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# Interpreting Services for Refugees: Hearing Voices?

Lucy Williams

Lecturer in Mental Health, The European Centre for the Study of Migration and Social Care, University of Kent

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## Abstract

This article examines current issues in the use of interpreting services, as experienced by refugees and asylum seekers in the UK. The paper begins with a review of relevant literature on interpreting services and relates it to the service context and the specific needs of refugees and asylum seekers. There follows a discussion of a small-scale research project carried out with interpreters working in these services. Recommendations are made which include the need to educate all three parties (the professional employing the interpreter, the interpreter and the client) in not only best practice and practical techniques of working with interpreters, but also broader issues such as the complexity of the interpreting process, the importance of establishing trust, competing agendas and negotiation of meaning that are implicit in the interpretation process.

## Key words

language interpreting; refugee; asylum seeker; user views

## Introduction

The literature on interpreting and interpreting services is extensive, and includes literature aimed at linguists and a professional interpreting audience, service providers and managers as users of interpreting services, as well as a small but growing body of literature aimed at promoting a service user view of interpreting services. This paper aims to add to this body of literature by describing a small research project carried out with interpreters working with refugees and asylum seekers, and to provide a literature review of a range of published material on interpreting services for this specific client group.

Reference is made primarily to services for refugees and asylum seekers as, while the professional staff who work with this client group may have experience of working with interpreters in other service settings, service providers working with refugees and asylum seekers need to take special note of the vulnerabilities of their clients. Refugee and asylum seeker users of services are either the subjects of immigration controls or will have been subject to them in the recent past, and this experience, combined with vulnerabilities stemming from their migration history, has a significant and

enduring impact on how they will experience services. Practitioners working with this group, be they interpreters or health and social care professionals, need to have some understanding of these issues and the capacity to adjust their practice accordingly.

Refugees are a vulnerable group for many reasons (Williams, 2005). They may be vulnerable because of their lack of English language skills, compounded by their unfamiliarity with the organisation of support services, local geography and culturally defined behaviours. Articles and reports describing the health needs of refugees and asylum seekers typically describe language and cultural difference as one of the most crucial barriers to receiving adequate health care (BMA, 2002; Burnett & Peel, 2001b; Taylor & Gair, 1999; Warfa & Bhui, 2003). Racism and systemic discrimination against asylum seekers and refugees affect the type of service they may receive (Raval, 2005 p199), and the disempowerment experienced while becoming incorporated into the asylum system may restrict their access to services and increase their vulnerability (Burnett & Peel, 2001a; Patel, 2002; Tribe & Morrissey, 2002).

Edwards (1995 p57) argues that people with limited English are 'doubly disadvantaged' in services, as not only are they subject to the same racism that affects English-speaking ethnic minorities such as Afro-Caribbeans, but also their lack of English increases their vulnerability to institutional racism. Given the often overt racism experienced by refugees, we may consider them to be yet further disadvantaged in services. Nationally in the UK and throughout much of the EU (Watters, 2005) there is a lack of services which are accessible and culturally appropriate for refugees and asylum seekers, and the low status of some such services affects service providers, who may themselves face discrimination in working with this group. Discrimination, accordingly, affects interpreters working in these services, not least as they may be, or have been, refugees themselves. Requiring the services of interpreters and other intermediaries in communication with officials and service providers can be a disempowering experience, especially if interpreting is of low standard or poorly managed.

In addition to vulnerability resulting from circumstances in their country of exile, the health and well-being of asylum seekers and refugees may also be compromised by their pre-flight and flight experiences (Ager, 1999; van der Veer, 1998), as refugees arrive having suffered from political persecution, conflict and violence. Refugees may suffer high levels of mental illnesses such as depression and PTSD (Burnett & Peel, 2001c; Silove *et al*, 2000; Warfa & Bhui, 2003), but there is a danger that mental illness and migration will be conflated – as if migration, especially forced migration, necessarily results in mental health difficulties. Farooq and Fear (2003 p104) quote Westermeyer (1989) to the effect that migrant populations exhibit a higher incidence of mental illness, but they do not discuss the cultural component of the expression and diagnosis of mental illness and distress that has over-estimated the incidence of mental illness in migrant groups (Fernando, 1995; Littlewood & Lipsedge, 1997).

