

Issues for interpreters and professionals working in refugee settings

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Abstract

Many countries around the world become recipient societies for refugees from a number of international 'hotspots'. The current paper examines problems facing interpreters in refugee settings in both the New Zealand and Australian contexts. New Zealand receives 750 quota refugees each year, all of whom spend the first six weeks after arrival at the Refugee Resettlement Centre in Mangere, Auckland. Several studies have shown that inadequate communication between healthcare providers and patients with limited English not only limits their ability to access services but also affects the quality of the services received (Minas et al. 2001). In theory, this issue could be alleviated by the use of interpreters; however, the latter may not always find it easy to carry out their task, especially when interpreting in refugee settings. Research instruments in this study included an online survey for interpreters and separate focus discussion groups involving interpreters and professionals working with interpreters in refugee settings. Responses indicated that refugee mental health interpreting, in particular, often involves unexpected challenges for both interpreters and professionals, which may be difficult to address. An examination of issues is followed by recommendations for ways of addressing these issues.

KEYWORDS: INTERPRETERS; HEALTHCARE COMMUNICATION; VICARIOUS TRAUMATISATION; INTERCULTURAL COMMUNICATION; INTERPRETER-MEDIATED COMMUNICATION; REFUGEE SETTINGS

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1 Introduction

New Zealand, as a signatory to the United Nations High Commission on Refugees (UNHCR) Quota Refugee Programme, accepts refugees from a number of countries including Central Africa, Colombia, Burma and Bhutan. Under this quota system 750 refugees arrive in New Zealand each year, all of whom spend their first six weeks at the Mangere Refugee Resettlement Centre (MRRC) in Auckland. During their stay, refugees attend English language and orientation to New Zealand classes (Hayward 2007) and also receive a range of specialist health and social services. All these encounters are facilitated by the use of interpreters. Interactions between refugees and public service providers after departure from the Resettlement Centre are also frequently interpreter-mediated.

Several studies indicate that inadequate communication between healthcare providers and patients with minimal English, not only limits access to services, but also affects the quality of the services received (Minas *et al.* 2001). In theory, this issue could be alleviated by the use of interpreters; however, interpreting in refugee settings has additional complexities which may impact on professionalism. Moreover, the authors, having worked closely with refugees in interpreting contexts, had anecdotal evidence of incidents where the ethical guidelines (cf. National Accreditation Authority for Translators and Interpreters, NAATI, 2010), as taught in both New Zealand and Australia, appear to have been ignored. If this was indeed true, the voice of refugees and the confidentiality of their communication potentially have been compromised.

This paper examines issues facing interpreters in refugee settings in both Australian and New Zealand contexts. Research instruments included an online survey and separate focus discussion groups (FDGs) for interpreters and professionals working in refugee settings. The survey was completed by 90 interpreters from both countries, while the FDGs were attended by New Zealand-based interpreters and professionals. Many participants in the study added individual comments about personal experiences regarding interpreted situations with refugee clients. The most common themes from the survey were explored in an FDG with the interpreter respondents. The outcomes of this FDG were then brought to a second discussion group with professionals (who employ interpreters) in order to obtain feedback on the issues raised. This paper provides an examination of the issues raised by interpreters and professionals and concludes with recommendations for addressing each of the issues and challenges.

2 Rationale

The impetus for the study was threefold: an understanding of the vulnerability of interpreters working within a context where most clients have experienced

a significant degree of trauma, the additional vulnerability of refugees who may be re-traumatised during the session, and finally, to explore anecdotal evidence of lack of professionalism among some interpreters working with refugee clients. It should be noted that a significant proportion of interpreters working in refugee contexts had come to New Zealand or Australia as refugees themselves. The study has two underlying assumptions. The first assumes that interpreters may become traumatised or re-traumatised while working with refugee clients and that they may use various 'survival' techniques to cope with the resulting trauma. The second assumes that such survival techniques may negatively impact on the quality of interpreting; and hence indirectly on refugee clients.

Academic literature about aspects of the refugee experience highlights trauma and its effects, such as significant loss, lack of choice and power, and deportation or forced flight (Pittaway and Fergusson 1999; Hayward 2007). These prior experiences of many refugees may result in concentration difficulties, flashbacks, nightmares and emotional withdrawal as well as a possible reduced capacity to cope with new challenges (Anderson 2004). The retelling or revoking of trauma stories in such settings may unconstructively impact on the interpreter, especially if he or she shares a similar background to that of the client.

