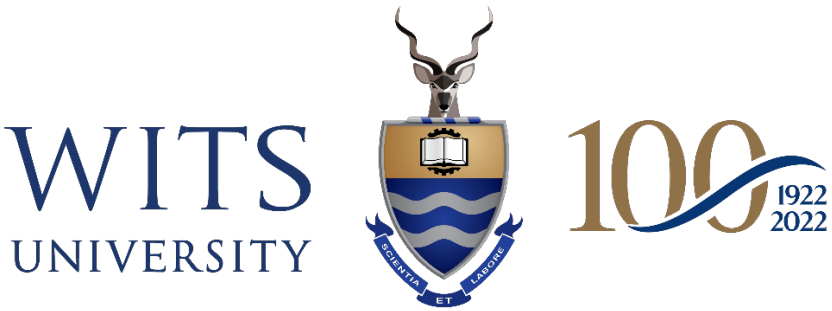

Assessing the South African Sign Language Interpreter's Impact on the Mental Health Therapeutic Alliance

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A thesis submitted in accordance with the requirements for the award of the degree, Master of Arts in Translation (Interpreting) by Coursework and Research Report

2024

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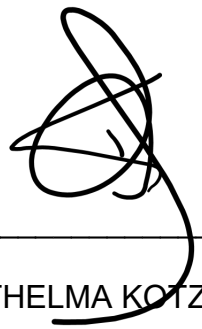
DECLARATION

I declare that the research study titled:

ASSESSING THE SOUTH AFRICAN SIGN LANGUAGE INTERPRETER'S IMPACT ON THE MENTAL HEALTH THERAPEUTIC ALLIANCE

is my own work, and that all the sources that I have quoted or used have been indicated and acknowledged by means of complete references.



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ABSTRACT

This research study assesses the impact of South African Sign Language (SASL) interpreters on the mental health therapeutic alliance. According to Rogers (1957, p. 96), the mental health professional and the client form a dyad; however, in therapy for Deaf people, with the addition of SASL interpreters, the relationship becomes a triad. Wadensjo (1998, p. 11) described this communication as a "communicative *pas de trois"* — a triadic communication model.

The theoretical framework for this study is the Relational Skills Model, focusing on its core components: empathy and trust-building. Cultural competence, as emphasised by Moleko (2012, p. 163), is also central to this research.

The study aimed to achieve an in-depth, interpretative understanding of all participants through an interpretative paradigm and a qualitative research methodology. Purposive sampling targeted three specific groups: mental health professionals who have used SASL interpreters during mental health therapy sessions with Deaf clients; Deaf participants who are profoundly Deaf, use SASL and have used SASL interpreting services during therapy; and SASL interpreters who have provided SASL interpreting services in mental health therapy sessions.

Data collection involved open-ended questionnaires and virtual interviews conducted with Deaf participants, analysed using the Interpretative Phenomenological Analysis (IPA) approach.

The findings indicate that mental health professionals in South Africa are not adequately equipped to deal with Deaf clients, and that the interpreting process does impact the establishment and maintenance of rapport and trust between the mental health professionals and Deaf clients when SASL interpreters are used during therapy. The study highlights the need for a specialised training programme in mental healthcare for SASL interpreters.

Keywords: Deaf Community, Interpreting, Mental Health, South African Sign Language (SASL), Therapy

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My heartfelt appreciation goes out to all the participants of this study. Your willingness to share your lived experiences with openness and honesty has been crucial to the success of this research. I am deeply grateful for your contributions.

LIST OF ACRONYMS

ACRONYM	EXPLANATION
ASCHP	Association for Supportive Counsellors and Holistic Practitioners
CFDS	Centre for Deaf Studies
DP	Deaf Participant
eDEAF	Employ and Empower Deaf
ICAS	Independent Counselling and Advisory Services
IPA	Interpretative Phenomenological Analysis
MHP	Mental Health Professional
NID	National Institute for the Deaf
PCT	Person-Centred Therapy
RSM	Relational Skills Model
SASL	South African Sign Language
SOLER	**S**quarely face client **O**pen posture **L**ean forward **E**ye contact **R**elaxed

Table of Contents

CHAPTER 1: INTRODUCTION

1.1 Introduction

This chapter introduces the study and provides the background and rationale, the research statement, the objectives and the research questions. Thereafter, the research methodology and theoretical framework are presented, followed by the outlines of the data collection and data analysis procedures. Finally, the ethical considerations, clearance and the chapter division of the research report are discussed.

1.2 Background and Rationale of the Study

Issues of mental health are prevalent in all countries around the globe. They affect people from all walks of life. Deaf persons are also affected by mental health issues, which require mental healthcare services.

A comprehensive review of existing literature, combined with conversations with Deaf leaders in organisations of the Deaf[1] and Deaf community members, did not reveal any evidence of Deaf psychologists practising in South Africa.

There are currently six Deaf individuals who have received training as counsellors with Lifeline in 2023 and 2024 (Prof. Storbeck, personal communication, 29 June 2024). One professional South African Sign Language (SASL) interpreter with a counselling qualification, who is a child of Deaf parents, is registered as a holistic counsellor with the Association for Supportive Counsellors and Holistic Practitioners (ASCHP). According to the researcher's knowledge, there are two hearing psychologists in South Africa who can use SASL to communicate with Deaf clients. The aforementioned is the extent of mental health services currently available to the Deaf community in South Africa. Therefore, in South Africa, Deaf persons are forced to make use of SASL interpreters to access mental healthcare services. London et al. (2020, p. 184) emphasised that mental health professionals are unable to communicate with their Deaf clients, and the lack of available, qualified and trained SASL interpreters in the healthcare field in South Africa is also stressed.

[1] The word “deaf” (lowercase d) refers to the medical condition of hearing loss. The focus is on the audiological aspect of the individual. “Deaf” (uppercase D) refers to people identifying with the Deaf community, its language, culture and social norms. It focuses on cultural identity and not just hearing loss.

O'Donnell (2020, p. 3) commented that language is a vital part of therapy and that, according to Hamerdinger and Karlin (2003, p. 1), the interpreter is a "necessary evil" to make the session successful. Roy (2015, p. 300) argued that the interpreter plays a more significant role than only that of a linguistic mediator; they also provide cultural and social input. The interpreter has a significant effect on the therapeutic alliance and, therefore, the success of the therapy. Williams and Abeles (2004, p. 644) asserted that any communication difficulties within the therapeutic alliance can obstruct the rapport between the mental health professional and the Deaf client.

There is a significant demand for SASL interpreters within the mental healthcare field. However, it is not clear what impact the SASL interpreter has on the success of establishing and maintaining rapport and a trusting relationship in the mental health therapeutic alliance.

1.3 Research Statement

This research study assessed the SASL interpreter's impact on establishing and maintaining rapport and trust between the mental health professional and the Deaf client. While Rogers (1957, p. 96) described the therapeutic relationship as a dyad, therapy involving Deaf clients with SASL interpreters forms a triad—a “communicative pas de trois” (Wadensjo, 1998, p. 11).

The study adopted an interpretative paradigm and qualitative methodology. It utilised the Relational Skills Model (RSM) developed by Midwinter and Dickson (2015, p. 20), which focuses on empathy, trust-building and cultural competence (Moleko, 2012, p. 163). Purposive sampling was used to include mental health professionals who had used SASL interpreters, Deaf clients who had used SASL interpreters during therapy, as well as SASL interpreters.

The following section outlines the objectives of the study.

1.4 Objectives of the Study

The objectives of this research study were to:

- determine whether mental health professionals in South Africa are equipped to council Deaf clients.
- investigate the interpreting process during therapy between mental health professionals and Deaf clients.

- investigate the dynamics in communication between the therapist, the Deaf client and the SASL interpreter during therapy sessions.
- identify the factors that influence the establishment and maintenance of rapport and trust between mental health professionals and Deaf clients when using SASL interpreters.
- determine whether SASL interpreters are equipped to interpret mental health therapy sessions.

1.5 Research Questions

This study aimed to address the objectives by asking the following questions:

- Are mental health professionals in South Africa equipped to council Deaf clients?
- Does the interpreting process impact the establishment and maintenance of rapport and trust between mental health professionals and Deaf clients when SASL interpreters are used during therapy?
- What factors could influence the establishment and maintenance of rapport and trust between mental health professionals and Deaf clients when using SASL interpreters during therapy?
- Are SASL interpreters equipped to interpret mental health therapy sessions?

1.6 Theoretical Framework

Midwinter and Dickson's (2015, p. 20) Relational Skills Model (RSM) was used as the theoretical framework to investigate the SASL interpreter's impact on the therapeutic alliance. The RSM focuses on the interaction dynamics and relationship development in the therapeutic session, which was central to this study.

1.7 Data Collection and Data Analysis

The study aimed to achieve an in-depth, interpretative understanding of all participants through an interpretative paradigm and a qualitative research methodology. Purposive sampling targeted three specific groups: mental health professionals who had used SASL interpreters during mental health therapy sessions with Deaf clients, profoundly Deaf participants who used SASL and had used SASL interpreting services during therapy, and SASL interpreters who had provided SASL interpreting services in mental health therapy sessions.

Data collection involved open-ended questionnaires and virtual interviews conducted with Deaf participants. The Interpretative Phenomenological Analysis (IPA) approach was used to analyse the participants' responses.

1.8 Ethical Clearance and Considerations

The researcher obtained ethical clearance (Protocol number SLLM-TRAN-3) from the School of Literature, Language and Media Ethics Committee to conduct the research study.

Questionnaires, participant information sheets and consent forms were made available to all participants, and were also made available in SASL, in video format. Participation in the study was entirely voluntary, and participants were informed that they could withdraw from the research study at any stage during the research.

Deaf participants were not anonymous to the researcher and supervisor during the data collection process because they used SASL in recorded video interviews. However, anonymity was guaranteed in the research report, because all video-recorded interviews were transcribed into English, and all identifying details of the participants were removed from the reported data analysis.

The researcher holds a Diploma in Counselling and is registered with the ASCHP as a Holistic Counsellor. The researcher was, therefore, equipped to deal with any situation where participants might have experienced emotional distress during the interview, in accordance with the Wits Ethics Distress protocol. None of the Deaf participants experienced any emotional distress during the interviews, consequently, the researcher was not required to implement any measures to manage or contain distress.

1.9 Chapter Division

This research report is organised into the following five chapters:

Chapter 1 lays the foundation in the Introduction, setting the stage for the research study. It further outlines the research questions, objectives and methodology.

Chapter 2 offers a comprehensive literature review. Topics include, but are not limited to, the global and African perspectives of psychology, mental healthcare in South Africa, and access to mental healthcare for the Deaf community in South Africa.

Chapter 3 presents the research methodological considerations, the research design, and the data collection methods, which together form the framework for the implementation of the research project.

Chapter 4 describes the analysis of the data collected and examines the interpretations and implications of the data.

Chapter 5 presents the findings and conclusions of this study, and offers recommendations.

1.10 Conclusion

This chapter has established a foundation for this research study by introducing its background, rationale and significance. It has articulated the research statement, objectives and questions, which provide a clear guideline for the study. The chapter has also detailed the research methodology, including the theoretical framework and data collection procedures, addressing ethical considerations. The demand for qualified SASL interpreters in mental healthcare is crucial for fostering trust and rapport between mental health professionals and Deaf clients. This chapter sets the stage for subsequent chapters, which will explore the literature, research design and data analysis, and finally present the findings and recommendations of the study.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This chapter investigates available research relevant to sign language interpreters' impact on the therapeutic alliance. It provides a broad outline of the history of mental health and psychology, discussing key concepts in psychology, sign language and the Deaf community. It also explores how rapport and trust are built and maintained between the therapist, the Deaf client and the SASL interpreter.

This literature review uses the narrative writing style rather than the systematic review style (Ferrari, 2015, p. 231). The narrative review style allows an author to investigate various areas without specific selection criteria. It provided the flexibility of using sources over a long period because the information for this study is not date-dependent. Since the systematic literature review style requires a more rigorous and structured approach to the review of literature, it was not suitable for this research study. Given that the current research study is a broad and exploratory in nature, the systematic literature review would have narrowed the scope of the review, limiting the depth of analysis.

2.2 The History of Mental Health and Psychology

Mental health[2] and psychology[3] have been discussed since 4000 BC in China and 1550 BC in Egypt, with references dating back to 2000 BC in Greece, to mention but a few early civilisations. Well-known philosophers such as Plato, Aristotle, Mencius and Hippocrates are the earliest contributors to psychological knowledge (Swartz et al., 2016, p.11). Psychology is the story of the soul, and Plato believed that humans strive to achieve happiness in life, which can only be achieved if the soul is tended to (Silverman, 2003, p. 130). This implies that psychology plays a role in humanity's happiness. Aristotle's contribution to psychology was the idea that the actions of humans always stem from their beliefs and desires (Matthews, 2003, p. 222). The contributions of the above-mentioned philosophers form the basis of what we understand about the psychology of humans today. However, the views of these

[2] Mental health according to the World Health Organisation, as cited in Galderisi et al. (2015, p. 231), is "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community".

[3] Psychology is "the study of the mind and behaviour" (American Psychological Association, 2018).

philosophers were, because of the times they lived in, not based on any scientific or researched evidence and are therefore oversimplified.

During the Middle Ages (in Europe) until the 16th century, in addition to the contributions of philosophers, religion significantly shaped discussions about psychology. Later on, reason started to play a role in these discussions. Swartz et al. (2016, p. 12) further noted that during the 18th century European Enlightenment period, church doctrine was no longer accepted at face value. Reasoning was required as a basis for comprehending the natural and social worlds. The Enlightenment period challenged religious authority, but it also incorporated and reinterpreted religious ideas within the framework of reason. Yet, the power of religion can never be underestimated—in the 21st century, the media still reports on the mindless following of church leaders by some people in South Africa. The 'Doom' prophet who sprayed his congregants with the insect killer, Doom, to rid them of evil spirits, and the so-called 'Snake Pastor' who fed his congregants dog meat and blood to heal them serve as examples. There are many other examples of how church leaders keep their churches full, week after week (Bhengy, 2019). Desperate people place their dreams, hopes and desires in the hands of these charismatic leaders in ways that defy logic or scientific reasoning. The examples mentioned above highlight the ongoing tension between reason and faith in modern psychological discourse and how religion still shapes mental health practices and beliefs. Religious and non-religious views of psychology often influence one other and continue to coexist.

After the 18th century, the concept of psychotherapy—the process of treating mental health problems by interaction and communication—began to take shape. According to Petersen (2007, p. 759), psychotherapy started to emerge as a definite discipline late during the 18th century, when Mesmer, a German physician, managed to treat patients by putting them in a hypnotic state. Joseph Breuer, an Austrian physician in 1880, invented the term "the talking cure" to explain the psychotherapy process.

Psychotherapy is defined as “any psychological service provided by a trained professional that primarily uses forms of communication and interaction to assess, diagnose, and treat dysfunctional emotional reactions, ways of thinking, and behaviour patterns” (American Psychological Association, 2018). Until World War I, psychotherapy was not commonly used, which propelled the need for services in the field of psychology, leading to the development of various psychological testing

instruments. The use of these psychological testing instruments was not always ethical or socially acceptable in times of war, because testing was often conducted without informed consent and was used on socially vulnerable people. Following World War II, the demand for counselling became substantial (Petersen, 2007, p. 761). The National Institute of Mental Health was established in 1946. Various training programmes in psychology were developed during this time, and the International Union of Psychological Science was formed in 1951. This Union aimed to coordinate psychological organisations and psychologists worldwide (Benjamin & Baker, 2012, p. 2).

It can be concluded from the history regarding mental health and psychology that the study of the mind and behaviours has long been a subject of human inquiry. Although various social, political and economic factors drive the professionalisation of any field, the logical path of professionalisation in psychology was followed, as per Wadensjo (1998, p. 49). She maintained that professionalisation typically begins with establishing an organisation of professionals who engage in the same field. After that, training programmes are developed and implemented, leading to certification in the profession.

2.3 Global Perspective of Mental Health and Deafness

According to Jacob and Patel (2014, p. 1433), 80 per cent of the global population affected by mental disorders[4] come from low-income and middle-income countries. This study focuses on mental health therapy sessions[5] involving Deaf persons in South Africa. Fellinger et al. (2012, p. 1037) suggested that the highest prevalence of Deaf people is found in low-income countries. This view aligns with the World Health Organisation's (2011, p. 9) report explaining some factors contributing to the high prevalence of disability, including deafness. One highlighted factor is insufficient healthcare services and infrastructure in these countries, leading to inadequate prevention, early detection and treatment of conditions that can result in disabilities.

Jacob and Patel (2014, p. 1433) claimed that mental health service provision in low-income countries is exceptionally scarce, and it is estimated that a mere 10 per cent of

[4] Mental disorder is “any condition characterized by cognitive and emotional disturbances, abnormal behaviours, impaired functioning, or any combination of these” (American Psychological Association, 2018).

[5] A mental health therapy session is a time set aside by a mental health professional to provide remediation for an individual experiencing an emotional or cognitive disturbance, abnormal behaviour or have impaired functioning (American Psychological Association, 2018).

global funds for mental health services are allocated to these low-income and middle-income countries. Fellinger et al. (2012, p. 1037) further reported that Deaf patients appreciate mental health professionals who make their services accessible through interpreting services. These authors further observed that Deaf individuals who had access to sign language interpreting services were more likely to access pre-emptive mental healthcare services[6]. Those who did not access mental healthcare services through sign language interpreting services instead used written communication strategies to communicate with their mental healthcare providers and were not likely to access pre-emptive mental healthcare services[7] (Fellinger et al., 2012, p. 140). This statement highlights the crucial role of sign language interpreters in improving Deaf persons' access to pre-emptive mental healthcare. It underscores the limitations of written communication while reinforcing the need for linguistically appropriate services.

Most available research on mental healthcare originates from first-world nations, such as those in Europe and the United States of America. Theories and models for mental healthcare based on research conducted in developed countries are not necessarily appropriate to use in third-world countries. Mental health professionals must be able to determine how to effectively provide therapy to people by understanding various factors, including but not limited to the person's background, upbringing, culture and language. Before applying first-world theories and models in a third-world setting, where the cultures, languages and backgrounds of people may differ significantly, mental health professionals must be mindful of who the persons behind the research and the development of the theories and models are (Swartz et al., 2016, pp. 18–19).

2.4 African Perspective of Mental Health

The African perspective on mental health is complex and shaped by historical, cultural and socioeconomic factors. Research in the field of mental healthcare has largely overlooked the African continent. According to Cooper et al. (2011, p. 320), in Ghana, Uganda, South Africa and Zambia, an average of only 2.3 per cent of publications on health focus on mental health. This lack of research resulted in a gap regarding the understanding of the unique mental health challenges faced by Africans, leading to a

[6] Mental healthcare services are assistance "related to the health and well-being of individuals and communities, including preventive, diagnostic, therapeutic, rehabilitative, maintenance, monitoring, and counseling services" (American Psychological Association, 2018).

[7] Pre-emptive mental healthcare services are interventions developed to prevent the escalation of mental disorders of the clients.

dependence on Western diagnostic models that may not always apply to the African context.

The concept of psychology has spread across Africa due to globalisation and colonialism. In the absence of local research about mental healthcare, Western ideas have been used to diagnose the mental health conditions of Africans, without taking into consideration the influence of context and the history of the continent. Swartz et al. (2016, p. 19) posed the following question: “How do we factor into our analyses that, in South Africa and many other countries, psychologists try to understand people without even being able to understand the languages these people speak?” This question also applies to the South African Deaf community that faces unique challenges, being both an African and a Deaf community. They use sign language, a language that most mental healthcare professionals do not readily understand.

Findings presented by Essien and Asamoah (2020, p. 2537) indicate that the biggest obstacles to mental healthcare in Africa are the need for more mental healthcare facilities, budget allocations and adequately trained healthcare workers. The lack of mental healthcare policies developed and implemented by governments in Africa was also noted.

Another obstacle to proper mental healthcare in African countries is the role that religious, faith and traditional healers play in the treatment of persons in need of mental healthcare services (Essien & Asamoah, 2020, p. 2538). Faith-based mental healthcare is seen as an unofficial part of mental healthcare; yet, it plays a vital role in Africa. These practices are deeply rooted in African culture, and persons with mental healthcare needs are often subjected to inhumane treatment by these traditional healers and faith-based practitioners. Another belief is that mental illness cannot be healed, and often, persons with mental healthcare needs carry a stigma and are ousted by their communities (Cooper et al., 2011, p. 313). Patel et al. (2007, p. 963) reported that in Mozambique, most persons with mental illness use traditional medication due to a shortage of service provision. Individuals with mental illness often do not receive timely required treatment, which in turn exacerbates the cost of treatment in the long term. Poverty is a major contributing factor to mental health issues. “Conditions of poverty can lead to high levels of stress, social exclusion, reduced access to social capital, malnutrition, obstetric risks and increased risk of violence” (Cooper et al., 2011, p. 309). According to Essien and Asamoah (2020, pp. 2537–2538), while 33 countries

in Africa have centres that provide community psychiatric care, twelve countries do not have such care facilities. Numerous scholars have also mentioned the lack of psychosocial rehabilitation services in many African countries, including South Africa.

The African mental healthcare landscape calls for contextually relevant and culturally sensitive approaches. There is a pressing need for more research on the African context, as well as the development of culturally appropriate mental healthcare policies, and the training of African mental healthcare professionals proficient in the languages and cultures of the communities in which they work. Integrating traditional and faith-based practices with formal healthcare systems will ensure the humane treatment of clients with mental healthcare needs, while respecting the various cultures and languages across the African continent, including South Africa, with its diverse range of cultures and languages.

2.5 Mental Healthcare in South Africa

Stein et al. (2008, p. 114) reported an alarming lifetime prevalence of mental health disorders among South Africans of approximately 30 per cent; yet, as per Shisana et al. (2024, p. 2) the World Mental Health Survey of 2024 indicates a lifetime prevalence of mental illness of 15.8 per cent in South Africa, which is lower than the prevalence in countries such as Columbia, France, New Zealand and the United States of America. Although there is no explanation for the disparity in the figures reported by Stein et al. (2008) and the World Mental Health Survey as presented by Shisana et al. (2024), the reasons for the high burden of mental health disorders in South Africa can be attributed to various factors.

Marais and Petersen (2015, p. 2) explained that mental illness, which is seen as a chronic illness, often occurs alongside a physical illness, often creating an additional load on the country's healthcare system. South Africa’s burden of disease can be attributed to the high number of HIV/AIDS infections, non-communicable diseases and further illnesses related to malnutrition, maternal health and other injuries. As a result, mental healthcare is not seen as a priority and has not received the required funding to adequately provide for mental healthcare needs. Although the level of mental healthcare in South Africa is better than that offered in most other African countries, only one in four persons requiring mental healthcare receives the required care (Marais & Petersen, 2015, p. 2).

Efforts are being made at improving mental healthcare service delivery to the South African population. An example of such an effort is the National Mental Health Policy Framework and Strategic Plan. The aim of the National Mental Health Policy Framework and Strategic Plan 2013–2020 is to assist with the integration of mental healthcare services into the primary healthcare system of South Africa. The latest National Mental Health Policy Framework and Strategic Plan 2023–2030 (Department of Health, 2023) explains the shortcomings of the 2013–2020 National Mental Health Policy Framework and Strategic Plan in its Introduction. The obstacles mentioned in this document are the lack of implementation plans and insufficient staff and funding. This statement supports one of the findings in the research of Marais and Petersen (2015, p. 6) that one of the significant challenges to the success of this Policy Framework was the lack of implementation on a service level. The lack of implementation can be blamed on a lack of awareness of the Policy Framework on the level where services are rendered. The 2023–2030 policy framework aims to direct Government activities to ensure that attention is paid to all mental health conditions across all spheres of the South African population, and that various stakeholders are involved across all levels to provide adequate mental healthcare services. Another document that emphasises the right of access to information and services in the language of the patient or client is the National Patients' Rights Charter (Health Professions Council of South Africa, 2023, p. 2), which states that information and access to healthcare information should be available in the language that the patient best understands. The language that is best understood by the majority of Deaf persons in South Africa is South African Sign Language (SASL).

2.6 Mental Healthcare for Deaf Persons in South Africa

Mall and Swartz (2012, p. 496) stated that Deaf South Africans are more vulnerable to mental health conditions than hearing people, due to a lack of communication and a lack of accessible information. The lack of communication in all aspects of life for Deaf persons in South Africa causes mental health conditions such as anxiety, stress, depression and isolation. Cromwell (2004, p. 1) asserted that Deaf people encounter the same emotional difficulties as persons in the broader hearing communities. In interviews conducted with leaders in the mental health advocacy space, Mall and Swartz (2012, p. 493) found that the mental health conditions faced by Deaf people are the same as those found in the broader hearing community, but that the prevalence of disorders such as anxiety, stress and depression are higher in the Deaf community.

Using the statistics as presented by Shisana et al. (2024, p. 2), the number of Deaf South Africans exhibiting some form of mental health condition can, therefore, be estimated to be at least 15.8 per cent of the Deaf community of South Africa. According to Mall and Swartz (2012, p. 493), mental healthcare services that are accessible to the Deaf community of South Africa are much more restricted than the services available to the hearing community because there is a shortage of SASL interpreters available to provide access to these mental healthcare services.

Elkington and Talbot (2016, p. 368) stated that South Africa's healthcare system offers "monolingual health services in a multilingual society". London et al. (2020, p. 183) observed that in the healthcare sector in South Africa, 80 per cent of healthcare appointments are carried out across a language divide. This means that 80 per cent of mental health professionals do not use the same language as their clients. This obstacle also pertains to Deaf persons because they need SASL interpreters to bridge the language divide between themselves and the hearing mental healthcare professional. The need for more qualified and trained SASL interpreters is further emphasised. It is asserted that both local and international research indicates the importance of the sign language interpreter in the mental health therapy session "…as critical in establishing trustful and clinically effective relationships…" (London et al., 2020, p. 186).

Contrary to the statement by London et al. (2020, p. 186), Hamerdinger and Karlin (2003, p. 1) explained that the Southern District Court in Florida ordered that mental health services must be provided by a mental health professional who are fluent in sign language, arguing that the use of sign language interpreters in therapy sessions is not appropriate as it does not equate to equal access to mental health services.

The ideal situation will be to have enough mental health professionals fluent in sign language to service Deaf clients without using sign language interpreters. However, very few hearing people learn and become sufficiently proficient in sign language to offer therapy to Deaf clients directly. The provision of mental healthcare services to Deaf South Africans through mental health professionals who are fluent in SASL is the ultimate dream, which will most likely remain as such for years to come, given the current situation in South Africa. SASL interpreters are currently the best solution to the problem for Deaf people regarding access to mental healthcare services for Deaf people.

2.7 Deaf Community of South Africa

Historically, there have been two perspectives regarding deafness: (i) the medical or pathological perspective and (ii) the socio-cultural perspective. The medical perspective views the Deaf person as an individual with a deficiency. In the case of Deaf individuals, the perceived deficit is that they cannot hear and are therefore classified as disabled. For this reason, people who subscribe to this perspective would want to provide a medical solution to deafness. On the other hand, the socio-cultural perspective recognises that the Deaf person belongs to a community that shares the same values, culture and language. The socio-cultural perspective promotes the recognition of Deaf individuals' human rights and their ability to be self-sufficient and independent (Ram & Muthukrishna, 2001, pp. 40 - 41). From the socio-cultural perspective, the Deaf community can be defined as individuals who use sign language as primary communication method and view themselves as a linguistic and cultural minority (Barnett, 1999, p. 18). As a cultural and linguistic minority, Deaf persons must function in a world that is dominated by hearing people. A significant portion of the Deaf community perceives the hearing community as the oppressor. Baker-Shenk (1985) described the oppressor as people from a majority group who "denigrates your self-worth, your abilities, your intelligence, and your right to be different…" (p. 44). She goes on to explain that the oppressed group are denied the opportunity to influence the organisations and institutions that impact their lives, rendering them powerless and leaving them to feel frustrated. Because most sign language interpreters are hearing people, they are often regarded as the oppressor as well. Therefore, Deaf clients do not always trust sign language interpreters and many of them will not always communicate with the sign language interpreter to indicate they are not understood. This situation has improved, with members of the Deaf community assuming leadership roles in their communities.

Akach and Morgan (2015, p. 393–394) explained the unique position of sign language, its development, as well as the Deaf community. They argue that for any language to grow and develop, the users of the language live together as a community. However, unlike hearing communities, the Deaf community does not live together in a specific geographical area, and therefore, sign language does not generally develop and grow under the same circumstances as spoken languages do. Schools for the Deaf play a pivotal role in children acquiring sign language, where the language develops and grows. These schools are vital lifelines for the Deaf community. The authors further

commented that the South African perspective of Deaf culture and the Deaf community is one where they are viewed as a group of individuals who use the same language—SASL—and share a common Deaf culture.

