account of data to be created. An inductive approach will ensure that the themes identified are strongly linked to the data. This analysis method is appropriate for the current research, as it will assist the understanding of how compassion is communicated in an interpreter mediated therapeutic relationship, and what barriers exist for the development of such a relationship.

Participants

Participants will be registered with The National Registers of Communication Professionals working with Deaf and Deafblind People (NRCPD). They will be BSL interpreters who translate English into BSL and BSL into English. They will also have worked with Deaf individuals accessing mental health services. The chief researcher will recruit participants through various channels. This will include online advertisement on twitter, blogs and websites which will make the research visible to the intended participant group. Services and charities which employ and provide BSL interpreters will also be contacted, so that the research may be disseminated on their websites and with their members. Research has found that the basic elements for analysis and the creation of meta-themes are present within six interviews (Guest, Bunce & Johnson, 2006), while Baker and Edwards (2012) suggested that a sample of up to 12 allows for comprehensive data collection and analysis, while also being feasible to complete within time constraints.

Materials

A small poster will be disseminated online and amongst relevant websites, to advertise the research (Appendix A). A longer information sheet (Appendix B) will be sent to individuals who express their interest in taking part, so that they have a greater understanding of what the research entails. If they are happy to take part, they will complete and sign a consent form (Appendix C). This consent form will be completed and signed in person prior to a face to face interview, or completed, signed and sent to the chief researcher prior to a telephone or skype interview. Interviews will be conducted with reference to an interview schedule (Appendix D) and recorded using a digital recording device. Audio files will be transferred to an encrypted portable memory drive. The files from this memory drive will then be transferred to a password protected H drive

on Lancaster University's secure computer network. Digital audio files will then be deleted from the digital recorded and encrypted memory drive following transfer. Transcription and analysis of the anonymised transcripts will take place on the University H drive via a virtual private network (VPN). At no time will files be downloaded onto PC or laptop hard drives. Any paper documents will be scanned and saved on to the University H drive. Hard copies of documents will then be destroyed. Recordings will be kept until the point of being transcribed, and will then be deleted. Upon completion of the interview, participants will either receive in person or be sent a debrief sheet (Appendix E).

Procedure

Participants will be recruited through a variety of channels and can express their interest in taking part by contacting the researcher via telephone, email or post. Those who contact the researcher to express their interest will be sent an information sheet which explains the research in greater detail. Individuals can read through this sheet and seek answers to any further questions before confirming to take part. The chief researcher will contact the participant in order to arrange a convenient time, date and place for interview. Interviews may take place within the grounds of Lancaster University, at the participants' place of work (with the relevant permissions, as interpreters work on a freelance basis but can do regular bookings with a service), at the local office of the organisation they work for, or via telephone or skype. These options will be discussed with the participant and the most appropriate will be chosen. The researcher will endeavour to meet participants in person for interview where possible, but will retain telephone and skype interview options for participants who may have limited availability for face to face interview due to geography or other factors. The limitations to

confidentiality of data will be considered with participants using these methods and any measure which can be utilised to increase confidentiality and security will be considered. If the participant travels in order to attend interview, travel expenses will be reimbursed up to the value of £20.

At the interview (or shortly prior for telephone/skype interviews), participants will read through and sign a consent form which confirms their agreement to take part. A short introduction by the chief researcher will emphasise that it is the participant's choice to take part and that they can withdraw their consent up to two weeks following their interview. It will be explained that the interview will last for around an hour and will be recorded using a digital recording device. At the stage of creating a typed transcript of the recording, data will be anonymised and any identifying information pertaining to the participant will be omitted. Participant's names will be replaced with a pseudonym. Once the completed transcript is typed, the audio recording will be deleted.

When the interview is completed, there will be a debrief period in which participants will be thanked for their participation and asked if they have any final questions or queries regarding the research. They will be provided with a debrief sheet which reinstates the purpose of the research, explains what happens to the data next and provides relevant contact details, should the participant wish to speak with anyone relating to the research following interview.

Analysis

All data obtained in the study will be from subjective accounts provided by participants. The data will be analysed using thematic analysis. This method identifies and analyses patterns within the data, leading to interpretation of aspects of the research topic (Braun

& Clarke, 2006). Its theoretical freedom and flexibility allows for a rich, detailed and complex account of data to be created.