The study, therefore, sought to examine the complex nature of interpreting in refugee settings with a view to identifying possible solutions. At the commencement of the study, evidence existed of a growing awareness among (mainly mental health) professionals of the complexities involved in working with interpreters in refugee settings. Similarly, there was awareness that interpreters were breaching the ethical guidelines (NAATI 2010) taught in both Australia and New Zealand, mainly in terms of accuracy, impartiality and confidentiality.

Many, but by no means all, interpreters mediating communication in refugee settings have completed interpreter training programmes. In New Zealand such programmes usually involve 90 contact hours for liaison interpreting courses, which is considered the basic entry level qualification. In Australia courses are of a similar duration, although some interpreters may simply have successfully completed a one-off accreditation test from the National Accreditation Authority for Translators and Interpreters (NAATI). Occasionally, however, individuals are employed to act as 'interpreters' or (more correctly) language aides on an ad hoc basis when trained interpreters in minority languages are not available. Although interpreters may share a language with the incoming refugee group, they may not come from the same culture or ethnicity. For interpreting to be effective both a shared language as well as cultural background is important in order to preserve the intended

(culture-specific) meaning. When incoming refugees constitute an entirely new ethnic or language group in the recipient society, the employment of interpreters from similar (but not the same) language backgrounds may be unavoidable, and this may result in interpreters having quite different dialects and cultural understandings. An example of this in New Zealand is the case of minority ethnic and linguistic groups from Burma such as the Rohingya ethnic group, where first language Bengali speakers were initially asked to interpret for this group. It is inevitable that misinterpretations will occur in these contexts.

As mentioned previously both Australian and New Zealand interpreter training programmes insist on similar ethical guidelines (NAATI 2010) which emphasise accuracy and impartiality at all times and do not endorse patient advocacy within the interpreting role (Roberts-Smith *et al.* 1991). This differs in some aspects to the Code taught in other countries, including Canada and the United Kingdom (cf. Zimman 1994). Interpreter training in Australia and New Zealand also insists on the use of the first person at all times. Bot (2007), however, describes how interpreters occasionally revert to the use of the third person in mental health interviews, as if to distance themselves from what was being said. It could be argued that the use of the first person can contribute to vicarious traumatisation (Crezee *et al.* In Progress). This study, however, sought to determine the extent to which interpreters do experience trauma transfer (Bontempo and Napier 2012) or omit or censor information in order to protect their own or perceived cultural feelings – a practice which could result in a compromise of accuracy and impartiality. The authors were keen to explore further whether breaches of interpreting ethics might be due to interpreter training deficits or to poor preparation, briefing and support for interpreters.

Research has indicated that many refugees have traumatic memories of betrayal, torture or (sexual) violence which may resurface during health investigations (Vloeberghs *et al.* 2011). However, there is a paucity of studies investigating re-traumatisation of interpreters working in these contexts, more specifically how re-traumatisation, if it exists, might impact on the interpreter's ability to continue to carry out his/her role professionally.

The key aspects of the ethical guidelines as applicable to this study are:

- the need for accuracy: accuracy involves always using the first person (i.e. if a male interprets for a female, he assumes her 'voice'), without censoring, adding or detracting from the client's statement. Well-trained interpreters will therefore ask for repetition or clarification if they are not sure about the meaning and will have good note-taking and consecutive interpreting skills;

- the need for impartiality: this involves interpreters giving the client a voice without adding his or her own opinions or reactions. A triangular seating arrangement facilitates communication between the professional and the client, with the interpreter sitting to one side at equal distance to both the client and the professional;
- disclosing any possible conflict of interest;
- declining assignments which are outside of one's area of competence – for example, interpreters working in healthcare settings should ensure they are very familiar with healthcare terminology (Crezee 1998; Gentile *et al.* 1996; Ginori and Scimone 1995).

As has been noted, professionals are not always able to engage the services of trained interpreters in the language and culture of the recipient. If refugees are from small communities and speak languages with limited diffusion, professionals may be forced to employ untrained interpreters who perhaps are not aware of the existing ethical guidelines and may construe their role differently to trained interpreters. Within refugee contexts the consequences of unethical interpreting can be extremely harmful for individuals who already have survived situations of betrayal and disloyalty.