In their research, Ram and Muthukrishna (2001, p. 43) discovered that the majority of Deaf participants in their study do not consider themselves disabled. The overarching feeling is that society disables them because society does not provide access to information and communication in sign language. It can, therefore, be concluded that in order for Deaf persons to be abled members of society and to exercise their rights as equal citizens, there is a need for sign language interpreters. The question is: How large is this community in South Africa, and how many Deaf persons require access to SASL interpreting services? According to "Empowering Vulnerable Communities: MTN's Commitment to Inclusive Technology" (2023, p. 1), more than 2.8 million people in South Africa have hearing or speech difficulties, of which 600,000[8] are SASL users (Storbeck, 2023, p. 1).

2.8 Interpreting

"If there were no different cultures, there would be no interpreters" (Lane, 1985, p. 179).

"Interpreting is the process of fully understanding, analysing, and processing a spoken or signed message and then faithfully rendering it into another spoken or signed language" (NAJIT, 2016, p. 2). This means that interpreting is used when people from various linguistic and cultural backgrounds interact. The interpreter will listen to the speaker's message and convey the meaning of the speaker's message into the language of the other party to the conversation. Interpreting can be described as the enabler of understanding and communication between various interlocutors (Kohn & Kalina, 1996, pp. 118-119). While the statement provides a foundational understanding of interpreting, it lacks nuance in areas such as cultural mediation, interactional dynamics, and ethical considerations. The role of interpreters in society cannot be underestimated since they can be regarded as an instrument to break down barriers between different communities, serve to restore imbalances in society and provide access to crucial services to minority communities in various settings.

[8] There are significant discrepancies in the numbers of SASL users reported by the national census and the numbers reported by Organisations of Deaf persons in South Africa. The numbers vary from 1,609,386 reported in 1994 to 600,000 reported in 2023.

Different types of interpreting occur in various settings. These types of interpreting include, but are not limited to, court or legal interpreting, liaison interpreting, medical interpreting, media interpreting, educational interpreting, remote interpreting and conference interpreting. The varied settings will require the interpreter to use different modes of interpreting. Although simultaneous and consecutive interpreting have historically been viewed as the two main modes of interpreting, there are two other modes of interpreting, namely, sight interpreting and whisper interpreting. Sign language interpreting should not be seen as a mode or a type of interpreting; it is interpreting into and from a language articulated in visual-spatial modality. During the NATO Conference of 1977, Ingram (1978:109), as cited by Grbić and Pöllabauer (2006), asserted that no research in the field of interpreting can be seen as complete if it does not consider sign language interpreting (Grbić & Pöllabauer, 2006, pp. 248, 251 - 252). The reference to Ingram's assertion reinforces the necessity of including sign language interpreting in the field of interpreting studies. The focus of this current research study is SASL interpreting in the mental health therapy session.

2.9 Interpreting for Mental Healthcare

Generally, interpreters are trained to convey a coherent and culturally appropriate message to the receiver of the interpretation. It is important to note that the training of interpreters is generally, and has historically been, based on the theories and principles of conference interpreting. The role of the conference interpreter is that of a conduit only, and this role is not necessarily relevant to all interpreted settings. In light of the increasing number of people migrating from their home countries to foreign countries, there have been increased calls for interpreters to play a more active cultural mediation role when interpreting in community-based or liaison interpreting situations (Schuster & Baixauli-Olmos, 2018, p. 734). Angelelli (2008, p. 151) argued that the interpreter's role can differ across all settings. In training programmes, the typical role of the conference interpreter—the detached, impartial language conduit—has been transferred to other settings, such as medical and legal settings. Interpreters should receive training in the mental health field to avoid filtering the information they interpret as a part of the interpreting process. Filtering can distort the message in a way that impacts the therapy session (Hamerdinger & Karlin, 2003, p. 1). The reason for filtered information is that people make sense of utterances and words in different and unique ways. "… [W]ords in and of themselves carry meaning, a meaning that can be decoded and subsequently re-coded into words belonging to another language" (Hamerdinger

& Karlin, 2003, p. 6). One must remember that whatever the interpreter interprets will shape what the central interlocutors say in response (Wadensjo, 1998, pp. 6, 67).

Young et al. (2019, p. 91) explained that interpreting is not just a cross-lingual exercise; it is a portrayal of the Deaf person as a whole. The interpreter interprets the spoken language by choosing the exact words, tone of voice and register they deem appropriate. The Deaf client cannot access the spoken interpretation and will not know how the interpretation comes across. The hearing mental health professional understands and makes meaning of the interpretation through the tone of voice, choice of words and register that the interpreter uses. All of these factors give meaning to the message that is passed on from the Deaf individual via the interpreter.

Wadensjo (1998, p. 11-12) claimed that when an interpreter is brought into a communication situation, it becomes "a communicative *pas de trois*"—a dance for three people. “Clinical work has traditionally been viewed as a dyadic interaction where the relationship between the clinician and the consumer becomes the mechanism for treatment” (Hamerdinger & Crump, 2022, p. 341). Some complexities come into play when there is an interaction and communication between two people (a dyad) versus interaction and communication between three people (a triad). Such complexities include the absence of a direct relationship between the central interlocutors and the disturbance of the natural conversational turn-taking process. Within the triad, the interpreter is responsible for making sense of what is being said by the central interlocutors and synchronising the conversational activity (Wadensjo, 1998, p. 153). The success of the interpreted communication event depends on both interlocutors' trust in the interpreter. The interlocutors must trust that what they say will be interpreted accurately and with the same intention as the original message. However, Llewellyn-Jones and Lee (2013, p. 58) argued that it is not only interpreting with accuracy that ensures trust, but also the value the interpreter places on the individuals they are interpreting for, as well as their contributions.

Angelelli (2008, p. 150) further suggested that the interpreter brings their own perspective to the interpreting situation, which includes knowledge of language, which holds power, and may, through behaviour, influence the interpreted event. Roy (2015, p. 300) clarified this point by saying that the interpreter in the communication event is the only person who understands the languages and cultures of both the participants in the conversation. This responsibility makes the interpreter essential for

communication flow, and can potentially influence the outcome of the communication between the two interlocutors, making the interpreter an active contributor to the communication event. The interpreter also provides cultural and social input and not only linguistic input. The interpreter can also unintentionally become a co-participant in the interpreted event by doing things that interpreters are trained to do: introduce themselves, suggest seating arrangements, explain the interpreter's role and inform the parties how the communication will work, showing that the interpreter is not simply a conduit in the communication event. However, Wadensjo (1998, p. 19) compared the presence of an interpreter in a communicative event with that of a photographer—a non-person. The interpreter takes part in the communication event on their terms, as they can choose to be involved in the event or to stay completely impartial. Wadensjo (1998, p. 240) explains that:

> [t]he principle of impartiality involves, on the one hand, a duty to relate neutrally to people and what they say, that is, to convey a neutral—meaning *no*—attitude of one's own to both parties and their goals in interaction.

De Bruin and Brugmans (2006, p. 361–362) suggested numerous advantages of using sign language interpreters in therapy sessions. One of these advantages is that the interpreter can provide cultural information and interpret non-manual features such as facial expressions and dialect. The therapy session can be powerful when the therapist and the sign language interpreter have an effective partnership and if the role of the sign language interpreter is clearly defined.

De Bruin and Brugmans's assertion (2006, p. 362) raises the following the questions: What should the role of the sign language interpreter be in the mental health therapy session? Should the sign language interpreter be impartial and detached from the therapy session, or should the interpreter play a mediator role instead? Dickinson (2014, p. 52) asserted that if the sign language interpreter maintains a wholly impartial and detached role, it will perpetuate the power imbalance between the Deaf and the hearing interlocutor. Research by Roy (2015, p. 324) indicates that the interpreter is an active participant in the communication event.

McIntire and Sanderson (2015, p. 330) clarified the various roles that the sign language interpreter can play in the communication event by providing the following potential messages that the interpreter can send.

- *The Helper:* “You can’t do it – let me do it for you.”
- *The BI-BI:* “I am your ally – what is it you want?”
- *The Communication facilitator*: “I am your advocate – I’ll help you do it.”
- *The Conduit/Machine*: “I’ll give you everything that’s said – do it yourself.”

The message with each role shows much about the interpreter's power in the communication event. The conduit or machine role of interpreting, is what most trained interpreters do, especially if their training is based on the conference interpreter model. Roy (2015, p. 300) claimed that because conferences and events with only one speaker are more open and more noticeable to the public, it is assumed that all interpreting occurs in this manner. While conference and public interpreting have been the topic of many research studies because they are so open and accessible, one-on-one interpreted conversations are generally private and not accessible to the public, making it challenging to be a topic of research.

In the conduit or machine role, the interpreter will be wholly impartial and detached from the communication event, which means that the interpreter will not hold any power over any of the two interlocutors. According to Dickinson (2014, p. 51), this role is also called the “invisible language conduit”, and much of the available literature portrays the interpreter in this light. In this role, the interpreter merely conveys spoken or signed messages into another language. For example, the interpreter in this role will leave all introductions and explanations in the hands of the Deaf person. This role creates the impression that the Deaf person can function independently (McIntire & Sanderson, 2015, p. 328).

The interpreter in the helper role retains the power. In this model, the interpreter plays the role of a helper as if the interlocutors or the Deaf persons cannot act or do anything for themselves (McIntire & Sanderson, 2015, p. 328). The helper role can disempower the Deaf person, and the interpreter can be perceived as controlling (Dickinson, 2014, p. 51). Usually hearing people do not know how the interpreting process works, and they do not understand the role of the interpreter, and therefore, it needs to be explained to them. An example of an action by an interpreter in the helper role is that the interpreter will control the introductions between the two interlocutors and explain the interpreter's role to the hearing person.

The communication facilitator role, also called the “Active Third Participant” (Dickinson, 2014, p. 53), allows the interpreter to take on the role of a facilitator in the interpreting situation, and the interpreter can act as a cross-cultural mediator during the communication event. An example is when the interpreter explains to the Deaf person an action by the hearing person that can be attributed to hearing culture (McIntire & Sanderson, 2015, p. 329).

The bilingual and bicultural role is where the interpreter views the hearing and Deaf interlocutors as equals. The interpreter in this role will respect both interlocutors' rights and responsibilities and acknowledge their role to contribute to a successful communication event (McIntire & Sanderson, 2015, p. 329).

McIntire and Sanderson (2015, p. 329) opined that each interpreting situation requires an evaluation to determine the best-suited role. The role that the interpreter will play will largely depend on who the Deaf client is as well as their background. However, according to Elkington and Talbot (2016, p. 366), the most frequently favoured role for interpreters in mental healthcare settings is the bilingual and bicultural role. Llewellyn-Jones and Lee (2013, p. 70) suggested that interpreter training programmes should equip interpreting students with the required knowledge and skills to play different roles. Swabey (2018, p. 81) proposes that the sign language interpreter should possess, besides their qualification in interpreting, knowledge and understanding of which linguistic, community and cultural factors can impact mental healthcare interchanges. The sign language interpreter must know how to strike a balance between professionalism, empathy and adaptability, be familiar with the legislation that pertains to mental healthcare, and know the fundamental applications used in mental healthcare sessions.

Lesch (2011, p. 366) argued that barriers in communication between individuals are often not only linguistic. The barrier of power disparity is often a contributing factor in communication barriers. Power can be defined as “to exercise authority or dominating influence over; to direct; to regulate” (Lesch, 2011, p. 330). Power disparities can be caused by culture, class and gender. A disability, such as deafness, can be another contributing factor, and Deaf people often experience multiple barriers to communication, exacerbated by the difficulties in terms of race or class as well as their deafness that they experience in their communities. McIntire and Sanderson (2015, p. 330) provided an example of a sign language interpreter who does not want to interrupt

the hearing person to interpret what the Deaf person is signing. This behaviour is seen as appropriate in the hearing culture, but the Deaf person may perceive it as being controlling. Therefore, the sign language interpreter must understand their role in empowering or disempowering Deaf clients. Dickinson (2014, p. 56) stated that in most interactions between Deaf and hearing people, there will be a disparity in power. The reason is that Deaf persons use sign language—a typical minority language—putting them in a disadvantaged position when communicating with a hearing person, who will typically use the language of the majority. It is, therefore, vital for the sign language interpreter to be professional and sensitive to the needs of both interlocutors when working in the mental healthcare field. Power disparities are not only linguistic but also cultural and systemic. A sign language interpreter who hesitates to interrupt a therapist, adhering to hearing norms, might inadvertently silence the Deaf client. Such actions, while perceived as polite in hearing culture, can be disempowering in Deaf culture. There is a need for sign language interpreters working in mental healthcare to actively monitor and balance power, and not simply transmit language. Sign language interpreter training must include training to equip the professionals with the competencies to navigate potential power disparities.

Akach and Morgan (2015, p. 397) argued that "a professional is trained to recognised standards of competence, adheres to a recognised code of practice and enjoys the support and regulation of a professional structure". In South Africa, we have come a long way in the professionalisation of the SASL interpreting profession. Several tertiary institutions offer SASL interpreting at Master's and Doctor of Philosophy levels, and the Board of the South African Language Practitioner's Council (South African Government, 2014) was duly appointed by the Minister of Sport, Arts and Culture in 2023. This Board is responsible for establishing the accreditation and registration process for all language practitioners in South Africa.

The first professional medical training for SASL interpreters was conducted in 2012 to increase the number of SASL interpreters trained in healthcare settings (London et al., 2020, p. 187). The course, "Introduction to Community Medical Sign (SASL) Language Interpreting", was offered to twelve students by the University of Cape Town, School of Public Health and Family Medicine, in November 2011 and March 2012 (Newsroom, 2012). There has not been any further training of this nature that specialises in SASL interpreting in healthcare settings.

Elkington and Talbot (2016, pp. 366–367) cautioned about the potential obstacles when using an interpreter in the mental healthcare setting. Some obstacles mentioned are the possibility of misinterpretation, additions and omissions, which can lead to a misdiagnosis of the client. The study by Cokely (2015, pp. 149–154) found four types of errors made by sign language interpreters during the interpreted medical interview. First are perception errors made by the sign language interpreter when not accurately reading information provided by the Deaf person, for example, errors in reading fingerspelled names or proper names. Secondly, memory errors can occur when the Deaf or hearing person shares too much information, and the sign language interpreters' short-term memory fails. Thirdly, errors can occur when the sign language interpreter is not able to comprehend what is being said or misses a part of the message, which then changes the meaning or intent of the message. These errors are referred to as semantic errors. Lastly, a performance error is made while interpreting the source language into the target language, for example, spelling mistakes or omitting important information.

The potential secondary trauma that the interpreter may experience when the client's presenting problem triggers memories of similar experiences that the interpreter may have is also a potential hurdle that could affect the therapy session. Benjamin et al. (2016, p. 74) opined that untrained interpreters may overidentify with clients in the mental healthcare setting. Another potential obstacle is the non-adherence to the prescribed Code of Ethics for interpreters. Corey et al. (2017, pp. 4 - 5) explained that a Code of Ethics in any profession is a broad operational direction. Some fundamental aspects covered in most codes of ethics, including that of SASL interpreters, are confidentiality and privacy, accepting work that you are adequately skilled to do, and always striving to uphold a high standard of professionalism. The Code of Ethics for sign language interpreters encompasses all the values that are important and promotes professionalism and explains how interpreters are expected to behave (WASLI, 2024).

Many of the obstacles mentioned above can be significantly reduced if the interpreters are trained and professional. Using untrained interpreters can be regarded as a violation of the client's rights and may raise ethical concerns. The importance of field-specific training cannot be underestimated. Benjamin et al. (2016, p. 79) asserted that the need to train interpreters in the medical and mental healthcare field must receive

urgent attention. They further mentioned the importance of educating mental health professionals on working with interpreters, rather than merely training them on "using" interpreters. The benefits of employing trained interpreters include but are not limited to improved provision of services, accurate diagnosis, and interpreters familiar with medical and psychological terminology. The level of trust between the client and therapist increases when trained interpreters are used (Elkington & Talbot, 2016, p. 367).

2.10 Mental Health Professionals' Required Knowledge of Language and Culture

Corey et al. (2017, p. 16) asserted that every effective, multicultural mental health professional must be sensitive to their clients' cultures. Language forms an integral part of any culture, and good interpersonal skills depend on understanding the individual's culture and language (DeVito, 2019, p. 44).

Intercultural interaction, according to Spencer-Oatey and Franklin (2009, p. 3), is a communication event where two persons from different cultures interact and where at least one of the two parties recognises that the differences in cultures are notable. According to Hamerdinger and Crump (2022, p. 342), due the fact that the majority of Deaf people did not have access to natural language acquisition from birth or a very young age, many of the members of the Deaf community are language deprived, which affects their psychological and social development. This disadvantage is essential to take into account for a mental healthcare worker when working with a Deaf client because Deaf persons cannot always express themselves and describe their emotions and thoughts (Williams & Abeles, 2004, p. 643).

According to Corker (1994), as seen in Williams and Abeles (2004, p. 644), 90 per cent of all messages are conveyed through non-verbal methods. The mental health professional must know the non-verbal indicators to establish and maintain a trusting relationship and rapport with the client. Spencer-Oatey and Franklin (2009, p. 39) discussed non-verbal behaviour in different cultures. Eye contact was one of the behaviours discussed by the authors, by using an example of an American Indian student who was disciplined by an educator. The student looked down and lowered his head, since this is considered a sign of respect in American Indian culture. However, the educator expected the student to make eye contact as he was unaware of this cultural convention.

Williams and Abeles (2004) consider sustained eye contact crucial in Deaf culture and sign language. The Deaf client may interpret a lack of eye contact from the therapist as non-committal and antagonistic. “The act of breaking eye contact in a visually based conversation destroys the communication bridge” (Williams & Abeles, 2004, p. 644).

Antolovi (2017, p. 10) also discussed the impact of eye contact or a lack thereof and how it can be misinterpreted by a therapist unfamiliar with the client's specific cultural conventions.

During the interpreted therapy session, the Deaf person will maintain eye contact with the SASL interpreter when the therapist is talking. By keeping eye contact with the SASL interpreter, eye contact between the therapist and the Deaf client will obviously be limited.

Another cultural difference between Deaf and hearing clients is the phenomenon where Deaf people prefer to share elaborate stories to provide context to the actual point of the story. Storytelling plays a vital role in Deaf culture, and it is often the activity of telling the story that is the most important part of therapy for Deaf people. Initially, during the first therapy session with a hearing therapist, Deaf people may only provide short replies to questions asked. However, as the relationship develops and they start to trust the therapist, the storytelling aspect of Deaf culture will come to the fore (Williams & Abeles, 2004, p. 644). Hearing mental health professionals who are not familiar with Deaf culture may experience the storytelling as frustrating, and behaviours that are regarded as acceptable in Deaf culture may be misinterpreted, or the Deaf person may be incorrectly diagnosed (Morere et al., 2019, p. 243).

Rogers (1957, p. 96) asserted that the core conditions for therapeutic change are, first, the psychological contract[9] between two individuals; second, that the client will be in an incongruent state[10]; and third, the therapist will be congruent. The fourth condition is that the therapist must show their full support and completely accept the client and what they say. The therapist must feel empathy for the client and, lastly, be able to communicate their empathetic understanding with the client. This research paper focuses on the first condition mentioned by Rogers. He maintains that the mental

[9] The psychological contract is the agreement between the therapist and the client that states both parties' responsibilities. For example, a therapist must keep all information shared during the session confidential. The client's commitment in the contract is to cooperate with the therapist.

[10] “Incongruent” means when there is a misalignment and not a balance between the authentic and ideal selves.

health professional and the client are in a dyad within a psychological contract. However, with therapy for Deaf people, the addition of SASL interpreters transforms the relationship into a triadic one. This triadic relationship contrasts with Rogers' belief that only two individuals should be involved in a therapeutic relationship. Cromwell (2004, p. 5) stated that having an interpreter in the therapy setting makes them part of the interaction, and the dyad will become a triad.

2.11 Building Trust and Rapport in the Therapeutic Environment

Mental health professionals use the RSM to build client relationships. The RSM is a framework that highlights the importance of interpersonal skills and the relational factors that play a role in the mental health therapy session. Midwinter and Dickson (2015, p. 20-21) stated that the RSM comprises five phases. First, the relationship between the client and the therapist must be established by making contact and meeting the client. The therapist will use basic counselling skills, such as attending and active listening, which forms part of rapport building. During this phase, the therapist will also contract with the client. After the first phase, the mental health professional will work on developing the relationship by identifying the problems and assessing the client's situation. The therapist will use various skills such as questioning, reflecting content and feelings, and summarising. The third phase of the RSM is working with the relationship. During this phase of the RSM, the therapist will confront the client with realities and challenge their perspectives by probing and providing feedback to the client. The next phase is the established relationship, where the therapist will work with the client to devise action plans, set goals, and maintain and conclude the relationship. During this phase of the RSM, the therapist will provide the client with self-management strategies to ensure that the client maintains the implementation of change. This research study investigates how effective the first phase of the RSM is when an SASL interpreter is involved as a linguistic mediator.

McLeod and McLeod (2011, p. 44) listed numerous skills that are crucial for a counsellor within the counselling setting. One of the core principles listed is the skill of attending. Attending and listening skills are best summarised using Egan's SOLER model (Stickley, 2011, p. 396). The acronym can be explained as follow: 'S' is for *facing the client squarely*, 'O' is for *adopting an open posture*, 'L' is to *lean toward the client* at times, 'E' is *maintaining eye contact* with the client, and the 'R' is to be *relaxed* (Midwinter & Dickson, 2015, p. 25). The therapist must be aware of their non-verbal

communication, which McLeod and McLeod (2011, p. 45) listed as "bodily awareness". Midwinter and Dickson (2015, p. 25) raised non-verbal communication as an integral aspect of the skill of being attentive. The client and therapist's body language, facial expressions and eye contact communicate much information. The therapist needs to pay close attention to the client's non-verbal messages and what their (the therapist's) non-verbal messages communicate to the client. Non-verbal messages can include, but are not limited to, body messages, eye communication, touch communication and facial communication (DeVito, 2019, pp. 137 - 150). According to Smaby and Maddux (2011, pp. 28–29), the therapist must possess the ability to ask open-ended questions to explore the client's needs. If the SASL interpreter is not trained in mental healthcare strategies, they may misinterpret the question, potentially making it challenging for the therapist to navigate and determine the issues at hand.

Empathy is another vital principle in mental healthcare, especially in the therapeutic setting. It can be defined as the ability of the therapist to put themselves in the client's shoes and tune into the client's feelings (Midwinter & Dickson, 2015, p. 14). Egan and Reese (2021, pp. 37-38) posited empathy as the effect others' feelings and experiences have on our own feelings and thoughts.

During the interpreted therapy session, some of the principles of the SOLER model may be affected. Facing the client squarely is not always comfortable for the hearing mental health professional if there is a third party that must be considered. Leaning toward the client at times may not have the desired impact, because the Deaf client will be paying attention to the SASL interpreter, and it is difficult to maintain eye contact with the Deaf client since the Deaf client needs to maintain eye contact with the SASL interpreter to see the message. These factors may impact the therapeutic alliance.

Several scenarios can play out within a triadic alliance. One possibility is the alignment where the Deaf client and the interpreter are seen as the primary unit, with the therapist as the outsider. Another possibility is that the therapist and the interpreter are seen as the primary unit, with the Deaf client as the outsider. The last possibility, and the most preferable, is that the therapist and the Deaf client form the primary unit, with the interpreter as the communication facilitator (Brunson & Lawrence, 2002, p. 579).

2.11.1 Deaf Client and Interpreter

Williams and Abeles (2004, p. 645) opined that apprehensiveness about dealing with a Deaf person may affect the rapport building between therapist and Deaf client.

Cromwell (2004, p. 5) explained that some therapists may encounter feelings of helplessness because their usual skill and experience as a mental health professional is of no use when working with a Deaf client. The use of a sign language interpreter will not assist in such a situation, as it may further exacerbate the mental health professional's feelings of isolation and loss of control over the therapy. Some mental healthcare professionals may feel excluded, distanced, or judged, and may also feel that they are competing with the interpreter, because they do not understand the role of the sign language interpreter. It is equally essential for the Deaf client to understand the interpreter's role because the Deaf client may see the interpreter as an ally and a supporter. The close relationship that may exist between the interpreter and the Deaf client because of a shared language, an understanding of Deaf culture, and connection to the Deaf community has the potential to frustrate the therapeutic process and relationship between the therapist and Deaf client (Hamerdinger & Crump, 2022, pp. 342 - 343). De Bruin and Brugmans (2006, p. 368) explained that the interpreter may be seen as a threat, a trespasser, and a person evaluating the mental health professional's skills. Furthermore, this situation could be exacerbated if the sign language interpreter has experience in the mental healthcare field. These factors can potentially lead to a power struggle between the therapist and the interpreter.

Cultural conventions, such as a hug as a greeting and polite discussions before and after the session, may be perceived by the therapist as threatening their relationship with the Deaf client. Antolovi (2017, p. 38) mentioned instances of interpreters conversing with the Deaf client before and after a therapy session, almost acting as a therapist and supporting the Deaf client. This behaviour can be detrimental to the therapeutic alliance because the therapist is not included in these conversations.

2.11.2 Mental Health Professional and Interpreter

A factor that may impact the trust relationship is that the Deaf community is small, and the Deaf client may feel that confidentiality will not be maintained. Since there is a lack of qualified sign language interpreters, the Deaf person may know the interpreter from other events or settings and will, therefore, wonder if the interpreter will disclose the content of the therapy session with others. Deaf people's typical experiences are that hearing people discuss their cases with other hearing people (Williams & Abeles, 2004, p. 645). Cromwell (2004, p. 4) opined that some Deaf people may experience the presence of an interpreter as an intrusion. Depending on their life experiences, the

Deaf person may also suspect that the therapist and interpreter, since they are both hearing people, are allies and, therefore, feel overrun by hearing people. The concept of the hearing person as the oppressor is discussed in 2.7 (Deaf Community of South Africa), which explains the lack of trust in the interpreter and the therapist.

The mental health professional must understand that the sign language interpreter is not responsible for sharing any prior knowledge about the client with the mental health professional. The interpreter is not a mental health professional, and the mental health professional is not an interpreter. Mutual respect for the different roles is vital for relationship-building between the therapist and the sign language interpreter (Williams & Abeles, 2004, p. 646).

Stansfield (1981), as cited in O'Donnell (2020, p. 10), explained that the Deaf client may see the therapist and the interpreter as allies, and several factors may contribute to this perception. First, the interpreter and therapist are hearing persons who share a spoken language and are seated next to each other in the therapy room. The Deaf person relies on the interpreter to convey the message accurately to the therapist.

2.11.3 Mental Health Professional and Deaf Client

Corker (1994), as cited in Williams and Abeles (2004, p. 645), explained that Deaf individuals may present checks to see if the mental health professional can be trusted. An example of this is that the Deaf person may leave the decision-making to the mental health professional to see if they will take control of the Deaf person's life as hearing people in their lives typically do.

According to the research conducted by Brunson and Lawrence (2002, p. 579), the interpreter’s impact on the therapeutic alliance is more significant than what was initially believed to be the case. The research of Brunson and Lawrence (2002, p. 576) focused on the influence of the mood of the interpreter and therapist on the Deaf client. The results of the research found that the depressed mood of the interpreter had a significant impact on the Deaf client, more so than the depressed mood of the therapist. It is believed that this is because of the importance of eye contact that is maintained between the interpreter and the Deaf client. Trained and professional sign language interpreters generally do not influence the interpreting. However, the therapeutic setting is a different scenario because of the emotional nature of such setting (Brunson & Lawrence, 2002, p. 579).

Hamerdinger and Karlin (2003, p. 5) stated that the interpreter will be loyal to either party in the therapeutic relationship. Typically, the loyalty will be with the Deaf person, which has severe consequences within the mental health setting. It can bring about co-dependency, which, according to Ahmad-Abadi et al. (2017, pp. 301–302), can bring about a situation where the interpreter wants to take control of the relationship and looks to find emotional fulfilment in the relationship with the Deaf client. Prasko et al. (2010, p. 189) discussed the concept of transference and counter-transference, and explained that transference is when clients redirect their feelings towards the therapist or interpreter in the interpreted session. Counter-transference is the redirection of feelings from the therapist or interpreter towards the client. Mental health professionals are aware of these potential pitfalls and can guard against it. However, the sign language interpreter may not be aware of this, and when transference or counter-transference occurs, it can be detrimental to the therapeutic process. Therefore, a solid professional relationship and alliance between the interpreter and the mental health professional is vital.

Brunson and Lawrence (2002, p. 579) argued that the interpreter can become an effective communication tool by spending time with the interpreter before the session, in preparation for the session. Preparation includes background and clinical information, such as personality and presentation. A lack of training in counselling and psychology means that the interpreter can be negatively impacted since they are not trained to process emotionally laden sessions (Brunson & Lawrence, 2002, p. 579).