The chief researcher will keep a reflective journal throughout the research process. Each interview transcript will also be read over several times until the researcher is familiar with the content. Reflections from the journal and notes from the read through of each transcript will lead to the creation of a list of potential codes. The next stage will involve generating a list of recurring patterns or items throughout the data. This process of coding the data is inductive and will be repeated in order to strengthen or discard codes until a list of themes are generated. These themes are generated through a process of evaluating and considering the wider meaning of codes. Themes can incorporate repeated ideas, metaphors, shifts in topic and other factors. Saldana (2009) stated that it is important in analysis to consider what is missing from the data, as well as what is present. Once themes are generated, the data will be searched for evidence that supports or negates each theme. This process will reshape themes, indicating whether they require expansion or condensing. Following this process, the final themes for the research will be generated. This method will be useful in gaining an understanding of the triadic relationship, how interpreters believe compassion is communicated in an interpreter mediated therapeutic relationship, and what barriers exist for the development of such a relationship.

Practical issues

The chief investigator must be contactable throughout the research, in order to answer questions or provide information to participants. Posts which advertise the research online will include phone and email contact details for the chief investigator, so that participants can get in touch. Information sheets given to participants following an expression of interest will also include a postal address, so that participants can return

consent forms/other correspondence if necessary. Contact details for the academic supervisors, field supervisor, the Programme Director for the DClinPSy and the Associate Dean for Research of the Faculty of Health and Medicine will also be included in the information sheet, in case participants have any queries or concerns regarding the research. A mobile phone will be provided by Lancaster University for research purposes and the email address will be the chief investigators academic account. The postal address provided will be for the Division of Health Research within Lancaster University.

Any printing or postage costs will be covered by the University and chief investigator. However information sheets, consent forms and debrief sheets will be shared between researcher and participant via secure email where possible, which will minimise printing costs. If participants would rather receive paper copies of the information sheet and consent form, these will be sent out along with a self-addressed and stamped envelope, so that participants may return the consent form. When these are returned to the chief researcher, they will be scanned on the University's secure H drive. The hard copies will then be destroyed. The debrief sheet can also be sent to participants via post or email, dependent on their preference. Reimbursement of travel expenses may be considered for participants who travel to the University, outside their place or work, or to their place of work on a day they are not working, in order to take part in the research. They will be reimbursed up to the total of £20, with note of their mileage or receipt of public transport.

Ethical concerns

It will be emphasised to participants that participation in the research is voluntary, and they hold the right to withdraw from the study up to a certain point. Before interviews, the chief investigator will explain the procedure for ensuring confidentiality of

participant data. Interviews will be recorded, and audio recordings will be transferred on to Lancaster University's secure H drive. The audio recordings will then be deleted from the digital recording device and encrypted portable memory stick used for the transfer. Participants will be asked to discuss their work and role within a therapeutic relationship. This may include discussing particular pieces of work/clients, which may prove to be an ethical concern regarding the confidentiality of that data. I will minimise this by encouraging participants to speak generally about their experiences. If they feel a particular example would illuminate a point, I will ask that participants do not provide too much contextual detail and change/omit all relevant names/information which could identify others.

If participants share information that implies risk of harm to themselves or others, I will break confidentiality and seek support from my supervisors, so that appropriate action can be taken. This could involve potential malpractice towards a Deaf person with mental health problems from a clinician that the participant names/is aware of and who is currently practicing.

Timescale

The following timescale is subject to ethical approval being granted. Any delays will lead to readjustment of the timescale.

1. Submission of FHMREC ethics will take place in June 2016
2. With ethical approval granted, the distribution of advertising materials for the research will be shared with appropriate source – September 2016
3. Await expression of interest from participants and interview – September - October 2016
4. Completion of transcripts and analysis of data to take place- November 2016

5. First draft of empirical paper – January 2017
6. Second draft of empirical paper – February 2017
7. Hand in of thesis – May 2017

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Appendices

Appendix A: Interview Schedule

Interview Schedule



Mental health and Deafness: Interpreters' perspectives on compassion and the development of and barriers to the therapeutic alliance between a clinician and their Deaf client

Introduction:

Thank you for meeting with me today. I would like to ask you some questions about your experiences of being a BSL interpreter for a Deaf client accessing mental health services. This should take around an hour, please feel free to ask for a break at any time. If you don't want to answer a specific question, please just let me know. What we talk about here will be kept confidential, however if what you say suggests that yourself or someone else is at risk of harm, I will have to report this to discuss this with my supervisors so that appropriate action can be taken, so that we can keep you and others safe. I understand that the work you do is also confidential, and so I am happy for you to speak generally about your experiences. If you feel there is a specific example that would illustrate a point, I would appreciate if you could change names/dates etc appropriately to protect the confidentiality of others.

