The Routledge Handbook of Translation and Health

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Publication details
Anne Birgitta Nilsen
Published online on: 10 May 2021

How to cite: Anne Birgitta Nilsen. 10 May 2021, Interpreter-mediated communication with children in healthcare settings from: The Routledge Handbook of Translation and Health

Routledge
Accessed on: 05 Dec 2023

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Interpreter-mediated communication with children in healthcare settings

Anne Birgitta Nilsen

1 Introduction

Although most of an interpreter’s assignments in healthcare settings will involve interpreting between adults, interpreting for children is also a common occurrence. Therefore, it is important that both the interpreters and those who use their services know how to handle interpreter-mediated conversations with children. In this chapter, I will focus on oral interpreter-mediated communication with children in healthcare settings from the perspectives of both practice and research. First, I will provide a literature review of the research related to interpreter-mediated communication with children with a focus on methodology. Based on this review, I will attempt to answer some theoretical, as well as some practical questions. The former will look at which research methods and what types of data have been used in interpreter-mediated communication with children, and which research themes have, to date, been explored. The review findings will show that very little research has been done in interpreting for children in general and in the healthcare context in particular. Studies coming from areas unrelated to health services nevertheless can provide invaluable knowledge and information about interpreter-mediated communication with children in healthcare.

Most of the extant research on the subject is based on qualitative methods and interviews. Several of the studies considered in the review highlight the need for special training for interpreters, as well as for service users in interpreter-mediated communication with children. They also indicate that there is a need for information on how to train professional interpreters with a view to interpreting for children.

In the second part of this contribution, I will discuss some practical questions based on existing knowledge drawn from research and practice. The questions that will be posed will focus on the facilitation of interpreter-mediated communication with children, how interpreting for children differs from interpreting for adults, and what kind of skills, training and knowledge interpreters and service users need when conducting interpreter-mediated dialogues with children. The chapter will then conclude with some recommendations for future research.
2 Research on interpreter-mediated communication with children

Interpreting for children, and especially for young children, is a largely unexplored field within public service interpreting (for the few exceptions, see Gotaas 2007; Hitching and Nilsen 2010; Nilsen 2013; van Schoor 2013). A few researchers have conducted studies on sign-language interpreting for children in schools (e.g. Hjelmervik 2009; Schick, Williams and Kupermintz 2006; Winston 2004), but in this chapter, the focus is on interpreting in the public sector in general and in the health services in particular, therefore I will not be covering this education-focused literature.

Of the limited number of studies found for this review, very few are from the healthcare sector. In fact, the only research that I was able to find from the field of healthcare were two Swedish studies from childhood cancer care centres in Sweden (Granhagen Jungner et al. 2016; Granhagen Jungner et al. 2018). The other studies mentioned below are not located within healthcare, but nevertheless provide valuable knowledge about interpreter-mediated communication with children in general, including within healthcare settings.

The studies covered in this review (see Table 17.1 below) are based on qualitative methods (20 studies), with the exception of one survey (in Balogh and Salaets 2015) undertaken by the EU Co-Minor/INQUEST project, which investigated the questioning of minors in six different European jurisdictions. The results from the survey testify to the frequent occurrence of pre-trial interpreted interactions involving children in several European countries. It also reveals that interpreted child interviews in pre-trial settings are still unexplored territory. Another important finding from this survey is that ‘the professional group of child support workers apparently knows the least about the role of

Table 17.1 Overview of data and methods used in qualitative studies of interpreter-mediated communication with children

<table>
<thead>
<tr>
<th>Method and data</th>
<th>Reference and country</th>
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</thead>
</table>
| Interviews with interpreters (3) | Granhagen Jungner et al. (2018), Sweden  
Granhagen Jungner et al. (2016), Sweden  
Balogh and Salaets (2015), Belgium |
| Interviews with minors and families (3) | UNICEF (2018), Belgium  
Keselman et al. (2010), Sweden  
Keselman et al. (2008), Sweden |
| Interviews with service users in the public sector (4) | Powell et al. (2017), Australia  
Fontes and Tishelman (2016), USA  
Balogh and Salaets (2015), Belgium  
Matthias and Zaal (2002), South Africa |
| Experimental studies (3) | Kanstad and Gran (2016), Norway  
Balogh and Salaets (2015), Belgium  
Nilsen (2013), Norway |
| Audio recorded institutional dialogues with minor asylum seekers (2) | Kjelaas and Eide (2015), Norway  
Keselman, Cederborg and Linell (2010), Sweden |
the interpreter’ (Balogh and Salaets 2015: 199). This research is relevant for interpreter-mediated encounters with children in healthcare settings and may serve as an inspirational example to follow in healthcare. So far, there is no knowledge about the frequency of interpreter-mediated encounters with children in healthcare settings. We also do not know the extent of healthcare workers’ knowledge about the role of the interpreter or how interpreter-mediated communication is handled in healthcare settings.

