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## Woven Voices: Recommendations for Counsellors Working with Professional Interpreters Des voix concertées : Recommandations aux conseillers et conseillères travaillant avec des interprètes professionnels

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### ABSTRACT

This study used the enhanced critical incident technique to examine meaningful incidents that helped, hindered, or were desired by 7 professional interpreters (PI) working in mental health care. Data analysis resulted in 562 critical incidents (CI), 258 helping CIs, 223 hindering CIs, and 81 wish-list items. Counselling and education recommendations are provided, which include PI's intrapersonal processes; counsellor's presence, collaboration, and education on PI-mediated sessions; community and government support for PIs; and clients' understanding of PI-mediation sessions, communication style, family dynamics, and community.

### RÉSUMÉ

Dans cette étude, on a eu recours à la technique améliorée d'analyse d'incident critique pour examiner les incidents significatifs qui se sont révélés favorables ou défavorables ou qui ont été souhaités par 7 interprètes professionnels (IP) travaillant dans le domaine des soins de santé mentale. L'analyse des données a résulté en 562 incidents critiques (IC), 258 IC favorables, 223 IC défavorables et 81 éléments souhaités. L'article propose des recommandations en matière de counseling et d'éducation, notamment en ce qui concerne des démarches intrapersonnelles des IP; la présence, la collaboration et l'éducation des conseillers en lien avec les séances tenues par médiation d'un IP; le soutien communautaire et gouvernemental des IP; la compréhension par les clients des séances tenues par médiation d'un IP, les styles de communication, la dynamique familiale et les rapports avec la collectivité.

Due to globalization and immigration, Canada's population is ever-expanding and socio-culturally diverse, with 7,321,060 (22.9%) citizens speaking a non-official language as of 2016 (Brisset, Leanza, & Laforest, 2013; Statistics Canada, 2017). Individuals with limited English proficiency are confronted with severe health service challenges related to language, even when there is a mandate for access to health services without language barriers (Canada Health Act, 1984, s. 3). Problematic outcomes in client mental health include improper diagnoses, counsellor errors, medication complications, and longer hospitalizations (Brisset et al., 2013; Flores, 2005; Hunt & de Voogd, 2007; Paone & Malott, 2011). As

the first point of contact for clients during a crisis, professional interpreters (PIs) normalize mental health and aid the counsellor's cultural understanding (Brisset et al., 2013; Miller, Martell, Pazdirek, Caruth, & Lopez, 2005). Studies have shown that PIs can help clients trust therapy, leading to greater treatment compliance and satisfaction (Tribe & Tunariu, 2009). Unfortunately, many counsellors are uninformed regarding PI-mediated sessions and, therefore, do not collaborate with PIs (Hsieh & Hong, 2010).

The purpose of this qualitative study was to investigate factors that help and hinder PIs working in mental health counselling sessions. The central research question was, "*What is currently helping and hindering PIs with their work in mental health counselling sessions, and what would be helpful for PIs if it were possible?*" Findings advance insight on PIs' and counsellors' collaboration, proliferate the current literature, and support institutional change regarding clients' PI-mediated mental health. Existing literature presents limited information on factors that help and hinder PIs' communication, collaboration with counsellors, navigation of ethical dilemmas, and management of vicarious trauma. PIs' perspective is nearly non-existent in the literature. In this article, we summarize the PI-mediated health care literature and present our methodology, results, implications and practical recommendations, study limitations, and future research suggestions.

#### SUMMARY OF PI-MEDIATED HEALTH CARE LITERATURE: STRENGTHS, OPPORTUNITIES, AND CHALLENGES

##### *Communication Among the Triad*

When the therapeutic dyad becomes a triad, communication challenges may emerge. The PI's presence may strengthen the PI-client relationship at the cost of the counsellor-client relationship (Greenhalgh, Robb, & Scambler, 2006; Hsieh & Hong, 2010). PIs can unintentionally alter communication through omission, revision, elaboration, and phrase changing, including turning open questions into leading questions (Brisset et al., 2013; Jacobs, Diamond, & Stevak, 2010; Paone & Malott, 2011; Raynor, 2016). Language influences individuals' perceptions of health and illness, thereby challenging PIs to convey non-equivalent messages into English accurately (Berthold & Fischman, 2014; Fatahi, Nordholm, Mattsson, & Hellstrom, 2009; Tribe, 1999). Mental health terms also stem from a Western worldview, whereas clients tend to use culturally-specific proverbs and humour (Tribe, 1999). PIs interpret consecutively or simultaneously, and from a first- (I) or third-person (he, she, they) perspective; for new clients and counsellors, this is unfamiliar and can be distracting (Flores, 2005; Hsieh, 2010; Miller et al., 2005).

##### *Relationship Dynamics: Trust, Control, and Power*

The PI's loyalty may lie with the client, the counsellor, or the language service provider, impacting power and trust dynamics. As a result, the client, counsellor, or PI may feel excluded at times (Tribe, 1999). Positive PI and counsellor attitudes enable trust during a session, consequently enhancing the therapeutic alliance.

Trust and belonging can be amplified when PIs share a community with the client (Engstrom, Roth, & Hollis, 2010; Miller et al., 2005; Tribe, 1999; Yakushko, 2010). However, PIs can also inhibit client participation due to embarrassment or distress about confidentiality (Engstrom et al., 2010). PIs may inadvertently gain control via providing inadequate informed consent or by altering conversation content.

On the other hand, counsellors may exert control by underutilizing PIs, limiting session duration, or monitoring differences in speech length (Engstrom et al., 2010; Hunt & de Voogd, 2007; Searight & Searight, 2009). Consequently, power differentials among the triad may leave clients feeling disempowered, fearful, and acquiescent (Tribe & Tunariu, 2009). Further, institutional constraints disempower PIs through limiting training, compensation, and PI availability (Brisset et al., 2013; Hsieh, 2010; Larrison, Velez-Ortiz, Hernandez, Piedra, & Goldberg, 2010).