Brunson and Lawrence (2002, p. 579) opined that because the interpreted therapy session is slower, it can affect the rapport building between the therapist and the Deaf client. They suggest that sessions where interpreters are utilised should be extended to 90 minutes.

The interpreters' ability to mirror and support the rapport-building methods of the mental health professional, and the client has a profound impact on the success of the therapy. The interpreter must learn rapport-building techniques and use discourse markers to build rapport. The lack of this knowledge can disrupt the therapy process (Mapson & Major, 2021, pp. 65, 71). The interpreter's rapport management skills and relational alertness can be supported by background knowledge of the client, which supports establishing and maintaining rapport (Mapson & Major, 2021, p. 66). The interpreter should be trained on the essentials of rapport management skills, which are

(i) having contextual awareness, such as being aware of the intent of the communication event, understanding the sensitivities and essential features of the specific interaction; (ii) having interpersonal attentiveness by being aware of the goals of the interaction and understanding the interlocutors' competencies and social identities; (iii) social information gathering, which can be obtained by meticulous observation of the interaction and understanding the different roles of the interlocutors; and (iv) emotional regulation when confronted with difficult and emotional situations; (v) accepting diversity of people; and (vi) stylistic flexibility, where a person can behave in a way to match others people's rapport responsiveness (Spencer-Oatey & Franklin, 2009, p. 102).

Mapson and Major (2021, p. 65) stressed the importance of using the same interpreter for a series of engagements to support rapport management because the interpreter will understand the client's history. Mapson and Major (2021, p. 65) further argued that there is a strong connection between the interpreter's familiarity with the Deaf client and the quality of the interpretation. Interpreters may initiate controlled turn-taking in the therapy session and unknowingly disturb the behavioural norms, which may impact how the Deaf person is seen by the mental health professional (Mapson & Major, 2021, p. 65). Theys et al. (2020, p. 40–41) mentioned that the emotional communication between the therapist and the client is disturbed in the interpreter-mediated communication session. One reason is that the client is less expressive when an interpreter is present, due to a lack of trust.

For this reason, mental health professionals prefer to use the same interpreter for all the sessions with the Deaf client to ensure a trusting relationship between the therapist and the interpreter. In this trust relationship, it is also important to ensure that the interpreter understands the strategies and terminology used by the therapist. According to Hamerdinger and Karlin (2003, p. 2), the mental health professional may not be aware that the interpretation of the session can change the essence of the therapeutic relationship between the therapist and the Deaf client. Brunson and Lawrence (2002, p. 579) stated that the mental health professional must be cognisant of the sign language interpreter's impact on the therapeutic alliance.

2.12 Conclusion

This chapter highlighted the complexities of providing mental healthcare services to Deaf individuals, particularly within the South African context. It considered the role of

the SASL interpreter in mental health therapy sessions, focusing on how they affect the therapeutic relationship between therapists, Deaf clients and SASL interpreters.

Using the narrative review style, this chapter further explored the need for mental health professionals to be culturally sensitive to Deaf individuals, recognise the significance of non-verbal communication, such as eye contact in SASL, and understand the complexities introduced by the presence of a SASL interpreter. The interpreter's role creates a triadic dynamic, impacting trust and rapport-building between the therapist and Deaf client. According to some of the literature, this relationship can be strained if the interpreter lacks mental health training, potentially leading to misinterpretations and disrupting the therapeutic process. Other scholars opined that the interpreter must go beyond mere interpretation, contributing to the therapy’s integrity and success.

The next chapter outlines the research methodology where the RSM will be used as a theoretical framework to provide a foundation for this research about the impact of the SASL interpreter on the mental health therapeutic alliance.

CHAPTER 3: THEORETICAL FRAMEWORK AND METHODOLOGY

3.1 Introduction

Chapter 3 discusses the theoretical framework and methodology of the research study on the impact of the SASL interpreter on the mental health therapeutic alliance.

The first section of this chapter specifically focuses on the theoretical framework, the RSM, used in the current study. It explains the five phases per Midwinter and Dickson (2015, p. 20) and elaborates on the RSM's core components: empathy, trust-building and cultural competence.

The following section discusses the research study's methodology by outlining various research paradigms, methodologies, and data collection and analysis processes. This section also explains the study's ethical considerations, validity and reliability.

3.2 The Relational Skills Model

3.2.1 Introduction

“A theoretical framework is a logically developed and connected set of concepts and premises – developed from one or more theories – that a researcher creates to scaffold a study” (Varpio et al., 2020, p. 990). Lederman and Lederman (2015, p. 597) opined that a theoretical framework is crucial to support and provided reasons for the noteworthiness of the research study.

The researcher considered the Person-Centred Therapy (PCT) approach by Carl Rogers, a prominent figure in humanistic psychology, as a potential theoretical framework for the current study. The PCT highlights the role of generating a therapeutic environment that promotes empathy, unconditional positive regard and congruence. The PCT further regards the client-therapist relationship as the primary channel to achieve success in therapy (Nelson-Jones, 2011, pp. 88-92). Corey et al. (2017, p. 75) discussed the importance of the client-therapist relationship by asserting that the relational model stems from the premise that therapy is a reciprocal process between the therapist and the client. They argue that the power balance between the therapist and the client in the traditional psychoanalytical model of the late 20th century was unequal because of the authoritarian way in which the relationship was managed. The

more modern relational model promotes a more collaborative relationship between the therapist and the client.

The RSM provides a sound theoretical framework for the current study, investigating the SASL interpreter's impact on the therapeutic alliance. The RSM focuses on the interaction dynamics and the relationship development in the therapeutic session, which is central to this study. On the other hand, PCT focuses mainly on creating a conducive therapeutic environment with a focus on empathy, unconditional positive regard and congruence. The RSM has several core components serving as focus points, such as empathy, which is the capacity to imagine what the client is feeling and to put yourself in the client's shoes. Trust-building is another core component of the RSM. Trust forms the foundation of any relationship; in the therapeutic relationship, trust is a vital component to the success of therapy. Cultural competence is also central to building and maintaining a relationship. Therapists must understand the client's cultural backgrounds rather than interpret their clients' actions using their culture (Moleko, 2012, p. 163). Gerber (1980, pp. 723-724) pointed out that a therapist who is unfamiliar with Deaf culture and psychosocial factors such as language development and isolation affecting Deaf persons, may misunderstand or misdiagnose these Deaf clients. The researcher considered the core components of the RSM as most suitable for the current study.

According to Midwinter and Dickson (2015, p. 20), the RSM has five phases: setting up the relationship, developing it, working with it, establishing it, and finally, maintaining and ending it. Each of these phases is discussed in this section.

3.2.2 Setting up the Relationship

During this first phase of the RSM, the relationship between the client and the therapist is established by making contact and meeting the client. Egan and Reese (2021, p. 14) maintained that one of the most critical factors contributing to a successful counselling session is the relationship between the client and the therapist, with the client's contribution regarded as paramount. The therapist uses basic counselling skills, such as attending and active listening, to build rapport. Attending to the client means showing interest through suitable eye contact, maintaining an open body posture and leaning forward during the session (Stickley, 2011, p. 397). The tone of voice and eye contact are essential factors in basic attending skills required in building rapport between the therapist and the client (Theron, 2008, p. 22). Active listening

involves the therapist demonstrating understanding by paraphrasing, recognising and accepting the client's feelings and asking questions (DeVito, 2019, pp. 188-189). During this phase, the therapist also contracts with the client.

3.2.3 Development of the Relationship

Phase two of the RSM involves developing the relationship between the therapist and the client. This development is achieved by identifying the problems and assessing the client's situation. The therapist will use various skills, such as questioning and reflecting on content and feelings. Asking open-ended questions during the therapy session assists the therapist in gaining a clear understanding of the client's feelings and obtaining more information. Reflecting content and feelings back to the client allows the client to feel heard and understood (DeVito, 2019, p. 189). Summarising is also a useful tool to employ during this phase of the RSM, because it can assist the client to organise their thoughts and to identify areas that require focus, especially if the client brings numerous matters to the session (Midwinter & Dickson, 2015, p. 49).

3.2.4 Working with the Relationship

The third phase of the RSM is working with the relationship. During this phase, the therapist will confront the client with realities, and challenge their perspectives by probing and providing feedback to the client. Midwinter and Dickson (2015, pp. 65-66) believe that confrontation or challenging the client is an important part of working with the relationship. The strategy of confrontation or challenging the client is used to clarify issues when the client makes contradicting statements, or to uncover a blind spot that the therapist has identified in the client. It is important that this strategy only be used once trust has been established. During this phase, the therapist must continue to employ empathetic listening. Empathetic listening is a technique used to understand what the client is experiencing from their perspective, by attempting to understand their feelings and experiences (DeVito, 2019, p. 190).

3.2.5 The Established Relationship

The established relationship is where the therapist will work with the client to devise action plans, set goals, and look at potential strategies for achieving the goals that have been set. In this phase of the RSM, the therapist guides the client to look towards the future by seeing that there is hope for an improved future. This sense of hope can be cultivated by assisting the client to re-orient themselves by investigating possible goals and finding strategies to achieve them. It is also important to assist clients in

moving from "possibilities to choices" (Egan & Reese, 2021, pp. 230-235, 246). Once the client has identified the options that they have, it is possible to progress to goal setting. The therapist can “draw together themes” that will guide the client to think about potential plans (Midwinter & Dickson, 2015, p. 108).

3.2.6 Maintaining and Ending the Relationship

Maintaining the relationship and eventually ending the relationship is the final phase. During this phase, the therapist will provide the client with self-management strategies to ensure that the client maintains the implementation of change. Egan and Reese (2021, pp. 275, 278) averred that the setting of goals and action plans are meaningless if there is no intent from the client to implement and action these plans. Brainstorming with the client is a suggested method to motivate the client to implement the goals that they have set for themselves. Once the client is motivated and has the intention to implement the goals they have set for themselves, the relationship can be terminated. The termination of the counselling relationship must be approached with caution, and it is important for the client to understand that they may return to the therapist for further sessions should they feel the need to (Midwinter & Dickson, 2015, p. 150).

3.2.7 Research Objectives and the RSM

The objectives of this study include but are not limited to, investigating the dynamics in communication between the therapist, Deaf client and SASL interpreter during therapy sessions. Further, the study aims to identify factors that influence the establishment and maintenance of rapport and trust between mental health professionals and Deaf clients when using SASL interpreters.

The description of the five phases of the RSM highlights that there is a deliberate structure to setting up and maintaining the therapeutic relationship. As several scholars have mentioned, a good relationship between the client and therapist is central to the positive outcome of therapy.

The current research study mainly focused on the counselling skills used in phase one of the RSM to investigate the impact of the SASL interpreter on the therapeutic alliance. This first phase of the RSM is crucial as it marks the initial meeting between the Deaf client, the hearing therapist, and the SASL interpreter; establishing the client-therapist relationship. The role of the SASL interpreter is pivotal at this stage; without them, the therapist would not have access to the information that the Deaf client brings to the session, nor would they be able to initiate and build a relationship. Major (2024, pp. 2-

4) reported that the relationship and rapport building and maintenance between two parties require relational work. In his study, two different sign language-interpreted health interactions between Deaf patients, doctors and sign language interpreters were recorded. His study aimed to determine the role of the sign language interpreter in relational work, meaning the role that sign language interpreters play in the rapport-building and maintenance processes in health interaction.

The current study aimed to investigate whether SASL interpreters have the basic understanding and training to comprehend their role in relational work and whether they recognise that factors such as tone of voice, body posture, paraphrasing and specific ways of framing questions are crucial to the success of the therapeutic relationship. Additionally, the study sought to determine whether mental health professionals working with Deaf clients are aware of cultural factors that may affect the therapeutic relationship and the potential impact the SASL interpreter may have on the therapeutic alliance.

The next part of Chapter 3 will discuss the methodology used in this research study.

3.3 Methodology

Research is the methodical process of investigating a specific field of interest to establish facts, gain new knowledge and improve people's lives (Rajasekar et al., 2013, p. 2). This part of the chapter outlines different research paradigms, methodologies, data collection processes, as well as data analyses. It details the ethical principles considered in this research regarding the impact of the SASL interpreter on the mental health therapeutic alliance.

3.3.1 Research Paradigms

Various paradigms can be used to approach research. A paradigm can be described as the lens or framework through which the researcher will view the data collected in the study. Common paradigms include positivist, post-positivist, constructivist and interpretivist paradigms. For this study, only the paradigms listed will be discussed briefly. Each of the research paradigms comprises an ontology, epistemology, methodology and method, and the researcher needs to understand the various characteristics of each paradigm to know which is the best fit for the context of their research (Alharahsheh & Pius, 2020, p. 39).

Neuman (2013) posited that ontological and epistemological assumptions form the basis of research methodology. "Ontology concerns the issue of what exists or the fundamental nature of reality", and “[e]pistemology is the issue of how we know the world around us or what makes a claim about it true” (Neuman, 2013, p. 93–95). Besides ontology and epistemology, methodology and method are essential parts of research since they are the strategies used to conduct the research and collect the data (Alharahsheh & Pius, 2020, p. 40).

3.3.1.1 Positivist Paradigm

The positivist paradigm is an approach that relies on scientific evidence to provide insight into how society operates. The ontology of the positivist approach assumes an objective reality that can be understood through verifiable observations and investigations. The epistemology of the positivist approach asserts that “knowledge can and must be developed objectively, without the values of the researchers or participants influencing its development” (Park et al., 2020, pp. 690-691). This means that positivists believe that true knowledge is attainable through the use of empirical evidence and scientific methods free from personal biases or subjective influences. The positivist paradigm was not suitable for the current study since the knowledge gained and developed in this study is influenced by the participants' values.

3.3.1.2 Post-positivist Paradigm

The post-positivist paradigm is described as a paradigm that combines the positivist and interpretive approaches and is developed in response to the limitations identified in the positivist paradigm. It argues that the background knowledge and values of the researcher can influence the study. The post-positivist approach strives for objectivity by recognising the potential biases that may influence the research study. The ontology of the post-positivist paradigm recognises that subjectivity plays a role in research. The epistemology of this paradigm is the assumption that research participants must be studied in context and that combining diverse views from participants’ personal experiences will provide a neutral perspective (Panhwar et al., 2017, pp. 253-256). This study valued the data gathered from all participants and did not assume a neutral perspective when data was combined because the data collected was inherently subjective. The post-positivist paradigm was, therefore, not suitable for the current study.

3.3.1.3 Constructivist Paradigm

Bogna et al. (2020, p. 464) described the constructivist paradigm as an approach where people construct their own interpretation and view of the world by making sense of their own experiences in life. The ontology of the constructivist paradigm focuses on how persons construct their own beliefs of reality through their personal perceptions, acknowledging the existence of multiple realities. The epistemology explains how humans gather knowledge and learn based on their perceptions and experiences in life. The belief is that knowledge is not discovered but is co-constructed by the participants and the researcher.

3.3.1.4 Interpretivist Paradigm

In contrast to positivism and post-positivism, the interpretive paradigm assumes that reality is subjective and socially constructed and that the researcher will be a part of the research and interpret the data. Alharahsheh and Pius (2020, p. 41) stated that:

> [i]nterpretivism is more concerned with in-depth variables and factors related to a context; it considers humans as different from physical phenomena as they create further in meanings with the assumption that human beings cannot be explored in a similar way to physical phenomena.

The interpretive paradigm is best suited for qualitative methods, and as Thanh and Thanh (2015, p. 24) claimed, many researchers are interested in investigating their participants' lived experiences, perspectives and understanding. The interpretivist paradigm shaped the current study in several ways. The interpretive paradigm highlighted the understanding of the subjective and nuanced experiences of the Deaf participants, mental health professionals and SASL interpreters, considering the cultural, social and situational contexts that influence the therapeutic alliance.

The goal was to obtain an in-depth, interpretative understanding of the experiences of all participants. To achieve this, the interpretive paradigm was employed. It was used consistently with the qualitative research method as a research strategy, as seen in Thanh and Thanh’s (2015) study, which employed the interpretive and qualitative research strategy to understand the lived experiences of students from Vietnam who were studying at a foreign university. This study, therefore, benefited from using this design. For further clarification, the qualitative research method is explained below.

3.3.2 Qualitative Research Method

There are three main research methods: quantitative, qualitative and mixed. Quantitative research is interested in gathering numbers, whereas qualitative research collects words as data (Neuman, 2013, p. 46). Academics have debated the precise meaning of qualitative research over the years because the term can mean various things to various researchers. Aspers and Corte (2019, p. 139) defined qualitative research as “an iterative process in which improved understanding to the scientific community is achieved by making new significant distinctions resulting from getting closer to the phenomenon studied”. This definition explains that qualitative research is the repetition of a process where the same questions are asked to different participants to understand the research topic better. The mixed method is defined as a combination of qualitative and quantitative research methods (Harwell, 2011, p. 151). Östlund et al. (2011, p. 370) argued that the mixed-methods approach has been used successfully in research studies within the healthcare field. Lund (2012, p. 157) mentioned several advantages of using the mixed-methods approach in research, including the ability to respond to multiplex research questions, provide a more comprehensive view of the study, and provide more valid conclusions.

The current research study used a qualitative methodology to ensure that the data collected provided a nuanced understanding of the topic. By employing qualitative methods, the study sought to bridge existing literature with new findings to address the research questions comprehensively. Focusing on narrative data over numerical responses by conducting interviews and using open-ended questionnaires allowed for an in-depth exploration of the impact of SASL interpreters on the therapeutic alliance, making it the most suitable approach for a subject where participants' lived experiences are crucial to the study.

This study used the qualitative method described above because the researcher needed to understand the impact of the SASL interpreter on the therapeutic alliance. Several researchers in the field of interpreting have conducted qualitative research. One such example is the study by Martin and Marti (2008, p. 208) that investigated the self-perception of the community interpreter. Russell and Shaw (2016, p. 7) also conducted a qualitative study, investigating the decision-making processes of interpreters by using an online questionnaire followed by virtually conducted focus group discussions to enable participants to share their lived experiences.

The current study used online open-ended questionnaires and virtual interviews with Deaf participants. The qualitative research method was best suited for since the number of Deaf persons accessing mental healthcare services is limited for various reasons discussed earlier in this paper. This study focuses on mental health professionals, Deaf clients and SASL interpreters involved in mental healthcare to ascertain their perspectives on the impact of the SASL interpreter in the therapeutic alliance. Data was collected from various participants using the qualitative research methodology.

3.3.3 Data Collection Methods

Data collection is the systematic process of gathering information using various tools and techniques, such as interviews and questionnaires, to answer research questions (Creswell & Poth, 2016, p. 148). Data collection aims to acquire evidence to draw conclusions for the research study (Babbie, 2013, p. 117). Several types of data collection methods can be used in a qualitative study, including, but not limited to, focus group discussions, observations, interviews and open-ended questionnaires (UpMetrics Staff, 2022, p. 1).

Questions posed to participants were founded on research questions presented in Chapter 1. The first question explored whether mental health professionals in South Africa are adequately equipped to deal with Deaf clients. The second examined the impact of the interpreting process on establishing and maintaining rapport and trust between mental health professionals and Deaf clients, especially when SASL interpreters are used during therapy. The third sought to identify the factors that could influence establishing and maintaining rapport and trust between the mental health professional and the Deaf client when SASL interpreters are involved in therapy sessions. Finally, the fourth assessed whether the SASL interpreters themselves are adequately prepared and skilled to deal with mental health therapy sessions. To respond to these questions, various data collection methods were considered.

3.3.3.1 Focus Group Discussions

Focus group discussions enable the researcher to bring several participants together and collect data from these participants at the same time. In this method, the researcher facilitates focus group discussions to gather information about the participants' views on the research topic. One of the benefits of the focus group discussion is that the data collected may be more comprehensive because participants

may feel more inclined to share when others are also contributing to the discussion. On the other hand, participants may be hesitant to contribute to the discussion if they do not feel at ease with the other participants (UpMetrics Staff, 2022, p. 1).

3.3.3.2 Observations

For many years, researchers in the fields of anthropology and sociology have used participant observation as a method to collect data. Kawulich (2005, p. 2) remarked that the observer must establish a rapport with the participants and their communities to the extent that they will feel comfortable enough to behave naturally even when the observer is in their presence. This data collection method entails observing the actions and reactions of the research subjects, without requiring direct contact with participants. A disadvantage of this method is the potential subjectivity of the researcher (UpMetrics Staff, 2022, p. 1).

3.3.3.3 Interviews

Interviews are often the preferred method of data collection in qualitative research studies. Interviews can be conducted through various methods such as in-person, telephone, online and email interviews, to mention a few. Eash of these has their own advantages and challenges. In-person interviews are regarded the golden standard in qualitative research because the researcher can observe the body language, enabling a warm, interactive environment. The disadvantages of in-person interviews are that they are expensive to conduct and may limit participation from participants in a different geographical area than the researcher. Telephone interviews are also an option but are less desirable than in-person interviews. Online interviews have become more popular with the emergence of technology, and may enable participants to be included even if they are situated in a different geographic area. The disadvantage of online interviews is that some participants may be excluded from participation if they do not have access to the technology required for such interviews. Emailed interviews are conducted via emails, which participants can respond to on their own time and without pressure from the researcher. Ratislavova and Ratislav (2014, p. 3) maintained that the advantages of emailed interviews are numerous in that it is a cost-effective method that does not require the participant and the researcher to be available at the same time (Heath et al., 2018, p. 31).

In this study, the researcher chose an online interview as the method to collect data from Deaf participants. This method was selected because it allowed for the recording

of the interview and utilisation of Zoom, which is easily accessible on various devices such as cell phones and laptops. Additionally, the online interview method was preferred for this group since it eliminated any travelling, which would have been required for in-person interviews, and written English in emailed interviews was avoided.

3.3.3.4 Questionnaires

Cohen et al. (2018, pp. 475–485) listed and explained various types of questionnaires, such as dichotomous, multiple-choice, rating scales and open-ended questionnaires. A particularly organised questionnaire for more significant numbers of participants will generally take the form of a dichotomous questionnaire asking for yes/no answers. Dichotomous questionnaires are functional to ensure that responses received are not vague. The multiple-choice questionnaire allows the researchers to add several options for the participants. It is important to provide a broad range of choices to give the participants options they consider true. Rating scale questionnaires are helpful when the researcher is interested in determining how strongly a participant feels about the response. An example of a response in a rating scale questionnaire is "strongly agree / agree / uncertain / disagree / strongly disagree" (Cohen et al., 2018, p. 481).

According to UpMetrics Staff (2022, p. 1), open-ended questionnaires are regarded as a cost-effective method of data collection. This method allows participants to remain anonymous, especially if these questionnaires are developed using platforms such as Google Forms and Survey Monkey.

Group discussions and observations were deemed unsuitable for the current research study since the topic is sensitive, and requesting participation in a group discussion is inappropriate. Additionally, as the data relied on participants to share their personal experiences, observation was not regarded a suitable data collection method. Therefore, the open-ended questionnaire was selected as the preferred data collection method for this research study's groups.

The researcher developed three open-ended questionnaires, focusing only on the participants' experiences and perceptions of rapport building during the interpreted therapy sessions. The questionnaires were aimed at three groups of participants: mental health professionals, Deaf persons and SASL interpreters. These different questionnaires were distributed electronically. The Deaf participants received the

electronic questionnaires in video format in SASL and were given the option to choose a Zoom interview or to complete the questionnaire.

According to Ratislavova and Ratislav (2014, pp. 453-455), there are several benefits to using electronically sent questionnaires. Although referring to emailed questionnaires, the benefits of using online questionnaires also include the possibility of obtaining data from participants who do not have the time to schedule face-to-face interviews, it enables the participants to take part anonymously, and persons from all provinces will have the opportunity to participate. Although the Deaf participants were invited to virtual interviews, the SASL video-recorded questionnaires were included for interested Deaf participants to decide if they would like to participate.

At the end of the questionnaire, the Deaf participants were invited to a virtual interview to provide their responses to the electronic questionnaire. The virtual interviews were recorded with the participants' consent.

At the conclusion of the questionnaire, participants from groups 1 and 3 were asked to provide consent to potential follow up by the researcher should clarification be needed. The researcher could then conduct virtual, semi-structured interviews with willing participants to gather further data on their experiences and perceptions of rapport building during interpreted therapy sessions, if required.

3.3.4 Participants

This section introduces the concept of sampling and describes the two main types of sampling—probability sampling and non-probability sampling—as well as the various non-probability sampling methods. It further discusses the three groups of participants targeted for this research study: mental health professionals, Deaf persons and SASL interpreters.

3.3.4.1 Sampling

"A sample is a subset of a population, and we survey the units from the sample with the aim to learn about the entire population” (Vehovar et al., 2016, p. 327).

Probability sampling can be described as the random selection of participants for a research study, gives everybody an equal opportunity to be selected to participate in the specific research study. In contrast, non-probability sampling does not rely on the cosmos to provide participants with the experiences required to respond to the specific research study.

Quota, expert, snowball, and purposive sampling are examples of non-probability sampling. Quota sampling will be employed when there is a need to have participants from specific groups, such as a certain percentage of males or females. Expert sampling is the sampling of individuals with the required expertise in the field of study of research. Snowball sampling is where the researcher has a network of individuals in the specific community they intend to research who can be contacted to spread the word about the research and bring the researcher into contact with specific people with the experience required to participate in the research study. The last type of non-probability sampling, purposive sampling, is when the researcher targets a specific group of participants with relevant experience of the research questions (Etikan & Bala, 2017, pp. 215-216).

The sensitive and confidential nature of mental health issues and problems experienced by Deaf people, complicated by the lack of available and accessible services, made it difficult to aim for a large group of participants. This study's participants were divided into three groups: mental health professionals who have worked with Deaf clients through SASL interpreters; Deaf persons who have used SASL interpreters in therapy sessions; and SASL interpreters who have interpreted therapy sessions. Given the sensitive nature of the study, no identifying information, including age, gender, or background, was collected. A combination of purposive and snowball sampling was employed because the research required responses from persons with relevant experience in the field of the current study. Purposive sampling was also used to ensure that the best possible data from a limited number of participants could be obtained (Palinkas et al., 2015, p. 534; Suri, 2011, p. 65). Palinkas et al. (2015, p. 533) asserted that purposive sampling is often used in qualitative research because it enables the researcher to identify and choose participants who can provide responses that will contribute meaningfully to the research. Purposive sampling was employed to recruit participants from three specific groups involved in the therapeutic alliance.

3.3.4.2 Group 1: Mental Health Professionals

The first group, consisting of qualified mental health professionals who have used SASL interpreters during mental health therapy sessions, play a crucial role in providing insights into the use of SASL interpreter services in mental health settings. Other reasons for involving this group of participants were to establish if they are

equipped to deal with Deaf clients, investigate the interpreting process during these therapy sessions and to identify factors that influence establishing and maintaining rapport and trust between them and their Deaf clients when using SASL interpreters.

According to Suri (2011, p. 69), there is a need to involve central role-players or collaborators who can be instrumental in identifying suitable respondents. The researcher involved collaborators to identify the mental health professionals who have worked with Deaf clients before, such as the Independent Counselling and Advisory Services (ICAS). ICAS has recently changed its name to LYRA Southern Africa and provides various professional services, such as employee health and wellness services, to large corporations in South Africa (ICAS, 2024). Several of these corporations that utilise the services of LYRA also employ Deaf persons. The researcher submitted various documents, such as the research proposal, the ethics clearance and the questionnaire, in an email to the LYRA Compliance Team, requesting the distribution of the questionnaire to mental health professionals who had worked with Deaf clients in the past five years. The mental health professionals who consented to participate in the research were invited to respond to the electronic questionnaire.

The researcher also contacted organisations such as the National Institute for the Deaf (NID), Employ and Empower Deaf (eDeaf) and the Centre for Deaf Studies at the University of the Witwatersrand (CFDS) to distribute the information to mental health professionals who work with Deaf individuals. The aim was to get a diverse, representative group of professionals varying in age, gender and years of experience.

To protect confidentiality, no names of Deaf clients, SASL interpreters, or content on mental health issues discussed were requested or required for this research topic.

3.3.4.3 Group 2: Deaf Persons

The second group, the Deaf participants, had to be profoundly Deaf, use SASL, and have used SASL interpreting services during mental health therapy sessions. The participation of Deaf persons was crucial in this study to gather their experiences of the interpreting process and the dynamics in communication between them, the therapist and the SASL interpreter. The Deaf participants provided their perspectives on whether the mental health professionals and the SASL interpreters are equipped to deal with therapy sessions involving Deaf clients.

The central collaborators, NID, eDeaf, and CFDS, were requested to distribute an electronic message among their member organisations, staff members, and Deaf people. The researcher also distributed the information with the link on social media platforms such as Facebook and various WhatsApp groups to call for volunteers. The snowballing technique also proved to be useful in the Deaf community.

