Cultus

THE JOURNAL OF INTERCULTURAL
MEDIATION AND COMMUNICATION

MEDIATING NARRATIVES OF MIGRATION

2020, Volume 13

ICONESOFT EDIZIONI - GRUPPO RADIVO HOLDING
BOLOGNA – ITALY

CULTUS

the Journal of Intercultural Mediation and Communication

MEDIATING NARRATIVES OF MIGRATION

2020, Volume 13

GUEST EDITORS

Raffaela Merlini
(University of Macerata, Italy)

Christina Schäffner
(Professor Emerita, Aston University, Birmingham, United Kingdom)

EDITORS
David Katan (University of Salento)
Cinzia Spinzi (University of Bergamo)

ICONESOFT EDIZIONI – RADIVO HOLDING
BOLOGNA

Table of Contents

Narrating narratives of migration through translation, interpreting and the media
Raffaela Merlini and *Christina Schäffner* 3

A Conversation about Translation and Migration
Moira Inghilleri and *Loredana Polezzi* 24

Easy *Ea*talian Chefs of Italian origin hosting cookery series on British television and mediating their cultural heritage
Linda Rossato 44

The mediation of subtitling in the narrative construction of migrant and/or marginalized stories
Alessandra Rizzo 70

Interlinguistic and intercultural mediation in psychological care interviews with asylum seekers and refugees: Handling emotions in the narration of traumatic experience
Francisco Raga, Dora Sales and *Marta Sánchez* 94

Interpreting Distress Narratives in Italian Reception Centres: The need for caution when negotiating empathy
Mette Rudvin and *Astrid Carfagnini* 123

From Italy with love: narratives of expats' political engagement in a corpus of Italian media outlets
Gaia Aragrande and *Chiara De Lazzari* 145

Journalistic translation in migrant news narratives: Representations of the *Diciotti Crisis* in British news brands
Denise Filmer 169

"Language barrier" in UK newspapers 2010-2020: Figurative meaning, migration, and language needs
Federico Federici 194

To Translate or not To Translate: Narratives and Translation in the UK Home Office
Elena Ruiz-Cortés 220

Notes on Contributors 239

Interlinguistic and intercultural mediation in psychological care interviews with asylum seekers and refugees: Handling emotions in the narration of traumatic experience

Francisco Raga
Universitat Jaume I, Spain

Dora Sales
Universitat Jaume I, Spain

Marta Sánchez
Universitat Jaume I, Spain

Abstract

This paper presents the results of our fieldwork with an NGO in the Valencian Community (Spain) that temporarily takes in asylum seekers and refugees (ASRs), especially from Arab countries, Eastern Europe and West Africa, and provides them with basic services, including psychological assistance. Following a qualitative methodology, interviews were conducted to collect the opinions and experiences of psychologists and interlinguistic and intercultural mediators who work with ASRs. We have observed that the aspects related to the different conceptions of mental illness (for example, the effect of spiritual entities), which can be decisive in the clinical interviews between psychiatrists and economic and social immigrants, play a somewhat secondary role in the clinical interviews. In this type of interview, cultural differences related to the patterns of communicative interaction between psychologist and patient have been seen to be particularly problematic, especially with regard to the expression of emotions during the narration of traumatic events suffered by ASRs. The initial results of the study demand an in-depth reflection on the communicative initiatives that mediators can put into practice in these interventions. Specifically, they call for a closer examination of the

communicative initiatives related not only to the interpretation or explanation of the cultural differences observed in emotional expressions, but also the verbal and non-verbal strategies that mediators can deploy to prevent the blockages that cultural differences of an emotional nature can generate in the narration of the traumatic experiences of ASRs. This paper makes some proposals for action in this regard.

Keywords: interlinguistic and intercultural mediation; psychological care interview; asylum seekers and refugees; narration of traumatic experience; qualitative study

1. Introduction

Interlinguistic and intercultural mediation (which we will refer to simply as "mediation") in the area of psychological care for asylum seekers and refugees (ASRs) is, at least in the case of Spain, in a blatantly precarious professional situation (Las Heras, 2010; León *et al*., 2016). For example, the language officers at the NGO that we examined in this study indicated that they occasionally hire interpreters when the person seeking psychological care does not speak French or English. Other NGOs and even some Refugee Reception Centres dependent on government institutions[1] do not even have the funds to hire interpreters in this type of situation.[2] This precariousness is largely attributable to various institutional and even ideological factors (Raga, 2019: 78), but also to the fact that research and training proposals, which should provide mediators' actions with a certain level of consistency (Verrept and Coune, 2018: 6), are still very much lacking and disjointed in this area. Various codes of ethics have indeed been put forward in recent decades for mediation in the area of healthcare in general (such as CHIA, 2002, and IMIA, 2016), and it seems reasonable for there to be a certain level of homogeneity in the actions of mediators who undertake their work in hospitals and health centres. However, in recent times, calls are being made for guidelines to be adapted to the individual characteristics of more specific areas of practice, such as those for mediation in reproductive health (Sales *et al*., 2014) and in psychiatric care (Raga *et al*., 2014).

[1] We are in the process of extending our research to these Refugee Reception Centres, which in Spain actually have fewer ASRs than some NGOs.

[2] Some kind of linguistic mediation does seem, however, to be guaranteed in legal communication contexts involving ASRs (Las Heras, 2010).

2. Research design

As part of a project that the authors are carrying out on mediation processes in the field of mental health care for patients of foreign origin in Spain, especially in the Valencian Community, this paper presents the results of the initial phase of that research, focused specifically on psychological care for ASRs. The research questions at this stage are the following: Do the communicative interactions that take place in the field of psychological care for ASRs present specific characteristics, different from those in other fields of mental health care? Are these characteristics related to the emotional circumstances of ASRs? Do these characteristics require mediators to perform their work in a specific way?

The aim of this paper is thus to describe the healthcare, social and interpersonal characteristics of interactions between ASRs, psychologists and mediators, by analysing the type of intercultural communication problems that are linked to these characteristics. The paper focuses specifically on ASRs' utterances used to express emotions and their impact on the narration of traumatic events. It also puts forward (albeit tentatively due to the early stage of our research) a number of mediating interventions that would appear to be most appropriate in this type of communicative situation.

In order to achieve this, we will first consider what is set out both in the studies on the psychosocial situation of ASRs and in the few studies on the work of mediators in this area. This evidence will then be compared and contrasted against data yielded by the interviews we carried out with some of the professionals working at an NGO that collaborates in an official capacity in the reception and integration processes for ASRs in the Valencian Community.