Most of the qualitative studies relating to interpreter-mediated communication with children collected their data through interviews (10 studies), and most of these studies were based on data gathered in Sweden (5 studies) and Belgium (4 studies). These studies utilised interviews to explore the experiences of the interpreters, the minors and the users of interpreting services. The studies based on interviews include:

1) Interviews with interpreters:
   a) who interpreted for healthcare staff and patients/families with limited Swedish proficiency in childhood cancer care centres in Sweden (Granhagen Jungner et al. 2016; Granhagen Jungner et al. 2018)
   b) who interpreted in the legal sector in Belgium (Balogh and Salaets 2015)

2) Interviews with minors:
   a) investigating their experiences with interpreter-mediated asylum hearings in Sweden (Keselman et al. 2010; Keselman et al. 2008)
   b) who are immigrant and refugee children in Belgium (UNICEF 2018)
   c) who were participants in an experimental study in Belgium (Balogh and Salaets 2015)

3) Interviews with service users:
   a) who are conducting investigative interviews with child complainants of sexual abuse in Australia (Powell et al. 2017)
   b) who are child forensic interviewers and child advocacy centre directors in the United States. The interviews in question investigated their experiences, practices and opinions regarding their daily interviews with children and families who are not native speakers of English (Fontes and Tishelman 2016)
   c) in the legal sector in Belgium (Balogh and Salaets 2015) and in South Africa (Matthias and Zaal 2002)

In addition to the studies based on interviews, two studies are based on linguistic analyses of audio recordings of institutional dialogues with minor asylum seekers, one in Sweden (Keselman, Cederborg and Linell 2010) and one in Norway (Kjelaas and Eide 2015). There are also three experimental studies with very young children: a pilot study based on linguistic analyses of video-recorded experiments (Nilsen 2013), a study based on video recordings, interviews and observations in a kindergarten in Norway (Kanstad and Gran 2016), and a study based on interviews with children who participated in interpreter-mediated experiments in Belgium (Balogh and Salaets 2015). All the experimental studies focus on how the children respond to the interpreter’s translating activities and address the children’s understanding of the interpreter’s role.

For this review, in addition to the studies mentioned above, four theoretically-based literature reviews were examined. These focus on the challenges of interpreter-mediated interviews with minors in a criminal context (Böser and La Rooy 2018); on perspectives gained from studies on multilingualism (Nilsen 2015); on interpreter-mediated interviews with child witnesses and victims (van Schoor 2013); and, on forensic interviews with
children (Fontes 2010). In the following sections, I will present the main themes arising from this literature review, including the interpreters’ competence and lack of competence, as well as the competence of those using the interpreters’ services concerning selecting interpreters, facilitation of interpreter-mediated communication with children, and training for both interpreters and users.

3 Critical issues

3.1 The interpreter’s competence

The interpreter’s competence is fundamental to successful communication in interpreter-mediated sessions with children in healthcare. Several studies in the review refer to interpreters’ competence or lack thereof. In one of the studies, researchers explore the interpreters’ experience of interpreting for healthcare staff and patients/families with limited Swedish proficiency in childhood cancer care (Granhagen Jungner et al. 2016). This study suggests that interpreters must have the understanding and ability to manage cultural differences between the staff, patients and families; to consider the general health literacy of the family, i.e. their ability to understand the information they are provided at the hospital; to acquaint themselves with the competence of the interpreters who preceded them if they are to bridge any existing gaps in knowledge and provide continuity (Granhagen Jungner et al. 2016: 143). The results from this study show that healthcare staff are too focused on giving information in a unidirectional way. Despite the interpreters’ efforts, this affects the possibility for the family to understand the information and gain knowledge about their child’s illness and treatment. In addition, the study also finds that interpreters struggle with their colleagues’ lack of linguistic competence, meaning that they cannot trust that the information is consistent throughout the whole period of treatment.