The electronic message contained a written English text with a link to a video recorded in SASL explaining the research study, its aims and objectives, as well as the criteria for participation. Deaf persons who viewed this message, met the criteria, and were interested in participating in the study could click on a link navigating them to the SASL questionnaire. The Deaf participants could view the SASL recorded questionnaire in their own time. They could withdraw in the unlikely event that the questionnaire triggered a negative response. Access to the questionnaire also allowed them to think about their responses, which increased the data quality. The Deaf persons interested in participating were invited to a virtual interview with the researcher instead of completing the written questionnaire. Virtual interviews were chosen over in-person interviews, for their logistical flexibility enabling participants from across South Africa to participate at a time convenient for them. The interviews lasted less than 45 minutes and were semi-structured, with the questionnaire as the basis, and follow-up questions to clarify some responses were presented to the interviewees.

One Deaf person opted to complete the English version of the questionnaire. The responses were recorded on the Google form.

It is important to note that all ethical considerations were strictly adhered to, ensuring the confidentiality of the participant's private information throughout the research process.

3.3.4.4 Group 3: SASL Interpreters

The third group consisted of SASL interpreters who have provided SASL interpreting services during mental health therapy sessions. The inclusion and participation of SASL interpreters with this prior experience was crucial to understanding their view of therapeutic contexts, which can significantly enhance the quality and effectiveness of mental health interventions within the Deaf community of South Africa. The criteria for the participation of SASL interpreters were that they must work as SASL interpreters and have previously interpreted mental health therapy sessions.

The researcher requested that eDeaf, NID and CFDS distribute an electronic message explaining the research study and its aims and objectives to their SASL interpreters and members. The electronic message was also distributed on the SASL Interpreters' WhatsApp group, which has a membership of 90 SASL interpreters. The SASL interpreters interested in participating in the research were invited to respond to the electronic questionnaire.

To ensure confidentiality, no names of Deaf clients or details of mental health issues discussed were asked or required for this research topic.

3.3.5 Data Analysis

The word 'data', according to the Penguin Dictionary of Psychology, is defined as "the body of evidence or facts gathered in an experiment or study" (Reber et al., 2009, p. 190), and the word 'analysis' is "the process of separating a 'thing' into its component parts or elementary qualities" (Reber et al., 2009, p. 36). It can thus be deduced that data analysis is the process of examining the data collected during the study and making sense of the information. The purpose of conducting data analysis is to gain an understanding and insight into the collected data.

Content analysis, thematic analysis and Interpretative Phenomenological Analysis (IPA) are a few data analysis approaches that can be employed in qualitative research studies. Content analysis and thematic analysis are employed by the researcher when the aim is to systematically recognise and categorise themes to give an account of data collected by stating the information as it was collected, without analysing the underlying meaning of collected data. Content analysis is "a systematic coding and categorising approach used for exploring large amounts of textual information unobtrusively to determine trends and patterns" (Vaismoradi et al., 2013, p. 400). Thematic analysis is defined as a way of recognising, analysing and presenting data on the different themes that have been identified. These approaches were unsuitable for the current study since the objective is to gain in-depth understanding of and interpret the participants' lived experiences, making the IPA approach more suitable for the current study.

IPA is used to understand the experiences of people who find themselves in similar situations. The suppositions that support the IPA method concur that it is advisable to use a smaller number of participants to ensure that the similarity of their experiences can be analysed for a greater understanding of these experiences.

The process of analysing data in IPA follows two steps of interpretation—the participant interprets their view of the experience first, followed by the researcher who will interpret the participant's experience (Chatzidamianos et al., 2019). The IPA allows for investigating how participants make sense of their lived experiences through the qualitative research method. The qualitative research method allows the researcher to collect data rich in the lived experiences of the participants, allowing for a deeper understanding of the participants' experiences (Thanh & Thanh, 2015, p. 26). Therefore, IPA underpinned the research design of this study.

In the first step of the IPA process, the researcher transcribed each video-recorded interview from SASL to English. Each of the participants' responses to the questionnaires was tabulated. The researcher read and re-read the transcripts and responses to be immersed in the participants' lived experiences. Detailed notes were made on the transcripts, and responses were tabulated to note specific descriptions or conceptual comments. These responses were analysed to capture the essence of the participants' lived experiences accurately.

The second step of the IPA is to reinterpret the data from the researcher's perspective by identifying common threads and themes in the data, compiling a core list of cross-case themes, and interpreting the meaning of these to draw conclusions. It is vital for the researcher to adhere to ethical considerations during the data analysis process.

3.3.6 Ethical Considerations

The data collection of this research study commenced after the School of Literature, Language and Media Ethics Committee of the University of the Witwatersrand granted clearance. Questionnaires, participant information sheets and consent forms were sent to the central collaborators and distributed on various public platforms, such as WhatsApp groups, to invite potential participants. The documents outlined information about the research study and were made available in SASL in video format for Deaf participants. None of the participants were forced to participate and they were advised of their right to withdraw from the research study at any stage during the research.

The researcher has completed a Diploma in Counselling and is registered with the ASCHP as a Holistic Counsellor. Therefore, the researcher was equipped to deal with any situation where a participant might experience emotional distress during the interview, adhering to the Wits Ethics Distress protocol.

All data gathered during the research study will be kept confidential and secure on a password-protected laptop and stored securely in the OneDrive cloud. The data will be encrypted before it is stored on OneDrive. The research data will be securely stored and maintained for five years following the completion of the research report. Participants from Groups 1 and 3 could remain anonymous by completing the online questionnaire, where they did not have to provide any identifying information.

Deaf participants were not anonymous to the researcher and supervisor during the data collection phase because they used SASL and recorded video interviews. However, anonymity can be guaranteed in the resulting reports because the information on the video recordings was transcribed, and all identifying details of the participants were removed from the reported data analysis.

Babbie (2013, p. 408) cautioned against the “subjective judgements researchers face an obvious risk of seeing what they are looking for or want to find". The researcher’s conscious awareness of personal ethics, experiences and predispositions mitigated the impact of potential subjective judgements and ensured that the participants' lived experiences were not misinterpreted or suppressed.

3.3.7 Validity and Reliability of the Study

Ensuring the validity and reliability of the data collected is fundamental to guarantee that the findings of this study are accurate, consistent with the participant’s lived experiences and applicable to broader contexts. The careful design of the research questions and the rigorous methodology employed in this study ensure its validity and reliability. An additional key factor is that the researcher is a child of Deaf adults and is therefore considered a member of the Deaf community. The researcher is also a professional SASL interpreter with 30 years of experience in the field of SASL interpreting, providing an in-depth understanding of the challenges SASL interpreters face. Furthermore, the researcher holds a Diploma in Counselling and Communication, offering unique insights into the rapport-building strategies used by mental health professionals in therapy sessions. These factors collectively contribute to a comprehensive understanding of the lived experiences of Deaf participants, mental health professionals and SASL interpreters.

3.3.8 Conclusion

This chapter provided an overview of the RSM as a theoretical framework for investigating the impact of SASL interpreters on the therapeutic alliance in mental

health settings. By employing qualitative research methods, such as online interviews and open-ended questionnaires, the study ensures comprehensive data collection that is sensitive to the unique needs of Deaf participants. The use of IPA allows for an in-depth exploration of participants' lived experiences, offering valuable insights into the nuanced dynamics introduced by SASL interpreters. This approach maintains participant confidentiality and enriches the understanding of the RSM within the therapeutic context. In the following chapter, the researcher presents and analyses the data collected, as explained in this chapter.

CHAPTER 4: DATA ANALYSIS AND DISCUSSION

4.1 Introduction

Chapter 4 presents the analysis and discusses the data gathered through interviews and online questionnaires for the current study. First, the three different groups of participants are discussed individually, detailing the number of sessions attended, conducted, or interpreted, as reported by the participants, which briefly describes the participants' experience level. Thereafter, an analysis and comparison are conducted, linking the findings to the theoretical concepts discussed in the Literature Review (Chapter 2) and the RSM phase one, as discussed in the chapter on Methodology (Chapter 3).

As per the IPA, the first step of interpretation is the participant's interpretation of their lived experience. The second step is the researcher's interpretation of the participants' interpretation. The focus points of the analysis are matters of empathy and relationship building, trust, and cultural competence, which, according to the RSM, are the foundation of any relationship between the mental health professional and the Deaf client.

4.2 The Participants

The current study involved three groups of participants. Group 1 consisted of qualified mental health professionals, who have used SASL interpreters during mental health therapy sessions with Deaf clients. Six participants in this group responded—referred to in this study as MHP1 to MHP6. Only selected samples of the participants' responses will be presented throughout this chapter. The participants in this group have varying experience with sessions involving Deaf clients, ranging from two to between eleven and fifteen sessions.

MHP1: *Between 11 and 15 (I'm unsure.)*

MHP2: +_*7*

MHP3: *6 sessions*

MHP5: *2*

The majority of mental health professionals experienced sessions with Deaf clients interpreted by the same SASL interpreter. This means that the participants in this group do not have a broad perspective regarding different SASL interpreters, limiting the

ability to make a comparison between the skills, knowledge and styles of different SASL interpreters. However, the quality of the data remains the same.

Group 2 involved participants who are profoundly Deaf, use SASL and have attended therapy sessions making use of SASL interpreter services. Four participants in Group 2 responded—referred to as DP1 to DP4. Only selected samples of the participants' responses are presented throughout this chapter. The number of mental health therapy sessions attended by the four participants from Group 2 varied, ranging from three to 20 interpreted therapy sessions.

> DP1: *I can say perhaps six times this year but much more in the past I would say more than 20 times.*
>
> DP2: *So, I would say I've only had three sessions that was interpreted.*
>
> DP4: *In total I can say six or seven times.*

The number of sessions that the Deaf participants attended is enough to provide meaningful responses to the questions asked.

Group 3 consisted of SASL interpreters who have provided SASL interpreting services in mental health therapy sessions. By including SASL interpreters with this experience was crucial to grasping their view of the therapeutic alliance and the factors that influence establishing and maintaining rapport and trust between mental health professionals and Deaf clients. Another reason was to find out whether they feel that mental health professionals are equipped to deal with Deaf clients and if they themselves feel equipped to deal with therapy sessions as SASL interpreters. Five SASL interpreters responded to the questionnaire, and the number of mental health therapy sessions interpreted by these participants ranged from ten to more than 30 sessions. They are referred to as SASLI1 to SASLI5 for the purposes of this study. Only selected samples of the participants' responses are presented throughout this chapter. It was essential for this study to understand the level of experience and qualifications of the SASL interpreters who participated. Hamerdinger and Karlin (2003, p. 1) stressed that the success of the therapy session depends on the qualifications of the sign language interpreter.

The responses to the two questions related to years of experience and qualifications or accreditation revealed that the qualifications of the SASL interpreter participants vary from a Master's degree in Translation and Interpretation to a Diploma in Liaison

interpreting, a Postgraduate Diploma, and a BA Honours in Linguistics with interpreting as a focus.

According to the response to Parliamentary Question No. 3638 on 14 October 2022 about the level of qualifications required for a person to be appointed as an interpreter in the lower and high courts of South Africa, a Senior Interpreter must have a National Diploma in Legal Interpreting at NQF Level 5 with three years practical experience, or a qualification at NQF Level 4 with ten years' experience. A Principal Interpreter will need a National Diploma in Legal Interpreting plus five years' experience (Ministry: Justice and Correctional Services RSA, 2024, p. 2). Considering these requirements for legal interpreting, the participants of this study are all highly experienced in the field of SASL interpreting, and they would be considered principal interpreters in the justice system. Three of the five SASL interpreter participants also hold accreditation with the South African Translators' Institute (SATI). All five of these participants noted working in various settings such as business, educational, legal, medical and community-based settings.

Mall and Swartz (2012, p. 493) mentioned the lack of trained SASL interpreters as per their discussion with Prof. Sokudela about the limited availability of mental health services for Deaf persons which is exacerbated by "SASL interpreters are rarely available in places where such services are provided". This statement is supported by London et al. (2020, p. 184) who maintained that there is a "dire absence of SASL interpreter services provided by qualified, trained professionals nationally". As can be seen from the data, the participants all received some qualification in the field of SASL interpreting, which signifies an improvement in the situation since Mall and Swartz (2012) and London et al. (2020) raised the concern. The participants from this group did not mention any specialised training in mental health settings. Benjamin et al. (2016, p. 79) urged the consideration of specialised training of interpreters in the medical and mental healthcare field. Specialised training has yet to be realised in South Africa, with the only training session focusing on medical interpreting held in 2012 at the University of Cape Town (London et al., 2020, p. 187).

The responses received from the SASL interpreters about whether they feel equipped to deal with mental health therapy sessions are a clear indication that there is a need for specialised training in the field of mental health.

> SASLI1: "*I do not feel fully equipped to deal with mental health therapy sessions because I have never been trained to work in such a context-specific setting."*
>
> SASLI3: "*I think there should be a course focusing on medical interpreting. Because there are a lot of factors that we experience that we never talked about during the trainings*."

The views of the participants from Group 2 on the question of whether SASL interpreters are equipped to deal with mental health therapy sessions are as follows:

> DP1: *"There are different settings like academic settings, therapy settings etc and it cannot be expected of all interpreters to know and work and have experience in all kinds of settings."*
>
> DP2: "*Very few interpreters. Out of 10, I would say there are three or four who have the necessary skills. Not all of them, and keep in mind that the mental health interpreting setting is particularly difficult because the interpreter may have their own mental health issues to deal with."*

The statement by DP2 is in line with the notion by Hamerdinger and Crump (2022, p. 347) that sign language interpreters must recognise and deal with their past trauma and mental health issues before working in mental healthcare settings. They further opined that interpreters working in mental healthcare settings should have attributes such as resilience, flexibility, appropriate boundaries and insight. This research study recommends developing a specialised mental healthcare training course for SASL interpreters. An example of a course of this nature exists in Alabama in the United States. The Mental Health Interpreter Training project offers a 40-hour training programme which includes an internship and examination (Hamerdinger & Crump, 2022, p. 343).

The rest of the data analysis will focus on the core components of the RSM, namely empathy, trust-building and cultural competence. Empathy and relationship-building are important in phase one of the RSM and are vital to the success of any mental health therapeutic session.

4.3 Empathy and Relationship-building

Empathy is the ability to put yourself in the shoes of the client and to be able to imagine how they feel. According to Midwinter and Dickson (2015, p. 14), empathy is one of the core components of building a relationship between the mental health professional

and the client. Demonstrating empathy effectively helps the client to feel understood during the therapy session and will allow for rapport and relationship-building. The questions posed to the participants of all three groups about empathy and relationship-building were questions related to their feelings about the relationships with the Deaf clients, the mental health professionals, as well as the SASL interpreters. DP1 responded to the question about the importance of mental health professionals receiving specialised training to work and communicate with Deaf clients, saying, *"I just got the feeling that they did not understand anything about me".* This points to the lack of empathy from the mental health professional from the perspective of the Deaf client. This section focuses on the success of empathy and relationship-building from the perspective of the participants of the three groups.

4.3.1 Mental Health Professionals' Experiences of Empathy and Relationship-building

The responses received from the mental health professionals will be presented in this section and clearly show that they value rapport and relationship-building and prioritise it in their therapy sessions. Responses to the question of the importance of establishing and maintaining rapport and trust in therapy indicate that the participants from Group 1 support the theory by Rogers (1957, p. 96) that a strong relationship between the therapist and the client is required to make therapy possible. MHP1 remarked: "*It is extremely important"* and MHP3 stated that it is "*[o]f the utmost importance, as that form the basis of the therapeutic relationship and consequently also the success of the intervention".*

Participants responded to the question about rapport-building strategies used by the participants in Group 1 when working with hearing clients:

> MPH2: "…*making them feel understood, valued and heard."*
>
> MHP6: *"…gathering information about their background, current personal information regarding relationships."*
>
> MHP4: *"Listening (actively), allowing client to talk, being non-judgemental, create a safe environment"*.

The purpose of the following question was to determine how the mental health professionals adapted their strategies to establish rapport and trust with the Deaf

clients. Most of the participants reported using the same strategies to build rapport with the Deaf clients. However, MHP6 and MHP5 responded as follows:

> MHP6: *"I found that I delved into the reason for the session much quicker without gathering the normal background information."*
>
> MHP5: *"Felt more formal, having to sit next to interpreter and talking so interpreter could hear me, whilst looking at my client, simplify my use of language."*

These responses show that these participants felt that the SASL interpreter impacts the mental health therapeutic alliance and the establishment of rapport.

The question about what specific strategies mental health professionals can employ to enhance rapport when working with an SASL interpreter elicited the following responses:

> MHP2: "*Eye contact with the client, respect, connect with the person, not the problem",*
> MHP3: *"set aside more time for building rapport, as the deaf client does not trust easily",*
>
> MHP4: *"Be open to work with an interpreter and the client",*
>
> MHP5: *"Foster a good relationship with the interpreter, be professional in your approach, be respectful of the complexity of counselling a deaf person with help from a SASL interpreter".*

These statements demonstrate the importance and need for the mental health professional-SASL interpreter relationship. From these observations, we can deduce that the SASL interpreter does impact the mental health therapeutic alliance from the perspective of mental health professionals, and that these participants are open to and see the need to form a relationship with the interpreter as suggested by De Bruin and Brugmans (2006, p. 361).

4.3.2 Deaf Participants' Experiences of Empathy and Relationship-building

Although the participants from Group 1 and Group 2 were not necessarily interlocutors in the same therapy sessions, the perspective of the Deaf participants offers unique insight into their relationship with mental health professionals.

DP1 explained:

> *"In my first session, I was very emotional because my father had just passed away. This person said: 'Oh, I see, your father passed away. Do you know any meditation*

> *techniques?' …this was not appropriate for a psychologist to do in the very first session. I just felt awful, I felt there was just a total disconnect between me and the therapist."*

DP4 relayed their experience of their relationship with the mental health professional:

> *"I feel this psychologist isn't understanding and they don't know how to respond to me"* and *"…they are just someone out there who I don't know. No relationship."*

DP2 explained her feelings about the rapport and relationship between her and the therapist as follows:

> *"I think if the communication was more direct with the therapist, I would have been able to build a relationship. I did not yet establish a relationship because I had to work through a third person."*

These statements are an indication that the Deaf participants felt that the mental health professional did not understand their situation, and that there was not an established relationship between them and the mental health professional. The mention of the fact that having to work through a third person impacted the establishment of a relationship. Theys et al. (2020, p. 41) suggested emotional communication is disturbed in the interpreted communication session because it has been found that the client is less expressive in the presence of an interpreter due to a lack of trust.

The interview with DP1 from Group 2 has revealed something interesting. She has been seeing a therapist who is familiar with Deaf culture and knows some SASL. The combination of being familiar with Deaf culture and SASL has significantly impacted the therapist's ability to establish a relationship and rapport with the Deaf client. This affirms Moleko's (2012, p. 163) statement that cultural competence is central to establishing a relationship between the therapist and the client. Although the therapist may not be fluent enough to conduct the session in SASL, they can provide some cues that they are actively listening to what the Deaf client is saying, by using hand gestures like "YES". This therapist also does not make physical notes in a notebook, because in doing that, they will lose eye contact with the Deaf client, resulting in a break in the communication.

> DP1: *"She [the psychologist] said that she had studied several courses and that is very rare for psychologists in South Africa to know sign language. She wanted to learn sign language, and she herself saw the need to understand Deaf culture better."*

The fact that the therapist does not take any notes during the session also indicates that, from a Deaf cultural perspective, it is vital to maintain eye contact with the Deaf person (Williams & Abeles, 2004, p. 644).

> DP1: *"...this therapist never takes any notes. She just reflects back to me and shows me she understands what I am saying. So, we have a very easy and smooth relationship, and I am very comfortable in that relationship."*

From this response, it is clear that an understanding of Deaf culture and some knowledge of SASL go a long way in establishing a relationship that makes the Deaf client feel valued and heard.

4.3.3 SASL Interpreter Participants' Experiences of Empathy and Relationship-building

Although the focus of this part of the study was on the empathy and relationship-building between the Deaf client and the mental health professional as the main interlocutors in the mental health therapy session, it was essential to determine how the SASL interpreters felt about their relationships with each of the two main interlocutors. The questions put to the SASL interpreter participants about relationships were how they felt at first when interpreting a therapy session and how they felt about their relationships with the therapists and the Deaf clients. Their responses exhibited a sense of deep awareness and respect for the privacy of the Deaf client, a clear understanding of their neutral role as SASL interpreters and the fact that they needed to ensure accuracy in their interpretations and behave professionally. Theys et al. (2020, p. 41) found that interpreters play an important part in facilitating emotional communication, since they enable the interlocutors to share their feelings. The following responses were received from the participants of Group 3:

> SASLI1: "*Deaf client/s also understood my role as the SASL interpreter. The Deaf client/s trusted not only my skills but they knew whatever was said in the session would be respected and not shared externally."*

> SASLI2: *"the setting is different from other because of the personal, emotional and delicate aspect of it."*

> SASLI3: *"I felt touched and sad by the session because I felt it was important to be part of the session emotionally to meet the equivalence of both client's responses"* and *"Trust".*

SASLI4: "*How to work through the overwhelming feelings, not knowing how to handle it.* and "*Not all understand our role as SASLI's"* and "*If they are more at ease with the relationship starts to get more trusting and open."*

SASLI5: "*It is difficult to interpret someone else raw emotions and deepest most private thoughts and then afterwards talk as if you know nothing of the sort"* and "*having to share intimate thoughts while being vulnerable, completely trusting me as interpreter to be professional."*

The results of this study strongly align with the RSM by illustrating that empathy and relationship-building are essential to therapeutic success, especially in the complex dynamic of SASL interpreted therapy sessions.

The issue of trust is a theme raised throughout the section on empathy and relationship-building.

4.4 Trust

Trejo-Phillips (2012, p. 39) opined that building and having trust in a relationship is a vital part of the success of therapy. It is implied in this statement that trust forms the basis of any relationship. The data explores the issue of trust from multiple perspectives. It includes the views of Deaf participants regarding the trust between them and the mental health professional and between them and the SASL interpreter. Another perspective is that of the SASL interpreter regarding their perception of the trust relationship between them and the Deaf client and between them and the mental health professionals.

4.4.1 Participants' Perspective of Trust

DP1 stated that *"[i]t is all about trust because I didn't know whether my story was safe with these people".* The feeling of having to trust two people with their story held great significance for DP1. According to Williams and Abeles (2004, p. 645), Deaf people may feel reluctant to trust that their story will be kept confidential, because the Deaf community is very small, with only a few sign language interpreters. This was also evident in the responses received from the Deaf participants when they were asked to choose between the following options:

a) Hearing therapist and use SASL interpreter
b) Deaf therapist – no SASL interpreter required
c) Hearing therapist who knows SASL – no SASL interpreter required

Three of the four participants preferred option C; therefore, no SASL interpreter will be required. DP3 preferred option B—a Deaf therapist. DP1 and DP 2 explained their reasons for not choosing option B:

> DP1: "*I will have trust issues because the Deaf world is just so small, and they will know everything*."
>
> DP2: *"The second option is a Deaf psychologist, counsellor or therapist. A Deaf person that is part of the Deaf community. They will gossip, they will not keep the information confidential."*

These statements support Williams and Abeles's (2004, p.645) argument that Deaf people may find it difficult to trust because the Deaf community is so small.

Responses by Deaf participants about trusting the mental health therapist were mixed. DP3 responded with a "*yes*" to the question whether they trusted the mental health professional. However, DP2 and DP4 clearly said that they did not trust the therapists. DP4 stated:

> *"No, there is nothing to trust because it was the first session, and we just did the introductions and moved on but things are still hard for me." "I really wanted to understand and resolve my issues but it didn't happen because they didn't help me."*

According to this statement, it is clear that the Deaf participant did not trust the therapists because the therapist did not take the time to connect or establish rapport with them after introductions. Egan and Reese (2021, p. 14) emphasised that the relationship between the therapist and the client is the deciding factor for a successful therapy session. DP4 said the session "moved on" straight after the introductions. The statement by DP4 shows that therapy was not successful. There was also a breach of trust because of the therapists' inability to assist them to feel better. Hamerdinger and Crump (2022, p. 343) noted that clients get to the therapy session with their own understanding of what the mental health professional or the interpreter will do. This indicates the need for education about the mental health professional's role in therapy; to ensure an understanding that mental health professionals are not responsible for providing solutions but for listening and guiding clients to find their own solutions.

DP2 mentioned that she trusted a second therapist more than the first one because the second therapist was highly recommended and female. Initially, the participant indicated that the gender of the therapist versus the gender of the Deaf client may play

a role in therapy. However, DP2 mentioned later in the interview that *“the first one was a male, but the fact that he did not know Deaf culture or deafness had the biggest influence absolutely".*

DP1 initially did not trust both the therapist and the SASL interpreter. She decided to record their session with a speech-to-text application on her phone, which she checked for accuracy after the session. She only started trusting them after reading the recording. *"After that, I could trust them both, and I think I might have looked for another therapist or another interpreter if the outcome of that Otter app wasn't good."*

In this section, the focus will specifically shift to the trust Deaf participants place in the SASL interpreter. DP3 clearly stated that they trusted the SASL interpreter, and DP2 mentioned that they were unsure if they could trust the interpreter. During the therapy session, DP2 questioned whether they could trust the interpreter to relay their story accurately. DP2 also mentioned not being able to trust the SASL interpreter because they previously confided in SASL interpreter in confidence before the therapy session, and this SASL interpreter added the information, gained from communication outside of the session, to the record of what the Deaf client said during the session. This breach of confidentiality significantly impacted on the Deaf person’s trust in the SASL interpreter. This Deaf participant further mentioned that she could no longer trust the SASL interpreter because she (the Deaf client) had signed something to the SASL interpreter during the session and explicitly asked the SASL interpreter not to interpret this to the therapist. However, the SASL interpreter ignored the request and interpreted this to the therapist. DP4 responded that not all SASL interpreters can be trusted.

DP2 also explained that in her experience with one SASL interpreter, the content of her therapy session was somehow shared with members of the Deaf community, and the only other person who knew about the contents was the SASL interpreter. This statement again emphasises the issue of trust and a significant breach in the trust relationship between the Deaf person and the SASL interpreter.

DP3 mentioned that they were confused when the interpreter continued to ‘interpret’ into English from the SASL long after they had stopped signing. Trejo-Phillips (2012, p. 82) remarked that the length of the interpretation of the target language is not always the same as the source language, which may cause mistrust in the interpreter from the mental health professional’s perspective. The statement by DP3 shows that mistrust

in the interpreter because of the perceived length of the interpretation, is also experienced by the client in this study.

The mistrust in the SASL interpreter is often based on the perceived level of skill and experience of the SASL interpreter. The Deaf person's understanding of the role of the SASL interpreter in the therapeutic environment is another factor that contributes to the mistrust of the SASL interpreter. According to DP2, the SASL interpreter was hand-picked by them, and they expected the SASL interpreter to be there for them only. *"I mean I was having a conversation with the interpreter not with the therapist …the situation is about ME, it's not about anything else."* This statement can be interpreted in two ways. First, that the Deaf person sees and uses the SASL interpreter as an ally in the therapy session and that the SASL interpreter was employed to support and make them feel safe. Hamerdinger and Crump (2022, p. 343) commented that the Deaf client may see the interpreter as an ally and that this is generally not a problem in the liaison or community interpreting setting. However, they posited that this can frustrate the relationship between the Deaf client and the therapist in the mental health setting. Secondly, it may convey that the Deaf person does not clearly understand the role that the SASL interpreter should play in the therapy session.

All five SASL interpreters who participated in the research study felt that the therapist and the Deaf clients trusted them. The researcher interprets this fact to be an indication of the respect that the participants have for the Deaf client's right to privacy and the confidence they have in their own ability to interpret. As explained in Chapter 2 of this research study, Llewellyn-Jones and Lee (2013, p. 58) opined that accuracy is not the only factor that creates trust in the relationship, but that the value the interpreter places on the individuals and the contributions of these individuals whom they are interpreting for, is another factor that creates trust. The researcher believes that the professional behaviour of SASL interpreter participants can be attributed to their SASL interpreter training. Three of the five participants hold accreditation with SATI and have signed a code of ethics highlighting accuracy and confidentiality, which plays a significant role in SASL interpreters' understanding of the importance of accuracy and confidentiality that form the basis of trust in any relationship. Williams and Abeles (2004, p. 646) pointed out that a sign language interpreter with a qualification shows an awareness of the code of ethics that includes a focus on confidentiality, unbiasedness and professionalism.

4.4.2 Factors that Influence the Trust Relationship

Some positive factors that could influence the establishment of rapport and trust between the Deaf client and the mental health professional, as mentioned by MHP1, are the contribution of the SASL interpreter to building a rapport and a positive atmosphere or 'vibe', which extended to creating a sense of connection and acceptance for the client. MHP2 responded that *"[t]he SASL interpreter was very professional. It put me as well as the Deaf client at ease".* The statement about professional behaviour from the SASL interpreter supports the argument by Williams and Abeles (2004, p. 646) that the professional behaviour of the sign language interpreter will ensure that both the therapist and the Deaf client feel safe during the therapeutic session.