The interviews took place between June and November 2019, and on average each interview lasted seventy minutes. The interviews with the psychologists were held on the NGO's premises, whereas the interviews with the mediators took place in their homes. In both cases, they were semi-structured interviews addressing a wide range of issues. In the interviews with the mediators, questions were asked about their training and professional experience, terminological difficulties, confidentiality, impartiality, development of conversational dynamics, characteristics of non-face-to-face mediations, and vicarious trauma (See Appendix 1). In the interviews with the psychologists, questions were asked about their training and professional experience, organisational procedures in the NGO, the social situation of ASRs in the host country and, specifically in the NGO under study, the general characteristics of clinical interviews, the

main psychological problems that ASRs often have, and the social stigma of mental illness (Appendix 2). Following the transcription of the interviews, a qualitative discourse analysis was carried out on the data thereby obtained.

Specifically, we interviewed: one mediator hired by the NGO on an hourly basis for interviews with Arabic- and French-speaking ASRs (Mediator A); one mediator hired by the NGO for interviews with Russian ASRs (Mediator B); one mediator for interviews with French-speaking sub-Saharan ASRs (Mediator C); one psychologist hired by the NGO who works primarily with social and economic immigrants (Psychologist A); and one psychologist hired by the NGO who works primarily with ASRs (Psychologist B). With a view to future research in this field, it seems essential, among other initiatives, to know the opinions of the ASRs themselves on the subjects covered in this work. However, for various reasons, we have not been able to incorporate them into the current phase of our research.

In this paper, we specifically analyse: (1) the responses related to the characteristics of mental health care in the ASRs' cultures of origin and their impact on clinical interviews, (2) cultural differences in the expression and regulation of emotions, especially in the narration of traumatic events, and (3) the role of mediators regarding these issues. These topics provide an organisational framework for the analysis of the opinions expressed in the interviews. In each of the following three sections, the discussion is presented in an integrated manner, using verbatim quotes to illustrate the interviewees' viewpoints.

3. Psychosocial characteristics of ASRs attending the psychological care departments

The first characteristic is related to the type of care received. Although a notably high percentage of ASRs receive psychological care,[3] very few cases are referred from the psychological care department to the public health service psychiatric department (Achotegui *et al.*, 2016: 11). Psychologist A mentioned that, in recent years, she has only referred a couple of people (of the hundreds she has treated) to psychiatric departments. She explained that this referral was because those individuals

[3] Some reports mention figures of between 40% and 70% (Díaz *et al.*, 2018).

needed to be prescribed medication to mitigate the particularly severe effects of the acute depression they were experiencing.

Psychologist B, on the other hand, mentioned that, of the several hundred patients she had treated in the two years she had been working at the NGO, she had only referred around ten individuals to the psychiatric department, most of them with extreme trauma-related symptoms or post-traumatic stress disorder:

> On the one hand, there are the people who go to primary care to be given anxiolytic or antidepressant medication, but many of these do not go to mental health: it is only a pharmacological support to psychological therapy. Those who are referred are people with post-traumatic stress symptoms, and then there are those who come in with a bipolar, or psychotic, disorder. (Psychologist B)[4]

In terms of the types of disorders experienced by ASRs, as indicated by Díaz *et al.* (2018: 112), "there is a high prevalence […] of clinical pictures of stress, grieving processes, traumas, somatisations such as headache and muscle pain, sleep disorders, and clinical pictures of anxiety, depression and post-traumatic stress disorder". Without a doubt, post-traumatic stress disorder is the one most commonly cited as a characteristic of ASRs. However, many authors have doubts regarding not only the direct relationship between the condition of ASRs and post-traumatic stress disorder, which may develop into a pathologisation process for ASRs, but also of the very existence of a specific disorder which we can refer to as post-traumatic stress disorder (Beneduce, 2004: 115; Ingleby, 2005: 10-11; Achotegui *et al.*, 2016: 49; Evangelidou *et al.*, 2016: 70-73). Psychologist A indicated that she does not trust the classification of post-traumatic stress disorder. In her view, what ASRs have in common is trauma itself, which can manifest as anxiety, depression or anxious-depressive symptoms, depending on the individual:

> I don't diagnose post-traumatic stress syndrome. For me, in general, what they have in common is the trauma itself. We work with people who have gone through very traumatic situations, and who, depending on how they are, have more depressive, or anxious, or anxiety-depressive symptoms. (Psychologist A)

[4] The translations of quotes from the interviews and of some bibliographic references originally in Spanish were carried out by the authors of this work.

Psychologist B, on the other hand, mentioned that most ASRs have anxiety problems and, to a lesser extent, depression. She considers that the disorders directly related to trauma, which are far less common, are associated with more extreme symptoms that usually require medication and occasionally referral to psychiatric departments.

Whichever classification we follow, the psychological problems experienced by ASRs are always attributable to very specific external causes, i.e. particularly traumatic past experiences, such as war, persecution, and physical and psychological torture, which usually occur over long periods of time, both in the country of origin and during the escape journey (Ingleby, 2005: 7; Kramer, 2005: 135; Evangelidou *et al.*, 2016: 69). There is, however, some consensus that the social situation in which they find themselves on arrival in the host countries may have an even greater impact on their mental health problems (Achotegui *et al.*, 2016: 16).

Without a doubt, the issues related to the ASRs' own health culture play a crucial role in intercultural communicative situations in the area of mental health. Yet, it seems clear that the factor which will particularly determine the type of intercultural communication in interactions between ASRs and psychologists is that of the psychological, social and economic situation caused by the experiences undergone by ASRs in their country of origin, during their escape journey, and in the host country.

4. Types of intercultural communication problems in psychological care for ASRs

In line with the classification developed by Raga and Sales (2010), intercultural communication problems in the area of healthcare may be due to differences in the conceptions of how the human body, health, illness and the healing process work, and of the behaviours associated with these aspects. However, they can also be the result of differences in the communicative interaction patterns (CIPs) between the patient and caregiver that are observed within different cultures. To put it very briefly, CIPs refer to the communicative behaviours that only occur in face-to-face interactions, accompanying the spoken language in an inseparable way, and include all the significant aspects related to non-spoken language, turn-taking, paralanguage and verbal politeness (Raga, 2005: 165-167).

Clearly, both types of problems may occur in any intercultural clinical interview. Whilst most authors agree that psychologists working with

ASRs should have a certain level of communicative competence to help them understand the conceptions of mental health that are specific to the patients' cultures of origin (Lurbe, 2005: 209-210; Ingleby, 2005: 19; Evangelidou *et al.*, 2016: 74-75), in actual fact these differences are not usually highlighted as being a particularly distorting factor in interviews with psychologists, nor are there widely cited examples in this regard. We must consider that ASRs may naturally attribute the origin of their mental problems to the traumatic situations they have experienced in their country of origin, during the escape journey and in the host country, without the need to turn to, for example, spiritual explanations.

