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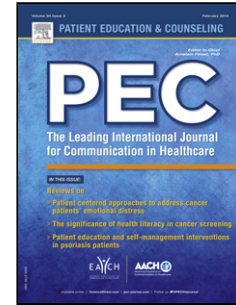
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Title:

Clinical communication and the ‘triangle of care’ in mental health and deafness: sign language interpreters’ perspectives.

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Highlights:

- Implementing a triangle of care facilitates effective therapeutic alliance
- A triangle of care model promotes service accessibility for deaf patients
- Sign language interpreters are more than just passive conduits of emotional content
- Clinicians may feel deskilled when working with sign language interpreters

Abstract

Objective: To explore the processes by which therapeutic alliance develops in mental health consultations with Sign Language interpreters.

Method: Semi-structured interviews with 7 qualified interpreters were transcribed and analysed with interpretative phenomenological analysis.

Results: Two key themes were generated: (1) Nurturing the triangle of care, where the therapeutic process relied on collaboration, continuity, and trust; and (2) Shared vision and knowledge, in which participants felt misunderstood and unsupported; there was a lack of deaf awareness and clinicians appeared to feel deskilled.

Conclusions: Interpreters should be viewed as valued members of clinical teams and have access to clinical supervision so that they can be supported in interpreting emotional distressing content. Clinicians can aim to be collaborative with interpreters and improve their knowledge of mental health issues that are relevant to deaf people.

Practice Implications: An aide-memoire of the role and practicalities of working with SL interpreters should be developed and disseminated to relevant services to support collaborative working with clinicians. A core competence in SL **interpreter** training is reflexivity. This should be embedded in educational curricula and facilitated through clinical supervision.

Funding by commissioning services should be subject to services being deaf aware and interpreters being mental health **aware**.

Keywords:

deafness; interpreters; mental health; therapeutic alliance; qualitative, IPA

1 Introduction

The involvement of Sign Language (SL) interpreters is the recommended adjustment by which mental healthcare provision can be appropriately delivered to deaf signers when professionals do not sign [1]. SL interpreting is cognitively demanding and different from spoken language interpreting due to the different language modalities involved (oral vs visual/gestural) [2]. Evidence suggests that across European countries the ratio of SL users to SL interpreters ranges between 8:1 and 2,500:1, with an average of 160:1 [3]. This lack of SL interpreters poses major challenges to deaf signers accessing mental healthcare as it often results in failure to meet their needs. In the UK, SL interpreters are not routinely sought or provided, which might partly be linked to the lack of available interpreters and the lack of suitably experienced interpreters in mental health. This makes services largely inaccessible to deaf signers [4,5].

Although the benefits of involving interpreters are considered in the literature, their role in healthcare continues to be misunderstood in both mainstream and deaf specialised settings [6–8], which often results in services not utilising their expertise. Sign Health [4] reported 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. SL interpreters constitute a vital communicative facilitator by relaying information to and from the deaf patient and, usually, the hearing health professional. du Feu and Chovaz [1] noted that in mental health services SL 'interpreting is much more than translating. It is a complex process and a bridge between two cultures'; akin to 'cultural brokers' [9]. This fits more closely to the community model of

interpreting [10], in which the interpreter's role goes beyond a traditional neutral approach [11–14].

The presence of SL interpreters during health consultations may impact on the development of meaningful and effective/therapeutic communicative exchanges between deaf patients and healthcare professionals. Clinical communication is a key component in the development of building positive therapeutic relationships and is one of the parameters of quality healthcare provision. A review of communication between hearing schizophrenia patients and service providers identified that empathy, interest in patient's life, a shared understanding of therapeutic goals, and ability to reflect could foster or hinder the development of meaningful therapeutic relationships [15]. Street Jr et al. [16] presented a model that highlights the processes by which communication directly or indirectly impacts on patient outcomes via patient understanding, trust, and clinician–patient agreement. These elements often increase treatment adherence and support the development of better self-care skills and result in improved health and well-being.

However, there is limited research exploring the perceptions of SL interpreters regarding their role in developing therapeutic alliance. The gap was addressed with the research question: What are the processes by which therapeutic alliance develops in SL interpreter mediated mental health consultations and how does the interpreters' presence influence the development of therapeutic alliance?