I will be using a digital recorder to record our meeting today, this will make sure that I don't miss anything that you have said.

Before we start, do you have any questions about the process, or the information/consent forms?

Establishing rapport and understanding motivation

Firstly, I'd just like to ask a few questions about you, how you became an interpreter and your feelings about your role:

- What motivated you to become a qualified interpreter/learn sign language?
- Personal experience? (dependent on response – omit next questions) ● Was the process of learning sign language hard?
- Did it make you reflect on/appreciate the challenge of Deaf individuals?
- What do you enjoy most about your job?
- What are the biggest challenges of your job working in mental health services?

- Do you ever feel nervous interpreting? What is the main feeling(s) you experience when you interpret in mental health services?
- What are your thoughts regarding current mental health service provision/accessibility for Deaf individuals?
- Has this improved/declined since you began your work?
- How does the service offered in specialist services differ from mainstream?
 - How are the staff/care different? Are you treated differently?
- Are there practices that you have seen in services/amongst staff that were particularly inclusive to Deaf individuals?
 - What factors make a service accessible to a Deaf individual

Therapeutic relationship

I'd now like you to think about your experience of interpreting sessions between a clinician and client, discussing psychological difficulties, in a mental health setting.

- Can you tell me how this situation is different from others you might interpret?
- What do you feel your role is in relation to developing a therapeutic relationship between those in the room?
- Whose role is most important?
- How do you think your presence impacts the relationship?
- Are you aware of this during session? Is it different for different sessions/people?
- What is the most challenging aspect of interpreting this kind of interaction for you/client/clinician?
- What behaviour from the clinician aids the development of a good rapport?
- Looking at client, talking to them etc
- Can you tell whether a clinician/client have a good rapport?
- If so, how? What about their manner/behaviour etc show this?
- Do you get the impression that their rapport exists solely through you, or does a connection develop between them?
- How/does your role change as the therapy progresses?
- Does the atmosphere change? Clinician/client/you?
- Do the client/clinician focus more on each other?
- Is there a difference when the clinician is a psychologist, rather than another health professional?

Compassion

I'd like to think about the connection between the people in the room during this kind of interaction, and the concept of compassion.

- How are feelings/emotions communicated through sign language?
 - What do you use; face, body language etc?
 - How do you communicate different levels of emotion? What of your presentation changes?
- I assume that both the client and clinician convey a number of emotions.

- What about your own emotions? How do these fit in the room?
- To you, is there a difference in how Deaf and hearing individuals understand or communicate emotions?
- What do you think 'compassion' means?
- Is it something that you see/get a sense of within a client-clinician communication?
- How can compassion be communicated in this situation?
- Is it important for you and the clinician to have a good relationship?
- Can you give an example of a good therapeutic relationship you have facilitated?
 - What was good about it? What was different?
- What do you feel is the most important factors to hearing clinicians and Deaf clients building a good therapeutic relationship?
 - Behaviour? Expression of emotions – face, body, gesture, eye contact etc?
- What about people with minimum language skills?

Looking to the future

Finally, I'd like to gain your opinion on how the accessibility to and care for Deaf individuals could be improved.

- How can mainstream services and clinicians support Deaf individuals with their difficulties?
 - What needs to change? What should be focused on/important to remember?
- With regards to building good relationships, what tips would you give?
- What are the most important factors in developing good therapeutic relationships with Deaf clients?
 - E.g. Consistency, empowering, helping client-clinician make connection, practical factors (eye contact, gesture etc)
- How do you see the role of the interpreter in mental health setting in the future? (Additional specialised training? On what? What about terminology?)