The process of seeking asylum in Europe requires potential refugees to emphasise their weakness rather than their strength, and the widely held presumption that refugees are 'bogus' until proven genuine works against refugees establishing trusting relationships in their country of exile and compounds the 'survival-

oriented mistrust' (Muecke, 1992 p519) that has its roots in experiences in their countries of origin. Asylum seekers and refugees have good reasons to be reluctant to trust the official bodies and their agents with whom they come into contact, and may themselves not be trusted or treated sympathetically by statutory agencies (Daniel & Knudsen, 1995; Summerfield, 2002). Health and social care service providers may find it hard to appreciate that refugees find them threatening as, for the most part, they are genuinely trying to improve the life and circumstances of their refugee and asylum-seeking clients. Despite this, refugees may not appreciate the difference between a social worker trying to promote a child's welfare and an immigration officer coming to detain a family. Tribe (1999, p569) writes that refugees may also be suspicious of the motivations of their compatriots who are employed or volunteer to help them, so interpreters too may find themselves the objects of suspicion.

### Interpreting services in health and social care

Commentators on refugee health stress the importance of providing effective interpreting services (Adams *et al*, 2005; Burnett & Peel, 2001b, 2001c; Tribe, 2002). Without them, potential service users are denied access and service providers are hampered in their attempts to provide good services. Interpreting services are crucial in all health and social care, acute and community-based, but all too often interpreting is treated as an extra service that can be added to the standard service rather than an intrinsic part of it. There are many published 'how-to guides' (for example Phelan & Parkman, 1995; Herndon & Joyce, 2004; Sanders, 2000) which aim to promote best practice in clinical and social care settings, but which do not discuss the theoretical basis for good practice or dwell on the complexities of transferring meaning across cultures and language. The broad range of services provided by interpreters working with refugees and asylum seekers demand different skills in different settings. While interpreting in health care services is much discussed in the literature, interpreting services in social care services are less represented. Clearly, interpreting in a long-term therapeutic intervention, such as psychotherapy or counselling, needs a different range of skills from those required in emergency settings.

Likewise, interpreting in community support settings requires different skills from interpreting for statutory agencies. In all these settings, the purpose of the interactions and the nature of the relationship between client and service provider are quite different, yet papers which emphasise the importance of interpreters take a simplistic approach to their use. A BMA report (2002) on the health care needs of asylum seekers, for example, identifies language and cultural differences as the most important barrier to health care, but simply states that trained interpreters should be used, without analysing why language is a barrier and how interpreters, trained or otherwise, can overcome it (BMA, 2002 p11-12). These writers do not articulate what they, as service providers, expect from interpreters, preferring to leave the onus on interpreters to ensure 'professionalism'. Authorities on the process of interpreting recommend many different models and approaches to interpreting but despite this range,

*There is an overwhelming consensus on what constitutes the best practice, and it seems that welfare professionals and researchers perceive a need to exert large amounts of control over the process* (Edwards, 1998 p199).

This consensus is evident in the majority of the articles and reports reviewed here, but it is a consensus that appears to be breaking down, to allow a new vision of interpreting as a more positive activity that has significant value in itself.

Key differences in models of interpreting may be based on the concept of objective neutrality and the degree to which interpreters remain visible or invisible in the interpreted exchange. Angelelli (2004 p8) describes interpreters as adopting an 'invisible' position when they remain outside and independent from the conversation; acting as 'language-switching operators', assuming that exact equivalents of meaning exist between languages. A 'visible' position places an interpreter as a co-constructor of the interaction. Angelelli (2004) advocates a visible role for interpreters in medical settings, as she considers that it enables them to go beyond mere linguistic translation which can be '...indifferent to the parties' access to the message or lack thereof' (2004 p11). Angelelli, along with Hwa-Froelich & Westby (2003), cites the work of Davidson (2000), who has stated that:

*Interpreters are not, and cannot be, neutral machines of linguistic conversion, both because they are faced with the reality that linguistic systems are not 'the same'... and also because they are themselves social agents and participants* (Davidson, 2000 p410 quoted in Hwa-Froelich & Westby, 2003).

Hwa-Froelich and Westby (2003 pp80-2) propose a continuum from neutral to active. At the neutral end of the range, interpreters 'merely pass messages back and forth', while at the active end, they 'negotiate between two cultures and establish ties of trust and respect'. Authorities such as Kaufert and Koolage (1984), Mudarikiri (2002) and Raval (2005) argue that maintaining strict neutrality can reduce the value of interpreters, and that an active role (as opposed to a passive or neutral role), which makes use of the personal as well as linguistic skills of an interpreter, enhances interviews. Patel (2002 p222) brings us back to the specific case of interpreting in refugee services, arguing that the historical and socio-political context of the work makes insistence on neutrality impossible. She writes that a therapist must affirm a position of 'solidarity' with clients who have suffered human rights abuse, and extends this ethical position to the interpreter who, after all, must facilitate the therapeutic intervention.