2 Method

2.1 Study design

Interpretative Phenomenological Analysis (IPA) was chosen due to its principles of understanding homogeneous lived experience (i.e. a single group) and making sense of

individual meanings and interpretations [17,18]. The theoretical underpinnings of IPA indicate that small numbers of participants are preferable to ensure the homogeneity of the narratives and to enable deep and meaningful exploration of participants' lived experiences. A double hermeneutic exists in IPA: participants make sense of their own world, and the researcher makes sense of the participant's sense of the world [18]. A semi-structured interview topic guide (cf. supplemental material) was developed based on existing literature on clinical communication, therapeutic relationships [19] and guidance on the principles of IPA methodology [18]. The current study is reported in adherence to the COREQ guidelines [20].

2.2 *Participants and sampling*

Purposive sampling was utilised to identify suitable participants [18]. Qualified BSL interpreters over 18 years old, who interpreted mental health consultations for deaf people in primary or secondary healthcare settings, were recruited via online participant appeals and snowballing methods. Participants had to be registered with either The National Registers of Communication Professionals working with Deaf and Deafblind People (NRCPD) and/or Association of Sign Language Interpreters (ASLI). In total, seven participants were interviewed (6 females). The female to male ratio corresponds to the profession demographics [21]. All participants discussed experiences of SL interpreting between deaf patients and hearing clinicians. Participant demographics (with pseudonyms) are available in Table 1.

INSERT TABLE 1 HERE

2.3 *Procedure*

Interviews were conducted in spoken English, lasted between 55-85 minutes, were audio recorded and transcribed verbatim. The study was reviewed and approved by the Lancaster

University Faculty of Health and Medicine Research Ethics Committee (REC number: FHMREC15109).

2.4 *Data Analysis*

Analysis followed IPA guidelines [20], and emergent themes were developed for each transcript before synthesis across all the transcripts. Accounts were homogeneous, with no disconfirmatory codes, but participants' experiences modified the understanding and coding of overarching themes. The research team included a doctorate in clinical psychology trainee, an academic experimental psycholinguist with clinical expertise in mental health and deafness who is a SL interpreter, an academic psychologist with research expertise in clinical communication, and a BSL user, clinical psychologist specialised in mental health and deafness. All members of the research team were hearing.

3 Results

The analysis generated two superordinate themes: (1) Nurturing the triangle of care, and (2) Shared vision and knowledge. These themes reflected systemic processes that underlie elements of communication that lead to developing and maintaining effective therapeutic relationships (Table 2 for subordinate and superordinate themes).

INSERT TABLE 2 HERE

3.1 *Nurturing the triangle of care*

This theme represents the importance of collaboration and trust to nurture a 'triangle of care'.

Communication - Interpreters reflected on nurturing this triangle of care by ensuring they communicate 'compassion and truth', while knowing that they depart from the literal

transliteration of the expressed language: “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). Interpreters are a bridge between the patient and clinician, allowing the patient to be heard, and providing important context for clinicians. Katie, however, stated that “I can’t always explain what it is, but I can make sure the clinician is aware of it”; highlighting that facilitating a therapeutic alliance develops organically and without conscious awareness.

Unlike therapeutic relationships between hearing individuals, communication of compassion does not rely on voice, because this ‘is just the mechanism through which language is conveyed’ (Lucy). Also, “deaf people can communicate an awful lot with a look or a gesture, movement kind of thing.” (Karen). In that sense, “emotional range is just as present in sign as it is in spoken language... You can see, feel and hear it” (Tom). Openness assists the communication of compassion in the triangle of care.

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)

To nurture the triangle, patients and clinicians must be able to develop their own rapport rather than relying on the interpreter. Paula often takes a direct approach in supporting this process:

I'll ask them [health professionals] 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. (Paula)

Every individual has a role in both the development of the triangle of care and communication of compassion.

Trust and the balance of power - Trust was a prominent theme in all accounts and was 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. (Lucy)

Tom concurred, noting that “managing [rapport] between three people can be tricky”. This has implications for building trust within the triangle of care. Trust can foster equality, as illustrated by Sally: “We were an equal triad, and each person was as valuable as the other”. Interpreters are also aware of the balance of power in the consultation. Awareness of dynamics and emerging alignments is important in nurturing the triangle of care through equal interaction.