The negative factors mentioned were having a third person in the session and the mental health professional not feeling comfortable with the interpreter. Mental health professionals responded as follow in this regard:

> MHP5 stated: *"being too aware of the interpreter in the room, not trusting the interpreter."*
>
> MHP6 said: *"The process of not communicating as directly as in one-on-one sessions and the fact that one has to transition to having a third person in the session."*

In the researcher's experience as a professional SASL interpreter who has interpreted several mental health therapy sessions, the reactions from mental health professionals are, in most cases, that they are opposed to having a third person in the room, since they are entrusted with keeping the client's information and story confidential. Having to deal with a third person and having to wonder about the ethical conduct of the SASL interpreter is generally a big concern. Participants' concerns regarding a third person in the room and having to trust them is validated by DeVito's (2019, p. 234) remarks that it is essential for therapists to maintain confidentiality; if the information is revealed to others, it can destroy the trust relationship between the client and the therapist. It can be daunting for a mental health professional to have a third person in the room because it leaves them feeling exposed and not in control, something which they are not typically used to. They are now faced with having to deal with a Deaf client and a SASL interpreter. The mental health professional's reaction will indicate their level of confidence as a mental health professional and their ability to deal with an unfamiliar situation. As per the admission of the participants of Group 1, they have not received any training to work with Deaf clients, which also means that they do not necessarily

understand the role of the SASL interpreter. In contrast to some statements regarding mistrust and feeling uncomfortable with the SASL interpreter, MHP1 is optimistic and open to working with the SASL interpreter as a co-therapist. The statement by MHP1 that *"[t]he adjustment required me to shift perception from the translator as co therapist to the translator as translator"* supports De Bruin and Brugmans' (2006, p. 361) claim that if the sign language interpreter and the mental health professional work together properly, it can have a powerful impact on the therapeutic session.

The challenges faced by the participants from Group 1 when providing therapy to Deaf clients were varied. MHP1 felt helpless and incompetent; MHP2 attempted to understand the Deaf client's world, and MHP3 believed that the Deaf client was challenged in different ways "*which might have impacted the situation"*. MHP5 also commented on challenges: *"Difficulty being spontaneous, not always being able to explain myself well enough, not always feeling sure that the client understood what I was trying to convey, could not really work on an emotional level."*

With these responses, they acknowledged that they are not equipped to deal with Deaf clients, that they lack an understanding of the Deaf client's world, and that they do not trust the SASL interpreter to convey their messages and intent to the Deaf client.

The factors that may influence the trust relationship between themselves and the mental health professional and the Deaf client, as identified by the SASL interpreter participants, can be categorised into four groups based on the analysis:

- **Accuracy of the interpretation and faithfulness of the message:** Hamerdinger and Crump (2022, p. 346) highlighted that interpreting in the mental healthcare setting demands high proficiency. This view is supported by SASLI1's emphasis on the importance of accurate interpretation from the Deaf client to the mental health professional and from the mental health professional to the Deaf client. An inaccurate interpretation often leads to a mismatch between questions and answers or responses from the mental health professional and what was said by the Deaf client.

  SASLI1: *"Failure to interpret/voice the correct feelings etc for the mental health professional to work with – this would also be evident with the mismatch of answers and session not running smoothly."*

- **Professional Boundaries:** Everything said or signed during the session must be interpreted because it may lead to mistrust. Spending time with the mental health

professional before the Deaf client arrives may cause mistrust as per the comment by SASLI4:

> *"If you and the therapist have a conversation without them being there or you not interpreting everything that is being said."*

This statement is interesting, as it contrasts with the suggestion by De Bruin and Brugmans (2006, p. 361) that as a powerful component of a successful therapy session, the therapist and the sign language interpreter must have an effective partnership with clearly defined roles. This effective partnership will include a conversation between the SASL interpreter and the mental health professional to discuss approaches and strategies and clarify roles.

Another issue that may influence the trust relationship between the SASL interpreter and the mental health professional is when the session's content is discussed between the SASL interpreter and the Deaf client outside the session. To answer the question about factors that could influence the trust relationship between them and the therapist, SASLI2 stated that: "*Discussing the sessions with Deaf client outside of the sessions*." Hamerdinger and Crump (2022, p. 345) warned against a situation where the sign language interpreter establishes an alliance with the Deaf client outside of the therapy session and advise that contact between the Deaf client and the sign language interpreter be minimised by, for example, not spending time together in the waiting room.

- **Confidentiality:** Maintaining confidentiality is one factor that significantly impacts the trust relationship between the Deaf client and the SASL interpreter. SASLI2 opined that having a conversation about the Deaf client with a mental health professional may be deemed a breach of confidentiality. *"Breaking confidentiality principle by discussing sessions with the therapist."*
- **Effective communication:** This ensures that all parties are included in all communication and that no one feels left out. SASLI1 responded to say: *"Failure to interpret everything happening in the room during the session"* and according to SASLI5: *"[i]f the interpreter needs clarification but doesn't seek clarification/doesn't manage the communication process well."*

The factors that may influence the trust relationship, according to the Deaf participants, are factors such as a lack of communication and understanding. DP1 felt uncomfortable with the therapist who bought her and the SASL interpreter a warm drink before the session. This gesture from the therapist was interpreted as a 'bribe' and

inappropriate. The situation was further exacerbated by the fact that the SASL interpreter also received a coffee, which DP1 interpreted as the therapist failing to understand the role of the SASL interpreter. To DP1, the SASL interpreter is not the client and should, therefore, not be treated to a coffee. Although there are differing views on the role that the sign language interpreter should play in the therapy session and the effect that the role of the sign language interpreter has, Dickinson (2014, p. 52) stated that if the sign language interpreter maintains a detached, conduit role, the power imbalances between the hearing and the Deaf interlocutors will be perpetuated. According to McIntire and Sanderson (2015, p. 328), if the interpreter takes the role of a conduit or machine, they will be completely impartial and detached from the communication event, which means that the interpreter will hold no power over any of the two interlocutors. However, any power imbalances between the two interlocutors will remain. The participants in Group 1 had the following to say about their perceptions of the power dynamics in the interpreted session with the Deaf clients:

> MHP1: "*I wasn't aware of any power dynamic between myself and the translator."*
>
> MHP2: "*The power dynamics between the client and the therapist remain almost the same. The interpreter tries not to disturb the balance."*
>
> MHP5: "*I was not so aware of power dynamics in these sessions."*
>
> MHP6: "*I did not find the power dynamics challenging since I was still in control of the communication process and responding to the client."*

These statements indicate that the SASL interpreters of these interpreted sessions played the conduit, machine role because the mental health professionals did not recognise any unusual power dynamics during their sessions.

The difference in race between the therapist and the Deaf client was also raised as a factor that could impact the trust relationship, because the therapist did not understand the culture of the Deaf person.

> DP1: *"I mean in general I think people should learn about other people's culture and language… she was a white person and then I would explain how we do it in Indian culture… she was superior to me, yet I had to do all the explaining."*

"The challenges of trust and cultural differences in the triadic relationship may often coincide because of a lack of understanding of the culture and the language of the client" (Trejo-Phillips, 2012, p. 51). The findings corroborate the RSM's assertion that

trust is a cornerstone of effective therapy. The participants highlighted the need for therapists to cultivate cultural competence, understand community dynamics, and navigate the complexities introduced by additional parties like interpreters to build and maintain trust with their clients.

4.5 Cultural Competence

DP3 expressed the belief that the mental health professional, due to a lack of understanding of the Deaf culture, might think that Deaf people do not have manners. This statement aligns with Gerber's (1980, pp. 723-724) view that a therapist who is unfamiliar with Deaf culture and the psycho-social factors that affect the Deaf person's way of life may misinterpret or misdiagnose the Deaf client. The lack of cultural competence of the mental health professionals featured strongly in the Deaf participants' comments.

> DP1: "*My first experience with a counsellor or a psychologist was that they did not know anything about Deaf culture, and I just got the feeling that they did not understand anything about me."*
>
> DP2: "*Yes, I think it is important because if they do not understand the Deaf community or the Deaf way of life, they will not form a connection with the Deaf client… I think they won't be able to relate unless they have learned about Deaf culture and the Deaf community."*
>
> DP4: *"Yes, I believe psychologists must learn the basic things about Deaf people as well as the culture and the differences that exist in cultures."*

All five participants from Group 1 reported not receiving specific training to work with Deaf clients. The responses to the question of whether they think that it is important for mental health professionals to receive specific training to work and communicate with Deaf clients are as follows:

> MHP1: *"It would be ideal for many more health professionals to receive specific training."*
>
> MHP2: *"It will assist us in understanding the deaf and their challenges much better."*
>
> MHP3: *"It will make you more aware how to communicate in the correct manner (for example not to look at the interpreter, but to maintain your focus on the client). Also training regarding the culture of the deaf people."*

MHP5: *"I found that I was not quite prepared for the difficulties that limitations with language and vocabulary would play in therapeutic work."*

These responses highlight the challenges these mental health professionals encountered during their sessions with Deaf clients, and illustrate the need for training to equip them to work effectively with Deaf clients.

One question in the questionnaire for participants from Group 3 asked how mental health professionals can enhance their understanding and responsiveness to the unique needs of Deaf clients. The purpose of this question was to determine which components, according to the SASL interpreters, impacted service delivery to the Deaf client in the mental health setting.

SASLI1: *"It is important that mental health professionals understand better the behaviour."*

SASLI2: *"Deaf sensitisation training."*

SASLI4: *"They must undergo training in Deaf culture, learn how to use interpreters and learn some basic skills communicating with Deaf persons."*

SASLI5: *"They should avail themselves for information sessions from professionals in the field; they should be willing to listen to the advice of both Deaf clients and experienced interpreters."*

These responses indicate SASL interpreters' frustration regarding the mental health professionals' inadequate knowledge about Deaf culture and Deaf persons' way of life. SASLI5 mentioned that they regard it as essential for mental health professionals to listen to guidance from experienced interpreters. This statement supports De Bruin and Brugmans' (2006, p. 361) claim that the interpreter can provide cultural information, which is one of the advantages of using a sign language interpreter in therapy sessions. Hamerdinger and Crump (2022, p. 83) asserted that respect shown by therapists and sign language interpreters for each other's roles is vital to establish trust and rapport. This can be achieved by a meeting before the session with the Deaf client to clarify roles and discuss strategies that will be used during the session.

4.6 Conclusion

Chapter 4 highlighted the varied experiences and qualifications of the study participants. The key findings emphasise the importance of empathy, the challenges

of building rapport and relationships due to communication barriers, and the critical role that cultural understanding plays in fostering effective therapeutic relationships.

Trust is crucial to the success of any therapeutic session. In this chapter, the dynamics of trust were explored from the perspective of the Deaf participants as well as the SASL interpreter participants. The Deaf participants expressed mixed feelings about trusting mental health professionals and SASL interpreters, and the perceptions of qualifications and professionalism and breaches of confidentiality often influence these feelings. On the other hand, the SASL interpreter participants expressed that they felt trusted by both the Deaf clients and the mental health professionals they have worked with. The researcher attributes this to their qualifications, accreditation, years of experience, and adherence to a Code of Ethics for SASL interpreters. The factors influencing trust relationships include accurate interpretation, professional boundaries, confidentiality, and effective communication. The understanding of Deaf culture also plays a significant role. Both the participants from Groups 2 and 3 highlighted the need for mental health professionals to learn more about Deaf culture and the way of life of Deaf persons, which will improve their responsiveness to Deaf clients.

Finally, the findings and recommendations of this study are presented in Chapter 5.

CHAPTER 5: FINDINGS AND RECOMMENDATIONS

5.1 Introduction

Chapter 5 presents this study's findings and recommendations. The findings are presented by replying to each of the research questions that correspond to each of the objectives of this research study. The recommendations are offered after the presentation of the findings.

5.2 Summary of the Study

In summary, this research report covered the following:

Chapter 1 introduced the study and set the stage by briefly outlining the background and rationale of the study, the research statement, objectives and research questions. It also presented the research methodology, the theoretical framework, and outlines the data collection and data analysis procedures. Additionally, ethical considerations and ethics clearance were explained.

In Chapter 2 the available research relevant to the impact of sign language interpreters on the therapeutic alliance was presented. It offered a broad outline of the history of mental health and psychology and discusses key concepts in psychology, sign language, the Deaf community and how rapport and trust are built and maintained between the therapist, the Deaf client and the SASL interpreter.

Chapter 3 discussed the Relational Skills Model as the theoretical framework for the current study. It further describes the various research paradigms, methodologies, data collection and analysis processes and the ethical considerations, validity and reliability of the study.

Chapter 4 presented the data analysis and discusses the data collected during the research study.

Chapter 5 presents a summary of the study, the findings as well as the limitations of the current study. Finally, this chapter offers the recommendations of the study based on the findings.

5.3 Findings

The research study's title is "Assessing the SASL Interpreter's Impact on the Mental Health Therapeutic Alliance". This study was conducted by answering four research questions investigated during the research. The findings are presented in 5.3.1 to 5.3.4.

5.3.1 Are mental health professionals in South Africa equipped to deal with Deaf clients?

The participants from Group 1, the mental health practitioners, reported that none of them had received specific training to work with Deaf clients. They all expressed that such training is essential for understanding Deaf culture and the challenges that Deaf people encounter in life. MHP1 noted that it would be ideal for many more mental health professionals to receive specific training, which underscores the recognition of this need. MHP5 said: "*I found that I was not quite prepared for the difficulties that limitations with language and vocabulary would play in therapeutic work."* This highlights the fact that a lack of knowledge regarding Deaf culture and SASL is a barrier to establishing rapport and a relationship, and it reflects the complexities the participants faced when working with Deaf clients.

According to Gerber (1980, pp. 723-724), a therapist who is unfamiliar with Deaf culture and psychosocial factors that affect the Deaf person's way of life may misinterpret or misdiagnose the Deaf client. Deaf participants articulated feelings of disconnect, with one participant stating that the mental health professionals might think that Deaf people are bad-mannered because they do not understand Deaf culture. DP2 noted that "*if they do not understand the Deaf community or the Deaf way of life, they will not form a connection with the Deaf client".*

The findings of this study indicate that mental health professionals in South Africa are not adequately equipped to deal with Deaf clients.

5.3.2 Does the interpreting process impact the establishment and maintenance of rapport and trust between mental health professionals and Deaf clients when SASL interpreters are used during therapy?

Rogers (1957, p. 96) believes that a solid relationship between the client and the therapist is a requirement for successful therapy, and the participants from Group 1

agree that rapport and relationship-building are crucial to making therapy work. According to Midwinter and Dickson (2015, p. 14), relationships and rapport can be established by being empathetic and showing the client that there is an understanding of their situation. DP1 stated, *"I just got the feeling that they did not understand anything about me"*.

The following statements from the participants in Group 1 indicate that the interpreter and the interpreting process impacted the establishment and maintenance of the relationship and trust:

> MHP3: *"I felt as if the third person impacted the nature of confidentiality of the session. It also made me feel more nervous and impacted by spontaneity"*.
>
> MHP6: *"At first I felt somewhat insecure in my role*,"

Williams and Abeles (2004, p. 644) consider sustained eye contact as crucial in Deaf culture and sign language. They opined that "the act of breaking eye contact in a visually based conversation destroys the communication bridge". Due to the Deaf client needing to focus on the SASL interpreter to understand what the hearing therapist is saying, there is limited opportunity for direct eye contact with the therapist. Antolovi (2017, p. 10) discussed the impact that eye contact or a lack thereof can have and how it can be misinterpreted by a therapist unfamiliar with the client's specific cultural conventions. It is often difficult for hearing people to maintain eye contact with a person who is not looking at them. It is also more comfortable to look at the person whose voice they hear. MHP2 noted that it felt more formal having to sit next to the interpreter and talking loud enough for the interpreter to hear while also looking at the Deaf person. This part of the interpreting process can impact establishing and maintaining rapport as well as trust between the mental health professional and the Deaf client.

Besides answering this research question, the data also pointed to the role that a good relationship between the mental health professional and the SASL interpreter will play in mitigating the impact that the interpreting process may have on the therapy session. Several of the participants from Group 1 mentioned the need to "*foster a good relationship with the interpreter*", as mentioned by MHP5, and to be open to working with the interpreter. This supports the argument by De Bruin and Brugmans (2006, p. 361) that when the mental health professional and the interpreter work well together, it can have a positive impact on the therapeutic relationship.

5.3.3 What factors could influence the establishment and maintenance of rapport and trust between mental health professionals and Deaf clients when using SASL interpreting during therapy?

The data of this study show that various factors influence the establishment of rapport and trust between mental health professionals and Deaf clients when SASL interpreters are used during therapy sessions.

Cromwell (2004, p. 5) stated that having an interpreter in the therapy space makes them a part of the interaction and will impact the dyad by making it a triad. The dynamics in communication between the therapist, Deaf clients and SASL interpreters during therapy sessions are no different from other therapy sessions, except that it is a triad instead of a dyad. The data revealed that establishing rapport and relationships with Deaf clients is lacking, and according to the participants from Groups 1 and 2, this can be attributed to the fact that there is a third person in the session who also needs to be considered, trusted and consulted. Some participants felt uncomfortable having an interpreter in the room, while others felt that the SASL interpreter was an asset and an ally.

Another factor that may impact the trust relationship is that the Deaf community is small, and the Deaf client may feel that confidentiality will not be maintained. Since there is a lack of qualified sign language interpreters, the Deaf person may know the interpreter from other events or settings and will, therefore, wonder if the interpreter will disclose the content of the therapy session with others. Deaf people's typical experiences are that hearing people discuss them with other hearing people (Williams & Abeles, 2004, p. 645). Cromwell (2004, p. 4) opined that some Deaf people may experience the presence of an interpreter as an intrusion.

The mental health professionals did not identify any cause for concern around power dynamics between them and the SASL interpreters. MHP1 remarked that *“I wasn’t aware of any power dynamic between myself and the translator”* and MHP6 stated that *“I did not find the power dynamics challenging”*. These statements indicate that the SASL interpreters of these therapy sessions played an impartial, machine role. However, Elkington and Talbot (2016, p. 366) considered the bilingual and bicultural role as the most favoured role for interpreters in the mental healthcare setting.

The findings of this study indicate that a lack of cultural competence by mental health professionals significantly influence the establishment and maintenance of rapport and trust between mental health professionals and Deaf clients.

The factors, as mentioned by all three participant groups, that influence the establishment and maintenance of rapport and trust between mental health professionals and Deaf clients when using SASL interpreters are issues related to trust, lack of understanding of Deaf culture, Deaf persons' way of life, and the role of the SASL interpreter.

5.3.4 Are SASL interpreters equipped to deal with mental health therapy sessions?

The SASL interpreter participants raised their opinions about their readiness to deal with mental health therapy sessions with the following responses. SASLI1 responded: "*I do not feel fully equipped to deal with mental health therapy sessions because I have never been trained to work in such a context-specific setting"*.

According to SASLI3 the focus should be on medical interpreting training: "*... I think there should be a course focusing on medical interpreting. Because there are a lot of factors that we experience that we never talked about during the trainings*."

It is evident from the data that the SASL interpreters do not feel entirely equipped to deal with mental health therapy sessions, highlighting the need for specialised training for SASL interpreters in this field.

Hamerdinger and Crump (2022, p. 50, 343) asserted that if the interpreter is not trained in mental health situations, such as the therapeutic process or associated goals, they, too, will not understand their work's impact on the therapeutic process. The authors further posited that the role of the interpreter changes depending on the needs of the client and the therapist. It is, therefore, crucial for the SASL interpreter to have a clear understanding of the various roles that the SASL interpreter can play as per the suggestion by Llewellyn-Jones and Lee (2013, p. 70), that interpreter training programmes should equip interpreting students with the required knowledge and skills to play different roles.

SASLI2 remarked that "*mentorship within the health therapy setting would assist on how one navigates the intricacies of interpreting your sessions in ensuring quality, adherence of code of ethics all with care and a level of sensitivity".* Swabey (2018, p.

81) proposed that the sign language interpreter should possess, besides their qualification in interpreting, knowledge and understanding of which linguistic, community and cultural factors can impact mental healthcare interchanges. The sign language interpreter must know how to balance professionalism with displaying empathy and adaptability, be familiar with legislation regarding mental healthcare, and be knowledgeable about the fundamental applications utilised in mental healthcare sessions.

5.4 Limitations of the Study

A limitation of the current study is the lack of representation of the participants of Group 2. All the participants were from the Gauteng Province, which limited the perspective to one specific geographical area. This geographical limitation means that the findings may not represent the experiences and perspectives of Deaf clients from other provinces in South Africa, which could have different cultural and socioeconomic influences. The inclusion of Deaf participants from other provinces with more diverse backgrounds would provide a more comprehensive understanding of the lived experiences of Deaf clients. Additionally, the topic of mental health is sensitive, not often spoken about and regarded as a taboo topic for some because of the fear of stigmatisation. This fact may have negatively impacted the number of participants from Group 2.

5.5 Conclusion

Based on the findings outlined above, the following conclusions can be made:

First, it is evident that mental health professionals in South Africa are not adequately equipped to work with Deaf clients. The lack of knowledge of Deaf culture and SASL poses a barrier to effective therapeutic relationship as per the statement by Moleko (2012, p. 163), that cultural competence is central to establishing a relationship between the therapist and the client.

Secondly, the interpreting process and the presence of an SASL interpreter impact the establishment and maintenance of rapport and trust between the mental health professional and the Deaf client. Cromwell (2004, p. 5) argued that the presence of the interpreter in the therapy space makes them a part of the interaction and will impact the dyad by transforming it into a triad. Because of the triadic nature of the interaction, the interpreting process can introduce feelings of insecurity and disrupt the natural flow of communication. Williams and Abeles (2004, p. 644) emphasised that eye contact is

a crucial element in Deaf culture, and in the current study it is mentioned that eye contact is often compromised, resulting in the difficulty of developing trust between the mental health professionals and Deaf clients.

The findings revealed several factors that influence the establishment and maintenance of rapport and trust when SASL interpreters are used in the therapeutic setting. Williams and Abeles (2004, p. 644) pointed out that the Deaf community is small and the Deaf participants raised concerns about confidentiality when using SASL interpreters during therapy sessions. The lack of understanding of Deaf culture among mental health professionals exacerbates these concerns. Another factor that significantly affects the dynamics of the therapeutic relationship is the perception of the role of the SASL interpreter—whether they are viewed as an ally or an intrusion. Hamerdinger and Crump (2022, p. 343) stated that the Deaf client may see the interpreter as an ally, which can frustrate the relationship between the Deaf client and the therapist in the mental health setting.

Finally, the SASL interpreter participants highlighted the fact that they are inadequately prepared to work in the mental health setting because of a lack of specialised training. Hamerdinger and Crump (2022, p. 50, 343) asserted that if the interpreter is not trained in mental health situations such as the therapeutic process or associated goals, they, too, will not understand their work's impact on the therapeutic process. The need for targeted training programmes for SASL interpreters was strongly emphasised. Such training should include understanding of therapeutic processes, cultural competencies and ethical considerations.

In conclusion, the study highlights the need for training to prepare mental health professionals and SASL interpreters for work with Deaf clients in mental health settings. Addressing these gaps through specialised training programmes and fostering collaborative relationships between mental health professionals and SASL interpreters can enhance the therapeutic alliance and improve mental healthcare services to Deaf clients.

5.6 Recommendations

The recommendations from the findings and conclusion of the current study are as follows:

1. **Training in Deaf culture and SASL:** Mental health professionals who wish to work with Deaf clients must undergo specialised training in Deaf culture and SASL.

   Implementation:

   - Develop and mandate a short course on Deaf culture and basic SASL communication for mental health professionals.
   - Partner with Deaf-led organisations and SASL trainers to develop the curriculum to ensure authenticity and cultural relevance.
   - Experiential components should include panels of Deaf persons, role-plays with Deaf clients, and interpreted session observation.
   - Offer training annually through universities, CPD-accredited platforms, or professional associations.

2. **Specialised mental healthcare training programmes**: To address the lack of specialised mental healthcare interpreter training identified in this study, a specialised training programme for SASL interpreters, specifically focusing on SASL interpreting in the mental healthcare field must be developed. An example of a successful training programme is the Mental Health Interpreter Training project in Alabama in the United States, which offers a comprehensive 40-hour training programme, including internships and examinations (Hamerdinger & Crump, 2022).

   Implementation:

   - Develop a modular training programme focused on the mental healthcare context, including modules on trauma-informed interpreting, ethical decision-making, interpreter neutrality, and working with multidisciplinary teams.
   - Incorporate practical components, such as supervised clinical observations, case study analysis, and peer supervision groups.
   - Collaborate with mental healthcare institutions to create internship placements for SASL interpreters in training.
   - Include a certification pathway, with assessment through written exams, practical evaluations, and portfolio submissions.

3. **Information sessions**: Such sessions should be aimed at the Deaf community discussing the role of the SASL interpreter in the mental healthcare setting and

the therapist's responsibilities in the therapy session. This will help Deaf persons to better manage their expectations.

Implementation:

- Design a series of Deaf-friendly information sessions, co-led by Deaf mental health advocates, SASL interpreters, and therapists, using SASL as the primary mode of communication.
- Focus content on clarifying roles, such as the interpreter's boundaries, confidentiality, the therapist's responsibilities, and how therapeutic processes work.
- Host sessions in accessible community spaces or online platforms regularly and record the sessions for asynchronous viewing.
- Create complementary materials, such as SASL video infographics and printed handouts, that can be distributed through clinics, schools for the Deaf, and organisations of Deaf people.
- Gather feedback from participants after each session to improve and adapt future events.

REFERENCES

Ahmad-Abadi, F. K., Maarefvand, M., Aghaei, H., Hosseinzadeh, S., Abassi, M., & Khubchandani, J. (2017). Effectiveness of Satir-Informed Family-Therapy on the Codependency of Drug Dependents' Family Members in Iran : A Randomized Controlled Trial. *Journal of Evidence-Informed Social Work, 14(4)*, 301 - 310.

Akach, P., & Morgan, R. (2015). Sign language interpreting in South Africa. In C. B. Roy, & J. Napier, *The Sign Language Interpreting Studies Reader* (pp. 389-399). Amsterdam/Philadelphia: John Benjamins Publishing Company.

Alharahsheh, H. H., & Pius, A. (2020). A review of key paradigms: Positivism VS interpretivism. *Global Academic Journal of Humanities and Social Sciences, 2(3)*, 39 - 43.

American Psychological Association. (2018, 04 19). APA Dictionary of Psychology Online. Washington DC, United States of America. Retrieved from https://dictionary.apa.org/psychotherapy

Angelelli, C. V. (2008). The role of the interpreter in the healthcare setting. In C. Valero-Garces, & A. Martin, *Crossing Borders in Community Interpreting: Definitions and dilemmas* (pp. 147-163). Amsterdam/Philadelphia: John Benjamins Publishing Company.

Antolovi, C. (2017). Lost in Translation "A Qualitative Study of Therapists Experience in Counselling Cross Cultural Clients and the Need for an Interpreter. Dublin, Ireland: Dublin Business School, School of Arts.

Aspers, P., & Corte, U. (2019). What is Qualitative in Qualitative Research. *Qualitative Sociology*, 139-160.

Babbie, E. M. (2013). *The practice of social research.* Wadsworth: Thomson Learning Inc.

Baker-Shenk, C. (1985). Characteristics of Oppressed and Oppressor Peoples: Their Effect on the Interpreting Context. *RID Convention: Interpreting: The Art of Cross Cultural Mediation*, (pp. 43-53). San Diego.

Barnett, S. (1999). Clinical and cultural issues in caring for deaf people. *Family Medicine - Kansas City 31*, 17-22.

Benjamin, E., Swartz, L., Chiliza, B., & Hering, L. (2016). Language barriers in health: lessons from the experiences of trained interpreters working in public sector hospitals in the Western Cape. *South African Health Review*, 73-81.

Benjamin, L. T., & Baker, D. B. (2012). The Internationalization of Psychology: A History. In D. B. Baker, *The Oxford Handbook of the History of Psychology: Global Perspectives* (pp. 2-17). Oxford: Oxford Library of Psychology.

Bhengy, C. (2019, February 28). Five pastors who have made headlines for all the wrong reasons. South Africa: Times LIVE. Retrieved 08 25, 2024, from https://www.timeslive.co.za/news/south-africa/2019-02-28-five-pastors-who-have-made-headlines-for-all-the-wrong-reasons/

Bogna, F., Raineri, A., & Dell, G. (2020). Critical realism and constructivism: Merging research paradigms for a deeper qualitative study. *Qualitative Research in Organizations and Management, 15(4)*, 461-484.

