The Experiences of Occupational Therapists Using Interpreters

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1. Introduction

Ireland has experienced unprecedented inward migration in recent times. According to the National Consultative Committee on Racism and Interculturalism (NCCRI 2008), 200 languages are now spoken in Ireland. The 2006 Census showed Ireland as having the fastest growing population in the European Union, with 420,000 foreign-born people living in Ireland making up 10.4% of the population (CSO 2007). The current recession will probably affect levels of inward migration, but many migrants will remain, and issues of multiculturalism and integration will continue to be of significance in Ireland (Mac Einrí 2008).

In 2008, the National Consultative Committee on Racism and Interculturalism commissioned a report on developing effective interpreter services in Ireland (NCCRI 2008). Focus groups were used to gain insight into the views of immigrants, interpreters and government service providers. The report stresses the fact that Irish interpreting services are unregulated and without quality control measures. There is an absence of legislation, policies, standards and no requirements in place for interpreters to have specialist training. In Ireland today, an additional complicating factor is the lack of a clear legal right to an interpreter in healthcare (Phelan 2009). According to Health Service Executive (HSE) policy, the Irish Health Service has nine key areas of responsibility in relation to patient care: access, respect, safety, communication, information, participation, privacy, being heard and prevention. It seems evident that, without the availability and use of quality interpreting services, these aspirations are not currently being fulfilled in the Irish context.

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The European Migrant-Friendly Hospitals project took place in twelve European countries between 2002 and 2005. This project noted that the health status of migrants and ethnic minorities is often worse than that of the general population due to poorer socio-economic status, sometimes traumatic migration experiences and lack of sufficient social supports. Following assessment of need it was found that language and communication were perceived as the most important problem areas in dealing with this client group and the most prominent need lay in improving interpreting services (MFH 2005). On completion of the Migrant-Friendly Hospitals Project (MFH), the National Intercultural Hospitals Initiative (NIHI) was established in Ireland as a means of implementing the MFH project and developed an Emergency Multilingual Aid for use in hospitals. With regard to standards of interpreters, however, the situation is quite poor in Ireland today as there is only one accredited training course for interpreting at Dublin City University. Otherwise, the interpreting industry consists of a small number of unregulated commercial interpreting agencies, mainly employing interpreters who do not have accredited training (Phelan 2006).

According to the World Federation of Occupational Therapists, Occupational Therapy is a profession which enables individuals to engage in everyday living and to achieve their full potential in the daily occupations of life. Occupational Therapists work with individuals, families, groups and populations to facilitate health and well-being through engagement or re-engagement in occupation. The person receiving occupational therapy leads the way with decision-making about the focus and nature of therapy intervention. The relationship between that person, his or her family and the occupational therapist is a collaborative partnership, the goal of which is to enhance occupational performance, health and wellbeing (Law 1998).

According to Fisher (1999), developing a therapeutic relationship is critical to the Occupational Therapy process. Yarwood and Johnstone (2002), state that establishing a therapeutic relationship depends on four issues: establishing rapport, respecting the client's wishes, developing a collaborative approach, and communicating effectively. The Association of Occupational Therapists of Ireland code of ethics and professional conduct

for members stipulates that Occupational Therapy services should be client-centred and treatment should be planned, executed and evaluated with client involvement. It would appear to be difficult to achieve client-centredness without the use of a trained interpreter in cases where a language barrier exists. However, literature from around the world shows that even in cases where interpreters are used, problems can arise.

2. Literature Review

A literature review revealed just one study in the field, a Master's thesis which focused specifically on the use of interpreters by Occupational Therapists (Taberski 2006). Therefore, in order to gain an insight into this general area, articles on cultural competency in relation to Occupational Therapy which made reference to interpreting were included. However, the main body of literature reviewed existed in the domains of nursing, medicine, physiotherapy and psychiatry/ psychotherapy.