Furthermore, Granhagen Jungner et al. (2016: 144) note that, for the interpreters in this study, the issue of neutrality becomes increasingly problematic, as they interpret for very ill children and therefore are emotionally affected. This means that they have to balance between their own compassion and professionalism, ‘as one interpreter put it, “sparing them my tears”’ (Granhagen Jungner et al. 2016: 142). In another article based on experience from the same hospital in Sweden, the authors observe:

The fact that the study was conducted in a pediatric oncology care context gives deeper understanding of the interpreters’ perspective of a complex situation and how they deal with it. This specific context means that interpreters had experiences of emotionally heavy situations, meeting children with life-threatening diseases, situations that possibly force interpreters to stretch their discretionary power to carry the bilingual conversation, and they reported doing so by using strategies clearly outside of their assignment.

Granhagen Jungner et al. 2018: 6

The observations cited above add to the call for a better clarification of the interpreter’s responsibilities, as noted by Powell et al. (2017: 99).

Van Schoor (2013: 65) notes that interpreters need to be particularly aware of their own potential influence on the communication during interviews with child witnesses and victims. Furthermore, the nature of the communication calls for a sensitive, child-friendly
attitude from the interpreter, where friendliness is carefully balanced with neutrality (ibid.). These points may be of particular importance in contact with sick or otherwise vulnerable children in healthcare settings. Similarly, Wadensjö’s study involving a medical examination (1998: 185) and Nilsen’s experimental study (2013) show that interpreters may be able to engage in coordinating initiatives to ensure a child’s continued cooperation during the interpreter-mediated communication.

3.2 The interpreter’s lack of competence and its consequences

Several studies in this review refer to their observation of lack of competence on the interpreters’ part. Although these studies refer to other contexts than healthcare, there is no reason to believe that interpreter competence in healthcare is any higher than the competence of interpreters in courts or elsewhere in the public sector. Furthermore, we also have no reason to believe that the consequences of this lack of competence are less serious in healthcare than for example in the courtroom. Therefore, similar concerns about the interpreter’s lack of competence would be valid for interpreter-mediated communication with children in healthcare settings.

Matthias and Zaal (2002) discuss the inability of many interpreters to relate to or communicate appropriately with child witnesses in South Africa. They claim that serious difficulties are encountered in many cases where children are expected to work with interpreters in the courts (Matthias and Zaal 2002: 368). These difficulties are such that South African courts frequently fail to meet the child-participation standards set in article 12 of the UN Convention on the Rights of the Child and article 4(2) of the African Charter on the Rights and Welfare of the Child. Child witnesses are sometimes harmed by the experience, and the result is frequently a failure of justice as the courts are hearing only ‘a faint echo’ of what the children would have been able to communicate if translation services had been improved (Matthias and Zaal 2002: 371).

In a Swedish study of asylum interviews with minors (Keselman et al. 2010; Keselman et al. 2008), the researchers demonstrated how a child’s right to be heard can be jeopardised by the use of non-professional interpreters. This occurred when the interpreters put leading questions to the children or omitted, distorted or caused doubts about things that the children had said. On the other hand, a study including professional interpreters (Nilsen 2013) suggests the opposite: that some professional interpreters pay more attention to what the child says than to what the adult says. Nilsen describes this as an instance of the child being empowered by the interpreter:

[...] The example illustrates Birgitte Englund Dimitrova’s discussion of the interpreter’s responsibility in the interaction process (Englund Dimitrova, 1997). Englund Dimitrova asks what the interpreter should do when the two parties in a dialogue compete for the floor. Which party should the interpreter choose to interpret for? Amongst our informants, the answer is in favour of the weaker party, meaning the party with less power in the communicative event, the child.

Nilsen 2013: 26

Nevertheless, the results of both studies indicate that there is a clear need to improve the competence of both the interpreters and the professionals who use their services. The studies also indicate a need for more research in this field.
In their article, Kjelaas and Eide (2015) use one case to emphasise how the interpreter’s omissions and changes can hamper communication between a minor asylum seeker and a social worker, to the extent that the communication eventually collapses. Similarly, a report based on interviews in Belgium states that:

These refugee children highlight the lack of support from guardians or lawyers. They bemoan the interventions of interpreters, which are too limited or ill-intentioned. And in the reception centers, children would like more help and to be given better information, right from the beginning, so they can better understand what game they are playing.