The opinions expressed in the interviews in relation to this issue are not particularly consistent. The Arabic mediator indicated that problems arising from the different conceptions of mental health are not very common, and that he only remembered some interviews in which ASRs from Yemen occasionally brought up the issue of the evil eye:

> I did have to explain the evil eye issue to the psychologist. There aren't many cases, but they exist. For example, someone tells you that the problems between his father and mother were because a woman who was jealous wrote a spell on a piece of paper, which they found thirty years later. And that person has every right to think that this is so. When it's something that doesn't exist here, I explain it to the psychologist. (Mediator A)

The Russian mediator mentioned that there are no significant differences between the Spanish and the Russian cultures regarding this issue. The French mediator stated that she was almost completely unaware of the health cultures of the ASRs from West African countries she worked with. Psychologist A agreed that having a certain level of training in intercultural competence was advisable, although she did not remember any cases in which these differences in terms of conception of mental health had caused any intercultural communication problems. In any case, she suspected that some of her patients also attended traditional healers residing in Spain, which generally did not cause any problems:

> Sometimes I have felt limited in my work […] because what I propose is not good enough for them. And in the end they contact a *marabout*,[5] here in Spain, who gives them something,

[5] *Marabouts* are traditional healers from the Maghreb region and West Africa, who follow the precepts of the Muslim religion, although they sometimes introduce elements typical of animist religions.

> and it turns out that it works and they start to feel good. It happened to me recently with a boy, and now he's doing very well. (Psychologist A)

The differing points of view in this case come from the statements made by Psychologist B, who indicated that ASRs, and particularly those of sub-Saharan origin,[6] typically tend to interpret their mental problems, particularly somatic manifestations (such as insomnia, nightmares and headaches), from a spiritual perspective, which includes phenomena such as witchcraft, possession and the evil eye.

> We continually run the risk of mistaking any type of disorder or emotional moment that a person is undergoing for a delusional or psychotic disorder. For example, a boy from Mali who came here had a stomach infection, due to E. coli. He believed that someone had put a bug in his body and that the bug was going to kill him. The explanation he gave was based on witchcraft, which is typical in his country. If the psychologist had not taken a cross-cultural view, this boy's expressions could have been interpreted as delusions, as symptoms of schizophrenia. (Psychologist B)

Psychologist B insisted, as mentioned above, on the need to adopt an intercultural outlook, one of learning, and avoid making the mistake of interpreting these spiritual manifestations as severe pathological symptoms such as psychotic or schizophrenic disorders.

The experiences of ASRs in their countries of origin and during the escape journey, the precarious administrative, socioeconomic and living conditions in the host countries, as well as the psychological consequences, in the form of depression, anxiety and post-traumatic stress, make cultural differences all the more important in clinical interviews with psychologists. This is especially so in terms of how they experience emotions and express them through different types of CIPs.

Intercultural difficulties in expressing and managing emotions, which are recurrent in almost every psychological interview with ASRs, are all the more relevant during interactions in which the psychologist tries to make the patient verbally relive the traumatic situations they had to endure. It

[6] As Psychologist A points out, Muslims adopt a more religious perspective and tend to interpret their mental problems as a divine plan: "Sometimes religious belief, such as believing that you cannot change anything, that it is destiny or the divine will, does more harm than belief in the evil eye. But other times, religious belief can also help you move forward".

should be noted that the traumatic events experienced by ASRs can be particularly dramatic. Mediator A offers the following example:

> On one occasion a young boy of Syrian origin told us that his father hung him from the foot of a tree above a fire and whipped him; in his flight, he had crossed several countries, in one country they kidnapped him and took his kidney out, and in another country they sold him into slavery. (Mediator A)

There appears to be a broad consensus regarding the enormous therapeutic value of the narration of traumatic events (Beneduce, 2004: 100). As noted by Lurbe (2005: 269), "the acknowledgement of trauma in one's own words, shared in a therapeutic space, is identified as being the only lasting method of psychological repair". However, several problems arise around the development of these narratives by ASRs, which make the work of psychologists and mediators difficult, and which advise that these narratives must not be forced under any circumstances (Achotegui *et al.*, 2016: 17). Firstly, trauma itself generates a series of psychological mechanisms that tend to block the memory and the narration of the events that have generated it. It causes feelings of guilt about surviving when many others have perished (Lurbe, 2005: 268), nightmares about the content of the traumatic events, memory lapses, frequent ruminations about what happened, cognitive attempts to suppress certain unpleasant thoughts or memories and a certain emotional numbness. As López (2017: 52) noted:

> Trauma, with its unspeakable condition, makes it difficult to deal with it. The difficulty in finding the words, the anticipated risk of breaking down if they start to speak, the feeling that nobody can understand the pain experienced and the distance from the references of the person who accompanies them explain the resistance to initiate a therapeutic process.

Furthermore, in clinical interviews where the memory and narration of the traumatic events are addressed both the psychologist and the mediator can be psychologically assimilated to the figure of the interrogator in torture sessions. As Beneduce (2004: 115) pointed out, "the therapist must witness the pain, but this means joining all those who in the past have violated the patient's privacy".

On the other hand, as mentioned above, ASRs in host countries may be experiencing equally traumatic experiences that stem from, among

other things, their legal and economic insecurity. As Pérez (2004: 98) observes, it is extremely difficult to establish a relationship of trust in these situations, since "any personal information can be used to repatriate you, and the data you might give could put the relatives or friends who remain in the country in danger". As Pérez elaborates, rejection reactions can also arise from people who have professional relations with ASRs, when faced with the latter's perception of mistrust, or even deceit or omission. It should be added that the refugee system in Spain already forces ASRs to go through this ordeal during interviews with police officers and public officials, in which they have to recount their traumatic experiences in a very direct and crude manner, with no kind of psychological support. The French mediator pointed out that these interviews are indeed the encounters in which ASRs face truly severe emotional problems:

> The psychologists don't insist much on ASRs' recounting or recalling these facts if they don't want to. They focus more on somatic aspects. Indeed, the recounting of traumatic events takes place mainly in the initial interview, without any psychological support, and in the interviews with the lawyers, who have to prepare the sessions with the police. This initial interview, which is focused on legal matters, is the hardest, because you see that the ASRs are really out of place, that they are afraid, that they don't really know where they are. Some administrative assistants don't have any empathy for the ASRs at all. (Mediator C)

Finally, as noted by Beneduce (2004: 105), traumatic events are embedded in a whole life and cultural experience. Memory is individual but also social and cultural. Its laws also depend on social norms, indicating "which parts of memory should be explored and which should be left in the shade". Similarly, as will be discussed below, the emotional CIPs that facilitate or hinder the narration of traumatic events differ significantly according to the cultural background of the ASRs.

Following Brody (1999: 15), emotions can be defined as motivational systems with physiological, behavioural, experiential and cognitive components, which have a positive or negative valence, with different degrees of intensity, and are usually caused by interpersonal situations or events that deserve our attention because they affect our well-being. In the last few decades, research into emotions has focused on determining the specific weight that both strictly universal biological factors and social, communicative, and cultural factors may have in surfacing emotions. In

this line, one of the most productive fields of study is that of display rules, that is, the informal rules of a social or cultural group about how to express emotions appropriately. As Winkelman stated (2009: 286), cultures present different interpretations of emotional expressions and different evaluations with regard to what is considered an acceptable response to basic emotions. The cultural formulation of basic emotions can intensify, minimise, modify or mask their expression.