2.1. Evidence for Using Interpreters

Systematic reviews by Flores (2005) and Karliner (2006) on the impact of medical interpreting services on the quality of health care reviewed thirty-six and twenty-eight studies respectively and found that using trained professional interpreters improves communication, patient satisfaction, and reduces medical errors and potential negative clinical consequences. This is supported by the findings of Hampers et al. (1999) and Baker et al. (1996). Vasquez and Javier (1991) found that incorrect diagnoses have been the result of inadequate provision of medically trained interpreters. Such errors as omissions, additions and substitutions have grave consequences for patient well-being. Throughout the literature there is widespread evidence of the benefit of using trained interpreting services as opposed to family members (Flores et al. 2003). However, the literature showed that use of family members as informal interpreters is very common. Meyer et al. (2010) argue that such family interpreters may offer certain advantages compared to interpreters outside of the family.

2.2. Avoidance of Using Formal Interpreters

Diamond et al. (2008), in a qualitative study of twenty physicians found that the participants did not request interpreters if bilingual family members were present. While acknowledging that their limited-English-speaking patients were not receiving equal care, the physicians weighed up the perceived value of using interpreters against their own time constraints. It was also noted that the participants normalised their under-use of interpreters. Rivadeneyra et al. (2000) had similar findings. Once more, doctors mentioned time constraints as a barrier to using interpreters. An Irish-based study conducted in Galway city (MacFarlane 2009) involved interviews with twenty-six Serbo-Croat and Russian-speaking asylum seekers and twelve General Practitioners. Many of the GPs managed consultations without a formal interpreter, using friends or family. Both GPs and patient groups identified use of children as interpreters as a cause of concern, given the sensitive nature of certain issues.

A survey of 657 Canadian Occupational Therapists on cultural diversity and Occupational Therapy practice (Lum et al. 2004) found that one in five used formal interpreters, 50% used unpaid family members or volunteers and 19.6% "did what they could" without an interpreter. Taberski (2006) used a survey to assess Occupational Therapists' use of formal interpreters in six counties in Upstate New York. The findings showed that the majority did not use formal interpreters although they felt that communication with clients with limited English was only partially effective. In a Swiss study (Bischoff and Loutan 2004) of 244 hospital services, using a questionnaire, it was found that 79% of respondents relied on relatives to interpret and only 14% often used paid interpreters. Gerrish et al. (2004) in a UK study using five focus groups, found that nurses perceived interpreting services as being inadequate. They preferred to improvise or work with informal interpreters or family members rather than champion the need for improved services. Thom (2008) states that denying a patient the opportunity to speak their own language is a denial of human rights and a form of negligence.

2.3. Negative Attitudes towards Using Interpreters

2.3.1. Suspicion and Mistrust

In an Australian study, Lee et al. (2005) explored the attitudes of six physiotherapists towards the healthcare interpreting service. The physiotherapists were found to be largely negative in their attitudes towards interpreters. Issues of time constraints, perceived costs of the service and distrust of interpreters emerged. Meyer (1992) in an article on Occupational Therapists working with Hmong children in the United States raised similar concerns regarding interpreter accuracy. In an England-based case study on the impact of language when administering the Assessment of Motor and Process Skills (AMPS) by an Occupational Therapist (Buchan 2002), it was found that the interpreter's non-adherence to non-directive responses during the assessment effected the overall assessment score. In a comparison between dyadic and triadic exchanges between doctors and patients in Madrid, Spain, and Minneapolis, USA, Valero-Garcés (2005) found that informal interpreters were seen to be more likely to act as an advocate for the patient and the interview tended to be faster than when using a formal interpreter. The author stresses that the use of informal interpreters is risky practice as the doctor cannot be sure of the interpreter's ability to interpret accurately.