Cool Down Period

- Wrap up interview. What did they enjoy/not enjoy? General feelings around the process/Choosing of pseudonym
- If applicable, travel expenses – Discuss process and provide/collect appropriate forms etc to complete this stage
- Second thoughts about your participation, please feel free to get in touch within the next two weeks. After that point, I will not be able to remove your data as it will have been collated with other data
- Thank them for participation and give them (in person or via email/post) debrief sheet

Appendix B: Participant Information Sheet



Participant Information Sheet

Mental health and Deafness: Interpreters' perspectives on compassion and the development of and barriers to the therapeutic alliance between a clinician and their Deaf client.

My name is Laura Wedlock and I am conducting this research as a third year student in the clinical psychology doctorate at Lancaster University, Lancaster, United Kingdom.

What is the study about?

The research wants to talk to BSL/English interpreters about their role in the development of a therapeutic relationship between a hearing clinician and a client who is Deaf. It is hoped that the research will identify factors that influence the therapeutic relationship. Compassion is a central feature to the development of this relationship, and this research also hopes to better understand how this is communicated and understood through an interpreter.

Why have I been asked to take part?

You have been invited to take part because you are a BSL/English interpreter. The study seeks information from people who experience both sides of the therapeutic relationship within mental health services. Interpreters play a vital role in facilitating the communication between clinicians and Deaf individuals. It is hoped that your knowledge can help improve understanding of what the needs of clients are, what clinicians can do to facilitate the development of positive relationships, and how services need to change in order to provide support for this demographic.

Do I have to take part?

No. It's completely up to you whether or not you want to take part. Choosing not to take part will have no impact on your work. You also have the right to withdraw from the study up to two weeks following your interview if you choose. If you decide you would not like your data to be used, please notify me within two weeks and your data will be destroyed.

What will I be asked to do if I take part?

If you decide you would like to take part, you would be interviewed either in person or via telephone/skype. This interview would last around an hour and be recorded using a digital recording device.

You will be asked to discuss your experiences of interpreting for Deaf individuals, and your opinions about the development of therapeutic relationships. I will ask you some questions, but you will also be free to share experiences and ideas you feel are relevant. Once the interview is complete, you will be given a debrief sheet to take away with you.

Will my data be kept confidential and secure?

Any personal data will be kept confidential and separately from your interview responses. Your interview will be typed into a transcript, and any identifying information including your name will be removed. Once your interview is typed into a transcript, the recording will be deleted. Transcripts will only be accessible to me and my supervisory team who oversee the work I conduct. At the end of the study, copies of your consent form and transcript will be kept securely by Lancaster University for ten years. At the end of this period, they will be destroyed.

There are however some limits to confidentiality. If what is said in the interview makes me think that you, or someone else, are at significant risk of harm, I will have to break confidentiality and speak to my supervisory team. If possible, I will tell you if I have to do this. Also, while every effort will be made, it is not possible to ensure confidentiality of participation if interviews take place on work premises during the working day. Finally, if you choose to be interviewed by Skype, I am not in a position to fully guarantee confidentiality due to the nature of online communications.

What will happen to the results?

The results will be summarised and reported in a thesis. This final report will be shared with Lancaster University, external markers, and may be submitted for publication in an academic or professional journal. Anonymised direct quotations from your interview may be used in the write up of the study, so your name will not be attached to them. You are welcome to request a lay summary of the results once the research is completed.

Are there any risks?

There are no risks anticipated with participating in this study and it is highly unlikely that you will experience any distress following interview. However, you will be provided with a debrief sheet following interview, which will include the contact details of some support sources should you require them.

Are there any benefits to taking part?

Although you may find participating interesting, there are no direct benefits in taking part. People who participate in interview based research often find the process rewarding.

Who has reviewed the project?

This study has been reviewed by the Faculty of Health and Medicine Research Ethics Committee, and approved by the University Research Ethics Committee at Lancaster University.

Appendix C: Participant Consent Form

Consent Form



Mental health and Deafness: Interpreters' perspectives on compassion and the development of and barriers to the therapeutic alliance between a clinician and their Deaf client

We are asking if you would like to take part in a research project that seeks to gain the experiences of interpreters involved in facilitating therapeutic relationships. Before you consent to participating in the study we ask that you read the participant information sheet and mark each box below with your initials if you agree. If you have any questions or queries before signing the consent form please speak to the principal investigator, Laura Wedlock.