### *PI Roles, Ethical Dilemmas, and Vicarious Trauma*

PIs assume client advocacy roles via empathy, assuring trustworthy care, and fulfilling requests such as filling in pre-session forms. However, increased client advocacy reduces PI neutrality, and when clients disclose information to PIs pre-session, this may shift the PI into a therapist-type role (Fatahi, Mattsson, Hasanpoor, & Skott, 2005; Hsieh & Hong, 2010; Paone & Malott, 2011). PIs can assume a cultural broker role by informing counsellors of cultural expectations or that interventions may need specific cultural sensitivity, thus supporting client engagement. PIs may also experience role conflicts. Those experienced in health care may be granted an unwarranted medical expert role (Hsieh, 2010; Kaufert & Koolage, 1984; Tribe, 1999). They are confronted with ethical dilemmas surrounding confidentiality or role expectations, especially when they and the client are part of a small community (Brisset et al., 2013; Kaufert & Koolage, 1984). The American Psychological Association's (2017) ethical guidelines note PIs with dual relationships are not appropriate. Limited PI availability, however, may leave no choice (Flores, 2005; Searight & Searight, 2009).

PIs can experience vicarious trauma due to empathic involvement with clients' traumatic material. This risk escalates when PIs share a cultural background with clients (Berthold & Fischman, 2014; Engstrom et al., 2010; Miller et al., 2005). Existing literature suggests a pervasive need for support through PI supervision, therapeutic groups, or post-session debriefing (Paone & Malott, 2011; Searight & Searight, 2009; Tribe, 1999).

## METHODOLOGY

We used the enhanced critical incident technique (ECIT) to investigate what is currently helping and hindering PIs with their work in mental health counselling sessions, and what would be helpful for PIs if it were possible. ECIT evolved from the original critical incident technique (CIT; Flanagan, 1954) and is useful

to understand topics not extensively explored using reliability and validity checks (Butterfield, Borgen, Amundson, & Maglio, 2005).

### *Participants*

PIs were recruited through interpreting agencies and met the inclusion criteria of being accredited or certified by a recognized PI agency and having a minimum of four years of experience in mental health settings. The participant sample consisted of 6 females and 1 male, ranging from 27- to 70-years old ( $M = 55$ ). Participants' years of experience as a PI in mental health ranged from 4 to 28 years ( $M = 16$  years). Participants spoke a total of 16 languages and worked in 11 languages, not including English.

### *Five Steps in an Enhanced Critical Incident Technique Study*

The CIT entails exploring helping and hindering critical incidents (CIs). ECIT augments CIT by including contextual questions at the start of the interview, exploring wish-list (WL) items in addition to the CIs, and implementing nine credibility checks (Butterfield, Borgen, Maglio, & Amundson, 2009). In Steps 1 through 4, we explored PIs' experiences working in mental health, formulated the ECIT interview guide including contextual questions, and collected and analyzed data following the guidelines (Butterfield et al., 2009; Flanagan, 1954). In Step 5, we conducted nine ECIT credibility checks (Butterfield et al., 2009) and reported our findings.

Interviews were audio-recorded and transcribed verbatim. The main component of the interview consisted of contextual questions, CI and WL questions (e.g., "What has been helpful to you in working as an interpreter in mental health counselling sessions?"), and probing questions (e.g., "How did it help?"). The interview concluded with demographic questions.

Data analysis was accomplished by extracting CIs and WL items from the raw data, developing categories, and ascertaining the level of specificity necessary to report the data (Butterfield et al., 2005; Flanagan, 1954). Nine credibility checks were satisfied to enhance validity and trustworthiness (Butterfield et al., 2005; Flanagan, 1954):

1. *Audio-recording interviews.* To ensure participant experiences were captured accurately and transcribed verbatim, promoting descriptive validity (Butterfield et al., 2009).
2. *Interview fidelity.* A coresearcher familiar with ECIT reviewed every third interview recording to ensure protocols were followed correctly (Butterfield et al., 2009).
3. *Independent extraction of incidents.* An independent judge randomly selected 25% of the transcripts to extract CIs and WL items for validating the original CIs and WL items by computing a percentage of agreement; 100% agreement was achieved (Andersson & Nilsson, 1964; Butterfield et al., 2005; Butterfield et al., 2009).

4. *Exhaustiveness.* Exhaustiveness occurred once new categories stopped emerging, thus achieving redundancy; this was achieved after the 6<sup>th</sup> participant interview (Butterfield et al., 2005, 2009; Flanagan, 1954).
5. *Participation rates.* The participation rates represent participants' CIs in each category, and at least 25% or more of the participants should be included in each category; participation rates establish credibility and represent category strength (Butterfield et al., 2005, 2009; Flanagan, 1954). See Tables 1 and 2 for participation rates.
6. *Placing incidents into categories by an independent judge.* An independent judge placed 25% of the CIs and WL items into the developed categories, and researchers computed a match rate of 90% agreement; the recommended match rate is 80% or higher (Andersson & Nilsson, 1964; Butterfield et al., 2009).
7. *Cross-checking by participants.* Participant cross-checking interviews served to confirm that categories were supported and that participants' voices were respected (Butterfield et al., 2005).
8. *Expert opinions.* Two experts with knowledge of the research topic verified that the categories were consistent with their understanding of the field. Both experts commented on the significance of the counsellor-PI teamwork category. The psychologist expert elaborated that the client's sense of safety may be compromised when PIs share the same community and PIs may face challenges in their attempt to set appropriate boundaries.
9. *Theoretical agreement.* The researchers' categories were compared with literature to confirm congruence, thereby increasing trustworthiness (Butterfield et al., 2009).

## RESULTS

We present the research findings in two components: contextual data and ECIT data. Thematic analysis of the contextual data outlines the participants' general sense of working as a PI in mental health settings. The ECIT data comprise all helping and hindering CIs and WL items, and individual categories' participation rates and frequencies. Categories are accompanied by definitions and participant quotes for more context (Butterfield et al., 2009).