I need to kind of separate/distance [from] that. I explain [to the patient], we should have that communication between the three of us...to ensure that we're all entering the room on an equal footing. (Sally)

Willingness to collaborate - Collaboration is fundamental to nurturing the triangle of care and aiding the therapeutic process. However, Karen's experience of collaboration was largely negative: “we are not engaged with the clinician. No briefings or debriefings”. Preparation aids

collaboration; it helps individuals share aims and provides opportunities to address 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)

While the involvement of an interpreter may differ between psychometric testing, consultations and treatment, rapport/therapeutic alliance building is necessary across all activities to achieve optimal results. Interpreters, however, shared a feeling of being left out despite the volume of information that they can contribute: “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” (Sally).

Importance of continuity and quality – participants felt that continuity of interpreter was important to fostering and maintaining therapeutic alliance. Changing interpreter could threaten the homeostasis of the triangle of care. Karen stated that “continuity of interpreter is important, but that’s not always something that we have...”. This often affects the quality of interpreting services, which Fiona attributed to the fact that interpreters are “booked up... months in advance”, or that interpretation services are provided by multiple agencies: “various spoken language agencies are dealing with BSL because they have won contracts” (Fiona). Fiona’s focus on the involvement of spoken language agencies and the implications for quality provision emphasises the nuanced set of skills required in SL interpretation. Karen felt that “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) and impacting on the development and maintenance of trust and therapeutic alliance amongst all parties

Interpreters need support – to facilitate the development of therapeutic relationships. 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. (Sally)

Interpreters might experience a double trauma process; they watch a client communicating their trauma that they subsequently interpret. To address this issue, participants discussed seeking peer supervision: “...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). Karen similarly felt: “...we are privy to some disturbing disclosures... There’s nowhere to put that when you get it”. Leaving such emotions unaddressed could have negative consequences on the interpreters. Sally reported on the impact of her work: “[The patient] 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!”. It is apparent that interpreters need emotional support.

3.2 *Shared vision and knowledge*

The second theme represented factors that can affect the development of shared **vision about optimum care provision and knowledge of the patient needs** between those in the triangle of care.

'The necessary evil' - Participants felt that the interpreter should be viewed as a co-facilitator in therapeutic settings. Karen felt that services should:

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. (Karen)

Karen's self-portrayal as 'a necessary evil' confirms a lack of understanding of the interpreters' role. Lucy concurred: "The idea of having us just come in and translate and add nothing more seems absurd...". However, Karen emphasised how interpreters struggle to defend their role, which can influence relationships with other professionals:

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. (Karen)

Karen highlighted two issues: clinicians not understanding the complexities of the interpreter role, and interpreters not feeling confident. This may result in clinicians feeling deskilled by the interpreter's presence.

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. (Paula)

Tom, however, acknowledged the clinicians' perspective: "...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".

Lack of Deaf awareness – **misunderstandings of the interpreters' role can arise from a lack of deaf awareness. This includes issues that pertain to the challenges experienced by deaf people, the collaboration between clinicians, interpreters and patients, and the skills required to establish effective communication among all parties.** Participants felt that clinicians might "assume that you know the deaf person...that you're some kind of keeper for [them]" (Fiona). **This lack of awareness** can make both interpreters and patients feeling misunderstood, hindering the development of therapeutic relationships. **Collaboration may be called for when an interpreter can contribute critical cultural/linguistic insights that are relevant to a clinician facilitating the therapeutic process (cf. *Willingness to collaborate*).** Sally 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". Fiona highlighted a clinician she worked with had level 1 BSL skills and felt that "sometimes people with a little bit of knowledge are as dangerous as those without...they bring their own assumptions [about the deaf patient]".

Understanding the key characteristics of deaf people's experience is particularly important during psychometric testing. Tom discussed the need for clinicians to understand the challenge of interpreting psychometric tests that are not designed for use with 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. (Tom)

Deaf awareness and the confidence to adapt practice aids the development of shared understandings and stronger therapeutic relationships.