2.3.2. Power Dynamics

Wardin (1996) surveyed 74 Occupational Therapists to compare verbal evaluation of clients with limited English and English speaking clients in a physical rehabilitation setting in the United States. While acknowledging that interpreter-use improved understanding for both therapist and client, Occupational Therapists most commonly used family members to translate. Interestingly, when using a professional interpreter, the main goal was for the client to understand the therapist's goals as opposed to the therapist gaining an insight into the client's wishes. This does not seem in keeping with the client-centred approach. This finding is echoed by Leanza (2005) in a review of the role of interpreters as seen by physicians working in paediatrics in Switzerland.

Raval (1996) explored 12 psychologists' experiences of working with Bangladeshi families in a paediatric mental health setting in London via questionnaire. Although therapists felt their work was enhanced through greater cultural understanding of their patients, they also commonly expressed a sense of detachment from the therapeutic process and a sense of powerlessness. Bolton (2002) used participant observation to elicit a psychiatrist's experience of working with interpreters in the United States. It was found that the psychiatrist no longer perceived himself as the direct agent of change, as it is the interpreter who determines the impact of statements. Miller et al. (2005) interviewed 15 psychotherapists in the United States on their experiences of using interpreters. Different therapists required interpreters to fulfil different roles; some required the interpreter to act as an invisible translation machine or "black box". Others saw the interpreter as an integral part of the triad. Therapists working from this perspective were more likely to rely on the interpreter as cultural consultant. Therapists noted an initial phase of discomfort and exclusion when clients and interpreters formed a greater bond of trust. In a phenomenological study of 15 emergency-room nurses based in the USA by Nailon (2006), participants found that interpreters could have great power in altering the atmosphere of care if they failed to conceal their discomfort or negative attitudes towards patient presentations. It was perceived that interpreter disengagement jeopardised the nurses' ability to convey concern towards patients and their families.

3. Method

A qualitative design was chosen for the purpose of this research as it yields richer and more in-depth meaning when studying individuals than quantitative methodology (Green & Thorogood 2005). It is evident from the literature review outlined above that there is a paucity of research specific to the experiences of Occupational Therapists using interpreters. Morse and Field (1996) suggest that qualitative methods be used when little is known about a phenomenon, and are particularly apt when describing a phenomenon from the emic perspective.

In this study – exploring Occupational Therapists' experiences of using

interpreters – ten participants were recruited for semi-structured interviews via the Occupational Therapy Department Managers of two Dublin-based teaching hospitals. Gatekeepers identified participants who were willing to participate in this study and who met the inclusion criteria of being practising Occupational Therapists who have had the experience of working with patients with limited English proficiency and interpreters. The participants were interviewed on the hospital sites. Interviews were recorded and transcribed verbatim and thematic analysis was carried out. To maintain anonymity pseudonyms were given to all participants**.**

4. Findings

4.1. Positive aspects of using an Interpreter

The Occupational Therapists interviewed in this study described their positive experiences of using an interpreter as being dependent on the characteristics of the interpreter. The interviewees repeatedly identified the characteristics that make a good interpreter as having an interest in and an understanding of the therapy, efficiency and diligence, empathy and a professionalism that encompasses accuracy in translation, an awareness of the boundaries necessary to protect the therapeutic relationship, and an appreciation of the confidentiality their role requires. The Occupational Therapists associated the presence of these factors with a positive experience of interpreter usage.

> my general experience has been positive .... one of the most recent examples was an Eastern European baby I was treating, they had a professionally employed interpreter…… she wasn't just interpreting she was also engaged and interested and seemed to have a very intelligent understanding of the therapy (Sarah)

For many therapists however, the positives associated with using an interpreter centred around a sense of necessity.

> without having the resource of access to interpreters there would be a number of patients who we would just absolutely struggle to

> assess and treat so, whilst the process itself it can be frustrating, it's obviously a useful resource to have access to (Angela)

> if the interpreter wasn't there at all how would you develop a therapeutic relationship, how are you going to have that relationship, so in reality it's better to have the interpreter there than not, so I think that the pros outweigh the cons… (Amy)

Many therapists also noted positives for the patient in having an interpreter present.