### *Contextual Data*

To begin, we asked contextual questions to obtain information on PIs' sense of communication, session atmosphere, personal meaning, roles, trust, control, and power dynamics. Table 1 illustrates the frequency and percentage of participants who discussed each theme, theme summaries, and participant quotes. The contextual data describes the PIs' general experiences in counselling sessions. Upon reviewing the themes, PIs' dedication to their work was evident through their intention to be supportive, their commitment to effectiveness in their roles, and their sensitivity to the process and to clients' and counsellors' needs.

Table 1  
*Contextual Data: Themes in Participants' Descriptions of Professional Language Interpreters*

Theme	Frequency and rate	Theme summary	Example of theme as captured in participant quote
Communication during session	7 (100%)	Complexities inherent in triadic communication.	"When the client tries to speak directly to you, they try to explain their feelings to you, not to the service provider and give some references that are not relevant in... the Canadian context; culture-specific things that would be hard to interpret" (Participant L).
Personal meaning of professional interpreter	6 (86%)	Helping community members through a literal voice and providing a sense of connection and comfort.	"I'm [a] fully trained professional who is there to try to understand something not at 30%, not at 40%, but at 99 to 100%. I help in such an important subject" (Participant EP).
Professional interpreter roles	6 (86%)	Roles as facilitator, language conduit, culture broker, and client advocate.	"You are a facilitator, you're an interpreter, you're a cultural broker. You should be, to some degree, a support system to both parties. There's a lot involved" (Participant N).
Atmosphere of session	5 (71%)	Atmosphere described as mostly supportive and rewarding.	"Each setting... gives a different vibe and feeling to the session, [dependent on] patient... culture... on the healthcare providers.... Sometimes it's extremely fulfilling because you know at the end of it a good job was done, but sometimes it's a bit frustrating" (Participant N).
Trust, control, and power dynamics	5 (71%)	Counsellors have control during sessions. Trust dynamics shift during a session for various reasons. Counsellors appear to have more institutional power than PIs or clients.	"The health care professional[s]... are the manager of the session.... The control has to be in the hand of the professional.... The trust issue can be really changing, even by one body language, or one smile, or one tissue handing. It really changes even in one session, multiple times... especially in [a] psychiatry unit" (Participant J).

### *Critical Incidents and Wish-List Items*

This study yielded a total of 562 CIs extracted from 7 participant interviews. There were 258 helping CIs, 223 hindering CIs, and 81 WL items. Table 2 illustrates the 14 categories, their respective participation rates and frequencies, and total helping and hindering CIs and WL items. Categories are ordered from the most common frequency of total helping and hindering CIs to the least.

Table 2  
*Number of Critical Incidents, Participation Rate, and Frequency for Each Category*

Category	Total CI (N = 562)		Helping CI (N = 258)		Hindering CI (N = 223)		WL item (N = 81)	
	P	N	P	n	P	n	P	n
1. PI self-awareness in interpreting.	7 (100%)	65	7 (100%)	38	5 (71%)	27	0 (0%)	0
2. Counsellor knowledge of effective PI-mediated sessions.	6 (86%)	62	6 (86%)	33	6 (86%)	29	5 (71%)	16
3. PI experience, interest, and passion for mental health.	7 (100%)	61	7 (100%)	53	4 (57%)	8	0 (0%)	0
4. PI focus and skill for effective interpreting.	7 (100%)	41	7 (100%)	27	4 (57%)	14	0 (0%)	0
5. Counsellor's professional respect.	6 (86%)	41	6 (86%)	13	5 (71%)	28	0 (0%)	0
6. Counsellor and PI teamwork.	7 (100%)	40	7 (100%)	40	0 (0%)	0	5 (71%)	17
7. PI adherence to a code of ethics.	7 (100%)	33	7 (100%)	22	4 (57%)	11	0 (0%)	0
8. Counsellor's active engagement.	5 (71%)	30	4 (57%)	19	5 (71%)	11	0 (0%)	0
9. Institutional advocacy and support for PIs.	6 (86%)	29	5 (71%)	6	6 (86%)	23	6 (86%)	33
10. Client's language, community, and culture.	6 (86%)	28	0 (0%)	0	6 (86%)	28	0 (0%)	0
11. Client understanding of effective PI-mediated sessions.	6 (86%)	16	0 (0%)	0	6 (86%)	16	4 (57%)	9
12. Client's capacity for effective engagement.	6 (86%)	14	0 (0%)	0	6 (86%)	14	0 (0%)	0
13. Intentional, dedicated physical environment.	4 (57%)	14	3 (43%)	7	4 (57%)	7	4 (57%)	6
14. Client's family involvement as hindering.	5 (71%)	7	0 (0%)	0	5 (71%)	7	0 (0%)	0

*Note.* P = Number of participants and participation rate as a percentage; N = Total number of CIs; n = Number of CIs or WL items within each helping, hindering or wish-list set.



1. *PI self-awareness in interpreting.* Every participant valued their PI role and considered their awareness of personal beliefs, limitations, biases, and value placed on their role as crucial to interpreting during mental health sessions (100% participation rate, 38 helping CIs). Participant N explained, “We have to be very familiar and alert towards our own biases, cultures, feelings, tolerance, abilities to manage because sometimes what is said or revealed is extremely traumatizing.” Participants also discussed biases and emotional reactions that hinder their interpreting (71% participation rate, 27 hindering CIs). Consequences such as “arrogant,” not “neutral,” and “step out of her [PI] role,” were a few participants’ examples.
2. *Counsellor knowledge of effective PI-mediated sessions.* Education for counsellors working with PIs was outlined as helping via a greater understanding and likelihood of following protocols in place, including notifying PIs beforehand of the appointment type so PIs can ethically accept, decline, or prepare for cases (86% participation rate, 33 helping CIs). Participants reported feeling hindered when counsellors lacked education on effective work with PIs, did not adhere to protocols, or had wrong expectations (86% participation rate, 29 hindering CIs). Participants also wished counsellors knew of recommended collaborative strategies with PIs (71% participation rate, 16 WL items).
3. *PI experience, interest, and passion for mental health.* Participants claimed personal and professional “experiences,” “education,” and “credentials” in interpreting or mental health, and shared culture with the client, help their interpreting work (100% participation rate, 53 helping CIs). A helping example from Participant N was,
 

I have experienced war, revolution, migration... I’m a female... [I’ve] lived in three continents... and I worked with UN refugees... I bring to the session years of knowledge, study, experience. It all comes together and makes that character that goes into that counselling session.