3 Method

The study¹ described in this paper employed the following research instruments:

- anonymous online survey for interpreters working in refugee settings;
- FDG involving a small group of seven experienced interpreters;
- FDG involving a small group of five professionals.²

The questionnaire sought to explore the extent of participant interpreter training as well as to ascertain whether respondents identified with a refugee background. It also aimed to examine interpreters' experiences and practices in relation to working in refugee settings and whether, within this context, they had ever felt the need for support (e.g. briefing, debriefing, further training or post-interview counselling).

Interpreters were invited through various interpreting services and professional associations to anonymously complete the online questionnaire. Interested respondents were asked to contact the main researcher if they were interested in joining an FDG at a later date. Interpreters and professionals who had expressed willingness to participate in an FDG were contacted and invited to join separate discussion groups, so that participants could discuss issues in a safe environment. The findings of the first FDG, convened in April 2011, were circulated among the interpreter-participants to seek final approval regarding

the information they shared and to delete any information that might compromise anonymity. During the second FDG, convened in May 2011 which was attended by professionals, a summary of the interpreters' FDG was used as a starting point for discussion.

All interpreter respondents (n=90) were over 20 years of age, with over 90% stating that they were aged over 30. Respondents were predominantly female (75.6%), whilst male respondents (24.4%) were in a minority. There was a representative range of ethnic backgrounds including African (8%), Latin American (10%), Middle Eastern (12.5%), North and South East Asian (19%) and other Asian (11%), while a sizeable 40% (n=35) described their ethnicity as 'other'. Approximately 60% of interpreter respondents were from New Zealand and the remaining 40% were Australian-based.

Professional participants included four interpreting service managers working in refugee settings and one educator working with refugees through interpreters. Although this group was small and only included one professional who worked directly with interpreters, the other contributors represented groups who were the collecting point for feedback from professionals working with interpreters. Such groups include doctors, nurses, educators, social workers, counsellors, psychiatrists, psychologists, physiotherapists, immigration and refugee status officers.

4 Findings

The table below shows that 36% of interpreter respondents held NAATI accreditation, available in both Australia and New Zealand. A pleasing result was that almost 60% of respondents had had either health or mental health training, where the former also incorporated aspects of mental health issues. The duration of training was not specified by respondents. Based on what is known about the New Zealand context, interpreters likely would have completed an 18-contact hour programme in mental health interpreting organised by a District Health Board or a 90-contact hour advanced health interpreting course at a University. The table shows that some respondents had ticked more than one option; hence it was unclear how many interpreters considered themselves completely 'self-taught'. According to respondent comments, training ranged from 'speaking two languages' or a BA in English or another language to Advanced Health Interpreter training and NAATI level III professional accreditation. Some interpreters had only a translation qualification which was somewhat concerning, as interpreting and translation require related but quite different skill sets (Bontempo and Loggerenberg 2010). Any interpreters working in health or mental health settings should have a very good understanding of and familiarity with the settings and medical terminology used (Crezee 1998).

Table 1: Types of interpreter training

Question: Please describe the type of interpreter training you have had		
<i>Answer Options</i>	<i>Response Percent</i>	<i>Response Count</i>
Self-taught/learned from experience	38.2%	34
Liaison Interpreting Training	42.7%	38
Advanced Interpreting Training (Health)	37.1%	33
Advanced Interpreting Training (Legal)	19.1%	17
Mental Health Interpreting Course	23.6%	21
NAATI qualification Level II (Para Professional)	19.1%	17
NAATI qualification Level III (Professional)	19.6%	15
Interpreting workshop	46.1%	41
Translation Certificate	25.8%	23
Other (please describe below)	12.4%	11
<i>answered question</i>		89
<i>skipped question</i>		1

When asked whether they were from a refugee background themselves or whether they would describe themselves as a refugee, 22% of respondents answered 'yes'. A slight majority (52%) stated that they had interpreted in refugee settings more than 10 times within the last 12 months, with 11% stating that they had interpreted in these settings between 1 and 5 times within the last year.