> it's valuable because it also enhances your therapeutic relationship with the patient in that you are finding out things that maybe they have been wanting to say to you for a while and haven't been able to tell you (Jane)

> the patient can sort of breathe a sigh of relief when an interpreter comes in and finally they can get their message across and finally I can empathise with the things that are troubling the patient and his/her concerns (Angela)

4.2. Negative aspects of using an Interpreter

Many negative aspects of interpreter usage were discussed over the course of the interviews, for example boundary issues, interpreters becoming upset by the patient's diagnosis, giving inappropriate reassurance to patients, suspicion around accuracy of translation and a sense of loss of control.

4.2.1. Overstepping Boundaries

Many of the therapists had issues with interpreters overstepping professional boundaries through becoming emotionally involved with the patient and being overly inquisitive regarding patient information.

> I felt that the interpreter was becoming quite emotionally involved in the dynamic, so rather than sitting beside me and translating

> what I was saying he held a mini-conversation with the family, he seemed to be conversing a lot more than he should have been (Marie)

> the interpreter was really shocked by the patient's disability and the things they could and couldn't do and was asking inappropriate questions about the patient and just being kind of nosy I suppose... (Jane)

> some of them can be quite inquisitive about the clients which is while, okay yes, it's good, it shows an interest, shows they do care about the person, but it's actually inappropriate for them to know that information, so I suppose them questioning you can kind of catch you off-guard sometimes (Ann)

The issue of interpreters giving patients inappropriate advice and reassurance was also raised by interviewees.

> giving advice, giving maybe reassurance that's not quite appropriate, like telling a patient their hemiplegic arm is going to be fine (Jill)

4.2.2. Doubts about Accuracy

Some of the Occupational Therapists interviewed also raised doubts about the level of accuracy in interactions involving interpreters.

> with the best will in the world maybe the interpreters are not even translating exactly what we want to say, or they might paraphrase but in doing so can take it out of context or they may not say it with the same kind of tone, they might use more words to describe what we are saying you know, so I think you definitely lose when you are using interpreters (Bridget)

4.2.3. Difficulty with Building the Therapeutic Relationship

The experience of a sense of loss in relation to the therapeutic relationship was noted by many of the interviewees.

> You're just putting another barrier in the therapy process – it makes it harder to kind of engage with that patient and kind of move forward (Angela)

> When there is a third party there you lose a lot of the subtleties in conversation, you can sort of lose the little kind of colloquialisms people present with, in their language. Sometimes it can be more difficult to ascertain their moods or how they are presenting things so, definitely, it does change the dynamic (Marie)

> I think the patient is very passive when there is an interpreter. (Nuala)

4.2.4. Loss of Control

For many interviewees, the involvement of an interpreter altered the dynamic, affecting in particular their sense of control.

> having the three-way communication, sometimes the patient almost sees the interpreter as the therapist and it can affect the dynamic so I think it becomes more two-way (Angela)

> I just kind of feel you don't have the same – I suppose, maybe power is the right word – that you don't have the same kind of control (Elizabeth)

4.3. Coping Strategies when not Using an Interpreter

4.3.1. Use of Family Members

The Occupational Therapists interviewed expressed varied views around the

use of family members as interpreters. For some therapists the use of family members was deemed preferable and offered many advantages. Some of the therapists proposed that family members should be used as a precursor to calling an interpreter, as they could offer rich information on the patients' personality, background and social context. Also, it was stated that it was better to use family members as they have a personal stake in conveying important information to the patient.

> I always like to see a family member coming in, it's easier than an interpreter, you know…they are going to go home and check the splint is right, or that they are wearing it, so there is more carry-over in the treatment (Nuala)

> But I think if it can be done through family members it's a lot better because you are kind of killing two birds with the one stone… you are educating the family member and you are also getting that translation you know (Jane)

> the family members often have an awful lot of the autobiographical stuff, that collateral that's really useful (Angela)

For other therapists, use of the family was deemed inappropriate, in that family members could have their own agenda; interpreting could be an added burden for family members, who themselves are already taking in information and also there may be fear amongst them of reporting deficits.