 Conversely, several participants highlighted a lack of mental health education provided to PIs as a hindering factor (57% participation rate, 8 hindering CIs).
4. *PI focus and skill for effective interpreting.* All participants elaborated on the importance of the PI’s focus, skills, and strategies for accurate interpreting during mental health interviews (100% participation rate, 27 helping CIs). Participant J explained that during session, PIs “call ourselves in a third person. We don’t say ‘I.’ [We say] ‘Interpreter would like to clarify the situation,’ ‘Interpreter is not familiar with the term,’ [or] ‘Can interpreter have some time to look [it] up in the dictionary?’” Participant N detailed, “If you cut them [clients] off, either the emotions stop or the train of thought stops.... So, if you need tools like taking notes, do it very subtly.” Some participants stated their well-being or lack of focus could hinder their work in mental health (57% participation rate, 14 hindering CIs). Participant EP found it “extremely difficult to do end of life meetings” after losing his own father.



5. *Counsellor's professional respect.* Counsellors' "patience," "respect," and "supportive" attitudes toward PIs and clients were detailed as significantly helpful (86% participation rate, 13 helpful CIs). Participant EP stated, "What helps me the most for mental health [is] I enjoy the professional aspect... [and] general kindness from both sides [PI and counsellor]." Participants also explained difficulties due to counsellors' "frustrations," "impatience," "biases," and "blame" toward PIs, clients, or other counsellors, causing "fragmented" health care teams (71% participation rate, 28 hindering CIs). Participant N protested, "A lot of them have no value for what job we do." As a hindering example, Participant J said,
 

[When counsellors get] frustrated... the blame can come to us, and when that happens, we feel like our job is undermined and it's really hard for us to be neutral and impartial.... [Or if the health care team is] fragmented, the patient can really feel it... they can see body language.... [However,] the support or the vibe, the attitude, the personality of the health care team can be very helpful.
6. *Counsellor and PI teamwork.* All participants stressed the significance of working with counsellors as a team, collaboratively providing time for PI introductions at the beginning of sessions, fostering communication, and preparatory attention to the personal safety of the PI and client (100% participation rate, 40 helping CIs). Participants emphasized a desire for counsellors to treat them as part of the same team, with respect, appreciation for PI roles and assets, and prior notification of session type (71% participation rate, 17 WL items). Participant J suggested counsellors "include health care interpreters as part of [the] health care team.... Not just 'them' team, but 'us' team."
7. *PI adherence to a code of ethics.* A code of conduct surrounding confidentiality, professional boundaries, potential conflicts, and roles played a significant helping role for all participants (100% participation rate, 22 helping CIs). Conversely, some participants indicated via real-life and hypothetical stories potential struggles for PIs to abide by the code of ethics (57% participation rate, 11 hindering CIs). As a hindering example, Participant J said,
 

Still, every day I'm [*sic*] struggle with that code of ethics... because of my arrogance, because of my experience... I can really assume a lot of things, and that hinder[s] me being accurate and being faithful to the message I am supposed to interpret.... It's a constant fight with myself to be a good interpreter, not the language.
8. *Counsellor's active engagement.* Participants expressed appreciation for counsellors supervising sessions by looking at and speaking directly to clients; monitoring speech length, body language, and facial expressions; and requesting PI clarification (57% participation rate, 19 helping CIs). Participants described challenges of counsellors not actively participating, such as speaking only to the PI, or being distracted entirely (71% participation rate, 11 hindering CIs). As a hindering and helping example, Participant J said,

[When counsellors] multitask... while I'm interpreting—they make notes, get their folder, and in the worst-case scenario they even dictate with their own info—... the kind of noise is not helpful. We need to have someone that can make us feel like they're watching us to do [a] good job. It's not that we need to have that kind of watching person, but still it kind of forces us to do a better job. Also, although they [clients] do not understand the language, as a professional, especially if you are [a] counsellor,... you need to see the reaction of the patient when we are actually saying it.

9. *Institutional advocacy and support for PIs.* Participants highlighted support with work-related misunderstandings, regulating and certifying PIs, PI research, mental health support, and lobbying for mandated PI use as helping factors (71% participation rate, 6 helping CIs). Participant L emphasized, “more people in the field and more certified people and more regulated profession” would benefit the PI community and clients. Participants discussed obstacles such as compensation cutbacks, long commutes, restricting the use of PIs, and PIs feeling unsupported in their mental well-being (86% participation rate, 23 hindering CIs). Participant G stated, after “distance, cost... you pay the parking, and if they [language service provider] give you \$26, what did you make? But then you say, ‘Who cares?’” Participants desire increased compensation, more educational opportunities, a regulated PI profession, and a mandate to use PIs (86% participation rate, 33 WL items). Participant L articulated, “Requirements to have a certified qualified interpreter for the session would really help.” Participants also desire increased mental health support via post-session debriefing, resource lists, or therapy, and for basic mental health training for PIs in mental health settings.
10. *Client's language, community, and culture.* Participants cited hindering factors such as clients' limited understanding of or stigma toward mental health and PIs, terms or expressions being regional or language-dependent, or PIs sharing a small community with clients (86% participation rate, 28 hindering CIs). Participant I explained that clients are “quite open with me when the professionals aren't there... because it's a small community, so you know them.... You can't just be like a stranger. There is a social interaction happening.” Participant M detailed when clients or PIs “don't understand what mental health is... and the stigma against it [is] very difficult... it can be very dangerous when you are trying to help the client.”
11. *Client understanding of PI-mediated sessions.* Participants felt challenged when clients lack an understanding of the purpose of their appointment, of the PI's role and ethical duties, or of typical session processes (86% participation rate, 16 hindering CIs). Participant EP expressed, “They [clients] don't know... We care to do word for word and we care that everything is transparent... that I am not on the side of the doctor.” Participants expressed desires to have clients be informed of the PI's role, assets, limitations, and ethical duties (57% participation rate, 9 WL items).