These display rules can affect both non-verbal and verbal language. With regard to non-verbal language, Matsumoto *et al.* (2007) cited the classic work by Ekman and Friesen (1969), in which Americans and Japanese were recorded while watching highly stressful films:

> When viewing the stimuli alone, both American and Japanese observers showed the same emotions on their faces; when in the presence of a higher status experimenter, however, cultural differences emerged. While the Americans continued to show their facial signs of negative emotions, Japanese observers were more likely to mask their negative feelings with smiles. (Matsumoto *et al.*, 2007: 27)

As regards verbal language, for example, De Leersnyder *et al.* (2013: 2) remarked that the Inuit avoid expressions of anger at all costs. They try not to interact verbally with others when they are in this state, and avoid talking about their own anger. Basso (1972) noted that the Apaches systematically use silence when they meet very angry or very sad people.

With regard to our informant NGO, communication difficulties deriving from the verbal and non-verbal expression of emotions were observed. With respect to the former, psychologist B noted that the ASRs with the greatest difficulties when it comes to expressing their feelings are men of Slavic origin and some of Arab origin (but less so those from the Maghreb region):

> The cultural and gender perspective is very influential. Talking about emotions with a man or with a woman is completely different. People from Ukraine, Russia and Belarus are often more reluctant to express their emotions. In some cases, there are very striking reactions, for example, you ask someone: "Have you felt sad this week?", and that person is offended, and he or she says: "How dare you ask me that?" There are also quite a few emotional barriers with people coming from Syria, and not so many difficulties with people from North Africa. (Psychologist B)

With specific reference to the non-verbal expression of emotions, the Arabic mediator commented on the extremely harsh nature of some of the ASRs' narrations he has to interpret,[7] and added that he (being a fellow citizen of some of the ASRs) perceives some emotional expressions, conveyed through specific CIPs, which may be misleading for psychologists:

> There was a boy of Moroccan origin who looked at the social worker and began to laugh a lot, and she interpreted this as a form of sympathy and kindness. But I warned the social worker that, in fact, that laughter was very rare in his culture of origin, that this boy was in a very bad state, that he was losing his mind. And now he's going to a psychiatrist. (Mediator A)

Achotegui *et al.* (2016: 17) indicated that gaining their confidence should be the main objective of the first contact with refugees. Patients should therefore not be forced to describe the traumatic experiences they have gone through or to relive and openly express the emotions that these events create in them.

On the other hand, it does seem advisable to make efforts to avoid personal, social and cultural barriers that often hinder ASRs' free verbal and emotional expressions in clinical interviews. To achieve this, the role of mediators is essential. As Theys *et al.* (2020: 41) note, mediators seem to play a crucial role in the interactive process of co-constructing emotional communication, because they validate and enable the contributions of the other participants, and thus create common ground and mutual understanding. However, these authors argue that the process may call into question the neutrality of mediators.

[7] A particularly relevant issue in this area is that of the vicarious trauma, or emotional contagion, sometimes experienced by mediators. Martin and Valero (2008: 2) note that community interpreters will always find themselves in "circumstances in which it would be difficult for any human being to remain unperturbed". Merlini and Gatti (2015: 142) further clarify that the kind of empathy the mediator should display implies "understanding and perceiving the other's emotional state, but without acquiring it".

5. The role of mediators

Interlinguistic and intercultural mediation can be defined as the process of facilitating oral communication, in its linguistic and cultural dimensions, as carried out by professionals, especially in the field of public services. For a while now, the debate regarding the visibility vs. invisibility of mediators in the healthcare domain has evolved into an attempt to specify the degree and type of visibility which is required by the specific circumstances of each type of clinical interview. The enormous cultural burden characterising mental health, as well as the importance of interaction between healthcare staff and patients in this area,[8] have led us to consider a maximum level of mediators' visibility. Indeed, on occasions, psychologists themselves require mediators to play a role close to that of a co-therapist, actively taking part in diagnosis and treatment (Pérez, 2004: 6; Bot, 2005: 79-80). Psychologist A is against such active participation by mediators, while Psychologist B is in favour of it.

As we have mentioned, there are few studies dedicated to mediation in the psychological care of ASRs. However, they generally confirm the active communicative role of mediators working with this group of patients (Pöllabauer, 2005, León *et al*., 2016: 33), and in general (with a few exceptions such as Bancroft 2017), they consider it even necessary (Patel, 2003: 222; Evangelidou *et al*., 2016: 72). Psychologist B's comments regarding her experiences with mediators lead us to believe that the mediators' frequent lack of training and the extreme emotional circumstances in which they carry out these interviews make it a very regular occurrence for them to move too far away, and unduly so, from the basic principles set forth in the codes of ethics (such as CHIA, 2002, and IMIA, 2016).[9] In doing so, they seem to implement excessive communicative initiatives, which can sometimes contaminate the whole therapeutic process. This same psychologist indicated that the following cases are common:

[8] As noted by Collazos and Casas (2007: 256), "in psychiatry, given the lack of biological markers, the diagnosis is purely clinical, which makes communication fundamental; if it fails, the diagnosis, and therefore the treatment, also fail".

[9] However, as indicated by Merlini and Gatti (2015: 144), in the National Code of Ethics for Interpreters in Health Care, a highly influential document drawn up by the National Council on Interpreting in Health Care (NCIHC) in 2004, it is noted that: "Responding with empathy to a patient who may need comfort and reassurance is simply the response of a caring, human being" (NCIHC, 2004: 16).

- the mediator becomes too involved from an emotional perspective;
- the mediator tries to adopt an excessively neutral type of emotional expression, which breaks down the communicative understanding between the ASR and the psychologist;
- it is clear that the patient is not understanding what the mediator is saying;
- the mediator establishes dyadic conversations with the patient, details of which he or she fails to relay to the psychologist;
- the mediator takes the patient's side;
- the mediator unduly reinterprets the psychologist's questions.

Krystallidou (2012: 77) notes that the presence of mediators significantly alters some aspects of the nature of doctor–patient interaction. Doctors find it difficult to develop a relationship with their patients, make more eye contact with mediators than with patients, sometimes feel excluded from mediator–patient interaction, and perceive patients as being uncommitted. Patients tend to ask doctors fewer questions, and perceive them as less respectful and less concerned about them as individuals.

Before going on to specify the characteristics of the mediators' communicative initiatives required for these clinical interviews, we would contend that mediators themselves must be aware of and have basic proficiency in the principles set forth in the codes of ethics. Equally important is that mediators have some knowledge of the general characteristics of clinical interviews with psychologists, of the communicative aspects that may be relevant in delivering diagnoses and treatment, and of the strategies that psychologists may deploy in this context (Hlavac *et al.*, 2020: 338). It seems clear that the particular personal, social and cultural characteristics of ASRs appear to require mediators to have a specific type of communicative initiative. Without neglecting the aspects related to cultural differences in the conception of mental health, the mediator must be specially prepared (and duly trained) to avoid misunderstandings related to CIPs, particularly those expressing emotions.