> you have to be careful with family members because, not that they have an agenda, but they have an opinion on things as well (Marie)
> family members are difficult because often their insight might not be great into the patient's deficits and then they use their own interpretation of what's going on and there is the whole emotionally subjective experience of the patient by their family member… I'm sure they don't want to report deficits because they are afraid what the implications might be. (Amy)

4.3.2. Other Hospital Staff

In the absence of formal interpreters, many of the interviewees mentioned use of other hospital staff as a possible avenue for communication. This was seen as being more convenient, cheaper, more easily accessed, involved less time spent in organising, was more flexible as the staff worked on the wards and allowed the Occupational Therapists greater flexibility in scheduling appointments due to the onsite presence of staff.

> it's the convenience of having somebody in the ward that is there for the week, they know the background of everything that is happening with the patient and, the context of the information that I need to know. (Elizabeth)

> I don't know whether this is the best way but I mean a lot of staff have Spanish and that has been used. Now, again, all staff who work in hospitals have to have the confidentiality with them and things like that as well (Roisin)

It was felt that hospital staff often had medical training, had a better sense of the patient and, if present to interpret sessions, could follow up on therapy instructions with the patient on the ward post-session. Some of the interviewees liked the consistency involved in using staff as it was mentioned that there is difficulty in getting the same outside interpreter for multiple sessions. It was noted that if patients were agitated, the presence of a familiar face to interpret was calming. Other advantages mentioned were greater background knowledge of hospital staff on conditions experienced by patients, as often outside interpreters could appear confused by the material covered in Occupational Therapy sessions.

> I felt he (the interpreter) was looking at me as if to say what do you mean by that, whereas the guy on the ward understood straight away what I was asking (Elizabeth)

4.3.3. Demonstration and Gestures / Creative Modes of Communication

Another mode of communication mentioned in the absence of interpreters was the use of demonstration and gesture in order to convey a message. Therapeutic use of self was deemed very important. It was also noted that occupation as a medium for therapy, enabled practitioners to use activity and action to communicate the desired message. The study participants viewed this as an advantage over other disciplines.

> most of the time patients from other countries have little bits of English we can draw on, kind of incorporate into therapy and using demonstration and gestures, especially keeping it within a functional context can really help to reduce the need for interpreters (Theresa)

> [Having to communicate with clients with limited English]…does happen – and one has to draw on therapeutic use of yourself really, isn't it, and be very careful to limit your language, speak less, keep it quieter, use other modalities. (Sarah)

4.4. Therapist Responses to Problems Encountered

In the course of the interviews, the therapists were quite solution-focused and made a number of suggestions to improve the *status quo* in relation to interpreter usage. Their recommendations included establishing boundaries with interpreters in advance about the importance of maintaining the therapeutic relationship between therapist and patient, the importance of accurate translation and also familiarising the interpreter with the terminology in use.

> I think you need to sit down with them at the start and to prepare them for the interview process, tell them your expectations of what they should do and then maybe debriefing them afterwards and…. like it's important that anything that is said within the room is kept confidential because again they don't all have training, so you have to wonder what standards they have. (Amy)

Half of those interviewed also proposed the creation of a bank of hospital staff with language skills, whom the therapist could draw on in the absence of a professional interpreter. Interviewees deemed this option as preferable as the on-site hospital staff could offer consistency and flexibility to the Occupational Therapists.

> you have staff here in the hospital, people from Eastern Europe that can speak the language and know what to be looking out for, they could be paid extra you know, they are based here in the hospital, they understand the context of the patients and you know it's just the accessibility of having somebody there more regularly that would be a big thing. (Bridget)

5. Discussion

The Occupational Therapists interviewed all discussed both the advantages and limitations to working with an interpreter. They all perceived communication to be more difficult in those situations that required an interpreter than in those that did not. This perception is echoed in a study of physicians' experiences (Rosenberg et al. 2007). In their positive experiences of using interpreters, therapists focused on an increased ability to communicate with the patients and increased engagement. This resonates with findings by Flores (2005) and Karliner (2006).