Please initial each statement:

1. I have read the information sheet explaining the purpose of the research and fully understand what is expected of me. ☐
2. I confirm that I have had the opportunity to ask any questions and gain further information about the research. ☐
3. I understand that my interview will be audio recorded and then made into an anonymised typed transcript. ☐
4. I understand that audio recordings will be kept securely until an interview transcript has been created, and then deleted. ☐
5. I understand that my participation is voluntary and that I am free to withdraw up to two weeks following interview. ☐
6. I understand that once my data have been anonymised and incorporated into themes it might not be possible for it to be withdrawn, though every attempt will be made to extract my data if required. ☐
7. I understand that some of my words and phrases will be used in the write up of the final report. These will also be used in the presentation of the project and if the project is published. ☐

8. I understand that any information I give will remain strictly confidential and anonymous unless it is thought that there is a risk of harm to myself or others, in which case the principal investigator will need to share this information with her supervisory team. ☐
9. I consent to Lancaster University keeping written transcriptions of the interview for 10 years after the study has finished. ☐
10. I understand and have read the above and agree to take part. ☐

Name of Participant_____ **Signature**_____

Date _____

Name of Researcher _____ **Signature** _____

Date _____

Appendix D: Participant Debrief Form

Debrief Sheet



Mental health and Deafness: Interpreters' perspectives on compassion and the development of and barriers to the therapeutic alliance between a clinician and their Deaf client

Thank you very much for taking part in my research.

What happens now?

A transcript of our interview will be typed up in the weeks following our meeting. In the two weeks following interview, you may still choose to withdraw from the study if you no longer wish your data to be used. If this is the case, please contact me via the most convenient method. After this two week period, the transcript will be analysed and collated together with other interview transcripts and I will be unable to extract and delete your individual data.

If you would like a lay summary of the results, I would be happy to send this to you upon the study's completion.

What if I need to speak with someone following interview?

I sincerely hope you found the interview to be a positive and interesting experience. If however the experience has brought up difficult feelings, or left you feeling distressed, I would encourage you to contact one of the services listed below:

The Association of Sign Language Interpreters

Professional association providing mentoring, supervision and discussion forums for BSL interpreters

Tel: [REDACTED]
Email: [REDACTED]

MIND

Mental Health charity providing support and advice

Tel: [REDACTED]

Text: [REDACTED]
Email: [REDACTED]

Samaritans
Charity providing a listening/signposting service

[REDACTED]
Tel: [REDACTED]
Email: [REDACTED]

Finally, if you have any further questions following interview, or want an update on the research, please feel free to contact me using the details provided:

Laura Wedlock

Email: [REDACTED]

Phone: [REDACTED]

Thank you again for taking part, your input was invaluable.

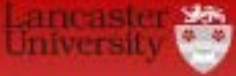
Appendix E: Blog Post



My name is Laura Wedlock, and I am a trainee clinical psychologist in the final year of my doctoral training at Lancaster University. I want to gain the accounts of BSL/English interpreters regarding their role in facilitating the development of a therapeutic relationship between a hearing clinician and a client who is Deaf. Compassion is a central feature of the development of a positive therapeutic relationship, and previous research with hearing people has evidenced how this can be communicated via touch and voice. There is however no research that considers how compassion is communicated to and understood by a Deaf client.

Interpreters have a unique role and facilitate communication in this relationship. Their perspectives will highlight the factors which assist the development of a good relationship, and the challenges which can cause ruptures. The project aims to give voice to the interpreters to talk about their views on therapeutic alliance in mental health practice. Research results could aid consideration regarding the adaptations that both mainstream services and clinicians must make in order to increase accessibility and positive outcomes for Deaf individuals.


Appendix F: Poster




Mental health and Deafness: the voice of the interpreter.

Are you an NRCPD registered interpreter?

Have you worked with Deaf individuals in mental health services?



 If so, it would be wonderful to hear from you. Please contact **Laura Wedlock**, Trainee Clinical Psychologist to learn more and express interest in taking part.