Brunson, J. G., & Lawrence, P. S. (2002). Impact of sign language interpreter and therapist moods on deaf recipient mood. *Professional Psychology: Research and Practice, 33(6)*, 576.

Chatzidamianos, G., Fletcher, I., Wedlock, L., & Lever, R. (2019). Clinical communication and the 'triangle of care' in mental health and deafness: Sign language interpreters' perspectives. *Patient Education and Counseling, 102(11)*, 2010-2015.

Cohen, L., Manion, L., & Morrison, K. (2018). Questionnaires. In L. Cohen, L. Manion, & K. Morrison, *Research Methods in Education, (8th ed.)* (pp. 471-505). Routledge.

Cokely, D. (2015). The interpreted medical interview. In C. B. Roy, & J. Napier, *The Sign Language Interpreting Studies Reader* (pp. 146-156). Amsterdam/Philadelphia: John Benjamins Publishing Company.

Cooper, S., Bhana, A., Drew, N., Faydi, E., Flisher, A., Kakuma, R., . . . Skeen, S. (2011). Recommendations for improving mental healthcare systems in Africa: Lessons from Ghana, Uganda, South Africa and Zambia. In K. Kondlo, & C. Ejiogu, *Africa in Focus: Governance in the 21st century* (pp. 309-325). Cape Town: HSRC Press.

Corey, G., Nicholas, L. J., & Bawa, U. (2017). *Theory and Practice of Counselling and Psychotherapy (2nd SA ed.).* Cengage Learning.

Creswell, J. W., & Poth, C. N. (2016). *Qualitative inquiry and research design: Choosing among five approaches.* Sage publications.

Cromwell, J. (2004, August). What are the effects of using interpreters in therapy with British Sign Language users? Retrieved 04 21, 2024, from https://www.jimcromwellinterpreting.com/peripheralbrain/2004/08/what-are-efects-of-using-interpreters.html

De Bruin, E., & Brugmans, P. (2006). The psychotherapist and the sign language interpreter. *Journal of Deaf Studies and Deaf Education, 11(3)*, 360-368.

Department of Health. (2023, 03 30). *https://www.health.gov.za/wp-content/uploads/2024/02/National-Mental-Health-Policy-framework-and-strategic-Plan-2023-2030.pdf.* Retrieved 07 10, 2024, from www.health.gov.za: https://www.health.gov.za/wp-content/uploads/2024/02/National-Mental-Health-Policy-framework-and-strategic-Plan-2023-2030.pdf

DeVito, J. A. (2019). *The Interpersonal Communication Book (15th ed.).* Pearson Education.

Dickinson, J. (2014). *Signed Language Interpreting in the Workplace.* Great Brittain: Douglas McLean Publishing.

Egan, G., & Reese, R. J. (2021). *The Skilled Helper: A client-centered approach (3rd EMEA ed.).* Cengage Learning.

Elkington, E. J., & Talbot, K. M. (2016). The role of interpreters in mental health care. *South African Journal of Psychology, 46(3)*, 364-375.

Empowering Vulnerable Communities: MTN's Commitment to Inclusive Technology. (2023). *Communications Today*.

Essien, B., & Asamoah, M. K. (2020). Reviewing the common barriers to the mental healthcare delivery in Africa. *Journal of Religion and Health, 59(5)*, 2531-2555.

Etikan, I., & Bala, K. (2017). Sampling and sampling methods. *Biostatistics International Journal, 5(6)*, 215-217.

Fellinger, J., Holzinger, D., & Pollard, R. (2012). Mental health of deaf people. *The Lancet (British edition), 379 (9820)*, 1037-1044.

Ferrari, R. (2015). Writing narrative style literature review. *Medical Writing, 24(4)*, 230-235.

Galderisi, S., Heinz, A., Kastrup, M., Beezhold, J., & Sartorius, N. (2015). Toward a new definition of mental health. *World Psychiatry, 14(2)*, 231-233. doi:10.1002/wps.20231

Gerber, B. M. (1980). Interpreting for hearing-impaired patients in mental health settings. *American journal of orthopsychiatry 50(4)*, 722-724.

Grbić, N., & Pöllabauer, S. (2006). Community interpreting: Signed or spoken? Types, modes, and methods. *Linguistica Antverpiensia, New Series-Themes in Translation Studies, 5*, 247-261.

Hamerdinger, S. H., & Crump, C. J. (2022). Sign language interpreters and clinicians working together in mental health settings. In C. Stone, R. Adam, R. Muller de Quadros, & C. Rathmann (Eds.), *The Routledge Handbook of Sign Language Translation and Interpreting* (p. 560). Routledge.

Hamerdinger, S., & Karlin, B. (2003). Therapy using interpreters: Questions on the use of interpreters in therapeutic settings for monolingual therapists. *JADARA-ROCHESTER NY-, 36*, 12-30.

Harwell, M. R. (2011). Research design in qualitative/quantitative/mixed methods. In C. F. Conrad, & R. C. Serlin, *The Sage handbook for research in education: Pursuing ideas as the keystone of exemplary inquiry, 2nd ed.* (pp. 147-164). Madison: University of Wisconsin.

Health Professions Council of South Africa. (2023, 09 30). *https://www.hpcsa.co.za/Content/upload/professional_practice/ethics/Booklet_3_Patients_Rights_Charter_vSept_2023.pdf.* Retrieved 08 03, 2024, from www.hpcsa.co.za: https://www.hpcsa.co.za/Content/upload/professional_practice/ethics/Booklet_3_Patients_Rights_Charter_vSept_2023.pdf

Heath, J., Williamson, H., Williams, L., & Harcourt, D. (2018). "It's just more personal": Using multiple methods of qualitative data collection to facilitate participation in research focusing on sensitive subjects. *Applied Nursing Research 43*, 30-35.

ICAS, S. (2024, 04 26). *ICAS About us*. Retrieved from www.icas.co.za: https://www.icas.co.za/about-us

Jacob, K. S., & Patel, V. (2014). Classification of mental disorders: A global mental health perspective. *The Lancet (British edition) 383 (9926)*, 1433-1435.

Kawulich, B. B. (2005). Participant observation as a data collection method. *Forum Qualitative Sozialforschung/forum: Qualitative Social Research, 6(2)*, 1-28.

Kohn, K., & Kalina, S. (1996). The strategic dimension of interpreting. *Meta 41(1)*, 118-138.

Lane, H. (1985). Closing Address - The Secret of the Orchard. *RID Convention: Interpreting: The Art of Cross Cultural Mediation*, (pp. 175-179). San Diego.

Lederman, N. G., & Lederman, J. S. (2015). What is a theoretical framework? A practical answer. *Journal of Science Teacher Education, 26(7)*, 593-597.

Lesch, H. M. (2011). In search of an interpreting research methodology for Africa. *Southern African Linguistics and Applied Language Studies 29(3)*, 361-373.

Llewellyn-Jones, P., & Lee, R. (2013). Getting to the core of role: Defining interpreters' role space. *International Journal of Interpreter Education, 5(2)*, 54-72.

London, L., Zweigenthal, V., & Heap, M. (2020). Ensuring equal access to health services for the Deaf in South Africa. *South African Health Review 2020(1)*, 183-191.

Lund, T. (2012). Combining qualitative and quantitative approaches: Some arguments for mixed methods research. *Scandinavian Journal of Educational Research, 56(2)*, 155-165.

Major, G. (2024). Healthcare interpreting as relational practice: Understanding the interpreter's role in facilitating rapport in health interactions. *Interpreting and Society*, 1-22.

Mall, S., & Swartz, L. (2012). Addressing intersections in HIV/AIDS and Mental Health: The Role of Organizations for d/Deaf and Hard of Hearing Individuals in South Africa. *American Annals of the Deaf, 156(5)*, 492-500. Retrieved from https://www.proquest.com/scholarly-journals/addressing-intersections-hiv-aids-mental-health/docview/1010398537/se-2

Mapson, R., & Major, G. (2021). Interpreters, rapport, and the role of familiarity. *Journal of Pragmatics, 176*, 63-75. doi:https://doi.org/10.1016/j.pragma.2021.01.020

Marais, D. L., & Petersen, I. (2015). Health system governanace to support integrated mental health care in South Africa: Challenges and opportunities. *International Journal of Mental Health Systems, 9(1)*, 1-21.

Martin, A., & Marti, I. A. (2008). Community interpreter self-perception: A Spanish case study. In C. Valero-Garces, & A. Martin, *Crossing Borders in Community Interpreting: Definitions and dilemmas* (pp. 203-230). Amsterdam / Philadelphia: John Benjamins Publishing Co.

Matthews, G. (2003). Aristotle: Psychology. In C. Shields, *The Blackwell Guide to Ancient Philosophy* (pp. 211-227). Oxford: Blackwell Publishing Ltd.

McIntire, M. L., & Sanderson, G. R. (2015). Who's in charge here. In C. B. Roy, & J. Napier, *The Sign Language Interpreting Studies Reader* (pp. 328-337). Amsteram/Philadelphia: John Benjamins Publishing Company.

McLeod, J., & McLeod, J. (2011). *Counselling skills: A practical guide for counsellors and helping professionals.* McGraw-Hill Education.

Midwinter, R., & Dickson, J. (2015). *Embedding Counselling and Communication Skills: A Relational Skills Model.* Routledge, Taylor & Frances Group.

Ministry: Justice and Correctional Services RSA. (2024, 10 05). *Static RNW3638-221103.* Retrieved from Parliamentary Monitoring Group | South Africa: https://pmg.org.za

Moleko, A. (2012). Cultural and cross-cultural psychology. In M. Visser, & A. Moleko, *Community Psychology in South Africa* (pp. 163-176). Pretoria: Van Schaik Publishers.

Morere, D. A., Dean, P. M., & Mompremoer, L. (2019). Mental health assessment of deaf clients: Issues with interpreters use and assessment of person with diminished capacity and psychiatric polulations. *JADARA, 42(4)*, 241-258.

NAJIT. (2016, March 5). T&I Descriptions. Retrieved 09 13, 2024, from https://najit.org/wp-content/uploads/2016/10/TI-Descriptions-2016-03-05.pdf

Nelson-Jones, R. (2011). *Six Key Approaches to Counselling and Therapy.* Sage Publications.

Neuman, W. L. (2013). *Social research methods: Qualitative and quantitative approaches.* Boston: Allyn & Bacon.

Newsroom. (2012, June 15). Medical interpreters a boon for publich health. *University of Cape Town News*. Cape Town, South Africa. Retrieved from https://www.news.uct.ac.za/article/-2012-06-15-medical-interpreters-a-boon-for-public-health

O'Donnell, J. (2020). "The necessary evil"- an exploration into the provision of sign language interpreters in therapy and its effect on the therapeutic relationship. Dublin, Ireland: Dublin Business School.

Östlund, U., Kidd, L., Wengström, Y., & Rowa-Dewar, N. (2011). Combining qualitative and quantitative research within mixed method research designs: a methodological review. *International Journal of Nursing Studies, 48(3)*, 369-383.

Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration and Policy In Mental Health And Mental Health Services Research, 42*, 533-544.

Panhwar, A. H., Ansari, S., & Shah, A. A. (2017). Post-positivism: An effective paradigm for social and educational research. *International Research Journal of Arts and Humanities, 45(45)*, 253-259.

Park, Y. S., Konge, L., & Artino Jr, A. R. (2020). The positivism paradigm of research. *Academic Medicine, 95(5)*, 690-694.

Patel, V., Farooq, S., & Thara, R. (2007). What is the best approach to treating schizophrenia in developing countries? *PLoS Medicine, 4(6), e159*, 0963-0966.

Petersen, C. A. (2007). A Historical Look at Psychology and the Scientist-Practitioner Model. *American Behavioral Scientist, 50(6)*, 758-765.

Prasko, J., Diveky, T., Grambal, A., Kamaradova, D., Mozny, P., Zigmundova, Z., . . . Vyskocilova, J. (2010). Transference and countertransference in cognitive behavioral therapy. *Biomedical Papers, 153(3)*, 189-197.

Rajasekar, S., Philominathan, P., & Chinnathambi, V. (2013). Research Methodology. In D. Rajasekar, & R. Verma, *Research methodology* (pp. 1-53). India: Archers & Elevators Publishing House.

Ram, A., & Muthukrishna, N. (2001). Voices of deaf adults in South Africa. *Perspectives in Education, 19(1)*, 39-52.

Ratislavova, K., & Ratislav, J. (2014). Asynchronous email interview as a qualitative research method in the humanities. *Human Affairs 24*, 452-460.

Reber, A. S., Allen, R., & Reber, E. (2009). *Penguin Dictionary of Psychology*. England: Penguin Books.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21(2)*, 95.

Roy, C. B. (2015). A sociolinguistic analysis of the interpreter's role in simultaneous talk in a face-to-face interpreted dialogue. In C. B. Roy, & J. Napier, *The Sign Language Interpreting Studies Reader* (pp. 298-326). Amsterdam/Philadelphia: John Benjamins Publishing Company.

Russell, D., & Shaw, R. (2016). Power and privilege: An exploration of decision-making of interpreters. *Journal of Interpretation, 25(1)*, 1-26.

Schuster, M., & Baixauli-Olmos, L. (2018). A Question of Communication: The Role of Public Service Interpreting in the Migrant Crisis - Introduction. *The European Legacy, 23(7)*, 733-737.

Shisana, O., Stein, D. J., Zungu, N. P., & Wolvaardt, G. (2024). The rationale for South Africa to prioritise mental health care as a critical aspect of overall health care. *Comprehensive Psychiatry, 130, 152458*, 1-6.

Silverman, A. (2003). Plato: Psychology. In C. Shields, *The Blackwell Guide to Ancient Philosophy* (pp. 130-144). Oxford: Blackwell Publishing Ltd.

Smaby, M., & Maddux, C. (2011). *Basic and advanced counselling skills: Skilled counselor training model.* Wadsworth: Cengage learning.

South African Government. (2014, May 19). The South African Language Practitioners' Council Act. *Government Gazette*. South Africa.

Spencer-Oatey, H., & Franklin, P. (2009). *Intercultural Interaction: A Multidisciplinary Approach to Intercultural Communication.* Basingstoke: Palgrave Macmillan.

Stein, D. J., Seedat, S., Herman, A., Moomal, H., Heeringa, S. G., Kessler, R. C., & Williams, D. R. (2008). Lifetime prevalence of psychiatric disorders in South Africa. *The British Journal of Psychiatry 192*, 112-117. doi:10.1192/bjp.bp.106.029280

Stickley, T. (2011). From SOLER to SURETY for effective non-verbal communication. *Nurse Education in Practice, 11*, 395-398.

Storbeck, C. (2023, June 22). *www.wits.ac.za/news/latest-news/opinion/2023-06*. Retrieved from www.wits.ac.za: https://www.wits.ac.za/news/latest-news/opinion/2023/2023-06/sign-language-is-set-to-become-official-in-south-africa-.html

Suri, H. (2011). Purposeful Sampling in Qualitative Research Synthesis. *Qualitative Research Journal, 11 (2)*, 63-75.

Swabey, L. (2018). Interpreting in Healthcre Settings: More than Needles, Blood, and Terminology. In L. Roberson, & S. Shaw, *Signed Language Interpreting in the 21st Century: An overview of the profession* (pp. 73-92). Washington, DC: Gallaudet University Press.

Swartz, L., de la Rey, C., Duncan, N., Townsend, L., & O'Neill, V. (2016). *Psychology: An introduction .* Oxford University Press Southern Africa.

Thanh, N. C., & Thanh, T. T. (2015). The interconnection between interpretivist paradigm and qualitative methods in education. *American Journal of Educational Science, 1(2)*, 24-27.

Theron, M. J. (2008). *A manual for basic relational skills training in psychotherapy (Doctoral dissertation).* Pretoria: University of South Africa.

Theys, L., Krystallidou, D., Salaets, H., Wermuth, C., & Pype, P. (2020). Emotion work in interpreter-mediated consultations: A systematic literature review. *Patient Education and Counseling, 103(1)*, 33-43. doi:https://doi.org/10/1016/j.pec.2019.08.006

Trejo-Phillips, P. (2012, September). Interpreters in a psychotherapeutic triad interpreting for torture survivors: An intergrative literature review through a cultural competency lens. Wright Institute Graduate School of Psychology.

UpMetrics Staff. (2022, July 25). 8 Essential Qualitative Data Collection Methods. Retrieved September 05, 2024, from https://blog.upmetrics.com/essential-qualitative-data-collection-methods

Vaismoradi, M., Turunen, H., & Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nursing & Health Sciences, 15(3)*, 398-405.

Varpio, L., Paradis, E., Uijtdehaage, S., & Young, M. (2020). The distinctions between theory, theoretical framework, and conceptual framework. *Academic medicine, 95(7)*, 989-994.

Vehovar, V., Toepoel, V., & Steinmetz, S. (2016). Non-probability Sampling. In C. Wolf, D. Joyce, Smith, W. T, & Y. C. Fu, *The SAGE handbook of survey methodology* (pp. 327-345). Sage.

Wadensjo, C. (1998). *Interpreting as interaction.* London: Longman.

WASLI. (2024, 08 07). *Code of Ethics*. Retrieved from World Association of Sign Language Interpreters: https://wasli.org/your-wasli/code-of-ethics

Williams, C. R., & Abeles, N. (2004). Issues and Implications of Deaf Culture in Therapy. *Professional Psychology: Research and Practice 35(6)*, 643-648.

World Health Organization. (2011). *World Report on Disability.* Geneva: World Health Organization.

Young, A., Oram, R., & Napier, J. (2019). Hearing people perceiving deaf people through sign language interpreters at work: on the loss of self through interpreted communication. *Journal of Applied Communication Research 47(1)*, 90-110.

APPENDICES

APPENDIX A: Ethics Clearance

SCHOOL OF Literature, Language and Media ETHICS COMMITTEE
CONSTITUTED UNDER THE UNIVERSITY HUMAN RESEARCH ETHICS COMMITTEE (NON-MEDICAL)

CLEARANCE CERTIFICATE **PROTOCOL NUMBER: SLLM-TRAN-3**

PROJECT TITLE Assessing the South African Sign Language interpreter's impact on the mental health therapeutic alliance

INVESTIGATOR Thelma Kotze

SCHOOL/DEPARTMENT	SLLM/Translation
DATE CONSIDERED	21 June 2024
DECISION OF THE COMMITTEE	Approved
RISK LEVEL	Minimal risk
EXPIRY DATE	21 June 2025

ISSUE DATE OF CERTIFICATE 28 June 2024 **CHAIRPERSON** Prof. Anette Horn

A. Horn

cc: Supervisor : Dr. Celimpilo Dladla

DECLARATION OF INVESTIGATOR

To be completed in duplicate and **ONE COPY** returned to the Chairperson of the School/Department ethics committee.

I fully understand the conditions under which I am are authorized to carry out the abovementioned research and I guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research

PLEASE QUOTE THE PROTOCOL NUMBER ON ALL ENQUIRIES

APPENDIX B: Participant Information Letter: Mental Health Professionals and SASL Interpreters

Participant Information Letter to Mental Health Professionals and SASL interpreters

Dear Sir / Madam

My name is Thelma Kotze. I am a Masters student in the Translation and Interpreting Department of the University of the Witwatersrand, Johannesburg. As part of my studies, I will undertake a research project. I am assessing the South African Sign Language (SASL) interpreter's impact on the mental health therapeutic alliance. I will be conducting my research under the supervision of Dr Celimpilo Dladla and co-supervised by Mr Dennis Mhlanga.

As part of this research study, I would like to invite you to complete a questionnaire discussing the role of the South African Sign Language (SASL) interpreter in mental health therapy session. The questions will not be about confidential mental health matters, but about the SASL interpreter. The data collected in the research study will be kept confidential and secure on a password-protected laptop and stored securely in the OneDrive cloud. The data will be encrypted before it is stored on OneDrive. The research data will be stored and maintained for a period of five years following the completion of the research report. With your permission, the data collected from this research project may be used by other researchers in an anonymized format. You will be able to participate anonymously, and your personal information and identity will be kept confidential.

You will not be given any direct benefits for your participation in this research study and there will be no personal costs to you if you participate. You will be able to decide not to participate in the study and you may decide to withdraw from the study at any time.

This research study will culminate in a research report and a summary of this report will be made available upon request. You are welcome to contact me on the contact detail below, should have any questions of clarity about the research study. Any concerns or complaints regarding the ethical procedures of this study may be directed to the Dr Celimpilo Dladla +27(0) 11 717 4261, email Celimpilopiety.Dladla@wits.ac.za.

Yours sincerely,

Thelma Kotze
563715@wits.ac.za
0832668124

Supervisor: Dr Celimpilo Dladla
Celimpilopiety.Dladla@wits.ac.za
Co-supervisor: Dennis Mhlanga
Dennis.Mhlanga2@wits.ac.za

APPENDIX C: Participant Information Letter to Deaf Participants

Participant Information Letter to Deaf Participants

Link to SASL version:
https://drive.google.com/file/d/1NhKGO69PMzsr44PKB3FtoBkJBMPfEfHr/view?usp=sharing

Dear Sir / Madam

My name is Thelma Kotze. I am a Masters student in the Translation and Interpreting Department of the University of the Witwatersrand, Johannesburg. As part of my studies, I will undertake a research project. I am assessing the South African Sign Language (SASL) interpreter's impact on the mental health therapeutic alliance. I will be conducting my research under the supervision of Dr Celimpilo Dladla and co-supervised by Mr Dennis Mhlanga.

As part of this research study, I would like to invite you to participate in a virtual (Zoom) interview responding to questions discussing the role of the South African Sign Language (SASL) interpreter in mental health therapy sessions. The questions will not be about confidential mental health matters, but about the SASL interpreter. The questions are available in SASL, by clicking on the link at the bottom of this letter. You may view the questions to make sure that you are comfortable answering these questions in the interview. The interview will be recorded and only the researcher and supervisor will view, analyse and transcribe the videos.

Should you prefer to respond to an anonymous, online questionnaire in writing, this option is available, and you may click on the link below to access the questionnaire that is also available in SASL.

Link to Questionnaire: SASL version:

https://drive.google.com/file/d/1jw2M2xd1H4aIrpTpYolZeGzpd3Bo-mvG/view?usp=sharing

The data collected in the research study will be kept confidential and secure on a password-protected laptop and stored securely in the OneDrive cloud. The data will be encrypted before it is stored on OneDrive. The research data will be stored and maintained for a period of five years following the completion of the research report. With your permission, the data collected from this research project may be used by other researchers in an anonymized format. Should you choose to participate by completing the online questionnaire in written English, you will be able to participate anonymously, and your personal information and identity will be kept confidential. If you agree to be interviewed on video, you will not participate anonymously, however your personal information and identity will be kept confidential.

You will not be given any direct benefits for your participation in this research study and there will be no personal costs to you if you participate. You will be able to decide not to participate in the study and you may decide to withdraw from the study at any time.

This research study will culminate in a research report and a summary of this report will be made available upon request. You are welcome to contact me on the contact detail below, should have any questions of clarity about the research study. Any concerns or complaints regarding the ethical procedures of this study may be directed to the Dr Celimpilo Dladla +27(0) 11 717 4261, email Celimpilopiety.Dladla@wits.ac.za.

Yours sincerely,

Thelma Kotze
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Supervisor: Dr Celimpilo Dladla
Celimpilopiety.Dladla@wits.ac.za
Co-supervisor: Dennis Mhlanga
Dennis.Mhlanga2@wits.ac.za

APPENDIX D: Consent Form for Mental Health Professionals and SASL Interpreters

Consent Form for Mental Health Professionals and SASL interpreters

Title: Assessing the SASL interpreter's impact on the mental health therapeutic alliance

Name of researcher: Thelma Kotze (Student # 563715)

I, _____ agree to participate in this research study. The research study has been explained to me and I understand what my participation will involve. I agree to the following:

	Yes	No
I understand that the decision to participate in this study is completely voluntary. I am free to decide to not participate in this study.		
I understand that even if I agree to participate now, I can withdraw at any time or refuse to answer any question without any consequences of any kind.		
I agree that my participation will remain anonymous.		
I agree that the researcher may use anonymous quotes in his / her research report.		
I have had the purpose and nature of the study explained to me in writing and I have had the opportunity to ask questions about the study.		
I agree that the information I provide may be used anonymously after this project has ended, for academic purposes by other researchers, subject to their own ethics clearance being obtained.		
I understand that confidentiality will be maintained in the research report. No names and personal information of participants will be disclosed in the research report.		
I understand that under freedom of information legislation I am entitled to access the information I have provided at any time while it is in storage as specified above.		
I understand that I am free to contact any of the people involved in the research to seek further clarification and information.		

Name of Participant: _____ Name of Researcher: Thelma Kotze

Signature: _____ Signature: _____

Date: _____ Date: _____

APPENDIX E: Consent Form for Deaf Participants

Consent Form for Deaf Participants

SASL Version:
https://drive.google.com/file/d/1O7QdohwI7OvpPvFfpbOxobDu1LsPwqpb/view?usp=sharing

Title: Assessing the SASL interpreter's impact on the mental health therapeutic alliance

Name of researcher: Thelma Kotze (Student # 563715)

I, _____ agree to participate in this research study. The research study has been explained to me and I understand what my participation will involve.

I agree to the following:

		Yes	No
1.	I understand that the decision to participate in this study is completely voluntary. I am free to decide to not participate in this study.		
2.	I understand that even if I agree to participate now, I can withdraw at any time or refuse to answer any question without any consequences of any kind.		
3.	I agree that my participation will be video recorded.		
4.	I understand that video recordings will be stored in a secure password-protected laptop and stored securely in the OneDrive cloud; where they will be viewed and analysed only by the researcher and the supervisors for purposes of this study.		
5.	I agree that the researcher may use anonymous quotes in his / her research report.		
6.	I have had the purpose and nature of the study explained to me in writing and I have had the opportunity to ask questions about the study.		
7.	I agree that the information I provide may be used anonymously after this project has ended, for academic purposes by other researchers, subject to their own ethics clearance being obtained.		
8.	I understand that anonymity will be maintained in the research report. No names and personal information of participants will be disclosed in the research report.		
9.	I understand that under freedom of information legislation I am entitled to access the information I have provided at any time while it is in storage as specified above.		
10.	I understand that I am free to contact any of the people involved in the research to seek further clarification and information.		

Name of Participant: _____ Name of Researcher: Thelma Kotze

Signature: _____ Signature: _____

Date: _____ Date: _____

APPENDIX F: Questionnaire to Mental Health Practitioners

QUESTIONNAIRE TO MENTAL HEALTH PROFESSIONALS

1) How many sessions have you had with Deaf clients where you used an SASL interpreter?
2) What training, if any, have you received to work with Deaf clients?
3) Do you think that it is important for mental health professionals to receive specific training to work and communicate with Deaf clients? Explain
4) What is the importance of establishing and maintaining rapport and trust in your therapy sessions in general?
5) Explain how you felt at first when using a SASL interpreter during therapy sessions with Deaf clients. (Initial thoughts and lived experiences)
6) Explain how you experienced power dynamics in the interpreted session with a Deaf client/s?
7) What challenges did you encounter when providing therapy to Deaf clients?
8) In what ways can mental health professionals improve their understanding and responsiveness to the unique needs of Deaf clients?
9) What rapport building strategies do you use in your 'general' therapy sessions with hearing clients?
10) How did you have to adapt your strategies used to establish rapport and trust with Deaf clients through the SASL interpreter?
11) What factors could influence the establishment of rapport and trust between you and the Deaf client/s when using SASL interpreter/s during therapy?
12) What specific strategies can mental health professionals employ to enhance rapport when working with an SASL interpreter?
13) In your experience, are SASL interpreter/s equipped to deal with mental health therapy sessions? Explain
14) In your experience, what challenges do SASL interpreters face when interpreting complex emotional or psychological concepts?
15) Did you provide the SASL interpreter with a client's background information such as presenting problem, etc. in preparation for a therapy session?
16) Are there specialised resources or support systems available to SASL interpreters for Mental health-related interpreting work?
17) Will you be willing to engage in a follow-up interview with the researcher if necessary?

APPENDIX G: Questionnaire to Deaf Participants

Questionnaire to Deaf Participants

SASL Version: https://drive.google.com/file/d/1jw2M2xd1H4aIrpTpYolZeGzpd3Bo-mvG/view?usp=sharing

1. How many therapy sessions have you attended where there was an SASL interpreter?
2. Do you think that it is important for mental health professionals to receive specific training to work and communicate with Deaf clients?
3. Explain how you felt at first when using a SASL interpreter during the therapy session.
   (Initial thoughts and lived experiences)
4. Explain how you felt about your relationship with the therapist.
5. Explain how you felt about your relationship with the SASL interpreter.
6. Did you feel that you can trust the therapist? Yes / No
7. Did you feel that you can trust the interpreter? Yes / No
8. What factors could influence the trust relationship between you and the therapist?
9. In what ways can mental health professionals improve their understanding and responsiveness to the unique needs of Deaf clients?
10. In your experience, are SASL interpreter/s equipped to deal with mental health therapy sessions?
11. What challenges do SASL interpreters face when interpreting complex emotional or psychological concepts?
12. You have first-hand experience of therapy with a hearing therapist that do not know SASL. This means you need SASL interpreter.