UNICEF 2018: 12

Thematic analysis of semi-structured interviews with professionals about the interpreting process revealed the interpreters’ insufficient understanding of ‘best-practice’ in the child interview process; consequently, the recommendations focus on the need for more specialised training for the interpreters (Powell et al. 2017).

An important distinction between interpreter-mediated communication involving children and that involving adults lies in the consequences of inadequate and non-professional interpreting. Children are less able to assert their rights due to their status as minors and their generally less advanced communicative skills. As a result, an interpreter who does not take a child seriously and whose interpreting lacks accuracy is likely to reinforce the asymmetry of the relationship. Examples of such problems appear in the Swedish research (Keselman et al. 2008; Keselman et al. 2010), which found that interpreters sometimes cast doubt on children’s stories in asylum interviews. Compared to adults, children can be more easily transformed (or can transform themselves) from a person talked and listened to into an object that is talked about. The cross-cultural nature of the interaction may give legitimacy to the interpreters’ expressions of their own opinion, and this may reflect or reinforce the impression caseworkers have of children as less than able interlocutors (Böser and La Rooy 2018; Keselman, Cederborg and Linell 2010).

4 Practical issues

In what follows, I will focus on some practical issues related to interpreter-mediated communication with children, including the facilitation of such communication, and what kind of skills, training and knowledge interpreters and service users need when conducting interpreter-mediated dialogues with children.

4.1 The competence of those using interpreting services

In healthcare as well as in other public services, the competence of the users of interpreting services includes knowledge about planning and conducting an interpreter-mediated meeting with children. Nilsen (2015) argues that in public sector services we need to shift from a monolingual to a multilingual perspective when planning and conducting meetings with children and their families from linguistic minorities. The argument is based on research into interpreting, mostly in Norway, and on the broader research into children’s multilingual competences and multilingual practices. Once we have shifted to a
multilingual perspective, it becomes clear that the planning of a meeting must include the following steps:

1. Seek information about the multilingual competences and multilingual practices of the child and the parents in order to assess whether an interpreter is required
2. If needed, book a professional interpreter, as opposed to a bilingual helper; and
3. Check that the interpreter has the necessary competence to interpret specifically for children (Nilsen 2015: 128–129)

Planning involves first establishing whether there is a need for an interpreter. There is an obvious need for interpreters in cases where children do not speak the language of the public sector worker. However, there are cases with bilingual children where it is not so easy to determine whether an interpreter is needed. Fontes and Tishelman (2016: 55) note that participants in their interviews reported difficulties in deciding whether an interpreter should be called in to work with a specific bilingual child. In their study, comments by respondents such as this one was fairly typical: ‘Kids say they speak English but then you get into the room and it seems chopped up’ (Fontes and Tishelman 2016: 55). When assessing children’s linguistic skills and their need for an interpreter, there are many possible sources of error that may lead to a wrong assessment (Nilsen 2015). For example, it is well known that a child’s language choice is not necessarily controlled by the language in which the child is addressed (Nilsen 2015: 128). A multilingual child may choose not to speak the majority language in a particular situation because they wish to create a certain distance from, or not to relate to, a majority language-speaking person – for example, a doctor. In such a situation, the child may opt for the parents’ language if they are present, even when the child has greater command of the majority language than of the family’s language. In such cases, there may well be a need for an interpreter.

Studies of forensic interviews with children stress the importance of interviewing children in their preferred languages (Fontes 2010; Fontes and Tishelman 2016). This may also be important in healthcare. Experience shows that both memory and presentation are affected by the language chosen for an interview. Interviewees are apt to provide more details and demonstrate the full range of their competence when they speak in their preferred language (Fontes 2010: 285).

4.2 The ‘right’ interpreter

The necessary competence for those who use interpreting services includes knowledge about choosing the ‘right’ interpreter. An evaluation by the Norwegian Directorate of Immigration indicates that experience and formal education in interpreting in general are not in themselves indicators of success in interpreting for children (Hitching and Nilsen 2010: 41). The main concern expressed by asylum interviewers is that some interpreters are too dominant; on the other hand, there were also issues with interpreters whose manner was too passive and distant. Factors such as personality and body language emerged as important. For instance, some children were reported to be afraid of certain interpreters who interpret in the Norwegian public sector services. The Directorate’s findings suggest that not all interpreters are suitable for assignments involving children. As Matthias and Zaal observe:
It is thus necessary to move away from the idea that interpreters are interchangeable if they have the same language familiarity. As a starting point in developing improved selection procedures, court administrators should identify which of their interpreters actually want to work with children.