Table 2 indicates that health (75%) and mental health areas (52%) were most frequently mentioned as areas that respondents had been asked to interpret in. Other settings interpreters had worked in with refugee clients included the police (29%), detention centres (Australian respondents), Work

Table 2: Settings in which interpreters interpret for refugee clients

When interpreting for refugee clients, in what setting do you carry out most of your interpreting?		
<i>Answer Options</i>	<i>Response Percent</i>	<i>Response Count</i>
Health	75.0%	63
Mental Health or Counselling	52.4%	44
Court	31.0%	26
Police	28.6%	24
Probation Services	10.7%	9
Child Youth and Family	21.4%	18
RSB/RSAA	25.0%	21
Other Settings (Please list below)	29.8%	25
<i>answered question</i>		84
<i>skipped question</i>		6

and Income New Zealand, the Refugee Review Tribunal (Sydney), the AUT Refugee Education programme, the Inland Revenue Department and Housing New Zealand. About a quarter of respondents had worked as interpreters for either the Refugee Status Branch (RSB) or the Refugee Status Appeals Authority (RSAA) in New Zealand. The latter was renamed the Immigration Protection Tribunal (IPT) at the end of 2010.

The following section will focus on difficulties encountered by interpreters working with professionals and refugee clients in a variety of settings, bearing in mind that a majority of these were health-related.

5 Difficulties encountered by interpreters working with refugee clients

A significant number, approximately two thirds, of respondents indicated that they had experienced areas of difficulty when interpreting for individual refugees or groups. Common challenges included: refugees speaking too fast (34%); professionals speaking too fast (24%); professionals using difficult terminology (24%) (briefing or training of the professionals would help here); the use of dialects the interpreter was not familiar with (18%); and speakers mumbling or speaking in a low voice (44%). Interpreting at refugee tribunal hearings commonly involves the use of very complex discourse (Barsky 1994). It should be noted that the guidelines taught in New Zealand and Australia permit interpreters to interrupt and ask speakers to slow down or to moderate delivery. Alternatively, interpreters may switch to a simultaneously interpreting mode to ensure no information is lost. Paraphrasing or summarising is not permitted.

Survey respondents also noted that some professionals spoke in heavily accented English or used expressions interpreters were not familiar with. Professionals may forget that interpreters can be unfamiliar with idiomatic expressions if English is their second language, as these language forms are often not explicitly taught in international English classes (Crezee and Grant 2011). Respondents also commented that both professionals and refugee clients spoke often without pausing or their sentences were too long. It should be noted that most liaison interpreters (Gentile *et al.* 1996) interpret consecutively and that both professionals and clients need to pause regularly to enable the interpreter to keep up with the flow of the conversation (Ginori and Scimone 1995).

5.1 Vicarious traumatisation and re-traumatisation

Respondents who stated that they found interpreting in refugee settings problematic were asked to be more specific about areas of difficulty. Of those who answered this further question, 76% said they found the nature of the stories

told by refugees difficult. Several interpreters expressed that many stories reminded them of things that had happened to them (17%) or to their friends and family (31% of respondents) who were still in unsafe environments or had mental health problems. These interpreters commented that it was hard to interpret in situations where the news or prospects were grim for clients. Examples cited were: a mother who might still have children in their home country under threat of death or torture and by the time the required processes for family reunion were completed it might be too late (for those children); being asked to interpret for police officers whose role it was to inform a refugee family that a member of their family had been murdered (in the country of asylum). One interpreter said it was difficult maintaining a 'professional unemotional response to horrific experiences recounted' and then trying to deal with this 'without any professional counselling support'. Another felt helpless watching the family cry without being able to provide emotional support – the Australian and New Zealand ethical guidelines require the interpreter to remain impartial. One respondent said the accounts given by the refugee reminded him or her of not only what had happened, but also what was still happening in their home country; and a further respondent said that even though s/he was not from a refugee background, the traumatic nature of the stories 'pierced' the 'nice bubble' with which we choose to surround ourselves in the recipient society.

These sentiments were echoed in the FDGs which included seven experienced refugee interpreters. One participant reported she found it particularly distressing to interpret for women recounting stories of multiple rapes. Others said they often had to move from one interpreting context to the next and would sometimes arrive at a health interpreting situation, whilst still feeling 'raw' from a particularly upsetting interpreting assignment, only to be greeted in a rude and impatient manner by the (specialist) doctor in question. One participant said she would find it helpful simply to be asked 'how are you?' at the end of an emotionally taxing interpreting session or to be thanked at the end of a 'normal' interpreting assignment.