12. *Client's capacity for effective engagement.* Participants experienced difficulties with clients' communication, including sentence length (too short gives insufficient context, too long is impossible not to summarize), irrelevant answers, or not answering (86% participation rate, 14 hindering CIs). Participants also felt challenged when clients relied on limited English comprehension instead of on the PI, when clients withheld information due to distrust of the counsellor or the PI, or when clients disclosed information to the PI before the session but did not repeat it to the counsellor.
13. *Intentional, dedicated physical environment.* Participants mentioned counsellors having a clean and safe environment, using a "triangle seating arrangement," and warning of potential smell and noise, as helpful (43% participation rate, 7 helping CIs). Triangle seating is imperative because "it really shows that [the] interpreter is there as very unbiased" (Participant J). With this seating, clients "have to look at the doctor so that they can make a connection... I'm just the voice in the background" (Participant N). Participants also reported challenging environmental factors, including distracting appearances, smells, blood, screaming, and hitting, occasionally causing PIs to feel unsafe (57% participation rate, 7 hindering CIs). Participants expressed desires to have a safe and clean environment with appropriate seating (57% participation rate, 6 WL items).
14. *Client's family involvement as hindering.* Participants were hindered by clients' family members censoring, summarizing, or misinterpreting the client or the counsellor (71% participation rate, 7 hindering CIs). One hindering example was,
 

Patients have a right to ask for interpreters even if their relatives or kids or husband all come with them.... One [reason] is that medical terms, not everybody knows... second is that children tend to answer *for* parents or husbands *for* wife... or third, sometimes the patient doesn't want to say things in front of the family member, maybe private. (Participant N)

While the categories effectively capture what helps and hinders PIs working in mental health, they are divided into four groups to elicit implications for counsellors (see Table 3). We discuss them further under Counselling and Education Implications.

#### DISCUSSION

The literature suggests that client health outcomes are diminished when PIs are not used, yet many clinicians regard PIs as obstacles to therapy (Brisset et al., 2013; Flores, 2005; Greenhalgh et al., 2006; Hsieh, 2010). Society's expanding linguistic diversity necessitates further collaboration with PIs to serve this growing community better. We investigated this topic as counsellors, with expertise founded in mental health, and explored the PIs' perspectives on working in mental health counselling. Findings suggest counsellors, in a position of power, should

regard PIs not as obstacles but instead as humans and professionals who bring distinct resources to the counselling process.

This study revealed factors that help, hinder, or would help PIs working in mental health. The results are consistent with the literature regarding interpersonal dynamics and challenges involved in PI-mediated health care, thereby satisfying the final credibility check and increasing the trustworthiness of the study (Butterfield et al., 2009). Categories that are congruent with the current literature include *counsellor knowledge of effective PI-mediated sessions* (category 2); *counsellor and PI teamwork* (category 6); and *institutional advocacy and support for PIs* (category 9) (e.g., Berthold & Fischman, 2014; Brisset et al., 2013; Miller et al., 2005; Tribe, 1999).

For instance, Paone and Malott (2011) found that counsellors experience obstacles to collaborating and trusting PIs during sessions, which can be intensified if the counsellor's experience and knowledge are limited. However, Tribe (1999) points out that if the clinician collaborates with the PI, the clinician may become more reflective, thereby enhancing the therapeutic alliance with the client (categories 2 and 6). As well, Larrison and colleagues (2010) explained that institutional constraints such as limited training and compensation lead to less power and more work pressure and distress for PIs (category 9).

Table 3  
*Grouping of Categories with Brief Descriptions and Category Composition*

Grouping of Categories	Description	Categories contained
PI's intrapersonal processes	PI's intrapersonal processes of developing self-awareness of beliefs, biases, tolerances, values, and ethics through experience and education.	(1) PI self-awareness in interpreting; (3) PI experience, interest, and passion for mental health; (4) PI focus and skill for effective interpreting; (7) PI adherence to a code of ethics.
Counsellor's presence, collaboration, and education on PI-mediated sessions	Counsellor's influence on PI-mediated sessions through the respectful and inclusive treatment of PIs and clients, teamwork with PIs, and education on or adherence to protocols.	(2) Counsellor knowledge of effective PI-mediated sessions; (5) Counsellor's professional respect; (6) Counsellor and PI teamwork; (8) Counsellor's active engagement.
Community, and government support for PIs	Community and government influences on PIs working in mental health settings.	(9) Institutional advocacy and support for PIs; (13) Intentional, dedicated physical environment.
Client's understanding, communication style, family dynamics, and community	Client's influences on PI's experiences working in mental health settings.	(10) Client's language, community, and culture; (11) Client's understanding of effective PI-mediated sessions; (12) Client's capacity for effective engagement; (14) Client's family involvement as hindering.

Category 1 (*PI self-awareness in interpreting*), and category 3 (*PI experience, interest, and passion for mental health*), have not been sufficiently addressed in the literature. All participants cited these categories as significantly influencing their interpreting work in mental health. Exploring PI-mediated mental health from the PIs' perspectives enabled us to supplement current literature with helpful intrapersonal factors, such as the significance of PIs' self-reflexivity, ongoing self-awareness, the value PIs place on their helping role, and their assets. An understanding of categories 1 and 3 helps counsellors acknowledge PIs' involved roles and commitment to clients, promoting increased respect for PIs and enhanced counsellor–PI collaboration. Furthermore, Category 2 (*counsellor knowledge of effective PI-mediated sessions*) works in tandem with PI's self-awareness to underscore the importance of PIs' ongoing self-awareness.