Where an individual positions their practice on the passivity-activity continuum may depend on the training they have received and/or on their personal style, but a review of the advice for service providers working with interpreters rarely refers to this variability in approach (Adams *et al*, 2004; BMA, 2002; Freed, 1988; Herndon & Joyce, 2004; Phelan & Parkman, 1995). Many articles advising practitioners to use qualified interpreters do not consider how their practice might differ from that of non-qualified interpreters. Hwa-Froelich and Westby (2003 p82) discuss some of the many roles interpreters may adopt, including listener, speaker, gatekeeper, interviewer and social agent. The role that an interpreter finally adopts will probably have more to do with their preference than with the requirements of the service provider, who is likely to be ill-informed about the complexity of the task they have engaged an interpreter to do.

Freed's article (1988) is a good example of how interpreters have been seen in health and social care services – as necessary, but something of a problem for interviewers, whose natural interaction with their clients will be inhibited. She writes:

*The interpreter is a conduit linking the interviewer with the interviewee... should not add or subtract from what the primary parties communicate to each other (p316).*

This statement places the interpreter as secondary in the relationship, and assumes that communication across cultures and language can be achieved without 'addition or subtraction'. In a similar vein, Herndon and Joyce (2004) have produced some brief guidelines for working with trained and untrained interpreters. One of their arguments against using untrained interpreters is that they will 'screen' information they transmit (p39), the implication being that trained interpreters do not. As we have seen from the discussion of neutrality above, and from any consideration of the complexity of transmitting meaning across language and culture, interpretation is very much about screening and filtering information. Warfa and Bhui (2003) advise that interpreters should provide judgements only when specifically asked to clarify 'certain expression and symptoms in the patient's world-view'. This assumes that an interpreter will be able to provide this information on behalf of clients whose language they share, and that the practitioner will know when to ask for that clarification. In reality it can be very difficult to appreciate what we don't know and what we need clarification of.

This problem is developed further by Temple and Edwards, who point out that:

*People have particular histories and occupy social positions, which means that they do not see the world from another's standpoint (2002 p2).*

Watters (2001) describes how the 'refugee voice' is generally only present in therapeutic settings within pre-defined contexts and, in the case of the mental health services he analyses, the refugee voice is present only when it fits the expectations of the therapists. It can be assumed that this applies in other services, and that in health and

social care services generally practitioners will hold assumptions about their refugee clients. The implication is that the refugee voice is more likely to be 'heard' when it conforms to the expectations of the service providers. Interpreters have an interesting role in this interaction, as they may hold the key to amplifying the refugee voice when it speaks of issues that the practitioners do not expect to hear. If interpreters are to be controlled and channelled, it is these issues that will be lost.

The interpreting literature reviewed here includes much debate about various models of interpreting, ranging from the simplistic to the sophisticated and innovative. Analysis of these models, or modes (Tribe, 2005), is necessarily hampered by lack of consensus on nomenclature. The models generally follow the continuum between neutrality and engagement described by Hwa-Froelich and Westby (2003), but use other terminology. Tribe (2005 p170) proposes a psychotherapeutic or constructionist mode, a linguistic model, an advocate or adversarial/community interpreter mode and a cultural broker/advocate/bicultural worker (2005 p172). Sanders' list of models of interpreting also includes a 'professional team model' (2000 p7), and Raval (2005 pp203–205) describes a holistic model in which bilingual co-workers provide communication support as an integral part of professional teams.

This classification of models is not always useful to practitioners, as some refer to the management of services while others refer to the style of interaction between service provider and client. Terminology for describing the variety of interpreting services remains a challenge for those aiming to improve the standard of these services. The phrase 'community interpreting' is a case in point. Sanders says that she uses the phrase to imply 'an element of advocacy', but recognises that the Institute of Linguistics no longer uses the term, preferring the phrase 'public service interpreting'. Nevertheless, Sanders continues,

*public service interpreter and community interpreter have come to represent different models of philosophies of interpreting, but, because there is little recognition of these differences outside a specialised circle, we have continued to use these terms interchangeably (Sanders, 2000 Introduction).*

Here, then, is the rub. Reading the literature on interpreting, it is clear that only a few practitioners have acquainted themselves with the 'specialised circle' of linguists and highly qualified interpreters who make very precise differences between 'public service interpreters', for example, and 'community interpreters'. The heated debate in the Institute of Translators and Interpreters Bulletin (Benis, 2005a, 2005b; Korvak, 2005) is testament to this, and demonstrates that within the profession, the appropriate approaches and roles of interpreters are far from set. In his introduction to the debate, Benis (2005a p26) writes that professional interpreters:

*need to become better communicators and not just with the outside world, but also amongst ourselves,*

and certainly the lack of reference to the complexities of interpreting in much that is written about working with interpreters exemplifies Benis' concerns.