It was interesting to note that just one therapist felt that cultural understanding was enhanced by the use of an interpreter. Although most therapists agreed that this would be a favourable adjunct to the process, and repeatedly mentioned the need for viewing the patient in context, very few had asked the interpreter for such information**.**

The findings of this study on the theme of negative experiences of interpreter usage chimed with the literature reviewed. The main negative experiences noted in this study involved interpreters overstepping boundaries, offering inappropriate reassurance, doubts surrounding accuracy of interpretation, a sense of loss of control and difficulty in building the therapeutic relationship. Lee et al. (2005) found that physiotherapists had negative attitudes towards

professional interpreters because they did not trust their interpretation. Raval (1996) and Bolton (2002) found that practitioners experienced a sense of loss of control and detachment from the therapeutic process. This finding was also experienced by participants of this study. According to David and Rhee (1998) patients are more likely to believe that a healthcare provider is lacking in empathy in the presence of a language barrier.

In much of the literature, especially on the medical-model based disciplines, access to interpreters and cost and time constraints were repeatedly noted as being barriers to using interpreters (Smart & Smart 1995, Lee et al. 2005). In this study, cost was not overly focused on as a constraint to interpreter usage. However, past negative experiences of interpreter use appeared to inform attitudes towards interpreters. The interviewees identified similar drawbacks to using formal interpreters as earlier studies have identified when informal interpreters are used, for example family members, centring on issues of accuracy and boundaries. This finding may be related to the current state of interpreting services in Ireland, where interpreter services to hospitals are unregulated (NCCRI 2008). In this study it would seem that the absence of quality interpreting services appears to be detracting from the therapists' ability to communicate well with patients.

While some interviewees expressed wariness around use of family members as interpreters, many therapists viewed this mode of communication as preferable. These particular therapists noted that they preferred using family members and hospital staff due to their ability to supply the therapist with rich background information on the patient. This was not noted as strongly in other literature and may be in keeping with the strong client-centred ethos in Occupational Therapy of gaining an understanding of the patient in context and getting to know their narrative. According to Meyer et al. (2010), there may be good reasons for medical practitioners utilising family members as interpreters. These reasons include availability, proximity, potential loyalty, responsibility and participation. The Occupational Therapists interviewed offered similar reasons for using family members to interpret. From an ethical point of view, use of family members as interpreters may be a cause for concern as much of the literature views this as a poor mode of communication due to the risk of inaccuracy and lack of

patient privacy. Someone close to the client may introduce bias by altering, filtering, censoring or distorting information or endeavouring to normalise the message being transmitted (Phelan & Parkman 1995, Wardin et al. 1996). Meyer et al. (2010) have acknowledged that young family members who act as interpreters or language brokers face a risk of being overwhelmed by painful experiences and sensitive issues that are not appropriate for them. Literature from the patient perspective also points to a preference for the use of professional interpreters. Hadziabdic et al. (2009), in a study on migrants' perceptions of interpreter use, found that the immigrant participants could see the advantages of using family members to interpret, however few wanted this and would prefer to have professional interpreters employed. MacFarlane (2009) examined the experiences of refugees and asylum seekers in Irish general practice consultations. Participants felt the use of informal interpreters was inadequate, leaving them feeling worried and frustrated. Regarding the use of using gesture as a mode of communication, Woloshin et al. (1995) deem this as being an inadequate practice which can result in confusion for both patient and practitioner, thereby negatively impacting on treatment outcomes.