5.2 Training, preparation and briefing

The questions on training and education indicated overwhelmingly that interpreters would like briefing and debriefing, as they said no amount of training could adequately prepare them for interpreting assignments involving refugee clients and that briefings might protect them from vicarious traumatising. The authors wish to stress that the psychological safety of the interpreter should not in any way compromise the safety of the refugee client(s). Bot and Wadensjö (2004), in their article about mental health interpreting, mention that if the interpreter and professional are seen participating in jovial conversation, the client can feel 'unhealthy' in comparison to the person seeking

therapy and 'left out'. This underscores the importance of discretion and timing of briefing and de-briefing sessions, and it has to be stressed that these are for the purpose of supporting the interpreter but they should occur quite separately from interpreting sessions. Furthermore, it is argued that briefing and debriefing are important protective methods for preventing vicarious traumatisation of interpreters.

When asked whether they felt their training had prepared them for interpreting content that was traumatic or sensitive, almost half (48%) felt that although training had prepared them to some extent, it was insufficient; 39% of respondents replied that they felt it had prepared them thoroughly; and 13% felt it had not prepared them at all. Those respondents who had attended special courses for interpreting in the health and mental health sectors, felt much better prepared for interpreting for refugees in those settings. They felt that this training had familiarised them with mental health issues including anxiety disorders, depression, psychosis, schizophrenia and post-traumatic stress disorder, all of which had prepared them, to some extent, for the nature of some of the interviews and exchanges they were required to interpret for.

One respondent proposed that there should be special courses in 'interpretation for refugees.' Another respondent pointed out that 'training prepares the interpreter to some extent but it cannot foresee all possible scenarios, some of which are quite horrific'. Interestingly, an overwhelming majority (83%) felt that professionals should *always* brief interpreters when asking them to interpret for refugees. The fact that well over half of all respondents felt compelled to add personal statements to this question underlined the magnitude of this issue for interpreters. One interpreter stated: 'we are sometimes left in the dark and do not have much forewarning [sic], if any, of what the content of the conversation may be'.

Respondents were asked whether the professionals they interpreted for (teachers, counsellors, medical professionals and so on) had briefed them for this type of interpreting. Just over a quarter of respondents (27%) replied that they felt the professionals had briefed them thoroughly, while 65% replied that they had been briefed 'to some extent, but not enough'. A small minority of respondents said they had not been given any briefing. Reasons given for briefing interpreters included:

- 'If briefed, the interpreter can emotionally prepare himself/herself for any traumatic experiences the refugee might have gone through';
- 'It is better to know at least something before I start (to avoid too many surprises)';
- 'It is very important to understand the background of the client so that even more care and sensitivity can be brought to the interpreting'.

When asked whether the professionals involved debriefed the interpreter after they had interpreted for refugees in traumatic settings, 35% of respondents said 'Yes' while 65% said 'No' (n=51), and twelve respondents skipped the question. Debriefing was described as involving the discussion of cross-cultural interviews, language differences and any feelings that might have come up for the interpreter following the interpreter-mediated session. Again, this question elicited a lot of additional responses with over half of all respondents adding their own personal comments. Two respondents commented that only the professionals at Refugees as Survivors New Zealand (RASNZ) engage in debriefing, RASNZ being an organisation which offers mental health assessment and counselling for refugees. However, another respondent noted that debriefing is a regular practice at the AUT Centre for Refugee Education (AUT/CRE). Many of the counsellors and psychologists at RASNZ have been involved in a special working group project³ focusing on interpreters working in mental health settings and it is likely that this has led to increased awareness among professionals of the needs of interpreters as well as the formulation of specific guidelines around working with interpreters. This was reflected in the findings of an earlier study (Crezee 2003) in which interpreters reported that out of all health professionals, mental health practitioners were the most likely to brief and debrief interpreters.

Australian respondents reported that while the Refugee Review Tribunal (RRT) in Sydney was very good in terms of working with interpreters, as freelancers they were not debriefed or offered counselling by either the RRT or other hiring agencies. One respondent stated that s/he was only debriefed by professionals when they were seeking information about cross-cultural differences. On one occasion, this respondent was asked by the police whether s/he thought the refugee client was telling the truth.