As pointed out earlier, the interpreting literature contains little research or comment based on the views of the clients of interpreting services. The work of Andrulis and colleagues (2002) includes some client views, and shows that the lack of interpreters for patients who needed them resulted in a perception of poor care, as well as the possibility of actual bad care.

*Those who needed but did not get an interpreter were the least likely to report satisfaction with the courtesy and helpfulness of medical and support staff (Andrulis et al, 2002 p1).*

This US study also suggests that 27% of those needing, but not getting, an interpreter came away not knowing how to take their medication. This study, however, makes recommendations about the value of interpreting services in general, rather than commenting on users' perceptions of the quality of those services. Kassayie, carrying out research with Bangladeshis and Somalis in Tower Hamlets (unpublished), found that while service users were always asked their ethnicity, they were not asked what their preferred language was. Kassayie reports that users felt that interpreters need to have knowledge of the service they are working in, in contrast to service providers who focused on linguistic abilities (unpublished p15).

Alexander, Temple and Edwards (2004), who have carried out the most substantial research with users of interpreting services to date, similarly found variance between what professional interpreters and service providers wanted from interpreting services and what service users wanted. Alexander and colleagues contrasted professional interpreting standards with the views of users of interpreting services, and found that, while there were features in common, users were more likely to emphasise personal trust over the professional or abstract trust afforded by adherence to professional standards (2004 pp61-3).

This study, which included refugee users of interpreting services, describes a complex picture of relationships between individuals and communities seeking access to services, interpreters and facilitators of access. The professionalism of interpreters was generally found to be less of an issue than the perceived trustworthiness of interpreters; users valued ongoing relationships with interpreters. A 'good interpreter' was someone who was proactive on the part of the service user, and contrasted with a perception of professional interpreters who, some users felt, 'have an uncaring attitude or are actively against them' (2004 p59). Comparison with the literature reviewed above, written from either a service provider or a professional interpreter view, shows a stark contrast with users' views. While users emphasise connection and relationships, much of the service-led literature emphasises distance and standards. It is clear that much work needs to be done to bring these two views closer together.

## Researching interpreters' views

The study described below investigates the challenges of providing interpreting services to refugee and asylum-seeking clients, from the interpreter's perspective. It was felt particularly appropriate to study interpreters' views of their role, as the health and social care services that refugees use often rely on non-professional interpreters – that is, interpreters who may be very experienced and competent but who have no qualifications or membership of professional bodies. It should also be noted that this research is ongoing and is a relatively small-scale project.

Semi-structured, qualitative interviews were carried out with eight interpreters who work in services for refugees and asylum seekers in London and Kent. The interpreters worked in both voluntary and statutory services in such settings as the Benefits Agency, local councils, GP surgeries, hospitals, mental health services, social services, for the National Asylum Support Service (NASS), refugee support groups and ethnic minority cultural organisations. All had been born in countries other than the UK, and had experience of using interpreting services themselves. Some of them were refugees themselves, and not all had received final decisions on their immigration cases. The findings presented below are drawn from initial analysis of the research data, and quotations from the research participants illustrate key points.

It was expected that questions of trust would be significant in the study, partly because of the 'survival-oriented mistrust' described by Muecke (1992) and partly because of the complexities in social relationships described by Alexander, Temple and Edwards in their chapter on this issue (2004 pp45–57). This study found that the issue of trust was not so much about service users' reluctance to share information, but that they looked to interpreters to help them present information in ways that service providers would understand and which would help them achieve their goals. As the following quotation expresses, refugees may look to the interpreter to provide appropriate information to the service provider on their behalf.

*'Sometimes they think you know everything and they leave it all to you to explain but I can't just tell the doctor what the problem is.'*  
(Eritrean woman)

Some of the interpreters working with newly arrived refugees identified the period of arrival as a particularly difficult time for interpreters, because refugees may feel confused and bewildered, not only by their first experience of interpreting but also by their changed circumstances.