All therapists interviewed were aware of the problems they were experiencing with interpreters, were solution-focused and offered recommendations. There seemed to be a positive correlation between the therapists who pre-briefed interpreters before the therapy session, making clear what was expected of them, and a subsequent positive experience. The literature shows that this approach is very important: the therapist describes the session plan and emphasises that the interpreter should not become a more central figure in the session than the therapist or patient (Miletic et al. 2006, Searight 2009). Other recommendations offered included having a hospital bank of staff who were trained in interpreting skills. For the majority of therapists this offered the best-case scenario. However, according to Riddick (1998), the use of language banks within hospitals, apart from being cost effective and more convenient for staff, also has drawbacks as the language skills of employees are generally not tested or evaluated and employees may also become resentful due to the decreased amount of time available for their workload.

6. Conclusion

The aim of this study was to explore Occupational Therapists' experiences of using interpreters, as little research has been carried out on this topic. The interviewees repeatedly identified the characteristics that make a good interpreter as having an interest in and an understanding of the therapy, efficiency and diligence, empathy and a professionalism that encompasses accuracy in translation, an awareness of the boundaries necessary to protect the therapeutic relationship, and an appreciation of the confidentially their role requires. Many negative aspects of interpreter usage were discussed over the course of the interviews, for example interpreters overstepping boundaries, becoming upset by the patient's diagnosis, giving inappropriate reassurance to patients, suspicion around accuracy of translation and a sense of loss of control. Therapists who pre-briefed interpreters before the therapy session, making clear what was expected of them, appeared to enjoy a positive experience. Use of family members as interpreters was deemed preferable by some of the Occupational Therapists interviewed. Flores (2006) and Meyer (2004), amongst other researchers, have examined mediated medical encounters in detail and found that use of family members is a poor mode of communication as there is the risk of medical errors and inaccuracies and this practice may impinge on patient privacy.

As discussed, the crux of this issue seems to revolve around the fact that interpreting services in Ireland today are unregulated and the majority of interpreters have not received accredited training. There is no incentive for interpreters to invest in training and graduates of the only accredited interpreter training course in Ireland at Dublin City University are not necessarily prioritised for work. Some interpreting companies offer one-day training courses for interpreters but these do not necessarily focus on medical interpreting (Phelan 2009). The Occupational Therapists interviewed who had negative experiences of interpreter usage often attributed this to a failure of interpreters in meeting professional standards. The reality of migration to Ireland means that Occupational Therapists are confronted with the challenges of working in a country which does not yet have the infrastructure of a high quality, nationwide interpreting service. Recommendations following from this study include nationwide accredited training of

interpreters and also very importantly training of Occupational Therapists in best practice for use of interpreters.

According to Hagedorn (1995), for a therapeutic relationship to develop, trust and respect must be present. When communication is limited, there is a potential for misunderstanding between Occupational Therapist and client and the therapeutic relationship may be thwarted. A prerequisite to ensuring this relationship can exist within the Irish health service for non-English-speaking clients is the development of a nationwide quality interpreting service, peopled by interpreters who are conscious of the demands of therapy and are evaluated according to standards that can instil confidence in the Occupational Therapists who rely on them.

Since research on this topic is quite limited in the realm of Occupational Therapy, further exploration of this area would be advantageous. It would be interesting via a quantitative study to find out what percentage of the time formal interpreters are used versus family members or hospital staff. As this study took place in hospitals, further research within other Occupational Therapy contexts, such as in community settings, would further knowledge on this subject. Also, it would be insightful to find out from the client perspective, their experience of attending Occupational Therapy in both the presence and absence of an interpreter. Some of the issues identified as problems in these interviews can be directly related to the fact that a greater demand for interpreting services is a relatively recent phenomenon. In a sense, the complaints and *ad hoc* solutions cited are the inevitable 'growing pains' of demographic changes. It is clear that Occupational Therapists themselves are becoming conscious of the issue, as demonstrated by their suggestions for future improvements. To that end, many of the Occupational Therapists who took part in this study have now attended a half-day training course entitled 'Working Well with Interpreters', provided by a translation agency, and the first author is planning a follow-up study on this topic with many of the same research sample to evaluate the effect of this training on their perceptions of interpreter-mediated encounters.

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