Several studies on mediation in the healthcare context (see for instance Baraldi and Gavioli 2007, and Merlini and Gatti 2015) show that, contrary to what the codes of professional ethics and a large part of the specialised literature indicate, "interpreters are seen to challenge affective neutrality through affiliative responses which treat the patient's manifestation of feelings and worries as conversationally relevant, and, in some cases, further reinforce the healthcare practitioner's empathic model of communication" (Merlini, 2019: 222). Conversely, other studies, such as

those by Cirillo (2012) or by Leanza *et al.* (2013), note that affective initiatives by doctors and patients are often filtered or blocked by mediators, who try to stick to an objective medical tone. Interestingly, the latter study revealed an opposite trend among non-professional mediators, in many cases members of the patients' families, who were found to promote the affective aspects of doctor–patient interactions. In recent times, the benefits of this type of "family mediation" have been highlighted. For example, Hsieh (2016) argues that doctors in certain specialities, such as oncology, value very positively the emotional support that can be provided by a mediator who is a member of the patient's family. However, the same author also states that "a provider in mental health care may prefer professional interpreters over family interpreters due to concerns about patient privacy and treatment efficacy" (Hsieh, 2016: 46).

Literature data seem to indicate that the simple presence of a mediator does not guarantee fluid emotional expression between doctor and patient. Cirillo (2012: 119) explains that the establishment of an affective relationship may be simpler in dyadic conversations between doctor and patient (even if the latter does not speak the language of the host country correctly) than in conversations involving a mediator. Successful emotional communication will depend largely on the characteristics of the mediator in question, not only on his/her personal profile, but above all on the training he/she has received in the emotional components of communication. As Merlini (2019: 236) states, "people with a non-empathic disposition may act empathically under specific circumstances, and vice versa; empathy is a context-dependent, interactionally achieved outcome; and empathic skills may be acquired". If training in the emotional components of communication is to be effective, especially in a context such as the narration of traumatic events by ASRs, what is required is in-depth knowledge of the specific characteristics of emotional expression in this context and its cultural determinants. In the rest of this section, we look at some of the dilemmas that should be addressed in the development of this type of analysis.

In tune with earlier studies, and on the basis of our interview data, the following paragraphs detail some of the communicative initiatives that we consider may play a crucial role in preventing cultural differences (regarding the expression of emotions) from interfering in the narrative therapies of psychological interviews with ASRs.

1. Provided that circumstances allow it, it seems advisable to turn to a mediator whose gender and age do not pose a cultural problem for ASRs

to freely express themselves verbally and emotionally (Patel, 2003: 223). Psychologist A mentioned that, although it is common to assign psychologists whose gender and age fit the characteristics of ASRs, this is not the case in the NGO she currently works in.

2. Provided that the psychologists take the initiative, the therapeutic (but not the legal or administrative) objective of the narration of the traumatic events should be clearly explained to the ASRs in the specific context of the clinical interview. As the Arabic mediator noted, this is usually done in the first interviews with ASRs:

> Sometimes what the patient has told the lawyer does not match what he or she is telling the psychologist, and he or she is afraid that the psychologist will tell the lawyer. So we reassure them by telling them that "what you talk about here will not be made known to the managers of the NGO, or the lawyers, or the police, or the consulate of your country, or to anyone else". (Mediator A)

3. The role of the mediator can consist in explaining to psychologists and ASRs both the cultural differences in the conception of mental illness, and the emotional expressions of the intervening parties that may be causing some kind of intercultural misunderstanding. The Arabic mediator confirmed that he performs this type of task quite often.

This point was confirmed by Psychologist B, who indicated that, whether upon her own request or following the mediators' own initiative, these verbal explanation processes of cognitive and emotional cultural differences are common:

> Usually the interpreters will say to you: "Excuse me, about what the patient is saying, can I point out something that has to do with a cultural difference?" and they explain it to you. Or they say, "This question you're asking the patient may be a little misleading or problematic in their culture. Would it be all right if I explained to him/her why you're asking that question now?" They offer very necessary and very interesting explanations. (Psychologist B)

The Russian mediator, on the other hand, thought that cultural explanations should only be given when specifically requested by any of the intervening parties. She highlighted the risks of over-culturalisation

and attributing patients' behaviour to cultural factors that might instead be due to the patient's specific personal characteristics.[10]

4. Although both the psychologists and the mediators we interviewed indicated that, according to the protocol, the relationship between the ASRs and the mediators must be confined to the clinical encounter, on some occasions it would seem advisable for them to establish an interpersonal relationship (Bot, 2005: 35). Relationship-building, even if limited to a few moments before and after the interviews, can generate confidence in patients who are not used to these communicative situations. The Arabic mediator saw the development of a relationship – almost of friendship – between mediator and patient as highly beneficial.

As the Russian mediator noted, it is common for subsequent clinical interviews between a psychologist and ASRs to be carried out with different mediators. He was also firmly against personal rapport-building with patients:

> Sometimes you're not the only interpreter working with the same patient. The patient says, "I told you that the other day, don't you remember?" And it turns out that the other day he or she had been with another interpreter. And they get angry, because they've already made the effort to tell it. But if the ASR begins to trust the interpreter too much, he or she may start to think that they can expect something from the interpreter. It is not good to establish a personal relationship between the patient and the interpreter; you have to remain impartial. (Mediator B)

The French mediator pointed to a clear tendency to resort increasingly to remote mediation, with all the technical and interpersonal problems that this may entail:

> Telephone interpretations are terrible. There are a lot of technical problems, you can't hear anything well, and a lot of things are lost. Sometimes, if there are no images, you don't know if the patient is serious or joking. Also, many times you don't know which psychologist or ASR you are going to talk to, and you have to ask them who they are and ask them to set the scene a little bit. It's very complicated. (Mediator C)

[10] The Russian mediator explained that her view might be partially due to the fact that not many differences are actually observed between the Spanish and the Russian, Ukrainian or Georgian cultures.