Moreover, it is imperative that PIs receive adequate client information from counsellors before sessions to enable ethical acceptance or refusal of cases, and to mitigate against vicarious trauma. This self-awareness also works in tandem with Category 4 (*PI focus and skill for effective interpreting*), as effective interpreting requires PIs' awareness of any tendencies to summarize, revise, or turn open questions into leading questions; impacting communication and the therapeutic alliance.

Counsellor understanding of the client's worldview facilitates appropriate empathy, yet PIs are challenged when messages cannot be interchanged between languages (Berthold & Fischman, 2014; Tribe, 1999). Category 10 (*client's language, community, and culture*) illuminated such difficulties converting cultural expressions to English, as Participant L stated, "I can interpret that, but that doesn't make sense to the counsellor." Many participants articulated that mental health concepts are stigmatized or nonexistent in their language and cultural communities, hindering their efforts to interpret accurately. As Participant N articulated,

The questionnaires, the remedies are all designed for Western culture.... It's basically up to [the] interpreter to make each party aware of the awkwardness of the situation or the difference.... [The PI will tell the counsellor], "What you are about to ask is going to impact this person in this way, is a big taboo, and it's going to be insulting."

Category 6 (*counsellor and PI teamwork*) supplements scarce literature by highlighting specific helping experiences, such as counsellors allowing time for PIs to clarify language or culture differences and misunderstandings and debriefing with PIs to mitigate against potential vicarious trauma. Category 4 (*PI focus and skill for effective interpreting*) includes tasks not previously discussed, such as reviewing unfamiliar terms prior to and note-taking during the session. These results supplement limited literature with information for fostering comfort and trust: individual therapy requires consecutive, first-person interpreting, and group therapy requires simultaneous interpreting. Category 13 (*intentional, dedicated physical environment*), and category 2 (*counsellor knowledge of effective PI-mediated sessions*) demonstrate how counsellors' eye contact, seating arrangement, and understanding of PI ethics affect sessions.

The findings in this study add to the current literature concerning interpersonal dynamics and trust-building among the triad, stating that elements of trust “shift” during sessions and trust is often established first between the client and PI due to common language, though it extends to the entire triad (e.g., Brisset et al., 2013; Fatahi et al., 2009; Hsieh, 2010). Category 5 (*counsellor’s professional respect*) informs the literature by highlighting the importance of counsellors’ supportive attitudes to collaboration and teamwork. These supportive attitudes are imperative for client trust (Tribe, 1999; Yakushko, 2010).

This study also identifies categories that enhance clients’ informed consent, such as category 2 (*counsellor knowledge of effective PI-mediated sessions*) and category 6 (*counsellor and PI teamwork*), by allowing space for “interpreter introductions” that explain PIs’ ethical obligations surrounding confidentiality, roles, and loyalties. Our categories suggest that client trust is undermined when the following are lacking: category 1 (*PI self-awareness in interpreting*), category 5 (*counsellor’s professional respect*), and category 11 (*client understanding of effective PI-mediated sessions*).

Previous research has concentrated on ways in which PIs take control of sessions, and how counsellors develop strategies to regain control, describing these experiences as competitions (Brisset et al., 2013; Engstrom et al., 2010; Fatahi et al., 2005). Findings in our study suggested otherwise. Category 8 (*counsellor’s active engagement*) and category 6 (*counsellor and PI teamwork*) suggest that control is a valued asset of counsellors, through “active participation” and “managing” sessions. Participants explained the PI is viewed as “a butler who provides services” to both parties. In contrast, the counsellor “sets the mood” and maintains control by “supervising” and “monitoring” PI and client participation.

In category 7 (*PI adherence to a code of ethics*), all participants demonstrated how adhering to a “code of ethics is very important” regarding “confidentiality,” “conflict of interest,” or “dual relationship.” Unlike previous findings, this study illuminated the significance of the PI’s self-awareness while navigating ethical dilemmas, ethical role tensions due to a sense of client advocacy, and pre-session dilemmas when PIs’ values were weighed against emotional limitations. For example:

Of course, my immediate reaction was, “No way I’m going to help a garbage like this. He probably killed hundreds.” And the other side of me said, “You chose a profession for a reason. You don’t get to pick your clients. If he needs a voice to speak today, it’s your job to do it. So, I did it.” (Participant N)

This study’s categories revealed further insight into potential challenges and tensions that PIs experience in their attempts to satisfy conflicting roles; some PIs strongly identified as client advocates and simultaneously assumed cultural broker roles. Participant I explained, “As a member of the community who’s been here longer, with resources, I consider myself an advocate.” Fatahi et al. (2005) pointed out that client advocacy can be problematic when clients disclose concerns to PIs instead of counsellors. Category 11 (*client understanding of effective PI-mediated sessions*) and category 12 (*client’s capacity for effective engagement*) illustrated this dilemma. Participants elaborated that when a client discloses information pre-



session, the PI may “nudge” the client, asking the client to share this information with the counsellor.

Engstrom et al. (2010) found that PIs exhibit vicarious trauma through psychological distress, sleep disturbances, changes in affect, and disengagement; those who share a cultural background with clients are at higher risk. Categories 1 (*PI self-awareness in interpreting*) and 9 (*institutional advocacy and support for PIs*) address PIs’ potential vicarious trauma; participants requested mental health support and reported symptoms of “having nightmares,” “being overly worried,” “went to the bathroom to throw up,” “couldn’t stop crying,” and “detach myself from the case.” Categories that include strategies to ameliorate vicarious trauma not found in previous literature were: category 1 (*PI self-awareness of limitations and values*), category 3 (*PI experience and education in mental health*), category 9 (*institutional support for PI mental health*), category 6 (*counsellor and PI teamwork*), and category 2 (*counsellor knowledge*), including pre and post-session debriefing, and notifying PIs if there may be high-risk content. Participant N elaborated with an example of interpreting for a torturer:

It taught me something about me, what is my tolerance level.... That was a test for me, and although I am happy that I passed the test, I hope I don’t have to repeat the experience.... It had its effects on me... I was embarrassed to tell anybody.