    If you can choose, what would you prefer:

    1) Hearing therapist & use SASL interpreter
    2) Deaf therapist – no SASL interpreter required
    3) Hearing therapist who knows SASL – no SASL interpreter required.

APPENDIX H: Questionnaire to SASL Interpreters

Questionnaire to SASL Interpreters

1) How many years have you worked as SASL Interpreter?
2) Please briefly explain your experience in SASL interpreting (list number of years, qualifications, accreditations, training attended)
3) Please briefly list the settings that you typically interpret in (business, educational, legal, medical, community)
4) How many mental health therapy sessions have you interpreted?
5) Do you think that it is important for mental health professionals to receive specific training to work and communicate with Deaf clients? Explain.
6) Have you ever requested any background information of the client from the therapist, in preparation for the therapy session?
7) Explain how you felt at first when interpreting a therapy session. (Initial thoughts and lived experiences)
8) Explain how you felt about your relationship with the therapist during the therapeutic session/s.
9) Explain how you felt about your relationship with the Deaf client during the therapeutic session/s.
10) Did you feel that trusted by the therapist? Yes / No
11) Did you feel trusted by the Deaf client? Yes / No
12) What factors could influence the trust relationship between you and the therapist?
13) What factors could influence the trust relationship between you and the Deaf client?
14) In what ways can mental health professionals improve their understanding and responsiveness to the unique needs of Deaf clients?
15) In your experience, do you feel that you as SASL interpreter is equipped to deal with mental health therapy sessions? Explain
16) What challenges do you face as SASL interpreter when interpreting complex emotional or psychological concepts?

Will you be willing to engage in a follow-up interview with the researcher if necessary?

APPENDIX I: Responses from Group 1: Mental Health Professionals

Responses from Group 1: Mental Health Professionals

Responses from Group 1

Mental Health Professionals

1) **How many therapy sessions have you had with Deaf clients where you used an SASL interpreter**?

MHP1: Between 11 and 15 (I'm unsure.)

MHP2: +_7

MHP3: 6 sessions

MHP4: 10

MHP5: 2

MHP6: 4

2) **What training, if any, have you received to work with Deaf clients?**

MPH1: None

MHP2: None

MHP3: None

MHP4: None

MHP5: No training to work with Deaf Clients in particular but I completed my BPsych to be a qualified Registered Counsellor and am registered with the HPCSA

MHP6: None

3) **Do you think that it is important for mental health professionals to receive specific training to work and communicate with Deaf clients? Explain.**

MHP1: It would be ideal for many more health professionals to receive specific training. I've found that deaf people are almost invisible to the helping professions. There are large parts of the country where deaf people are not able to access health-related resources simply because there is no one available to communicate with them.

MHP2: Yes. It will assist us in understanding the deaf and their challenges much better.

MHP3: Yes, it will make you more aware how to communicate in the correct manner (for example not to look at the interpreter, but to maintain your focus on the client). Also training regarding the culture of the deaf people.

MHP4: Yes, but for all types of interpreters.

MHP5: yes - I found that I was not quite prepared for the difficulties that limitations with language and vocabulary would play in therapeutic work

MHP6: It would definitely be beneficial to understand their challenges with communication and how it implicates their struggle in receiving meaningful assistance to deal with mental health issues.

4) **What is the importance of establishing and maintaining rapport and trust in your therapy sessions in general?**

MHP1: It is extremely important.

MHP2: It is of utmost importance.

MHP3: Of the utmost importance, as that form the basis of the therapeutic relationship and consequently also the success of the intervention.

MHP4: Very important.

MHP5: Very important - the therapeutic relationship (for me) is what makes therapy possible

MHP6: It is always important since if that is not established the client will not feel comfortable to express emotions and get the best value from such a session

5) **Explain how you felt at first when using an SASL interpreter during therapy sessions with Deaf clients. (Initial thoughts and lived experiences)**

MHP1: The experience was seamless and really quite brilliant. I needed a little time to adjust, but once i got used to the role of the translator it was really easy. The adjustment required me to shift perception from the translator as co therapist to the translator as translator.

MHP2: A mixture of feelings: Nervous, Relieved and then very Impressed.

MHP3: It felt as if the third person impacted the nature of confidentially of the session. It improved after I got comfortable with the situation. It also made me feel more nervous and impacted by spontaneity.

MHP4: Initially strange not to look at interpreter and only at client. Became easier.

MHP5: Anxious and uncertain. Also exposed (due to interpreter being in the same room)

MHP6: At first I felt somewhat insecure in my role but after the process was explained to me I felt more comfortable.

6) **Explain how you experienced power dynamics in the interpreted session with a Deaf client/s.**

MHP1: I wasn't aware of any power dynamic between myself and the translator. It was very easy to work with the translator as an ally to get the job done. One could be unaware of your own blind spots so hopefully I did not pull any power trips that I was unaware of.

MHP2: The power dynamics between the client and the Therapist remains almost the same. The interpreter tries not to distrurb the balance. She tries to be in the background and enhance the process.

MHP3: It took longer to convey and receive information, which was something I had to get used to. I struggled to maintain the topic which were discussed.

MHP4: N/A

MHP5: I was not so aware of power dynamics in these sessions.

MHP6: I did not find the power dynamics challenging since I was still in control of the communication process and responding to the client.

7) **What challenges did you encounter when providing therapy to Deaf clients?**

MHP1: Well, without the translator nothing was going to happen. When clients communicated with me on WhatsApp it was more or less possible to communicate depending on the person. I felt quite helpless to assist at times, or to respond to the emotional appeal from the client in trying to sort out a simple issue, and I was incompetent: deaf, blind, and mute. I studied French and German and Russian and Latin. Wonder why no one ever thought that learning sign language may be more beneficial to an aspiring therapist?

MHP2: To understand their world - almost all deaf children had to stay in a boarding school far away from home. This afected their sense of safety, belonging to, being a part of a family.

MHP3: It is difficult to answer, as all the counselling sessions were done with the same client. She was challenged in different ways, which might have impacted the situation.

MHP4: Same as in normal therapy – establishing rapport right from the beginning.

MHP5: Difficulty being spontaneous, not always being able to explain myself well enough, not always feeling sure that the client understood what I was trying to convey, could not really work on an emotional level (focused more on problem-solving than emotional processing)

MHP6: I was concerned that in some instances the message may not be as clear as it would have been in direct communication but that concern was minimal.

8) **In what ways can mental health professionals improve their understanding and responsiveness to the unique needs of Deaf clients?**

MHP1: The process probably needs to start with creating greater awareness at all levels of training. It never even became an issue for me (once) during approx 17 years at university. Perhaps "Deaf" needs to be marketed as "kewl" in the identity politics market...along with alternate sexual/gender identities, neurological diversities. I'm not even being facetious. I live in Bethlehem in the Free state. Next week there is a workshop for Social Workers, Psychologists, Doctors, Pastors, and gentle folk of every stripe to understand transexuals better. I haven't ever heard of a workshop to teach these helpers to be sensitive to deaf people. i have colleagues who proudly tell everyone how much they are "ÄDHD" or "on the spectrum." Being deaf is out of sight and out of mind.

MHP2: Self education or courses. Maybe CPD courses.

MHP3: They can receive training or improve their knowledge regarding the deaf client's culture and needs.

MHP4: Understanding their individual needs and difficulty to communicate.

MHP5: Training and exposure

MHP6: They need to educate themselves about the concerns of Deaf clients in the therapeutic situation and make special effort to create good rapport and trust about the process.

9) **What rapport building strategies do you use in your 'general therapy sessions with hearing clients?**

MHP1: I tend to naturally have a "leaning in" orientation rather than keep a "professional distance" with my clients: "Put your painful heart on grandma's bosom, rather than let's observe and investigate you from a distance etc.

MHP2: Making them feel understood, valued and heard. Active listening.

MHP3: To engage about general aspects (weather, transport difficulties etc.) in order to relax them or to discuss their expectations regarding the session.

MHP4: Listening (actively), allowing client to talk, being non-judgemental, create a safe environment.

MHP5: Humour, empathy, warmth in tone and non-verbal communication, relaxed interpersonal style

MHP6: Gathering information about their background, current personal information regarding relationships etc, family connections, support network.

10) **How did you have to adapt your strategies used to establish rapport and trust with Deaf clients through the SASL interpreter?**

MHP1: I think I probably do a bit of the same (cos I can't help myself) and perhaps use a little more humour to make up for the message having to go through translation rather than directly.

MHP2: Tried the same rapport building strategies.

MHP3: It stayed the same. It was also easier, as the client knew the interpreter.

MHP4: To be patient & listen.

MHP5: Felt more formal, having to sit next to interpreter and talking so interpreter could hear me, whilst looking at client, simplify my use of language

MHP6: I found that I delved into the reason for the session much quicker without gathering the normal background information. I found this was explored rather in the session as the session progressed.

11) **What factors could influence the establishment of rapport and trust between you and the Deaf client/s when using SASL interpreter/s during therapy**?

MHP1: I think the translator I worked with contributed a great deal to the rapport. I had a good vibe with the translator and it expanded to embrace the client.

MHP2: It also depends on the Interpreter. The Interpreter I used was very profesional. It put me as well as the deaf client at ease.

MHP3: That a third person might hear their problems. I however think they are used to sharing their feelings/problems, as an interpreter are also used in a working environments etc.

MHP4: The relationship between the deaf client and the SASL interpreter.

MHP5: Not feeling comfortable with interpreter, being too aware of the interpreter in the room, not trusting interpreter

MHP6: The process of not communicating as directly as in one on one sessions and the fact that one has to transition to having a third person in the session.

12) **What specific strategies can mental health professionals employ to enhance rapport when working with an SASL interpreter?**

MHP1: I really don't know. Probably a little humility and gratitude for assistance in a situation where you would be out of your depth without the translator could go a long way.

MHP2: Eye contact with the client, respect, connect with the person, not the problem. Listen to what is amazing and hopeful. Work with mental health, not mental illness.

MHP3: To set aside more time for building rapport, as the deaf client does not trust easily.

MHP4: Be open to work with an interpreter and the client.

MHP5: Foster a good relationship with the interpreter, be professional in your approach, be respectful of the complexity of counselling a deaf person with help from a SASL interpreter

MHP6: Experience is key and just focussing on the content of the session and engaging with the client and making enough eye contact whilst switching between engaging with the interpreter and responding to the client.

13) **In your experience, are SASL interpreters equipped to deal with mental health therapy sessions? Explain.**

MHP1: I only have experience with one translator, and she was excellent at dealing with the task. I think she brought professionalism to my more laid back persona, and between the two of us the client could be supported with the appropriate gravitas and caring warmth combined.

MHP2: Yes. They do what they should do: Interpret.

MHP3: Yes, especially the interpreter I used, as she also had training in mental health.

MHP4: Yes, they just need to provide clear communication without adding.

MHP5: Unsure. I have only had exposure to one specific interpreter. She was excellent and I have had a very positive experience. She was well-equipped and very professional.

MHP6: I found the interpreter very professional and capable.

14) In your experience, what challenges do SASL interpreters face when interpreting complex emotional or psychological concepts?

MHP1: I'm not sure. I think the challenge is for the therapist to convey these concepts through verbal and non-verbal ways to ensure that the message is passed on as effectively as possible.

MHP2: I am not sure. Interpreting should not depend on understanding complex psychological problems.

MHP3: It is not always easy to translate the emotions of another person. Complex emotional problems might also embarrass interpreters, but as I mentioned, the interpreter was also trained in mental health.

MHP4: Listening skills & communicating exactly what has been conveyed by deaf person.

MHP5: I think it may be difficult to hear about a person's trauma/difficulties without being affected and without judging the person. Also, therapeutic processes are complex and I think interpreters are not necessarily well-equipped to understand this.

MHP6: Remaining impartial and remaining focused on their role as interpreter. Content of sessions may trigger emotions and they need to contain emotions.

15) Did you provide the SASL interpreter with a client's background information such as presenting problem, etc. in preparation for a therapy session?

Yes 0

No 6

16) Are there specialised resources or support systems, that you are aware of, available to SASL interpreters for mental health-related interpreting work?

Yes 0

No 2

Maybe 0

I don't know 3

- Working closely with psychologist & seek training in mental health disorders.

17) Will you be willing to engage in a follow-up interview with the researcher if necessary?

Yes 6

No 0

APPENDIX J: Responses from Group 2: Deaf Participants

Responses from Group 2: Deaf Participants

Responses from Group 2

Deaf participants

1) **How many therapy sessions have you attended where there was a SASL interpreter present?**

DP1: This year has been different because I have not attended many therapy sessions, but I can say perhaps six times this year but much more in the past I would say more than 20 times.

DP2: The first time I didn't have an interpreter then I realised that I needed an interpreter. For the second session I did have an interpreter. So I would say I've only had three sessions that was interpreted.

DP3: approximate more than 20

DP4: I feel that remember the first therapy that I had was for my marital problems. The second was with the social worker from DeafSA, also my marital issues and then two years ago my daughter tried to commit suicide, and I had some therapy. In total I can say six or seven times.

2) **Do you think that it is important for mental health professionals to receive specific training to work and communicate with Deaf clients?**

DP1: Yes, because my first experience with a counsellor or a psychologist was that they did not know anything about Deaf culture, and I just got the feeling that they did not understand anything about me. The interpreter was fine because the interpreter knows Deaf culture, knows Sign Language, but the psychologist not at all. So I felt a disconnect there. The communication was good with the interpreter there however I did not feel a connection with the person. I did not have any contacts of a person who knew Deaf culture and so I researched online to see whether I could find any professional who has specific experience with Deaf people. It took me a while to find someone. I eventually found a person, and they had experience with a deaf person who did not use sign language but was oral. I was willing to give it a try and take the opportunity because I just felt I was not ready to continue with that professional that I was seeing. I met the second person and I thought that it felt good I was more comfortable to discuss my issues and to open up to them. This was in Cape Town, but then I had completed my studies and I got a new job and then I could not continue the sessions because this therapist did not want to engage in online or virtual sessions. That was a pity, so in Johannesburg I had to search again for a person. I eventually found and met a person but I was but nervous because I was so sick and tired of explaining everything again. I thought this first session went well and I continued for a year with this therapist. The sessions weren’t amazing but it wasn't too bad at all. This therapist tried her best to learn Deaf culture and to learn different ways of communication. So she tried which made a difference to me because if you know someone is putting in effort to understand. That is great.

I felt just a little bit that it's okay for the therapist to know a little bit of Deaf culture understand of sign language but I always felt that there was something missing. I was missing something in that relationship and then I realised that it was because of her being from a different race/religious/cultural group. This psychologist was a white lady which means that she did not really understand my family culture that I come from. So I was uncertain and you know I would for example talk about family and religion which had big implications and affected my life. And to add to that I am Deaf which is a third aspect to consider. So there is a triple impact and so it wasn't easy to connect with her completely. It was fine, it was fine but it wasn't good and I thought to continue to look for someone that I can really connect with. I found another person. I have always seen older professionals, older psychologists, people that were older than me. However this new psychologist that I found was younger than me now I did not have a choice because I wanted to try something different. I had a fantastic experience. I did not have to ask if she understood Deaf people's way of life or if she knew sign language. I didn't have to do any of that because she had already studied sign language. She studied sign language or did a sign language course together with her psychology studies and therefore she understood. I love the way in which she would respond. You know how psychologists would always not the look but would write things down in their note book and would look at you and nod. But this person would sit and show me yes yes with her hands as you would in sign language so she would sign “ah yes” I felt an instant connection to her. That that is what I was looking for. It was like finally I had found someone. Sometimes would find that I don't know how to express myself and express the word, she would say “oh do you mean to say” this or that and she would understand what I was trying to say. We had an interpreter in these sessions but she could with her body language show that she understood. This created an immediate connection for me and I have been using the same psychologist for a few years now. In my experience I prefer to have a professional who has experience with Deaf people, Deaf culture & sign language plus of course my religious background and race. This person is also an Indian. This is my psychologist, she knows and she just gets it.

DP2: Yes I think it is important because if they do not understand the Deaf community or the Deaf way of life, they will not form a connection with the Deaf client. They will not understand and if they don't understand they are going to ask again to explain yourself, I think they won't be able to relate unless they have learned about Deaf culture and the Deaf community.

DP3: Yes, I feel therapy has no experience my as deaf's world. feel just nothing its just hearing worlds which bit strange and new experience for me and I feel all deaf's world during communication through therapy are skipped..

DP4: Yes I believe psychologists must learn the basic things about Deaf people as well as the culture and the differences that exist in cultures. Because the psychologists think that they must just follow what they’ve been taught, and they think they can council Deaf people. They think Deaf people will understand, but they don’t. Because many Deaf people also don't understand difficult terminology and difficult concepts that exist in psychology so Deaf people cannot relate to psychology or counselling.

3) **Explain how you felt at first when using a SASL interpreter during the therapy session. (Initial thoughts and lived experiences)**

DP1; Awful, awful! I felt awful. I was very nervous at first because I wasn't sure whether it would work well for me because I am an introvert. I struggle to share emotions and this is as a result of the way in which I was brought up. I struggled to just share my story. It's all about trust because I didn't know whether my story was safe with these people. So in the first

session it is normally basically the introduction, getting to know one another. This is just how the first session typically is. And then of course, you would delve deeper in to into what it is that you are there for in subsequent sessions. In my first session, I was very emotional because my father had just passed away. This person said “oh I see, your father passed away. Do you know any meditation techniques. I thought: ‘what, in the first session’? I thought discussion meditation in the first session was strange. I looked at the psychologist and then I looked at the interpreter with a frown on my face and the interpreter started giggling, because the interpreter also understood that this was not appropriate for a psychologist to do in the very first session. I just felt awful, I felt there was just a total disconnect between me and the therapist.

DP2: Thank you. I was pregnant at the time of my first session. My world was falling apart and I didn't know what to do. My boss decided that I should go to see a psychologist because things were really overwhelming and I needed to get some perspective. So I attended a first session without an interpreter but I immediately realised that it wouldn’t work so I booked a second session with an interpreter. The problem was is that I did not trust the first interpreter and the whole time she was signing I was wondering if I can trust her. It just did not work well for me. She wanted to add her own personal view at times whilst interpreting which did not give me the confidence that she would interpret accurately. I had discussed my issues with her before the session so she did have knowledge of my story. There was an instance after that therapy session where there were rumours in the community about the discussion with the therapist, which clearly came from the interpreter. When you socialise in the Deaf community, other interpreters also socialise and sometimes they share this kind of information. I know this because someone had said to me that I can just relax because they know how I feel. I thought but how do you know how I feel because the only place where I had expressed my feelings was at the therapy session which was interpreted. Clearly it had to come from the interpreter so that's how I found out. I did not really have any trust relationships with the other interpreters at the time. The second session that I went to was when I was extremely depressed, and I didn't know what to do. I was referred to a psychologist and I was very familiar with this interpreter that accompanied me to the session. I thought I could relax about and trust the interpreter but it didn't work well because this interpreter knew me so well that they thought they can just add a few things if I forget to share it with the therapist. I didn't want that! I wanted my own version to be interpreted. I didn't mean that I needed that interpreter to tell my story. Because I decided to talk about something else. There were also some things that I have never shared with the interpreter before which I wanted to tell the therapist. However, now the interpreter was adding information. I told the interpreter afterwards that I did not appreciate that and the interpreter said “but I thought I was helping you” and I said no that is not acceptable. The third interpreter was the worst. I thought perhaps I could trust this interpreter and when I started signing, the message did not get through to the therapist. I completely lost interest in the session. I mean, I would say I mean this and not that but the reflection that came back to me from the therapist was not accurate. I am quite good lipreading so I would lip read what the person was saying and check it against what the interpreter was saying and if you know sometimes the response from the therapist was totally off the point. I said that it is not what I meant and instead I mean this and that. I needed to continuously to repeat myself. It just left me feeling very disconnected from the session. That's the story of my three experiences.

DP3: Relieved that interpreter is here with me since been struggle communicate through text and papers. Relieved that interpreter is my voice, then next bit nervous and overwhelming because am not use to communicate a lot with hearing world through interpreter.

DP4:Honestly I was just frozen. I was frozen because there are things like when I'm there talking about my issues, some times I feel this psychologist isn't understanding and they don't know how to respond to me. The psychologist will give unrelated examples which leaves me to not bond with them and I am still left feeling hurt inside. So after a session with the psychologist I come how and nothing has changed for me inside. So I felt frozen and stuck.

4) **Explain how you felt about your relationship with the therapist**

DP1:

Interviewer: So was that to no fault of the interpreter? You felt a disconnect but not because of the interpreter. It was because of the strange behavior, in your opinion, from the therapist's side.

Participant: No. The question about having an interpreter in the room plus a psychologist now I have to trust two people!

Interviewer: Do you feel that that had an impact?

Participant: Yes when I book an interpreter for a session with a psychologist, I will look for a very good interpreter. I am very fussy with my interpreters because it's my right, it's my language, and it's my right to tell my story and I must know that the interpreter knows about confidentiality. That they abide by a code of ethics that state certain things which makes me comfortable and if they are not abiding by the code of ethics, I will feel that they do not respect my privacy and that is why I carefully select my interpreters. I must know that they know what they're doing and of course trust take time. I must look for an interpreter that's appropriate I have to look for a psychologist or a therapist too.

Whenever I tell my story to a psychologist they all seem to react differently and I think I have a rather good relationship with the third therapists that I had. Our relationship went well until there was one session where the interpreter cancelled at the last minute and I decided to go to the session anyway. I could see that it disturbed the therapist and the therapist and I had to communicate via WhatsApp. Typing messages to one another although we were both there in person. Whilst typing messages to one another we would try to maintain eye contact. Sometimes when I made a comment, she would write notes on a piece of paper but in the back of my mind I'm thinking but why are you writing things down? I know that most psychologists would take notes during the first session so that they can just make sure that they capture all the detail etc. for future use. I know it important for them to take those notes but then again, I wonder how they can support me and how can I build a relationship with this person when they continuously write notes. The next time we met and the interpreter was there, I realized that something had changed in our relationship. It was not the same anymore. I realised that the communication barrier that was created during the session without the interpreter caused me to feel uncomfortable. It was not the same as the relationship we had initially with the interpreter present and now, after the session where there was no interpreter. I just felt like… and I can't think how to describe the difference. I mean I can't think what is the word but it is just that we used to be okay before the session without the interpreter but after the session that the interpreter missed, I felt uneasy from then on. Anyway then I met the last therapist and this therapist never takes any notes she just reflects back to me and shows me cues that she understands what I am saying. She paraphrases and make connections or links between the things that we are discussing. So we have a very easy and smooth relationship and I am very comfortable in that relationship. However with my previous therapists I did not always feel our relationship was smooth.. I feel that it has to do with the fact that the therapists in the past would all use a piece of paper

or a book to write notes in about me but this last therapist of mine doesn't do that, she just looks at me and responds to me and what I am saying at that stage so that is how I feel about relationships with therapists. I think that psychologists should get rid of writing notes completely and just listen to me. That will help me, I would feel more comfortable with that, it is my experience.

DP2: I must say that I think with all three cases it was actually different. Funny with the first therapist, the therapist completely forgot about me and was totally fascinated with the interpreter. She would communicate with the interpreter about me. She would say things like: “Does she mean to say this or that”. I had to continuously tell the therapist that she needed to ask me the questions and not the interpreter. With the second therapist I just realized that I needed a relationship with the therapist and I tried to create a relationship however I just felt it didn't work very well because I needed to explain how I felt and the interpreter kept adding things. I want to share my personal experiences without having someone adding information. I asked the therapist if I could send an email to explain a little bit of my background but she said that that was not possible and that I needed to talk during the session. There were just some things that I wanted to say but I just didn't have a good relationship good enough for me to communicate my feelings. With the third therapist there was absolutely no relationship because the therapist had the attitude of “Shame she's Deaf and stupid”. She was very patronizing. That was how I felt about my relationships with the therapists.

Interviewer: You’ve explained your relationships with your therapists and I would like to clarify how you would describe these relationships? Non-existent, distant, disconnected, or how would you describe it?

Participant: Well, it is difficult to describe because I had to work through someone with the therapist. I think if the communication was more direct with the therapist, I would have been able to build a relationship. I did not yet establish a relationship because I had to work through a third person. It is difficult if you feel you have some reservations about the process then it's hard to create and build a relationship. With the second therapists I almost connected with the therapist but then the interpreter added information. When I tried to explain that I did not say that, the therapist kept interrupting me and wanting to go back to a previous point which I didn’t say and tried to explain what was happening. But the therapist insisted on discussing that point. I almost created a connection but then I lost interest. There was never any connection or relationship with the third therapist, it was a total disconnect.

DP3: Feel good but I am not good at experience hearing world like as therapy perceived deaf's culture wrong as maybe misunderstand, no manners..

DP4: I don't know they are just someone out there who I don't know. No relationship.

Interviewer: No relationship?

Participant: No relationship.

5) **Explain how you felt about your relationship with the SASL interpreter.**

DP1: It's like I said at first I always look for the right interpreter and if the first session goes well then that is fine and after the session nothing is said we talk about other things and not about what to say during the session so I can trust them. So for the second session that same interpreter would come and of course I can then know that I can always trust them that is just how I feel about it.

DP2: I did feel with the first interpreter there should be boundaries but then the second interpreter was completely neutral because I did not have a relationship with them, and they did not know me and they can therefore just in interpret for me. Because most interpreters know me it is very difficult for me to express myself because I'm not sure whether they can be trusted or weather they will understand me. Some interpreters will say that they cannot interpret for me because I sign too fast and that is a problem. I try to always build a relationship and work with the interpreter but it depends on the interpreter themselves. The majority of interpreters have a problem with knowledge of SASL linguistics. They don't have linguistic background. If I then talk about a specific word, if I feel people for example are discriminating against me and I feel depressed. The interpreter finds it hard to find the English terms for these signs. They don't know what I am talking about and they don't understand what I'm saying. I don't want to have to explain things always, I'm tired of that. It all depends on the interpreter, weather I can have a relationship with them or not.

DP3: All good, very comfortable sometime I don't know sasl sign well.

DP4: Honestly, when the interpreter is there you must remember that some interpreters language skills do not match up to that of the psychologist. Some psychologist stay at that level which means that the interpreter must be on the level of the psychologist some interpreters out there do not have that skill.

6) Did you feel that you can trust the therapist? Yes / No

DP1: Okay I have never said this to the interpreter but one day long time ago I used the Otter app to record the session. To record what the therapist was saying and what the interpreter was voicing and then I thought can I trust the interpreter. I mean it's not only the therapist or only the interpreter but I wanted to know. With the Otter app I could record what was said so I could determine if they could be trusted. And I found that they can be trusted. So then I felt that I can trust both of them it's because, I guess, I think you know… I am telling my story the interpreter has to relate that into English and then the therapist would listen to what is being said. The therapist will then say something that the interpreter will interpret to me. So it's hard to determine who I am supposed to trust. The Otter app did help me to decide whether I could trust or not. After that I could trust them both and I think I might have looked for another therapist or another interpreter if the outcome of that Otter app and what was said wasn't good.

DP2: With the first one I did not trust them at all. With the second one, I felt that I could trust them a little because they came highly recommended, and she was a female. The first therapist was a male. I started working on having a relationship with the second therapist but then she kept referring to what the interpreter had added earlier and that is where I lost trust. The third therapist, zero trust. There was zero trust.

DP3: Yes

DP4: Participant: No. No nothing because they didn't help me to understand so nothing.

Interviewer: Do you feel that you could trust the therapist?

Participant: No, there is nothing to trust because it was the first session and we just did the introductions and moved on but things are still hard for me. My problems still remain in my head. It was just still in the early stages. I am still confused, even until today. I am now 37 and I really wanted to understand and resolve my issues but it didn't happen because they didn't help me. The psychologist never studied how a deal with Deaf parents deal with their

children (CODAs) the psychologist doesn't know how to deal with different parents who have children.

7) **Did you feel that you can trust the interpreter? Yes / No**

DP1: Okay I have never said this to the interpreter but one day long time ago I used the Otter app to record the session. To record what the therapist was saying and what the interpreter was voicing and then I thought can I trust the interpreter. I mean it's not only the therapist or only the interpreter but I wanted to know. With the Otter app I could record what was said so I could determine if they could be trusted. And I found that they can be trusted. So then I felt that I can trust both of them it's because, I guess, I think you know… I am telling my story the interpreter has to relate that into English and then the therapist would listen to what is being said. The therapist will then say something that the interpreter will interpret to me. So it's hard to determine who I am supposed to trust. The Otter app did help me to decide whether I could trust or not. After that I could trust them both and I think I might have looked for another therapist or another interpreter if the outcome of that Otter app and what was said wasn't good.