*'When refugees come, the first meeting with the social worker is a cultural shock. Sometimes I wonder how much the client has grasped. Some*

*service providers just want to convey to the other person what they want to say and they aren't particularly bothered about how much the other person is understanding.'* (Albanian man)

On arrival, asylum seekers face a barrage of interviews and information about their new situation in the UK. Refugees are expected to provide information that will be the basis of their asylum claim in the UK, so it is of the utmost importance that they understand the context of the questions they are asked, the significance of the replies they give and that they can trust officials they meet enough to venture information freely. The above interpreter is expressing concern as to how much information newly arrived asylum seekers can assimilate, given the cultural shock they experience as they find themselves incorporated into an alien bureaucratic system. The official nature of many of these initial encounters between asylum seeker and Immigration and NASS (the National Asylum Support Service) also makes it unlikely that the asylum seeker would be able to seek further clarification or that the interpreter could ensure that the client had understood.

Despite the insistence on neutrality in much guidance on working with interpreters, service providers seem to expect interpreters to go beyond a 'professional', neutral role. The research participants frequently commented on their sensitive position between the service provider and the refugee client, describing how they were often expected to facilitate the exchange as much as transmit and translate the content of the questions and answers. A Kosovan woman described how, she 'had to bring her (the client) together as well as her case'. The interpreter, then, was expected to work proactively with the client, despite the general advice that interpreters should remain passive and neutral.

Power relationships in interpreting are often highly complex, as any of the three participants in interpreted interviews can exert power over the others. Research participants, for example, experienced being blamed by their refugee clients when the service provider had bad news to give, or when the outcome of the interview was not what the client had hoped for. The following quotation was typical.



*'People sometimes blame me, when they are refused accommodation, they have to blame someone, first the officer then they blame the interpreter.'* (Turkish man)

Interpreters may be blamed because they were assumed to have power to affect the decision of the service provider.

*'Sometimes they don't thank you, sometimes they accuse you of not doing the job and in the meantime they think you are a decision-maker. Because you are speaking their language.'* (Afghan man)

*'They blame the interpreter. Well it's not my fault. I'm not saying things have to be like that, the person who is in charge says it must be like that and that's it... afterwards you can experience other problems... people have had beatings and threats so you have to be very careful who you are dealing with.'* (Kosovan woman)

In these quotations we see how the interpreters' refugee clients may be able to transform a sense of being aggrieved into power over interpreters who, because of their position in the same community as their clients, may find themselves vulnerable when the refugee client feels they have been unfairly treated.

As well as experiencing complex power relationships with their clients, some interpreters interviewed felt powerless in their relationships with service providers and, as demonstrated by the quotation below, their powerlessness was aggravated by their peripheral position to the services.

*'As voluntary interpreter they don't look at you as an interpreter -- you are there to save them money - they don't let you tell them about the client or your role. They are not interested in what you are doing; they just want you to do the job.'* (Kosovan woman)

The study found that it was not only volunteer interpreters who felt under-valued, and many interpreters described being ill-informed about the nature of the

service, the service's expectation of them or basic information about the language, dialect or cultural needs of the client. Service providers often saw interpreters as technicians who could come into a relationship and provide a quick fix that would allow them to carry on with their work. The next quotation describes an interpreter's struggle to bring the competing agendas of the participants together.

*'The doctor wanted to be very quick, the client wanted to talk about himself, the tablets weren't helping. He was very angry and almost started screaming - it's like... calm him down and explain the situation - that she is here to try to help you so you must calm down and we explained again.'* (Turkish man)

Most of the interpreters interviewed described occasions when they felt that some sort of injustice had occurred that discriminated against either themselves or their refugee clients. The degree to which they felt able to address that discrimination differed, as did the degree to which they identified with the experience of the clients. The following quotations demonstrate two instances. The first refers to an exchange between a GP and a refugee client.

*'I would talk to the GP, but complain... I don't know. More problem for the client.'* (Eritrean woman)

In the next example, the service provider behaviour had a negative effect on the interpreter and the service user.

*'The psychiatrist had ten minutes for the patient and wanted to get everything briefly. She made it too short and hurried the patient; she didn't let him explain himself. The doctor was impatient with both of us and I was nervous and scared.'* (Tunisian woman)

In this case the interpreter felt unable to challenge the service provider - perhaps due to inexperience, as other participating interpreters indicated they would intervene to insist that the service provider slowed down the pace of interview.

In the study, interpreters felt powerless and under pressure from both the service users and the service providers, but a third possible dimension of power exists - the power that interpreters can wield over service users and providers. Despite the anxiety often expressed by service providers (I base this on personal experience of talking with service providers), in this research at least, no interpreter ever expressed any ability or desire to take control of an interpreted exchange.