When collaborating with PIs, there is a pervasive need to support their mental health. PIs’ repetition of first-person narratives of “torture,” “persecution,” “rape,” and “war” may elicit feelings of powerlessness and vicarious trauma symptoms (Berthold & Fischman, 2014). For example, Participant I explained:

We [PIs] go through a lot.... Things like abortions... people dying of AIDS and stuff, and abuse cases.... He [a client] was dying, [and] I had to tell him. It was very tough for me to do that. I needed to talk to somebody about it.... Also, the assigning agencies don’t know the case for confidential reasons.... You can’t really go and talk to them because they’re not supposed to know.... Sometimes you may need a resource for the interpreters. That’s the idea; that would be excellent, actually.

In summary, the results of this study support the literature regarding PI-mediated health care challenges and interpersonal dynamics, such as obstacles to communication and the therapeutic alliance (Brisset et al., 2013; Flores, 2005; Paone & Malott, 2011; Tribe & Tunariu, 2009). Our research enhances the literature by highlighting inadequately addressed phenomena, including PIs’ intrapersonal processes that foster effective engagement in sessions. Exploring the PIs’ perspectives enabled us to supplement current literature and acknowledge PIs’ involved roles and commitment to clients, promoting increased respect for PIs and enhanced counsellor–PI collaboration. Our categories further supplement limited literature with information for fostering comfort and trust among the triad (Tribe, 1999; Yakushko, 2010). To establish client trust, it is imperative that counsellors’



provide an appropriate environment and maintain supportive attitudes that foster collaboration and teamwork. This study also identifies categories that facilitate clients' informed consent and indicates that control is a valued asset of counselors. The categories also further support the literature by highlighting clients' lack of control and power.

Not evidenced in previous literature (Brisset et al., 2013; Hsieh, 2010; Larrison et al., 2010), this study illuminated the significance of the PI's self-awareness while navigating ethical dilemmas. The study revealed further insight into potential challenges and tensions that PIs experience in their attempts to satisfy conflicting roles, which are compounded by institutional constraints. Regarding mental health support for PIs, this study presents strategies to ameliorate vicarious trauma not found in previous literature. The findings highlight vicarious trauma symptoms and emphasize the role of the PI's self-awareness concerning stress and trauma.

### *Counselling and Education Implications*

The findings of this research illuminate what helps and hinders PIs in counselling sessions. The findings serve to inform counsellors of what they may experience or require in their essential role among the triad. This is helpful because the individual contributions of the professionals (Counsellor and PI) may not be entirely evident to each other. The following implications and recommendations are intended to benefit counsellors, and by extension, the PI-mediated counselling process. Suggestions are drawn from the categories and directly from participants' comments during interviews. We present implications using the four groupings of the categories, (a) PI's intrapersonal processes; (b) counsellor's presence, collaboration, and education on PI-mediated sessions; (c) community and government support for PIs; and (d) client's understanding, communication style, family dynamics, and community (see Table 4). Each categorical grouping comprises recommendations for counsellors working with PIs or for counsellor education on PI-mediated mental health care.

*PI's intrapersonal processes (Categories 1, 3, 4, 7).* These categories highlight the intrapersonal experiences of PIs during counselling sessions. This grouping is deeply informative for counsellors in order to align with PIs throughout the counselling process. PIs require information before sessions to inform their ethical decision making, including whether a prospective client case is within the scope of their professional and emotional competence; therefore, counsellors may provide a client overview beforehand. Participants noted this protocol is in place; however, counsellors are not filling in forms or are writing in "assessment' [as] the only word." Perhaps this misuse is because the counsellor does not have more information or because client confidentiality cannot be contravened.

Nevertheless, "assessment" may refer to a personality assessment, a career assessment, or a suicide risk assessment. Consequently, counsellors must fill in forms with all permitted information. This grouping of categories also highlights the challenges of developing self-awareness for PIs as they try to avoid summarizing, inaccurate cultural brokering, assuming a medical expert role, or excessive client

advocacy. A cofacilitated workshop could assist PIs in navigating ethical dilemmas, including self-exploratory or self-reflective practice components to address PIs’ biases, roles, and suggested cultural brokering techniques. Counsellors may include information on mental health, basic interviewing skills, vicarious trauma, self-care, and methods to navigate ethical challenges.

*Counsellor’s presence, collaboration, and education on PI-mediated sessions (Categories 2, 5, 6, 8).* The second grouping of categories indicates various ways a counsellor can be informed and can support PIs to be effective in their role in the counselling process. These categories emphasize professional misunderstandings and confirm that counsellors’ frustrations or mistrust may cause tension, which can be mitigated through counsellor education and adherence to protocols for working

Table 4  
*Groupings of Categories & Recommendations for Counsellors*

Grouping of Categories	Recommendations for Counsellors
PI’s intrapersonal processes (Categories 1, 3, 4, 7)	<ul style="list-style-type: none"> <li>• Counsellors can be aware of the significance for PIs to develop self-awareness surrounding beliefs, biases, tolerances, values, and ethics</li> <li>• Counsellors can address the potential for PIs’ biases and limitations by providing them with a client overview beforehand</li> <li>• Counsellors may co-facilitate a workshop with PIs to inform PIs on mental health, interviewing skills, vicarious trauma, self-care, and methods to navigate ethical challenges</li> </ul>
Counsellor’s presence, collaboration, and education on PI-mediated sessions (Categories 2, 5, 6, 8)	<ul style="list-style-type: none"> <li>• Counsellors are encouraged to foster a team approach with PIs</li> <li>• Counsellors could benefit from education on protocols for effectively working with PIs in mental health care</li> <li>• Counsellors can manage sessions by monitoring clients’ and PIs’ participation</li> <li>• Counsellors may prefer tele-interpreting as an option with vulnerable clients or in small shared communities</li> <li>• Counsellors can foster trust and professional collaboration by consistently working with the same PI when possible</li> <li>• Counsellors can be aware of the significance of debriefing with PIs pre and post-session</li> <li>• Counsellors are encouraged to maintain a positive attitude toward PI-mediated sessions</li> </ul>
Community, and government support for PIs (Categories 9 & 13)	<ul style="list-style-type: none"> <li>• Counsellors may foster emotional support, training, and advocacy for PIs</li> <li>• Counsellors can offer basic therapeutic skills workshops or organize a therapeutic group specifically for PIs</li> <li>• Counselling agencies may collaborate with interpreting agencies to set up group supervision for PIs</li> </ul>
Client’s understanding, communication style, family dynamics, and community (Categories 10, 11, 12, 14)	<ul style="list-style-type: none"> <li>• Counsellors would benefit from being mindful of clients’ language skills and family members’ involvement</li> <li>• Counsellors are encouraged to ensure clients receive information on PIs’ roles and significant ethical duties during the PIs’ introduction</li> </ul>