5. In line with the patient-centred healthcare model, it seems advisable to hand over some of the control of the sessions to the ASRs themselves, so that they do not feel that they are being subjected to anything that might resemble an interrogation. For example, as Messent (2003: 143) observes, it is advisable not to interrupt patients' narratives or emotional expressions. Both the Russian and the French mediators stated that, in general, there are no major problems with speaking turns, except in sessions in which many people are participating at the same time, such as workshops or informative talks:

> Turn-taking is sometimes difficult in the workshops. They talk fast and a lot. Besides, in a workshop there may be twenty attendees, but you only have to interpret for three, and each group goes at its own pace. Sometimes I have to ask the person giving the workshop to take a break, but other times I have to summarize a lot. (Mediator B)

6. It seems advisable that, in some way, the mediator should be attuned to the emotional expression of the ASR. Psychologist B mentioned that the communicative actions she expects from the mediator, in addition to interpreting, involve reproducing the paralanguage and non-verbal language of both the patient and herself:

> Paralanguage is very important in the psychological interview. Having the interpreter reproduce the tone of voice and volume of the psychologist helps a lot. It's great, because you very often say more with the tone than with the content. It's also important that the interpreter reproduces the patient's paralanguage but, above all, the psychologist's. (Psychologist B)

Although the Russian mediator preferred to be as "invisible" as possible, she considered it appropriate to reproduce both the paralanguage and non-verbal language, as she maintained that she had "to become the mirror of the intervening parties":

> If the patient is speaking slowly, I must do the interpretation slowly too, but without overacting. The imitation comes naturally, because it's about empathy. (Mediator B)

The French mediator considered it appropriate that the mediator's expressions be in tune with the paralanguage and non-verbal language of the ASRs, but called for softening manifestations when they may be too

extreme. This form of interpreting, almost in the theatrical sense of the expression, is envisaged by some codes of ethics (for instance, CHIA, section 5.a). It does not seem to be particularly advisable, however, in specific moments of extreme tension, in which the intervening parties raise the tone and volume of their voice, and make somewhat aggressive gestures.[11] On the whole, in the context of psychological interviews with ASRs, it may help create communicative understanding between the parties involved.

7. Finally, a most controversial strategy is the mediators' active management of patients' emotions. Raga (2018) argued that for the communicative problems related to differences in CIPs (that is, the communicative behaviours between the caregiver and patient) it seems advisable to make use of mediators' initiatives based on communicative actions. For example, if the patient is uncomfortable during a trauma consultation due to being naked in front of the mediator, the mediator can simply find a physical location that avoids visual contact with the patient. Or, for instance, if a doctor is using highly technical terminology, mediators may simplify it in their renditions into the patient's language. In these situations, some active interventions by mediators can help ASRs overcome the emotional block. As noted by Evangelidou *et al.* (2016: 72), "their intervention may make it easier for refugees to attempt to express their pain and the emotional suffering they are experiencing, which, for reasons related to pride and dignity, they may not do immediately before professionals in the healthcare and social areas". The mediator may create a suitable communicative atmosphere from the perspective of the culture of origin, so that the ASR is able to express the emotions required by the situation. For example, the Arabic mediator indicated that, on occasions, he performs CIPs that, in the patients' culture of origin, are appropriate to facilitate emotional expression. Such CIPs may consist in touching the ASR's hand, hugging him/her, or conveying reassurance, understanding and support:

> Once a girl told me that she had been kidnapped – to be prostituted – by her stepmother, who then took her and her sister to undergo genital mutilation. Her sister died, and the girl ran away and came here… It's impossible for this not to affect you. And, due to cultural closeness, you feel that person, in that moment, needs you to hold her hand, and touch her, and indeed that has a huge reassuring effect on the person. The psychologist,

[11] See also Hsieh and Nicodemus (2015).

> who is there in front of you, doesn't think this is bad, she understands. (Mediator A)

Clearly, these behaviours can lead to problems of different kinds and a partial loss of professional objectivity (Beneduce, 2004: 107), as noted by Las Heras (2010): "it is complicated to establish a suitable balance between empathy and professional distance and to maintain a proper attitude in emotionally difficult situations". In this sense, both the two psychologists who said they are in favour of verbal explanation of cultural differences and the Russian mediator were quite critical of the possibility of mediators carrying out this type of communicative action aimed at encouraging the patient's emotional expression, arguing that they may contaminate the therapeutic process:

> […] your job is not to show your personality, it is to be a mirror of the people you're interpreting, so that they feel more connection through you, but nobody needs your personality. You don't have to be totally invisible, but you have to control it. Your intercultural mediation can be in the very words you choose to translate. (Mediator B)

In our view, the mediator should aim to develop those non-verbal actions or those expressions of encouragement that are commonly used in the patients' cultures of origin in situations with an emotional charge similar to that observed in clinical interviews, as implicitly suggested in the above quote from Mediator A.

All in all, it seems evident that the mediator, as an individual and as a participant in the communicative interaction, will find it difficult to play a role that is completely devoid of emotion, as this could hamper the patient's emotional expression even further. What seems clear is that it falls upon the mediator to ensure that the intercultural differences between the CIPs of the psychologists and those of the ASRs do not lead to a breakdown in communication, especially with regard to expressing emotions.

6. Conclusions

A very high percentage of the ASRs in our study required mental health care during the initial stage of their stay in the reception centres. Most of them had problems related to anxiety and depression. Cases of severe

pathological symptoms, such as psychotic or schizophrenic disorders, were not very common. The psychologists of the NGO under study treated practically all the ASRs who had some kind of mental health problem. Very few cases required psychiatric treatment.

During the clinical interviews between ASRs (especially those of Arab and sub-Saharan origin) and psychologists, communication problems stemming from different cultural conceptions about the origin, nature and treatment of mental problems were detected.[12] However, in these situations, the key to intercultural communication problems lies above all in cultural differences in terms of the CIPs displayed by the ASRs and psychologists, particularly those used to express emotions. It is common for patients, especially from Arab and Eastern European countries, to have difficulties in expressing their emotions during the narration of the traumatic situations they have had to go through. These difficulties are largely due to cultural differences in display rules, that is, the informal rules of a social or cultural group about how to express emotions appropriately.

Obviously, the role of mediators is crucial in addressing communication problems of a linguistic and, especially in the contexts under study, cultural nature. The findings of the present study and of earlier ones suggest that there is no general consensus about the kinds of actions mediators should implement when dealing with differences in emotional expression. We have proposed a number of action guidelines for mediators who carry out their work in the area of clinical interviews between psychologists and ASRs. Given the early stage of our research, these proposals invite further discussion and should be regarded as mere hypotheses.

First of all, before being introduced to the specific characteristics of the interviews between ASRs and psychologists, and before being made aware of the communicative initiatives which mediators may undertake in this context, we consider it urgent that mediators be trained in interlinguistic and intercultural mediation techniques, as well as in the ethical principles they must abide by.

With regard to the type of intercultural communication problems observed, it seems advisable to provide mediators with specific training in the characteristics of the CIPs between healthcare staff and patients in different cultures, especially with regard to emotional expression. It also seems appropriate that a series of communicative actions be carried out, among which we highlight the following: the selection of mediators with

[12] This is not to say that there are no language issues, which we do not address in this research.

gender and age characteristics that are suited to the cultural characteristics of the patients, the explanation of the therapeutic value of the narration of traumatic events, the explanation of cultural differences in terms of emotional expression, the non-coercion of the free emotional expression of the patients, and the attunement with the paralanguage and non-verbal language of the patient. Finally, in situations in which the differences between the interaction patterns of psychologists and ASRs are causing a breakdown in the latter's emotional expression, it may be advisable that mediators adopt communicative behaviours (such as physical contact and expressions of encouragement) that, in the patient's culture of origin, tend to facilitate the manifestation of emotions.