Only 66 out of 90 respondents responded to the question inquiring about access to counselling after interpreting for refugee clients. Although 26% of respondents stated that they had been offered counselling, only 8% said they had taken up the offer. The remaining 67% stated that they had not had access to counselling and had not known where to go with their traumatic experiences. Some respondents described how they had developed strategies to 'block things out' adding that the need for counselling very much depended on how the individual interpreter was able to cope.

On further questioning about counselling support, replies varied. One respondent commented that RASNZ has been actively promoting and providing group and individual supervision for its interpreters. Another stated that interpreters should definitely be offered counselling because bottling up traumatic interpreting experiences could make them unwell, but this respondent was not sure which agency should offer the counselling. A third respondent

commented that he or she always left all his or her emotional feeling in the interview room. A fourth respondent said that some interpreters are probably more affected than others but stated that some of the things s/he had heard when working for the RSAA had been appalling. Another respondent commented that he or she had given up 'this type of interpreting' for the very reason that it was so traumatic.

Respondents mentioned the differences between agencies when it came to making counselling available to interpreters. One New Zealand-based respondent reported that whereas RASNZ was offering supervision meetings for interpreters once a month, other public agencies involved in assessing clients' refugee status such as the Refugee Status Branch or the RSA did not offer any briefing or debriefing even though interpreting assignments were, in the words of one survey respondent, 'extremely draining'. On the subject of the supervision or counselling offered, there was some cynicism. One respondent commented that whereas the RASNZ sessions were great, one never knew when one might need counselling and it was difficult to wait until the next monthly meeting. One person complained that it was difficult to know where to go for counselling. Nobody had ever told him/her where to go and whom to approach. Another respondent stated firmly that counselling should be offered by the agency requesting the service. Australian-based respondents said that interpreters should have access to counselling by professional counsellors, with one proposing that NAATI should arrange for this.

During the FDG, interpreters commented that the New Zealand-based Refugee and Migrant Services (RMS) – now Refugee Services Aotearoa (RSA) – had approached RASNZ to see if they might make body therapy available to RMS interpreters. These participants commented on how just ten minutes of body therapy was a great way to relieve negative emotion and stress following traumatic interpreting assignments. Overall, it would appear that interpreting agencies within New Zealand are becoming more aware of the needs of interpreters with two respondents noting that the Interpret NZ service is now offering professional supervision and another survey respondent mentioning that Interpret NZ always made counselling available to its interpreters.

Most respondents felt that further training might help them feel more comfortable about interpreting in refugee settings, with 78% saying 'Yes', and 22% saying 'No'. Different reasons were given for not considering further training necessary. One respondent stated that 'no amount of training can prepare me for interpreting in all cases.' Another respondent commented 'it would solve most issues if a quick but official briefing with the professional was included.' This view appeared to be shared by many other respondents. One respondent commented that 'no amount of training can prepare the interpreter for the often traumatic nature of the stories told'.

When asked specifically what training would be most helpful, answers varied, as may be seen from Table 3 below:

Table 3: Type of training and preparation desired

What sort of training would be most helpful?		
<i>Answer Options</i>	<i>Response Percent</i>	<i>Response Count</i>
Training on refugee issues	61.5%	48
Training on counselling	39.7%	31
Training on mental health issues and psychology	53.8%	42
Support group of interpreters working with refugees	65.4%	51
Other	12.8%	10
Please describe any other training that might be helpful:		18
<i>answered question</i>		78
<i>skipped question</i>		12

Respondents were also asked to describe what else might be helpful to have before interpreting assignments in refugee settings. They consistently commented on the necessity for tools to cope with the traumatic nature of refugee experiences. They suggested an increased awareness of the settlement process for refugees following arrival in New Zealand and training on therapeutic and non-therapeutic sessions with refugees and professionals. Respondents stressed the benefits of briefing and debriefing to their continued ability to carry out their duties, with one respondent stating:

I found non therapeutic sessions harder to deal with as there is no briefing or debriefing and no counselling for interpreters after a long and hard interview with immigration authorities. Professional [sic] in therapeutic sessions are more accessible to briefing and debriefing although both settings deal with almost the same sensitive issues.

Interestingly, the AUT Centre for Refugee Education, another non-therapeutic setting for interpreters, does provide briefing and de-briefing sessions for interpreters (and, indeed all staff) with every intake. Briefing was discussed favourably by respondents in this survey and especially when they were asked what they would consider helpful prior to interpreting assignments.