with PIs. Counsellors should be educated on norms of PI-mediated counselling sessions, such as seating arrangement, eye contact, the purpose of consecutive or simultaneous interpreting, the importance of PI introductions, PI ethics, monitoring clients' and PIs' participation, and notifying PIs regarding appointment type.

Counsellors concerned about client confidentiality and the therapeutic alliance may prefer tele-interpreting, "so the patients don't have to expose their identity, and they feel more comfortable." This is especially true with vulnerable clients or in small shared communities. Likewise, PI consistency increases client trust, strengthens the therapeutic alliance, and allows counsellors to foster a collaborative working relationship. If counsellors are informed of the importance of PIs' self-awareness, roles, and potential ethical dilemmas, counsellors might be better oriented to debrief with PIs pre-session about expectations. This will lead to increased respect and collaboration. Counsellor education may be facilitated through workshops or by distributing a training video for counsellors working with PIs, as suggested by one participant. A general implication is to remain open to PI-mediated sessions, viewing PIs as assets rather than obstacles to therapy.

*Community and government support for PIs (Categories 9 and 13).* It is useful for counsellors to be aware of the barriers PIs face concerning government and policy. This grouping of categories highlights PIs' dedication to interpreting and suggests specific ways that counsellors may support PIs. Counsellors may be informed of PIs' isolating experiences, lack of support, compensation, regulation, and mental health training. However, suggestions may not be actionable without more research and policy-making. Nevertheless, counsellors may be inclined to foster emotional support, training, and advocacy for PIs by offering basic therapeutic skill workshops or organizing a therapeutic group to talk about difficulties or ethical dilemmas in a safe setting. Alternatively, interpreting agencies could collaborate with mental health agencies to set up group supervision. This would allow PIs to voice and confront internal struggles and seek advice from a qualified professional while maintaining client confidentiality.

*Client's understanding, communication style, family dynamics, and community (Categories 10, 11, 12, 14).* This final grouping of categories informs counsellors of PIs' experience and their perspectives on client dynamics during counselling. These categories may facilitate conversations about what is unfolding in the therapeutic process. No helping factors were cited because participants perceived clients to be in a strained position and did not expect them to already know the PI's and counsellor's roles and ethical duties. Counsellors are advised to ensure clients receive this information during the PI's introduction. Counsellors should be mindful of clients' language skills and opt for a PI when the client's understanding appears limited or when family members are involved, potentially summarizing, withholding information, or acting aggressively toward the PI.

### *Limitations of the Study*

The results of this study should be considered with its limitations. Participants were recruited from a small geographic area, so results may reflect limited per-

spectives and experiences that occur in Greater Vancouver. In addition to mental health, participants worked in a plethora of settings, such as physical health, court, government, and immigration. All interviews focused on mental health; however, participants may have extracted select examples from other settings, potentially confounding their interpreting experiences. Participants' responses were past recollections and are subject to personal biases or difficulty accurately recalling experiences over time. This research was designed to be exploratory and to provide initial insights for supporting PIs in mental health. This study also identifies the need for future research.

### *Implications for Future Research*

Participants' emphasis on PI self-awareness, interdisciplinary collaboration, counsellor education on PI-mediated sessions, and support for PIs merits future research. Further inquiry into providing PIs with information before a session is warranted, to determine what is requested by PIs, what information is permissible to provide, and if this practice alters the percentages of mental health cases accepted. Several questions arise from this research: concerning interpersonal dynamics, how do transference and countertransference play out among the triad? Regarding PIs' mental well-being and professional competence: to what extent are PIs affected by vicarious trauma, and how might self-care, supervision, or therapy play a role? How might PIs benefit from mental health training? To address gaps in the literature on institutional support for PIs: how often are PIs used in mental health settings, and what education do counsellors have on PI-mediated sessions? What are client outcomes with and without PIs comparatively? How can communities prioritize working with PIs to effect positive institutional change, including addressing PI compensation, regulation, and support? Finally, client perspectives would be invaluable in improving collaboration with PIs to help future immigrants and refugees. These questions could be addressed through participatory action research, outcome studies, ECIT, or phenomenological research methods.

### *Conclusions*

PIs working in mental health are often misunderstood, underappreciated, and challenged with complex tasks and pressures. The two primary categories in this study, *PI self-awareness in interpreting* and *counsellor knowledge of effective PI-mediated sessions*, are considered the most significant influences on interpreting work in mental health. Participants provided an extensive list of factors they relied on to mitigate against interpreting challenges in mental health. This data encouragingly points to the potential for improved interdisciplinary collaboration, improved client health outcomes, and increased respect and support for PIs.

Optimistically, the results of this study will prove useful to counsellors and PIs, to better serve clients. The results of this research, specifically the WL items, contribute to the current literature by suggesting more collaborative interdisciplinary work and government policy shifts. Such changes will not likely occur immedi-

ately; however, with increased awareness, education, and dialogue, institutional PI-mediated mental health care change may be possible.

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