References

Achotegui, J. *et al.* 2016. *Protocolo para la atención en salud mental de las personas refugiadas en Cataluña.* Barcelona: Direcció General de Planificació en Salut. Generalitat de Catalunya.

Bancroft, M. A. 2017. "The voice of compassion: exploring trauma-informed interpreting". In C. Valero and R. Tipton (Eds.), *Ideology, Ethics and Policy Development in Public Service Interpreting and Translation*, Bristol: Multilingual Matters, pp. 195-219.

Baraldi, C. and Gavioli, L. 2007. "Dialogue interpreting as intercultural mediation: An analysis in healthcare multicultural settings". In M. Grein and E. Weigand (Eds.), *Dialogue and Culture*, Amsterdam and Philadelphia: John Benjamins, pp. 155-175.

Basso, K. H. 1972. "To give up on words. Silence in Western Apache culture". In P. P. Giglioli (Ed.), *Language and Social Context*, London: Penguin, pp. 67-86.

Beneduce, R. 2004. *Frontiere dell'identità e della memoria. Etnopsichiatria e migrazioni in un mondo creolo*. Milan: Franco Angeli, 1998.

Bot, H. 2005. *Dialogue Interpreting in Mental Health*. Amsterdam: Rodopi.

Brody, L. 1999. *Gender, Emotion, and the Family*. Cambridge, MA: Harvard University Press.

CHIA. California Healthcare Interpreters Association and California Endowment. 2002. *California Standards for Healthcare Interpreters: ethical principles, protocols and guidance on roles and intervention*. Available at http://www.chiaonline.org/Resources/Documents/CHIA%20Standards/standards_chia.pdf (last accessed 17 October 2020).

Cirillo, L. 2012. "Managing affective communication in triadic exchanges: Interpreters' zero-renditions and non-renditions in doctor-patient Talk". In C. J. Kellett Bidoli (Ed.), *Interpreting across Genres: Multiple Research Perspectives,* Trieste: EUT Edizioni Università di Trieste, pp. 102-124.

Collazos, F. and Casas, M. 2007. "Tratamiento psiquiátrico del paciente magrebí". In D. Moussaoui and M. Casas (Eds.), *Salud mental en el paciente magrebí*, Barcelona: Glosa, pp. 255-264.

De Leersnyder J., Boiger, M. and Mesquita, B. 2013. "Cultural regulation of emotion: individual, relational, and structural sources". *Frontiers in Psychology*, 4, pp. 1-11.

Díaz, N., Díez, A., Favieres, P., Muñiz, R., Senante, A., Valiente, M. and Amorós, M. 2018. *Informe 2018 de la Comisión Española de Ayuda al Refugiado (CEAR). Las personas refugiadas en España y Europa*. Madrid: CEAR. Available at https://www.cear.es/wp-content/uploads/2018/06/Informe-CEAR-2018.pdf (last accessed 17 October 2020).

Ekman, P. and Friesen, W. 1969. "The repertoire of nonverbal behavior: Categories, origins, usage, and coding". *Semiotica*, 1, pp. 49-98.

Evangelidou, S., Collazos, F. and Qureshi, A. 2016. "Guía breve sobre el apoyo en salud mental/psicosocial a los refugiados sirios en España". *Norte de Salud Mental*, XIV (55), pp. 66-77.

Hlavac, J., Surla, B. and Zucchi, E. 2020. "Relational, situational and discourse features of mental health interactions: perspectives from interpreters." In E. Ng and I. Creez (Eds.), *Interpreting in Legal and Healthcare Settings: Perspectives on Research and Training*, Amsterdam and Philadelphia: John Benjamins, pp. 313-342.

Hsieh, E. 2016. *Bilingual Health Communication. Working with Interpreters in Cross-Cultural Care.* New York and London: Routledge.

Hsieh, E. and Nicodemus, B. 2015. "Conceptualizing emotion in healthcare interpreting: A normative approach to interpreters' emotion work". *Patient Education and Counseling*, 98, pp. 1474-1481.

Ingleby, D. 2005. "Editor's introduction." In D. Ingleby (Ed.), *Forced Migration and Mental Health. Rethinking the Care of Refugees and Displaced Persons*, Dordrecht: Springer, pp. 1-28.

IMIA. International Medical Interpreters Association and Education Development Centre, INC. 2016. *Medical Interpreting Standards of Practice*. Available at http://www.imiaweb.org/code/default.asp (last accessed 17 October 2020).

Kramer, S. 2005. "Getting closer. Methods of research with refugees and asylum seekers." In D. Ingleby (Ed.), *Forced Migration and Mental Health.*

Rethinking the Care of Refugees and Displaced Persons, Dordrecht: Springer, pp. 129-148.

Krystallidou, D. K. 2012. "On mediating agents' moves and how they might affect patient-centredness in mediated medical consultations". *Linguistica Antverpiensia New Series-Themes in Translations Studies*, 11, pp. 75-93.

Las Heras, C. 2010. "Solicitantes de asilo, refugiados, apátridas: una Babel invisible". In L. González and C. Las Heras (Eds.), *La traducción y la interpretación contra la exclusión social*, Madrid: CE and CEAR, pp. 53-60.

Leanza, Y, Boivin, I. and Rosenberg, E. 2013. "The patient's Lifeworld: Building meaningful clinical encounters between patients, physicians and interpreters". *Communication & Medicine*, 10 (1), pp. 13-25.

León-Pinilla, R., Jordà-Mathiasen, E. and Prado-Gascó, V. 2016. "La interpretación en el contexto de los refugiados: valoración por los agentes implicados". *Sendebar*, 27, pp. 25-49. Available at http://revistaseug.ugr.es/index.php/sendebar/article/view/4921 (last accessed 17 October 2020).

López Neyra, G. 2017. "Intervención con personas refugiadas. Impacto sobre el proyecto vital. Claves para la acogida y el acompañamiento". In N. Sayed-Ahmad Beiruti (Ed.), *El bienestar psicosocial de las personas migrantes y refugiadas*, Madrid: Asociación Española de Neuropsiquiatría, pp. 41-54.

Lurbe, K. 2005. *La enajenación de l@.s Otr@.s. Estudio sociológico sobre el tratamiento de la alteridad en la atención a la salud mental en Barcelona y París*. Barcelona: Universitat Autónoma de Barcelona. PhD dissertation.

Martin, A. and Valero Garcés, C. 2008. "Introduction". In C. Valero Garcés and A. Martin (Eds.), *Crossing Borders in Community Interpreting. Definitions and Dilemmas*, Amsterdam and Philadelphia: John Benjamins, pp. 1-7.

Matsumoto, D., Yoo, S. H. and LeRoux, J. A. 2007. "Emotion and intercultural adjustment". In H. Kotthoff and H. Spencer-Oatey (Eds.), *Handbook of Intercultural Communication*, Berlin: Mouton de Gruyter, pp. 77-97.