One respondent advised that ‘a short briefing may prepare the interpreter in case of special or sensitive issues.’ Another agreed with this viewpoint, commenting that it would be helpful to be informed about the purpose and objective of the interview and that it would be good to know, for example, whether the professional was going to use the interview to teach the client relaxing techniques or to talk to them about the symptoms of panic attacks and so on. Yet another respondent said an interpreter with a good understanding of refugee issues should be able to cope with whatever might come up in

Table 4: What respondents would consider helpful prior to interpreting assignments

What would be helpful to have beforehand?		
<i>Answer Options</i>	<i>Response Percent</i>	<i>Response Count</i>
Information about what will be said or what questions will be asked	65.3%	49
Written notes	24%	18
Discussion with the professional about the client(s) and the reason for the session	70.7%	53
Please describe any other information that might be helpful to have beforehand:		11
<i>answered question</i>		75
<i>skipped question</i>		15

the interview. Overall though, a majority of interpreters expressed the need for a briefing by the professional to enable them to be best prepared for the interpreting assignment.

6 Training professionals how to work with interpreters

Some of the FDG participants complained that they felt a number of professionals did not treat them with respect. On further questioning, it appeared that mental health professionals were much more likely to treat interpreters with respect and to brief and debrief them than were medical practitioners in general hospitals. The need for professionals to learn how to work with interpreters was consistently raised by respondents. More specifically, respondents noted that professionals appeared to have a limited understanding of what was required of interpreters.

During the FDG one experienced interpreter recounted how a medical specialist had insisted on telling him how to work as an interpreter and had proceeded to give him incorrect instructions by telling him: 'I talk to you and you tell the patient that ...'. When the interpreter advised that he would be using the first person singular, the specialist had threatened to lodge a complaint about him. Other participants commented similarly and said that they felt that whereas the interpreters were generally well-trained, the professionals also needed to have a component in their training programmes where they were taught how to work with interpreters. Another FDG participant said that professionals often appeared to have no idea of the complexities involved in interpreting or that an interpreter might have just come from another, very traumatic assignment. One survey respondent also noted:

I believe there are some professionals who have had training in how to use an interpreter. When you work with them, you will notice how slowly they speak and way [sic] they explain everything step by step, waiting for you and for the client to finish

talking. However the ones who never used an interpreter before or had any training (not all of them are the same, so some are really good, a natural 'pro') are really difficult for them to work with. Sometimes they'll ask you why you are talking longer than he/she did and they don't understand that in some languages that don't have some words, you have to explain that and it might take longer than it usually takes in English.

7 Response from professionals

The participants represented a wide range of interpreting services and commented on the discussion points from the perspective of these services. Professionals sympathised with the interpreters' need for briefing but stated that statutory and legal reasons sometimes prevented them from providing interpreters with detailed information prior to interviews or court sessions taking place. One professional working for AUT/CRE pointed out that interpreters who worked at the Centre for Refugee Education were almost always offered briefing and de-briefing sessions; even though the interpreting context was seldom directly traumatic (albeit within a refugee context).

Participants supported the need for debriefing and counselling. They noted that in their experience professionals also were frequently adversely affected by some of the traumatic stories. One service provider was reported to have arranged for its contract interpreters to have access to a scheme known as the Employee Assistance Programme (EAP) which offers free counselling sessions for permanent staff. Other FDG participants were very interested to hear about this scheme.

Professionals made similar comments to the interpreter participants. All those using interpreting services should have training sessions on how best to work with interpreters. There seemed to be consensus that such sessions should be part of professional training programmes. It was reported that one health interpreting service provider organises courses where participating professionals receive professional development points⁴ for attending courses, making these programmes more attractive for busy medical professionals. Overall, professionals agreed with the views of the participants of the interpreters' FDG and were keen to work towards solutions to the issues raised.

8 Conclusion

Individuals from refugee backgrounds are likely to have specific vulnerabilities. Interpreters and professionals need to be aware that if the ethical guidelines (NAATI 2010) are not adhered to, former refugees may be deprived of a voice. However, findings in this survey indicate that respondents consider there to be challenges when working in refugee settings because of the often

traumatic and emotional nature of the encounters, irrespective of prior training. Interpreters also encountered difficulties such as refugee clients speaking very quickly due to the emotional nature of their stories or the professional person mumbling, not pausing, using unfamiliar or obscure terminology or jargon, or speaking with heavily accented English.