DP2: For all three of them: no trust at all because for example with the first one I realized that I couldn't communicate and then of course then there were the rumours which broke my trust completely. The second interpreter kept adding information even though I told her not to. She continued to share issues that I didn't say. Therefore I could not trust her and I felt that there was no point in coming forth with information. With the third one I remember very clearly that I told her in confidence during the session that there was something that I wanted to share but I think I will not say it. The interpreter went ahead and interpreted what I said to the therapist. I mean I was having a conversation with the interpreter not with the therapist! I thought to myself but why would she do that… I felt like she didn't have a relationship with me but she had a better relationship with the therapist.

Interviewer: That is a very interesting perspective. I am now going to deviate a little from the questions and clarify. You said that because you were having a conversation with the interpreter during this session and you told her that you were going to say something but that you don't think you're going to say it. You did not want the interpreter to voice that, correct?

Participant: Yes yes

Interviewer: All right, now can I play Devil's advocate a little. If the hearing person had to tell the interpreter that they wanted to say something but the interpreter shouldn't interpret that. How would you feel about that? If the interpreter did not interpret that to you, how would you feel about it?

Participant: Yes that's true.

Interviewer: It's just a different perspective and I don't really need a response from you.

Participant: I know but you are right I just think that in that situation it is different because the situation is about ME, it's not anything else. So if I was given certain information and I can tell the interpreter that I don't relate to any of it, and I feel I can't say something. I was trying to avoid that kind of communication but you are right. It's just that for me in that situation, the therapy session is about me and that's just how I feel.

Interviewer: I understand correctly, you feel that this situation is totally different from, for example a normal staff meeting and you think the interpreter should act differently?

Participant: Yes it's different in that way.

DP3: Yes

DP4: Yes a few of them I can say I can give them a five. I don't trust most of them.

8) **What factors could influence the trust relationship between you and the therapist?**

DP1: One thing that is important for me is to say when I am not in agreement. So if I don't agree with something I talk back because I am trying to express how I am feeling and if there is agreement I feel it can impact the trust relationship. It can sometimes happen that I don't agree with what they're saying and that can cause tension in the relationship and I'm thinking if for example you know they keep pushing and asking and drilling about a point that I raised and I never meant it to be taken up in that way but they are grilling on a specific issue so then sometimes I have to wonder if they really understand the point that I am making. So you know trust and communication and understanding goes together I think that can impact the trust relationship.

Interviewer: I made the questionnaire available in SASL for the Deaf participants and I am sure that you saw it. There I provided examples of things that could influence the trust relationship between the Deaf client and the hearing therapist, such as the therapist is a white person you are an Indian and that, because of our past, can make you feel that they are more superior they are rich and you are poor it means that they are more superior or perhaps because they are a hearing person and you are a Deaf person. These factors may impact the trust relationship. Are there any other examples that you think could impact the trust relationship?

Participant: One day the therapist bought me a warm drink, before our session and I mean I have not heard of such a thing. So you know it was as if she was like my boss so she bought me something to drink. I took the drink and I thought, "okay" but you know I don't know whether she thought it would make me feel more comfortable going into the session. But personally I don't think it's a good thing for a therapist to buy you a drink before the session or if it would be better to buy the drink after the session. Because during this session of course, I will tell my story and but when she gave me the drink before the session it made me feel… mmmm… I don't know how it made me feel.

Interviewer: Do you feel that that had an impact on the trust relationship between you and the therapist?

Participant: Yes yes because I never used to think of us as different but the day that she gave me the drink, I thought mmmmm??? She also bought the interpreter a drink and that made me feel uncomfortable. It made me feel like she did not really understand Deaf culture and that she didn't understand the role of the interpreter. I mean because she is not supposed to do that for the interpreter! I am her client. Why she also gave the interpreter a drink because the interpreter was there to interpret for me! So you know it's like I said before she was white I'm Indian and as I explained talking about culture. I still think that that had an impact. She didn't understand I don't think she understood I tried to explain, you know if I would tell her something then she would say "do you mean to say the so that" and then I would say no. It was just so exhausting to explain a during those sessions. I mean in general I think people should learn about other people's culture and language but I just thought is it really my responsibility to explain these things during a therapy session? Now she was a

white person and then I would explain this is how we do it in Indian culture/. For example, if as a young girl gets her period for the first time at the age of 9 or 10 then there is a big celebration. They bring the whole family together, you get to wear a beautiful sari even though you may be in pain you have to look pretty. The therapist was stunned, it was like wow she had just learned something in my therapy session. I wondered whether she's heard this before or not. And I have to explain these things all over again before I could tell her how it made me feel so it's like I'm educating her. I have a double role or actually a triple role because that's the Indian culture I have to explain and then I have to explain the fact that as a Deaf person in my culture I understood nothing of the celebration. I needed to just do what I needed to do at the time because only very few people in my very close circle of family knew sign language. Then I had to tell her how it made me feel. I had to explain there was a barrier between my own religion, my own culture and Deaf culture and then I had to again explain how I felt. All of this made me feel like there was a disconnect. How can I say… that's the word like she was superior to me yet I had to do all the explaining.

Interviewer: You mentioned something very interesting. You said that the therapist bought the interpreter a coffee and therapist should have known that the interpreter should be neutral the interpreter is the for me. There is no wrong or right response but do you think that the interpreter should not have any relationship with the therapist?

Participant: Let me say that I book the interpreter for the session so then they should not have a relationship because I am there to speak to the therapist yet I need an interpreter so no they should not have a relationship. Mmmmm, let me think… what I do find interesting is about the interpreter in Cape Town. That interpreter was very neutral and she never said a thing or made no small talk with the therapist, although the therapist tried to make small talk with the interpreter. The interpreter just remained completely neutral. That is the job of the interpreter.

Interviewer: So do you prefer it to be like that?

Participant: It is hard to say because I know the interpreter is human, the therapist is human, I am the client and I am human. But when it is time for the session the interpreter and the therapist should have no relationship. The focus should be on me. If they wish to have a friendly relationship after the session then it's their business but during the assignment they should not have any relationship. After the assignment they may do as they please.

DP2: I think it is not about male and female. I feel that it is because the therapist themselves don't know my culture and don't know my way of life and if I say something I don't need to say it in a specific way. I mean to say one thing and don't mean it as they interpret it. I could be sarcastic and the therapist will not understand. The interpreter is involved in that. They have the role of an interpreter but they don't see it from my perspective. In that situation and that has a huge impact because I was reliant on the interpreter and the therapist did not understand me at all and thirdly I rely on the interpreter to give me the information and it is not about this therapist but it's about giving ME the information. The therapist may be a good psychologist or counsellor but if they do not have any background knowledge about me as Deaf person - that I would say had the biggest influence in all three situations that I attended. Yes the first one was a male but the fact that he did not know Deaf culture or deafness had the biggest influence absolutely.

DP3: SASL interpreter is involved or Therapist needs learn sign language that is all.

DP4: Ok, I think you know that not all interpreters are the same. Some interpreters are brave enough to faithfully voice what the Deaf person is saying. Other interpreters don't always

understand the physical and the emotional side of what the Deaf person is experiencing. And the mental state that the Deaf person is in. There is therefore a mismatch between what is said by the Deaf person and what is interpreted. Sometimes I would say something and the response from the therapist would be something totally different then I have to wonder what is happening. Many Deaf people don't feel that attending only one therapy session is enough because they feel inside that they are still unhappy and the problems have not been solved because they are only given 30 minutes which is not enough.

9) **In what ways can mental health professionals improve their understanding and responsiveness to the unique needs of Deaf clients?**

DP1: I think there are many different levels of Deaf individuals. I am privileged because I have family members who know a little bit of homes sign, I have a degree from a university and many other Deaf people don't have these privileges. They don't have a level of language that allows them to engage with a psychologist. I think it must be difficult for the psychologist to negotiate and to form a relationship with that type of Deaf individual. Does the psychologists then understand where the Deaf person comes from? I think this psychologist or the mental health professionals should start to study more specifically about disabled people and specifically about Deaf culture, Deaf education and the Deaf way of life. I think there need to be a course that is started that can provide training to psychologists who are interested in working with Deaf people. Like professional interpreters, they have to socialise with Deaf people in the community and therefore psychologists should do the same. The same should apply to those professionals who want to work with Deaf people so that they can then know how to deal with Deaf people. I do not think psychologists in general understand Deaf people.

Interviewer: Your current psychologist is a young person who has already studied psychology and Deaf culture. She only knows basic sign language and can converse in basis SASL. Not enough to consult with a Deaf person without an interpreter but she creates and has managed to build a report with you because she knows your culture.

Participant: At first I asked the psychologist many personal questions like where she came from, why she had learned about Deaf people, where she had studied, etc. I felt that I had crossed a boundary with her but she said that it was okay because it is very rare to find a psychologist that understand Deaf culture and knows a little bit of sign language. In America you can find many of them but not in South Africa. That's why I asked her these things. She's said that she had studied several courses and that is very rare for psychologists in South Africa to know sign language. She wanted to learn sign language and she herself saw the need to understand Deaf culture better.

DP2: They must learn sign language themselves. I don't want to mention names but there is one person who knows sign language and who is a psychologist. It's a 50/50 situation because it again depends on the trust issue. For example: This person is a good signer and I hav I've had a conversation with this person and I asked if we could just have one session. This person agreed. It was just a random conversation, it was so I could see this person is a good fit to talk to. We sat down and had a brief conversation. I think about 2 weeks later when I came back to the same place other Deaf people there told me that they heard I had been to see this person. My biggest question to you now is when this Deaf person or this hearing person who socialises with Deaf people it means they will definitely not keep the information confidential. They will spill the beans. It also depends on the individual of course I mean it's like you, Thelma, I know when I tell you something I know whatever is discussed

will never get out you. I know that for a fact because you have accompanied some of my colleagues to meetings and you have never said a word to me about that. I can see that you won't disclose any information. This specific person I was referring to told me about some of the clients that they had seen before. I don't need to know that information. I already do not trust this person. It is a tough situation.

DP3: Deaf clients possess unique communication needs that necessitate a distinct approach from health professionals. Due to limited access to auditory information and nuances in language, Deaf individuals may require additional time and clarity to comprehend and respond to questions. Health professionals should be mindful of these challenges and provide comprehensive information before seeking input from Deaf patients.

DP4: I believe that perhaps some universities should when they conduct training for psychologists they should bring in live Deaf person to explain to them more about the world of Deaf people to build and understanding. Hearing psychologists focus only on other hearing people in theory. They have never met a Deaf person in real life and therefore they are unable to assist the Deaf person.

10) In your experience, are SASL interpreter/s equipped to deal with mental health therapy sessions?

DP1: Yes I always ask the interpreter whether they are ready to join me for a therapy session because I can understand their perspective. We are all human and you cannot always expect of an interpreter to act completely impartially and be completely professional in any session. There are different settings like academic settings, therapy settings etc and it cannot be expected of all interpreters to know and work and have experience in all kinds of settings. So I always ask the interpreter first whether they are okay with dealing with specific psychological issues and if they agree, then that's fine. I always first ask whether they agree. It's has happened before where I asked an interpreter for her availability for a second session. This interpreter had interpreted for me in a previous session. When I asked her if she could come with me again she said that she doesn’t feel that she can deal with it again. So she was she appreciated me asking how she felt because I felt that I trusted her and she seemed to deal well with interpreting the therapy session but when I asked she said no and I respect that. So I asked another person. I always ask before I attend a session.

DP2: Very few interpreters out of 10, I would say there are three or four who have the necessary skills. Not all of them and keep in mind that the mental health interpreting setting are particularly difficult because the interpreter may have the own mental health issues to deal with. Some Children of Deaf Adults (CODA) may have different feelings. They know Deaf culture they know the Deaf way of life and all have the heart. It can also be difficult for those interpreters because although they know how to adapt and be neutral. However, some who are not CODA, there are very few of them that have the knowledge of mental health, others don't and in the rural areas for example where would those interpreters find the information? It must be hard.

DP3: Yes

DP4: No because there's no help. They cannot help because some prefer to understand English others preferred to understand old sign language some preferred to sign slow and they are all different. You know that humans and their minds operate differently.

Interviewer: Repeat question:

Participant: Yes they must because you will see that in the Deaf community there is no understanding of mental health or even depression. People will just say you are crazy but you know you have a mental illness and you will need help. But it is often too late for Deaf people like this.

11) What challenges do SASL interpreters face when interpreting complex emotional or psychological concepts?

DP1: Oh yes I have seen it happen. I could see the interpreter looking at the therapist like they didn't understand what was being said. The interpreter then said to me "I'm sorry I don't understand" and then she had to ask this therapist to explain. Because the interpreter wants to make sure that she understood to be able to interpret accurately. Also while I was venting emotional issues the interpreter had to stop me to ask to make sure that she I understood. It is crucial for accessibility that she understand clearly. I can see that the interpreter sometimes gets emotionally involved because I have seen tears rolling down the interpreter's cheeks. Yes it's a challenge for them and often they have to ask the therapist to repeat a word and then it is explained which is good. I have never felt a time where I wanted to say 'come on get on with it' or 'tell me now what are they saying' because I know this interpreter must have challenges to adapt to the session. Interpreters can never be 100% correct. So I have seen that they can get emotional.

Interviewer: I understand. You were saying something and I interrupted you my apologies.

Participant: I could see that the interpreter was tearful but continued to interpret so I take my hat off to the interpreter for that. I think perhaps whatever I shared touched her … I don't know what she felt. Afterwards, after the sessions, I will normally ask the interpreter if they are okay. I know that it is the interpreters job but I also know that they are just human so I will also ask how they are, if they are okay, and then they would always thank me for asking. But we never go into the detail of what was said in the session. So yes I would also, before and after the session, say to the interpreter that if they have any issues that they must let me know. If they have issues with interpreting these sessions for them to let me know. If necessary, I will arrange another interpreter. So if the interpreter feels that it is just too intense, they should let me know. They don't have to continue the session or continue interpreting sessions after that and I am okay with that.

DP2: I think there are many barriers such as terminology that they don't understand. They may not be able to connect because they themself me have emotional issues. So if I don't as the client even cry but the interpreter cries, how does that work. I think it is a difficulty that interpreters may have. I want to also say that there was once where I asked an interpreter to interpret a session for me. Not a mental health session but to see a doctor for my breast. I thought I had breast cancer so I asked an interpreter if she could interpret for me and that I would pay her. The interpreter declined payment and said that she would love to volunteer because she's always wished that she can interpret for me. At the appointment, I was completely lost I wasted so much time because the interpreter got all emotional, I couldn't understand what was being said because she did not know the terminology. She kept asking me for the signs for words because she didn't know the signs. I have to teach her during my consult. I realised that it was not easy for her because it was her first time. There was a lump in my breast and the doctor explained that it would have to be removed surgically. Luckily I was able to follow the doctor by lip reading because the interpreter could not interpret much. And she got very emotional. I had to calm her down. I think terminology is the biggest challenge if the interpreter does not have knowledge of the subject, then it's a problem. I had

to stop the doctor to ask the meaning of certain words and it freaked the interpreter out because it was hard for her to convey the message. Mental health is not any easier.

Interviewer: All right. I would like to add another question. Do you mean that the interpreter should have specialized training in mental health, terminology or the mental health setting specifically?

Participant: Yes, definitely because not all interpreters can interpret in the setting if they think they can. They should specialize and learn. I feel that they should not say they can interpret everything because some interpreters just do anything. Another story that I wasn't happy with is when the interpreter is being paid, they do their work but when they are not getting paid they seem to think they don't have to convey all the information. I feel that is unfair because I have a need to access in information and the interpreter is a tool for me to access that information. If the interpreter think I won't know what they are voicing anyway. Some interpreters will just say “oh the doctor doesn't understand what you are saying” This just means to me that they are interpreting in correctly. That is why the doctor is not understanding!! I try to say that the interpreter doesn’t have to sign like an academic but to use more of the classifier system and be more animated. There are very few interpreters who can do that so if you are in the mental health setting and you are able to use the classifier system properly you know how to use roleshift then the message will be very clear to me as a Deaf person because I will have access to the content. However, not many interpreters can do that.

DP3: I feel sometime insure when interpreter is talking too long to therapy when I finish sign.. I trust interpreter but I don't know what were interpreter are saying to therapy... sometime when there is no complex emotional concepts I can point it out when interpreter are wrong.

DP4: It depends. For example you see when you go to court some say that they employed a professional interpreter. This interpreter doesn’t understand the signing by the Deaf person. Still the courts are not aware of Deaf people and their lives. The professional interpreter don't always understand when Deaf people sign. In that instance the court should know to employ a relay interpreter. This is the same with the therapy session, the psychologist may need really interpreters.

Interviewer: Repeat question

Participant: Yes, it is true. It is very difficult because if the interpreter is interpreting for me and I cry, then of course the interpreter must also cry. How will this person interpret accurately if they are not also crying, Do you understand? Yes.

Interviewer: Yes, I understand.

Participant: Yes, yes, which means interpreters must also study more. Including learning about emotions and the identification of emotions. They must study issues of psychology which means interpreters has to be trained on the ways of dealing with depressed Deaf individuals or interpreting in mental health care settings.

12) **You have first-hand experience of therapy with a hearing therapist that do not know SASL. This means you need SASL interpreter.**

    If you can choose, what would you prefer:
    1) **Hearing therapist & use SASL interpreter**
    2) **Deaf therapist – no SASL interpreter required**
    3) **Hearing therapist who knows SASL – no SASL interpreter required**

DP1: This is a difficult question… a hearing person who don't know sign language need an interpreter, second one is a Deaf therapist… I think that is a good option however I would say that I will have trust issues because the Deaf world is just so small and they will know everything. I have personally experienced it. I have studied counselling and know how they feel. I will welcome Deaf people to come to see mee because I've got a qualification but people are hesitant because I know so many other Deaf people. So I think more education is required so just like an interpreter has a code of ethics so do counsellors or psychologists have a code of ethics. Deaf people must be taught this. Then the third option is a hearing person who uses sign language… I will choose them.

DP2: That is a very difficult question because for the first option to get an interpreter. You could lose so much information and the connection with the therapist is missing. You will find it hard to find your way. The second option is a Deaf psychologist, counsellor or therapist. A Deaf person that is part of the Deaf community. They will gossip, they will not keep the information confidential. The third option… I think the third option. If I don't know the person and they are fluent in SASL and they don't socialise much with the Deaf community and they can remain neutral and keep things confidential then I think I'll choose the third option.

DP3: 3

DP4: Ah yes, B, I choose B. Yes, yes, yes

APPENDIX K: Responses from Group 3: SASL interpreters

Responses from Group 3

SASL interpreters

1) **How many years have you worked as SASL interpreter?**

Value	Count
19	1
30 years	1
7 years	2
8	1

2) **Please briefly explain your experience and training in SASL interpreting (qualifications, accreditations, training attended)**

SASLI1: 7 years experience as a professional SASL interpreter. SATI accredited with a MA degree in Translation and Interpreting.

SASLI2: I have been a professional SASL interpreter for 5 years , having completed an Interpreting and translation liaison diploma by SAQA and practical training in the field.

SASLI3: My first training was very insightful and it definitely gave me the knowledge to work in different settings.

SASLI4: Started at Deaf organisation 1993, attended pilot training at UFS in 1997, obtained SATI accreditation in 2006, obtained PG Diploma in 2003. Worked at DeafSA, SASLINC, ConvoZA and Freelanced. in Government, medical, mental health, Education, Conferences, VI, training in various fields.

SASLI5: BA Hons in Linguistics with interpreting as main focus. SATI accredited. DeafSA/NWU Level2 interpreter training course.

3) **Please briefly list the settings that you typically interpret in (bunisess, educational, legal, medical, community)**

SASLI1: Business, community & educational.

SASLI2: Business (Corporate), educational (university, college), community and legal

SASLI3: Educational, legal, medical and community.

SASLI4: Government, Medical, Mental health, Education, Legal, Conferences, VI, training in various fields.

SASLI5: Religion; translation; business; educational; legal; social services; mental health/medical; community; conferences etc.

4) **How many mental health therapy sessions have you interpreted?**

Value	Count
10	2
Approximately 15 – 20	1
Many over the years. I don't keep count.	1
More than 30	1

5) **Do you think that it is important for mental health professionals to receive specific training to work and communicate with Deaf clients? Explain.**

SASLI1: Yes. Hearing mental health professionals would need to understand how to work with Deaf clients. It is important for professionals to learn about Deaf culture, nuances, challenges and lack of incidental learnings so that the professional has a wholistic view of the person before them. This will help with understanding why the Deaf client would sign or behave in a specific manner before the hearing mental health professional.

SASLI2: Yes, training is imperative because the health professional needs to understand their Deaf client's culture and background so they can create a conducive environment that will create a safe space for the client for better communication, interaction and understanding of how they express themselves so the sessions between health professional and client yields positive results.

SASLI3: Yes, it is important for them to have an understanding of the Deaf culture and barriers that Deaf people experience. That will help the professionals to give well thought advice to the Deaf clients.

SASLI4: Yes, it takes a lot of mental and emotional energy and it is important to understand how to manage the energy before, during and especially after the session.

SASLI5: Yes. I've conducted information sessions for professionals who have Deaf clients, because I believe they need to know a bit about Deaf culture and -history in order to start to comprehend the complexities of Deaf people in a mainly hearing society which influences their experiences and add to the trauma they've endured from a young age. They also need to understand how to work with interpreters as part of their team of professionals, understanding why just any "interpreter" off the street cannot necessarily interpret in mental health settings.

6) **Have you ever requested any background information of the client from the therapist, in preparation for the therapy session?**

Yes 3

No 2

7) **Explain how you felt at first when interpreting a therapy session (Initial thoughts and lived experiences)**

SASLI1: Initially, I felt I was invading the Deaf clients personal space. I felt like a third person in the room privy to extremely personal information shared by the Deaf clients. I also felt I needed to approach such sessions differently because the setting called for extreme confidentiality and trust.

SASLI2: I was very nervous because i did not have background of the client and the therapist or counsellor. I was also battling with what interpreting strategies i would need to apply as the setting is different from other because of the personal, emotional and delicate aspect of it. i used my discretion by interpreting and voicing everything as it is.

SASLI3: I felt touched and sad by the session because I felt it was important to be part of the session emotionally to meet the equivalence of both client's responses.

SASLI4: Going to the session thoughts of what it is about and how you will handle it an whether you wiil be able to understand the Deaf person and convey the message from the therapist correctly. During the session a feeling of stress and anxiety to provide the best service to both parties and afterwords how to work through the overwhelming feelings not knowing how to handle it.

SASLI5: It is difficult - especially if you yourself has had therapy in your own life. You need to be able to stay completely neutral. In most cases you either know the Deaf client already or become familiar with the client as time goes on. It is difficult to interpret someone else raw emotions and deepest most private thoughts and then afterwards talk as if you know nothing of the sort.

8) **Explain how you felt about your relationship with the therapist during the therapeutic session/s.**

SASLI1: The therapist/s clearly understood my role as a SASL interpreter and therefore it made it easier to stay within my role.

SASLI2: It was very neutral and like an intruder in the session at first however after understanding their therapy style, i felt a bit more calm and more like mediator as a tool in bridging clear and comfortable interaction.

SASLI3: I felt trusted by the therapist.

SASLI4: Most relationships are professional. Not all understand our role as SASLI's.

SASLI5: It depends on the therapist. I have been privileged to work with therapists who's been either knowledgeable about Deaf people or at least comfortable working through an interpreter. If that is not the case, the interpretating situation is even more difficult than it is under normal circumstances.

9) **Explain how you felt about your relationship with the Deaf client during the therapeutic session/s.**

SASLI1: Deaf client/s also understood my role as the SASL interpreter. The Deaf client/s trusted not only my skills but they knew whatever was said in the session would be respected and not shared externally.

SASLI2: I felt almost the same as neutral and however that would be determined if the client has worked with my before so the relationship would either be very neutral or neutral with a sense of comfortability and trust.

SASLI3: Trust

SASLI 4: The Deaf person is usually unsure and stressed whether they would understand the interpreter and having a 3rd person in the room that they must trust. If they are more at ease the relationship starts to get more trusting en open.

SASLI5: With the clients I already knew well, it was at times difficult to see them suffer/see them outside of their comfort zone, having to share intimate thoughts while being vulnerable, completely trusting me as interpreter to be professional.

10) **Did you feel trusted by the therapist?**

Yes 5

No 0

11) **Did you feel trusted by the Deaf client?**

Yes 5

No 0

12) **What factors could influence the trust relationship between you and the therapist?**

SASLI1: Failure to voice everything signed by the Deaf person during the session. Failure to interpret/voice the correct feelings etc for the mental health professional to work with - this would also be evident with the mismatch of answers and session not running smoothly.

SASLI2: Discussing the sessions with Deaf client outside of the sessions.

SASLI3: Speaking to the Deaf client without voiceover to the therapist. Adding your own opinion

SASLI4: Not being professional. It is important to inform the therapist of everything you do even if you need to re-explain to the Deaf client what is being said or voice over the wrong answer because the Deaf client misunderstood the client.

SASLI5: If the therapist doesn't know how to work with an interpreter; if the therapist doesn't know how to work with Deaf people; if the therapist isn't willing to have a conversation with you as interpreter in order to understand the dynamics in a situation with 3 people iso 2.

13) What factors could influence the trust relationship between you and the Deaf client?

SASLI1: Arriving extremely early and having a lengthy discussion with hearing mental health professional before Deaf client arrives. Not maintaining eye contact with the Deaf person throughout the session. Failing to interpret everything happening in the room during the session.

SASLI2: Breaking confidentiality principle Discussing sessions with the therapist

SASLI3: Speaking to the therapist during, before and after the session without interpreting what was said.

SASLI4: If you and the therapist have a conversation without them being there or you not interpreting everything that is being said.

SASLI5: Breaking confidently; not interpreting everything completely and accurately; if the interpreter needs clarification but doesn't seek clarification/doesn't manage the communication process well.

14) In what ways can mental health professionals improve their understanding and responsiveness to the unique needs of Deaf clients?

SASLI1: Training on the unique challenges, history and culture of Deaf people needs to be taught to mental health professionals - it is important that mental health professionals understand better the behaviour and psychi of their Deaf clients because of the unique challenges I.e. Deaf people being a part of a language minority, typical family set up which leaves most Deaf people feeling isolated, lack of SASL equivalent signs to spoken language feelings and identifying of specific feelings etc.

SASLI2: Deaf sensitisation training

SASLI3: Learn Sasl or employ Deaf individuals in their practices

SASLI4: They must undergo training in Deaf culture, learn how to use interpreters and learn some basic skills communicating with Deaf persons.

SASLI5: They should avail themselves for information sessions from professionals in the field; they should be willing to listen to the advice of both Deaf clients and experienced interpreters - willing to communicate/liase with all stakeholders

15) In your experience, do you feel that you as SASL interpreter are equipped to deal with mental health therapy sessions? Explain.

SASLI1: Not fully. Yes, I have experience working in mental health therapy sessions however, I still feel there is a lot to learn and so much I can still work on to better equip myself to deal with such sessions. I do not feel fully equipped to deal with mental health therapy sessions because I have never been trained to work in such a context specific setting.

SASLI2: Yes i am equipped, however having peer SASL Interpreter debriefs and mentorship within the health therapy setting would assist on how one navigates the intricacies of

interpreting your sessions in ensuring quality, adherence of code of ethics all with care and a level of sensitivity

SASLI3: Not enough, I think there should be a course that can focus on medical interpreting. Because there a lot of factors that we experience that we never talked about during the trainings.

SASLI4: It depends on what the situation is. Due to a lack of information or training I would rather refer complex situations to interpreters trained in this field. This is not always possible and does it lead to added stress and anxiety due to not being fully equipped in mental health areas.

SASLI5: Mostly. But more training in the field and/or support structures would be beneficial.

16) **What challenges do you face as SASL interpreter when interpreting complex emotional or psychological concepts?**

SASLI1: Finding appropriate and equivalent signs to the complex emotions and psychological concepts.

SASLI2: How to control yourself being triggered How to impersonalize and maintain neutrality Being emotional and crying.

SASLI3: During this session you become a human being, not just an interpreter but a human being that have to forward the emotions to and from both clients. It’s stressful and difficult

SASLI4: It is difficult to handel the added stress and anxiety during and after the session if you doing justice to the session and Deaf person.

SASLI5: Making sure that you convey it correctly, that the client understands it correctly, that if there isn't complete understanding- knowing the difference between it being a communication problem or it being a mental health problem. Debriefing after a difficult session is also complex if you don't have a trustworthy person you can debrief with.

17) **Will you be willing to engage in a follow-up interview with the researcher if necessary?**

Yes 5

No 0