4 Discussion and Conclusion

4.1 Discussion

This study was designed to explore the processes that influence the development of therapeutic alliance in SL interpreter-mediated clinical settings. The findings confirmed the complexity of the therapeutic process previously been documented with hearing populations [22]. Two superordinate themes emerged: 'Nurturing the triangle of care' and 'Shared vision and knowledge'. Although communication relies on the interpreter, the results highlighted that communicating emotions is possible non-verbally [cf. 22] in 'a triangle of care'. This concept has been applied in supporting people with bipolar disorder [23], psychosis [24], and immigrants [25], and is recommended as best practice in mental healthcare [26]. The interpreter as a contributor to that structure, however, differs from the traditional patient, clinician, and informal caregiver dynamic.

The present study has not addressed the experiences of deaf patients, their informal caregivers, and of their clinicians. A systemic understanding of the triangle of care would also require these perspectives. In future studies, the type or form of therapy also needs to be considered. Confrontive forms of therapy [cf. 26], often require direct communicate interchanges. In such circumstances, interpreters should not "soften" a therapist's comments, as

this might inadvertently interfere with the therapist's intention. Our findings are based exclusively on SL interpreters with experiences in UK mental health settings. However, opinion papers from Australia and the Netherlands [27,28] and research from New Zealand and Ireland [29,30] report similar challenges, potentially signifying a global phenomenon.

Delivering power-balanced mental health services rely on collaboration, communication, and equal partnership [31]. It is important, therefore, that clinicians engage with interpreters to gain a comprehensive understanding of the patient, or else risk the possibility of not complying with established guidelines [32]. This is key because "comprehension of both linguistic and non-verbal utterances are salient to prognosis" [33]. SL interpreters, also, need to feel confident that they possess the skills to interpret mental health consultations and to be knowledgeable of the nuances that are particularly relevant to the area. They also need to be capable of interpreting language that could be symptomatic of the presence of mental health issues; for example, severe language dysfluency [34] or formal thought disorder in schizophrenia [35]. In such cases, interpreters should communicate that the deaf patient's language is atypical or unintelligible, to trigger further clinical exploration. Finally, interpreters should be familiar with mental health terminology, which, **in the US, it** can be achieved through specialist mental health interpreter training [36–40], **and where no such formal training exists achieved through mental health awareness training.**

Clinicians working with spoken language interpreters can feel powerless or detached from a process they usually feel central to [41]. This supports Pollard's [42] view that clinicians may not use their full range of skills when working with deaf patients. Similarly to our findings, it has been reported that clinicians can feel confused or threatened in their role, which potentially threatens therapeutic alliance [27]. To address this, Boness [43] emphasised an ethical obligation

to educate clinicians on how to work with deaf patients. Our participants considered preparation (i.e. briefing, debriefing) as key, in line with interpreter best practice guidelines [44].

It is widely accepted that psychometric tests that are normed on hearing individuals should not be used with deaf people [45–48]. In Tom’s quotation, the clinician appears to ‘allow’ the interpreter to change the questions asked so that a ‘right response’ is elicited. This raises concerns regarding the clinician’s understanding of what could compromise the validity of psychometric tests, the usefulness of a ‘right response’ when it does not reflect the person’s true ability and the interpreter’s role in the process. The involvement of mental health **aware** SL interpreters might safeguard against such pitfalls, but it does not address the linguistic incompatibility between the patient’s language and the language upon which test questions and norms are based. A collaborative partnership would allow SL interpreters to alert clinicians to these issues.

Similar to the research literature on the effects of continuity of care on clinical outcomes [49–51], the participants identified continuity of SL interpreter as influential to therapeutic relationships. However, two prominent barriers to interpreter continuity were identified; access to SL interpreters, and lack of quality assurance procedures. The barriers around accessing SL interpreters in healthcare provision are well established [52,53]. Our results, however, emphasise that *simply* involving a or any SL interpreter is likely to significantly impact on the development of therapeutic alliance. Participants also stressed that at least some of the lack of continuity of care was due to the lack of quality assurance procedures, whereby SL interpreting contracts are commissioned without due diligence of the expertise needed. Gentili and Holwell [54] developed an education module for mainstream services that enhances clinicians’ understanding of how to work with deaf people. Such modules could enhance clinicians understanding of what to expect

from a SL interpreter, and in effect inform service commissioning decisions. Both barriers require serious consideration by policymakers.