If models of interpreting can be seen to range from passivity to activity, then advocacy can be seen to interconnect with interpreting models at the active end of the continuum. One of the questions asked of all the interpreters interviewed concerned the degree to which they considered themselves to be advocates as well as interpreters. Some of the interpreters saw a blurring of roles, and were prepared to cross the boundary between a strict interpreting role and an advocate's role if they felt it was necessary. The following quotation, from a Turkish interpreter who works for NASS but who is a volunteer interpreter, claimed to be an interpreter rather than an advocate but nevertheless was clear in his allegiance to the community rather than to his employer.

*'I am supporting them against National Asylum Support Service and the Home Office.'*  
(Turkish man)

As a volunteer interpreter, there is no reason why he should not be acting in this way, but it must be queried how far the statutory agencies who used his services understood his informal advocacy role and whether his clients were always aware of his active role in interpreted exchanges.

Other research participants were very clear that they were there to advocate for clients, but that separation between advocacy and interpreting may be a fine line. The interpreter quoted below is highly professional in his approach, and has no qualifications but a great deal of experience of working with social services, the NHS, the police and other agencies.

*'You are there to be impartial; you shouldn't take sides but I have done it.'* (Albanian man)

This quotation demonstrates clearly the tension between the basic tenet of impartiality in linguistic models of interpreting and the role of interpreter as an aid to communication. The interpreter knows well that he should neither add nor take away from anything either the service provider or client says, but argues that if the two are to communicate fully, it may be that there is information that only he can add to facilitate understanding.

Interpreting services for refugees and asylum seekers are provided according to a range of different models of interpreting (whether or not these models are recognised or articulated by service providers), but interpreters in this research generally considered there to be two ways of interpreting - one formal, the other informal. Formal settings included Courts and settings when the interpreter's role was confined to the linguistic, 'conduit' or language-switching model. In informal settings, such as consultations with Benefit Agency staff, voluntary groups or social workers, interpreters were encouraged, and often expected, to participate more fully in the interview to the extent that sometimes they assisted the decision-making or information-gathering processes of the exchange. The quotation below describes some of the advantages of working in less formal settings where a team approach is adopted.

*'The client, the interpreter and the service provider have space to explain things and get the feedback from the body language too. So you understand when the person is not understanding although he is nodding!'*  
(Albanian man)

The experience of an Eritrean interpreter who works with her community in mostly voluntary services preferred informal models of interpreting, as the object of interpreted exchanges is to maximise client satisfaction with the service so that understanding can be achieved.

*'If people trust you it's good, better than someone from an agency coming in and doing the job. In some cultures refugees need the connection to feel comfortable.'*  
(Eritrean woman)

This community-based model was important to several of the interpreters interviewed; they felt that being part of their clients' culture or community was very important to their effectiveness as interpreters. One interpreter, who had himself only recently been through the asylum system, felt it was his knowledge of the system and of what the refugee clients were going through that mattered, as much as the fact that he could speak their language and act as an interpreter. In this case, his relative inexperience, lack of qualification and lack of credentials in the UK mattered less than his ability to communicate with clients from his position close to their culture and community.

One of the questions included in the interview asked participants about their motivation in working as interpreters. Some replied that they were motivated by the possibility of a stimulating and financially rewarding career, but the majority said that their chief motivation was to work with and for their community. This may not be representative of interpreters as a whole, but was significant in this group of interpreters. The following quotations demonstrate this.

*'I know how that feels and these people have big problems - like they have been locked up or had their children taken away.'* (Kosovan woman)

*'Some people really need help - I might give them my number. Especially if they are female. This is our culture. I am still a part of this culture.'* (Eritrean woman)

This last quotation shows how interpreters' sense of duty to their community may mean that they are prepared to support individuals beyond their professional roles. The majority of the participants indicated that they were prepared to enter into personal relationships with clients in order to support them.

Relations with the community should not be idealised, however. Refugee communities may be split along political, religious, cultural or other lines and, although individuals may appear to be appropriate and competent interpreters for communities, internal divisions may mean that some members of the community find them unacceptable. The following quotation gives an example.

*'I used to do more for the Eritrean community. Now they don't want me to interpret because of political problems. I have been badly treated by the community - shouted at, ignored, never thanked.'* (Eritrean woman)

In the interviews, the research participants were asked about the value or otherwise of qualifications. None felt that they would have had more work had they been qualified, and my own experience of services indicates that, when large numbers of refugees arrive in an area, necessity obliges services to use unqualified and inexperienced interpreters. In addition, participants were quite sceptical of the value of qualifications and felt that there was no substitute for experience and a reputation in the community and with service providers.