The survey and the FDG findings both suggested evidence of increasing awareness among (health) professionals of interpreters' needs to be respected as professionals and the importance of appropriate briefing and debriefing to help interpreters prepare for sessions and later to process the content. Although some services now consistently offer supervision and access to counselling, it was apparent that this is not always offered at crucial times. In terms of briefing, interpreters stated that even knowing what type of session was about to occur would be helpful (e.g. specifying the 'type' of therapy session).

Most significantly, approximately two thirds of the 90 respondents in this survey reported varying degrees of difficulty regarding interpreting with refugee clients. Interpreters emphasised vicarious traumatisation and/or stress when required to interpret the typically harrowing stories and circumstances of the refugee journey, losses or trauma experience. In some instances interpreters had come to New Zealand themselves as refugees, so their personal traumatic histories were triggered.

9 Recommendations

Several recommendations were made by both interpreters and professionals working with interpreters which could improve not only the professionalism of the service but also working conditions for interpreters.

- Provide briefing sessions before assignments to interpreters to mentally prepare for the assignment, especially as regards the nature and objective of the interview and any technical terminology they may have to convey. Incorporate the opportunity for questions and answers and for checking possible conflicts of interest. Also discuss mutually agreed processes should a situation arise where the wording or matter to be interpreted is culturally offensive. Some interpreters like written notes and these could be distributed at the briefing.
- Strengthen refugee-specific training in interpreter professional training programmes so that interpreters are fully prepared for the content of some sessions.
- Train professionals to work with culturally and linguistically diverse clients to better equip them to work with interpreters and alert them not only to incidents of unethical behaviour but also to the benefits of briefing and debriefing. Three-hour training sessions have been successfully

conducted in the past, incorporating simulated practice in working with interpreters. Intercultural awareness training would assist professionals to use culturally appropriate behaviours and language. Focused training might resolve issues of pausing, lack of clarity and overuse of jargon. Professionals might be unaware that refugee clients could have reduced understanding of concepts or colloquial or specialised language (even after interpreting). Professionals themselves need to be aware of the need for greater explicitness and checking client understanding when communicating in professional contexts with refugees. Furthermore, anecdotal evidence suggests that professionals may not be aware when interpreters are censoring or ‘coaching’ clients.

- Debrief interpreters to work through any issues that might have emerged as a result of interpreting in a refugee context. Alternatively, provide counselling, and supervision sessions.

Interpreters play an important role in refugee encounters with professionals in recipient societies. It is hoped the findings of this study might heighten awareness of the complexities of interpreting in refugee contexts and the need for all parties to be well trained, prepared and de-briefed.

Notes

1. Ethics Application Number 10/48 27 April 2010: Interpreting in refugee settings: issues for interpreters, trainers and professionals.
2. The authors would like to thank the participants and all those organisations who promoted the study.
3. The work group worked on a project entitled the *Regional Asian mental health interpreter workforce development project: phase II training implementation and evaluation.*, which was funded by the Northern District Health Board Support Agency. Following the project support training was rolled out among both interpreters and (mental) health professionals in Auckland. The former were given training in mental health conditions while the latter were taught how to work with interpreters. More information may be retrieved from: <http://www.asianhealthservices.co.nz/documents/Publications/AMHINT%20Phase%20%20Report.pdf>
4. Professional development points given are Continuing Medical Education (CME) and Maintenance of Professional Standards (MOPS). These are given for medical professionals attending CALD 1 (Culture & Cultural Competency), CALD 2 (Working with Migrants), CALD3 (Working with Refugees) and CALD4 (working with interpreters) e-learning and face to face programmes which have been certified through the University of Auckland Goodfellow Unit. The Royal New Zealand College of General Practitioners

(RNZCGP) has approved this CALD course for up to 3 hours endorsed CME for General Practice Education Programme Stage 2, (GPEP2) and Maintenance of Professional Standards (MOPS) purposes. The Goodfellow Unit is an RNZCGP accredited CME provider. For members of other professional bodies, a certificate indicating completion of a three hour educational activity is issued.

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