Merlini, R. 2019. "Through the Looking-Glass: Reflections of/on empathy in healthcare interpreter education". *Cultus Journal,* 12, pp. 220-245.

Merlini, R. and Gatti, M. 2015. "Empathy in healthcare interpreting: going beyond the notion of role". *The Interpreter's Newsletter*, 20, pp. 139-160.

Messent, P. 2003. "From postmen to makers of meaning: a model for collaborative work between clinicians and interpreters". In H. Raval

and R. Tribe (Eds.), *Working with Interpreters in Mental Health*, New York: Routledge, pp. 135-150.

NCIHC (National Council on Interpreting in Health Care). 2004. *National Code of Ethics for Interpreters in Health Care*. Available at http://www.ncihc.org/assets/documents/publications/NCIHC National Code of Ethics.pdf (last accessed 17 October 2020).

Patel, N. 2003. "Speaking with the silent: addressing issues of disempowerment when working with refugee people". In H. Raval and R. Tribe (Eds.), *Working with Interpreters in Mental Health*, New York: Routledge, pp. 219-237.

Pérez Sales, P. 2004. *Antropología psiquiátrica y psiquiatría transcultural*. Available at http://www.pauperez.cat/wp-content/uploads/2017/11/pau--texto-psicologia-y-psiquiatria-transcultural-borrador.pdf (last accessed 17 October 2020).

Pöllabauer, S. 2005. *"I don't understand your English, Miss": Dolmetschen bei Asylanhörungen*. Tübingen: Gunter Narr Verlag.

Raga, F. 2005. *Comunicación y cultura. Propuestas para el análisis transcultural de las interacciones comunicativas cara a cara.* Madrid: Iberoamericana.

Raga, F. 2018. "Crítica de la mediación intercultural: reflexiones en torno a un proyecto de investigación-acción en el ámbito sanitario". *I Congreso de SIETAR España. Competencia intercultural: clave para sociedades y organizaciones inclusivas*, Málaga.

Raga, F. 2019. "Interlinguistic and intercultural mediation at a standstill: causes and effects". In E. Di Maria (Ed.). *Health Right Across the Mediterranean. Tackling Inequalities and Building Capacities*, Genova: Genova University Press, pp. 69-81.

Raga, F., González, E. and Baouchi, H. 2014. "Mediación interlingüística e intercultural en salud mental". In Grupo CRIT. *La práctica de la mediación interlingüística e intercultural en el ámbito sanitario*. Granada: Comares, pp. 221-264.

Raga, F. and Sales, D. 2010. "El componente cultural en la formación para la interpretación y la mediación intercultural en el ámbito sanitario." In M. Carreras and M. E. Pérez (Eds.), *La mediación lingüística y cultural y su didáctica. Un nuevo reto para la Universidad*, Bolonia: Bolonia University Press, pp. 165-192.

Sales, D., Haij, H. and Sánchez, M. I. 2014. "Mediación interlingüística e intercultural en salud reproductiva." In Grupo CRIT. *La práctica de la mediación interlingüística e intercultural en el ámbito sanitario*, Granada: Comares. pp. 265-289.

Theys, L., Krystallidou, D., Salaets, H., Wermuth, C. and Pype, P. 2020. "Emotion work in interpreter-mediated consultations: A systematic literature review". *Patient Education and Counseling*, 103, pp. 33-43.

Verrept, H. and Coune, I. 2018. "Desarrollo de una guía para la mediación intercultural en la atención sanitaria en Bélgica." In R. Mendoza, E. Gualda and M. Spinatsch (Eds.), *La mediación intercultural en la atención sanitaria a inmigrantes y minorías étnicas. Modelos, estudios, programas y práctica profesional. Una visión internacional*. Madrid: Díaz de Santos, pp. 5-29.

Winkelman, M. 2009. *Culture and Health. Applying Medical Anthropology*. San Francisco: Jossey-Bass.

Appendix 1.

Outline for the interviews with psychologists about the biopsychosocial situation of the asylum seekers and refugees they treat, and about their professional experience in clinical interviews with mediators

- Training and professional experience of the interviewee
- What are the administrative procedures that are put in place for the psychological care of asylum seekers and refugees? What percentage of asylum seekers and refugees receive psychological care? How many patients are referred to psychiatric services? What other activities are psychologists involved in (workshops, seminars, etc.)?
- What is the socioeconomic situation of asylum seekers and refugees in the host country? What is the role of families and social support groups?
- What are the general characteristics of clinical interviews with asylum seekers and refugees? What is their duration and frequency? What types of treatment are implemented?
- What are the main psychological problems experienced by asylum seekers and refugees?
- What are the main differences between the biomedical conception of mental health and the conception proper to the cultures of origin of the patients? What about the relationship between patient and healer? How do they influence the development of clinical interviews? How do you deal with these differences?
- What are the main therapeutic challenges involved in the narration of traumatic events by asylum seekers and refugees?
- What are the main characteristics of the expression of emotions in the patients' cultures of origin? How do they influence the course of clinical interviews? How do you deal with them?
- What is the role of social stigma among asylum seekers and refugees in accessing mental health services?
- What have your experiences working with mediators generally been like? How does the presence of mediators influence the way interviews progress?
- How do you feel about a single mediator being involved in all the interviews with the same patient?
- Do mediators usually intervene to offer explanations related to cultural aspects and how does this influence the way the clinical interviews progress?

- Are mediators often emotionally involved in the conduct of clinical interviews and how does this influence the way the clinical interviews progress?
- What is your experience with mediation through remote audiovisual devices?
- Have you had any emotional problems as a result of your work in clinical interviews with asylum seekers and refugees and, if so, how do you deal with them?

Appendix 2.

Outline for the interviews with mediators about their professional experiences in clinical interviews between psychologists and asylum seekers

- Training and professional experience of the interviewee
- What are the main terminological problems you often encounter in this type of situation?
- How does the issue of confidentiality affect patients and what do you do to ensure it?
- How do you generally deal with the issue of fidelity, and in what circumstances do you consider adding, removing or altering some of the expressions used by your interlocutors?
- Are you faced with situations where one of your interlocutors wants you to take his or her side? How do you deal with dilemmas related to impartiality?
- Do you find yourself in situations where you are asked by one of your interlocutors to carry out functions that are not those of a mediator? How do you react in such cases?
- What are the main problems related to the spatial and temporal regulation of the communicative interactions you have encountered? How do you deal with them?
- Do you usually intervene in all the clinical interviews with the same patient? What are the advantages and disadvantages of this practice?
- What is your experience with mediation through remote audiovisual devices?
- What are the general aspects of the patients' cultures of origin with respect to mental health that tend to generate the most misunderstandings? What communicative strategies do you use in these cases?
- What are the emotional aspects of the cultures of origin of the patients and their life experiences that most influence the way clinical interviews progress? What communicative strategies do you use in these cases?
- Have you experienced any emotional problems as a result of your work as a mediator in clinical interviews with asylum seekers and refugees and, if so, how do you deal with them?