### Some implications for services

The interpreters who participated in the research project were selected to try to represent the mainstay of interpreting services in health and social care services for refugees. Arguably, none of them could be considered as a 'professional', none of them is a member of the Institute of Linguistics or accredited by recognised bodies. Some of them are definitely 'better' interpreters than others, but all work regularly for both statutory and voluntary agencies. Given their lack of training as interpreters and, in some cases their relatively poor language skills, it could be argued that they cannot give a good service to either their service user clients or service providers, but their dedication and knowledge of their clients' history, culture, community and situation can make up for this. Given what the literature reviewed above tells about the attitudes of some service providers to interpreters (Freed, 1988; Herndon & Joyce, 2004; Phelan & Parkman, 1995; Warfa & Bhui, 2003), service providers may not see these strengths as sufficient to make up for lack of technical skills.

Trained and qualified interpreters are simply not available in many refugee languages. The lack of interpreters leads to a homogenisation of communities (Edwards, 1995, 1998 p10) as, instead of clients receiving interpretation in their mother tongue, they have to accept interpretation into a related language. Dari-speaking Afghans, for example, often have to accept interpreters speaking Farsi (or Persian), while Pashtun-

speaking Afghans may have to use Urdu-speaking interpreters. In some services, this compromise may be acceptable, but in others, for example in immigration tribunals or in mental health care settings, it clearly is not. For refugees especially, language may be an important marker of identity, and being obliged to speak in the language of an oppressor, for example, may have a negative psychological effect. Temple and Edwards (2002 p8) remind us that:

*'identity is produced and not merely described in language'*

and that

*'words do not have any simple one-to-one descriptive relationship to the social world rather they are indexically embedded in the circumstance of their production'* (Edwards, 1998 p20).

The users of interpreting services need to keep these subtleties in mind if they are not to discriminate further against their already disadvantaged clients.

The literature referred to in this paper presents differing views about what interpreting services should aim for in working practices and technical competencies. These views reflect the range of services working with interpreters and, above all, the rapid expansion of demand for interpreting that has resulted in services developing to meet emergencies rather than as a result of clear strategic planning. The commissioning of services is now becoming a priority (DoH, 2004), and consortia and agencies are developing which aim to provide some assurance of quality. Without a clear and agreed idea of the standards that interpreters should aim for, however, it is unlikely that services will provide the range of service and practice that their clients need. The Department of Health (2004) guidance follows a linguistic model of interpreting that could preclude the development of innovative and user-focused services. Raval's paper (2005) and Tribe's work (Tribe & Morrissey, 2004; Tribe & Raval, 2002) are important antidotes to the traditional guides to working with interpreters, which tend either to problematise or to dismiss the role of interpreters in health and social care settings. It can only be hoped that

their collaborative approach to the challenges of effective and appropriate interpreting can be picked up by the commissioners of interpreting services, so that these models can be developed from their specialist field in mental health services to more general service settings.

In the concluding chapter of their volume on interpreting services in mental health, Tribe and Raval (2002 pp256-9) highlight the need for training for interpreters and those who work with them. Training in and understanding of the multiple and complex roles interpreters are expected to adopt must be a priority for all those working with interpreters and designing services that rely on them. There is little consensus about just how interpreters should work, and this naturally has an impact on the types of training that are available. Hwa-Froelich and Westby have criticised the training currently available and note that:

*The brief training that is provided comes from a mainstream perspective designed to promote the employer's goals, and the interpreter's perspective is rarely considered* (2003 p78).

This comment comes from a North American context, but is equally applicable elsewhere. A further criticism could be that the user's perspective is also lacking in the training of interpreters. Services need to consider the model of interpreting in which they wish to train their staff and interpreters. As we have seen, the linguistic model, with its emphasis on invisibility and neutrality, is still dominant as an 'ideal' form of interpreting even though, as Benis (2005a) points out, this model is not always suitable for health and social care settings.

There is no shortage of argument for training of all parties in the interpreting process (Farooq & Fear, 2003; Freed, 1988; Raval & Smith, 2003; Tribe, 2005 p169; Tribe & Raval, 2002) and training is seen as essential in promoting interpreters as valued fellow professionals. Tribe and Morrissey (2004 p132) recommend establishment of working agreements that guarantee interpreter expertise and the client's right to self-determination, while maintaining clarity of roles and relationships. In the research project, only one of the interpreters participating was a salaried member of staff. The others worked freelance or voluntarily, and the

freelance workers reported being called in to work at short notice with little or no information given about the interview they would be expected to interpret. Only the salaried employee had had any training provided by his employer, though some had undertaken training on their own initiative and at their own expense.