A key finding was the need for interpreters to be supported in their role. Dean and Pollard [55] posit that some interpreting situations might lead to high levels of strain. Harvey [56] argued that interpreters are likely to experience empathetic pain (also described as interpreters' vicarious trauma [57–59]). As professionals working in mental health, they are also likely to experience burnout if suitable and adequate resources are not available [cf. 60]. One such resource could be professional supervision. Participants felt that current supervision structures were not helping them process both the technical aspects of their role and the highly emotional content of their work. There is a growing body of literature that advocates for supervision for interpreters being conducted by interpreters [58] and the process to start from while in training [60], both of which should help meet SL interpreters' needs.

Previous literature identified a series of elements that foster therapeutic relationships [15,16]. The present study illustrated that displaying compassion towards patients is another important element in clinical communication and facilitates trust in healthcare providers [61]. Research with spoken language interpreters in healthcare settings indicates that compassion is communicated through all three individuals working together as a 'triad' [62]; compassion being communicated via voice [63] and touch [64]. While touch can be used with deaf patients (where relevant and appropriate), voice as an auditory property cannot. In SL interpreter-mediated consultations, communicating compassion requires the communication of the appropriate emotional tone, via the corresponding signs of what is being discussed, suitable body language with the appropriate culturally relevant facial expression, which collectively, as Hsieh and Nicodemus [57] highlighted it is complex and demanding.

However, whilst communicating compassion, participants revealed that they were not always aware of how they did it. The reasons for this are unclear, but articulating the process followed when interpreting relates to individuals' metacognitive abilities in 'thinking about thinking' or 'knowing about knowing'. Reflective practice in the context of supervision could enhance such metacognitive processing [65,66]. At present in the UK, professional supervision is a relatively new concept for SL interpreters and not mandatory[44]. Ensuring interpreters are supported emotionally via supervision will improve their services and, in effect, it will foster the therapeutic process.

4.2 *Conclusion*

This study explored SL interpreters' understandings of the context within which therapeutic alliance is developed and maintained when supporting deaf signers with mental healthcare needs. Interpreters cannot and should not be perceived as a passive and neutral conduit of emotional and highly sensitive information. Instead, interpreters should be equal partners in the triangle of care. This is an appropriate model that builds trust, fosters collaboration and facilitates the development of a structure that can result in appropriate diagnosis and treatment. Our findings also highlighted that interpreters need to be supported in their role through clinical supervision. This will safeguard against interpreters become emotionally distressed and encourage them to remain working in mental health services.

4.3 *Practice Implications*

This study highlights a need to establish the triangle of care in SL interpreted clinical settings as a viable and important model. Services would benefit from a summary information sheet explaining the role of SL interpreters and practical issues (e.g. talking to the patient and not the interpreter, etc.). Professionals should refrain from conducting consultations in SL if their SL

proficiency level is basic. Service commissioners should ensure that interpreters are mental health **aware**. Finally, interpreter training should be designed with reflexivity as a core competence and should be supported via clinical supervision that starts in training and continues thereafter.

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TABLE 1: Participant demographic information (n=7).

Pseudonym	Gender	Years qualified as SL interpreter	Motivation	Experience
Fiona	F	15	Linguistics degree	Primary ¹ & Secondary ² Care
Paula	F	10	Father worked with deaf people	Primary Care
Tom	M	15	Interest in languages	Primary & Secondary Care
Lucy	F	16	Child of Deaf adults	Primary Care
Sally	F	3	Night classes	Primary & Secondary Care
Karen	F	16	Has a child with hearing problems	Primary & Secondary Care
Katie	F	10	Night classes	Primary & Secondary Care

1. Provision of healthcare via first point of contact – e.g. general medical practice, A&E, social care

2. Provision of healthcare through referral to specialist mental health services – e.g. child and adolescent mental health services, forensic services

TABLE 2: Superordinate and subordinate themes identified in the study.

Superordinate themes	Subordinate themes
1. Nurturing the triangle of care:	Communication
	Trust and the balance of power
	Willingness to collaborate
	Importance of continuity and quality
	Interpreters need support
2. Shared vision and knowledge	'The necessary evil'
	Lack of Deaf awareness