These observations are consistent with the views of Jareg and Pettersen (2006: 45) who write that some interpreters are better suited than others to work in what they call sensitive situations, and interviews with children may well come into this category. Importantly, Jareg and Pettersen do not consider that the personal qualities that may render someone suitable or unsuitable for interpreting in sensitive situations are immutable. A person may be made aware of the need of, and then cultivate, the necessary qualities.

4.3 The facilitation of interpreter-mediated communication with children

Van Schoor (2013) concludes from her literature review that interpreters should be involved in the interview preparation process, as is prescribed by the UK Ministry of Justice\(^1\) (van Schoor 2013: 63). However, in the field of interpreting for children, very few articles or reports exist on how to facilitate oral interpreter-mediated communication. Such studies are often based on research into children’s cognitive development and the use of sign language (e.g. Rainò 2012; Schick 2001) or on personal experience (Bjørnås 2006; Phoenix Children’s Hospital 2008; Veritas Language Solutions 2012; Wilson and Powell 2001). According to Bjørnås (2006), who works as a consultant in Trondheim’s municipal interpreting services in Norway, there is little distinction between an interpreted meeting with children and one with adults, provided that both the interpreter and the user of the interpreting services follow the basic rules for conversing through an interpreter. In Norway, these rules are explained in an online document published by the Norwegian Health Directorate with the title ‘Guidance for interpreter-mediated communication’.\(^2\) In this document, the healthcare workers are, for example, instructed to talk directly to the patient, keep eye contact with the patient and not with the interpreter, and not to involve the interpreter in the dialogue. Nilsen (2013) supports Bjørnås’ views on children’s abilities to participate in interpreter-mediated communication and notes that a child’s participation is dependent on their understanding and acceptance of the system of turn-taking that is fundamental to consecutive interpreting. An important condition, however, is that the adult participants know how to handle such communication and can act as a role model for the child on how to communicate through an interpreter.

As noted by van Schoor (2013: 65), it is crucial to delineate the roles of the participants accurately at the start – particularly the difference between the roles of the interpreter and the interviewer. This should be done through a clear introduction and by strictly sticking to these roles during the interaction. Thus, health personnel should explain to the children who the interpreter is and what their function and role are. Children are very different depending on their age and level of cognitive development; furthermore, in many countries, ‘children’ as a group may include individuals from infancy to 18 years of age. Hence, this introductory information needs to be adapted to the child’s age and cognitive development. The following could, for instance, serve as an example adapted for a five-year-old:
This is the interpreter. Her name is Jamila. Jamila is here to help us so that you and I can talk together. Jamila speaks both Arabic and Norwegian. Jamila will never tell anybody what you have told us.

Böser and La Rooy (2018) highlight the importance of building rapport and draw attention to the necessity of establishing some ground rules in order to set the desired framework for participation. An example of such a rule could be that it is the person in charge of the communication who introduces the interpreter to the child, and not the interpreter themselves.

The complexities of rapport building in interpreter-mediated communication with children is also highlighted in experimental studies (Nilsen 2013; Kanstad and Gran 2016). Based on their experimental study in the Norwegian kindergarten context, Kanstad and Gran (2016) emphasise the importance of the child having full confidence in the interpreter; to achieve this, interpreters have to stretch their professional guidelines in a flexible manner. The interpreters interviewed by Kanstad and Gran (2016: 73) say that to gain the children’s trust they talk to the children or play with them before they interpret for them. Nilsen also finds that interpreters must maintain rapport during the interpreting process in order to connect with a child. Non-verbal language such as eye contact seems to play an important role in maintaining a desirable framework for participation. This confirms the findings of Böser and La Rooy, reported in their review article (2018: 214), about the importance of gaze patterns on the establishment of participant status in children’s interaction with adult interpreters.

Böser and La Rooy (2018: 214) also state that studies of face-to-face interpreting with adults in diverse institutional settings have highlighted varying degrees of asymmetry in the distribution of institutional and interactional power between participants. They acknowledge that this asymmetry may be further exacerbated in situations involving particular groups of participants, such as children. Böser and La Rooy (2018: 220) quote an interpreter from Catherine King’s research (2015: 72), working with children, who argues that ‘[i]f it is not possible to build up trust or rapport, then it may be more productive to arrange for another interpreter in order to carry out the interview’, a view that is supported by Balogh and Salaets (2015: 72). This may also be a solution in healthcare settings when there is a problem of building trust.