Different models of employment have different implications for staff, users and the management of services, but to maintain a high standard of service, all employees need training, induction, support and supervision. Bord (2005) writes that low rates of pay make it unlikely that community interpreting services for refugees will be carried out by professionally trained interpreters and, until interpreting services are funded and commissioned properly, the quality of service is unlikely to improve.<sup>1</sup>

Many of the guidelines on working with interpreters reviewed here place the onus on interpreters – first to be trained and second to work to the expectations of the service provider. In reality service providers are working with interpreters who are not fully trained or qualified. The onus should be on the service provider, rather than the interpreter, to ensure that the best possible communication and service are maintained. Service provider expectations are often poorly articulated, and there is a culture of blaming or suspecting the interpreter. Undoubtedly, service providers and managers need training in how to work with interpreters, and need to take responsibility for their own role in the communication to ensure that they give good, clear explanations of what the purpose of the interview is, what role they expect of the interpreters and, possibly most important, what the interpreter feels about the interview and the clients' needs.

The user, too, needs to be considered far more than seems to be the case at present. As finding interpreters at all is often a challenge, services may be reluctant to give service users the chance to reject an interpreter (or for that matter to let an interpreter refuse to work with the client) but, especially in services for refugees, individuals who may seem suited to one another may be unacceptable for reasons appreciated only by the individuals themselves. Alexander, Temple and Edwards (2004) demonstrate how different user perspectives can

be from those of provider perspectives, and that the concerns about confidentiality, neutrality and technical skill that pepper the literature are less important to users, who value more human forms of communication based on trust, empathy and ongoing relationships.

Interpreting services in health and social care settings generally are under-funded and managed extremely variably; some services invest in interpreting services while others treat interpreting services as an additional expense that should be minimised. Interpreting in refugee services is still patchy and highly dependent on local circumstances and the availability of suitably qualified individuals or communities. In areas with large concentrations of minority ethnic and refugee groups, services may be adequate, and there are doubtless pockets of excellent service provision. However, often services are not provided to meet individual needs but to provide a service to a homogenised group of, for example, Arabic speakers or Kurds, and the provision of the more unusual languages in any given area can be hit and miss. Benis (2005 p33) describes how professionals should strive against homogenisation and that they should place:

*an emphasis on serving the Algerian, French and Moroccan communities, each with their special cultural requirements, rather than a homogenous 'Francophone' client group.*

This emphasis is necessary not only to provide effective and appropriate care for speakers of languages other than English, but also to promote equitable access to services and to redress the social exclusion experienced by some minority ethnic groups as well as refugees and asylum seekers. It is well to remember Edwards' discussion of the power of language and how access to public and domestic spheres of life can be controlled and reduced by dominance of certain languages. She writes:

*The interaction between languages is part of the establishment and maintenance of hierarchical relations (1998 p3).*

Tribe (2005) has produced guidelines for a partnership model of working with interpreters in refugee services, which draws on her experience of working in mental

<sup>1</sup>The freelance interpreters interviewed in this study were earning an average of £10 per hour and some but not all were paid expenses.

health services for the survivors of torture. Despite having their roots in mental health services, these guidelines could apply equally to a variety of service settings, as they promote the idea of interpreters as fellow professionals with an important role in ensuring access and service quality. Interpreters can enhance interaction with patients and clients and need not be seen as a problem. Tribe (1999 p573, 2005 pp166-7) accepts that practitioners may feel threatened by the potential power of interpreters, but that with experience and training interpreters can allow practitioners to be more reflective in their work (Raval, 1996; Raval & Smith, 2003). Tribe and Morrissey (2004 p137) describe how interpreters can enhance understanding between client and service provider, as they may be able to provide insights into history and culture, for example.

Improved working practices should benefit clients, which would result in higher rates of return after health or other assessments and might result in clients getting the information they needed on the first occasion rather than after repeated visits to providers. It is also profoundly to be hoped that services based on partnership between service providers and interpreters could lead to a closer match between service provider and service user perspectives on the design and implementation of interpreting services for refugees and other client groups.

### Address for correspondence

Lucy Williams,  
Lecturer in Mental Health, The European Centre for the Study of Migration and Social Care, University of Kent Canterbury, Kent CT2 7LZ, UK  
Email: L.A.Williams@kent.ac.uk

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