Phone: Email:

Appendix G: Conditional Approval from the Research Ethics Committee



Faculty of Health and Medicine Research Ethics Committee

Our ref: FHMREC15109

21 July 2016

Laura Wedlock
Division of Health Research
Faculty of Health and Medicine
Lancaster University

Dear Laura

Re: FHM Research Ethics Committee application for project titled: *'Mental health and Deafness: Interpreters' perspectives on compassion and the development of and barriers to the therapeutic alliance between a clinician and their Deaf client'*.

Thank you for sending in the paperwork for your application. We appreciated reading about the project. We have a few minor concerns, and ask that you address the following in revising your application materials:

- **General** o Please use the correct Faculty logo (included at the end of the email in which this letter was sent).
- **Application section 11** o Amend the start date to take into account the timescale for ethical approval.
- **Application section 12** o State the minimum number of participants which will ensure your study is viable.
- **Application section 16** o Although you foresee no risks to you as a researcher, please consider what you would do in the event of difficulties arising. Include details here of the Lone Worker Policy or Guidance you are following (from which agency or source), outlining the main elements of it that apply to you. You may wish to use the University's Lone Worker Guidance (field work) as the basis of this section:

<http://www.lancs.ac.uk/depts/safety/files/fieldguidance.pdf>

- **Application section 19** o Please state here the circumstances in which you may have to break confidentiality (that is the 'limits to confidentiality', when you view that a participant has indicated they may cause harm to themselves or others (as detailed in your PIS).
 - o Where face to face interviews are at the participant's place of work, please comment in section 24 on how you will address confidentiality issues (or note that confidentiality may not be wholly maintained).
 - o Clarify here that you will be carrying out the transcription.
- **Application section 21** o Please state the length of time for which documents will be stored.
 - o Move all comments relating to audio files from section 21 to section 22. Audio files are included as a separate item on the application form since they contain more easily identifiable, and therefore sensitive, data.
- **Application section 22** o Move comments relating to electronic, digital and paper copies of data to section 21. o Please note here that your reason for earliest possible upload or your audio recordings is that it is not possible to encrypt your portable devices. If it is possible to encrypt them, please state this here.
 - o Please state in this section how will transcripts be stored and for how long. Please refer to the guidance notes in the FHMREC website for further information: <http://www.lancs.ac.uk/shm/research/ethics/>
 - o Please indicate in this section who will be responsible for the storage and deletion of data once you have completed your course.
- **Application section 24** o Clarify here how you will ensure confidentiality of participants whose interviews take place on work premises during the working day; or note that you will make it clear that confidentiality cannot be fully ensured in these circumstances.
- **Participant Information Sheet** o The language used in your PIS is very academic; we suggest simplifying this.
 - o **Do I have to take part?** Note that not taking part will have no negative repercussions in relation to treatment.
 - o **Will taking part be confidential?** Amend this to note that, whilst every effort will be made, it is not possible to ensure confidentiality of participation where the interview takes place on work premises during the working day.
- **Sources of support** o Currently there are no details of external support options. Please provide relevant suggestions.
- **Consent form** o Add an item noting that you will share and discuss data with your supervisor.

Ensure consistency between the application form, the Research Protocol and the supporting materials in line with the changes requested above.

Please use Lancaster University letter-headed paper for all participant materials

We ask that you attend to these in writing by (re)submitting to the FHMREC via [REDACTED] [REDACTED] the application document and materials with any changes highlighted. If your responses to the above are satisfactory then approval will be recommended on Chair's action. If you have questions, please feel free to contact me.

Yours sincerely,

[REDACTED]

Appendix H: Favourable Ethical Approval from Research Ethics Committee



Applicant: Laura Wedlock
Supervisor: Ian Fletcher
Department: Health Research
FHMREC Reference: FHMREC15109

23 August 2016

Dear Laura

Re: Mental health and Deafness: Interpreters' perspectives on compassion and the development of and barriers to the therapeutic alliance between a clinician and their Deaf client

Thank you for submitting your research ethics application for the above project for review by the **Faculty of Health and Medicine Research Ethics Committee (FHMREC)**. The application was recommended for approval by FHMREC, and on behalf of the Chair of the Committee, I can confirm that approval has been granted for this research project.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact me if you have any queries or require further information.

Tel: - [REDACTED]

Email: - [REDACTED]

Yours sincerely,

[REDACTED]