4.4 Training

Several studies recommend special training for interpreters to build competence in handling interpreter-mediated communication with children. I believe these recommendations also apply for healthcare. Matthias and Zaal (2002: 368) conclude that there is an urgent need to introduce new measures to improve the interpreting services available for children required to testify in South African courts. Furthermore, they recommend that a course should be designed that will lead to official certification of interpreters as ‘qualified to interpret for children’. Powell et al. (2017: 98) state that

interpreter training in the area of child abuse investigation needs to extend its focus beyond simply translating questions and responses in order to maintain their structure and meaning. Training should also build interpreters’ competency in maintaining
a non-verbal demeanour that facilitates accurate disclosure and maintains a context where children feel heard, understood and not judged.

Powell et al. 2017: 98

Balogh and Salaets (2015) suggest that training for interpreters who will be handling child interviews could include some background knowledge of the developmental stages of childhood and adolescence, possible disorders, the functioning of memory in children and language acquisition. They note that some knowledge about trauma and victimisation and the corresponding behaviours (e.g. panic, distrust, reluctance) are essential for all professionals working with child victims and witnesses. This is confirmed by the United Nations Office on Drugs and Crime (UNODC) Handbook for Professionals and Policymakers on Justice Matters Involving Child Victims and Witnesses of Crime (2009). Such skills would enable interpreters to anticipate certain behaviours and deal with them in the best possible way when working in a challenging environment (van Schoor, Balogh and Salaets 2015: 22). According to Matthias and Zaal (2002: 365), a study-participant who was a criminal court magistrate with considerable experience of working with court interpreters stated that a future course of child-competence training for interpreters should include the following outcomes:

• the ability to understand the stages of child development
• the ability to assess a child’s level of comprehension
• the ability to appreciate the more common effects of trauma on a child, especially the effects of rape; and
• knowledge about the way in which young, mentally-challenged or traumatised children tend to give evidence – for example, that it will not necessarily be in a logical sequence

This magistrate also emphasised that there is frequently a need for tremendous patience and gentleness when interviewing a child. Properly trained interpreters must, for example, be able to deal appropriately with the child breaking down and crying whilst giving evidence. Similar concerns arise when children suffer from chronic illnesses, may be recovering from highly stressful events, such as accidents, or are traumatised as a result of physical and/or sexual abuse. When these children are offered healthcare, their interpreters in healthcare settings will have to undergo similar training in dealing with sensitive situations.

4.5 Joint training

Already in 2002, Matthias and Zaal had highlighted an important point that emerged from their study, namely that interpreters (no matter how well-trained) will not be able to work effectively with children if other persons in positions of authority expect them to convey inappropriately complex language to children (2002: 368). It may therefore be suggested that a basic course of certification for working with children, as recommended above for interpreters, could very usefully be extended to other staff involved in interpreter-mediated communication within health care. Granhagen Jungner et al. (2016: 144) note that healthcare staff need training in the use of interpreters and that integrated systems need to be created for the booking and evaluation of interpreters.

Many studies have found that communication through an interpreter is a skill that must be learnt, as it differs significantly from other types of communication (e.g. Radanović
Children in healthcare settings

Felberg 2016). Of particular importance is an understanding of the intersection between the interpreter's and the public servant's areas of expertise. Successful communication in interpreter-mediated institutional dialogues requires specific skills from the interpreters and matching skills from the public service employees about how to communicate through an interpreter. It is imperative that training for interpreters and users is synchronised in order to avoid contradictory modes of operation (Radanović Felberg 2016: 154).

Several studies in this review recommend specialised training, not only for interpreters but also for other professionals who deal with interpreted communication with children (e.g. within the legal context, see Balogh and Salaets 2015; van Schoor 2013). Van Schoor (2013: 64) writes that ‘the key for guaranteeing high-quality interpreter-mediated interviews with child witnesses and victims lies in close collaboration between all involved professionals. Not only during the interviews, but also in the training phase, through the development of a joint training programme’. Van Schoor (2013: 64) comments that the main advantage of multidisciplinary training is that professionals from several fields can exchange their expertise on central topics. In healthcare settings, the benefits of bringing together the expertise of paediatricians, nurses, child psychologists and the interpreters could shed significant light on supporting children with health issues, communication techniques when the patients are children, as well as child development and psychology. This type of training would also provide an ideal opportunity to set up role plays where participants could practise interacting with children and learn how to work together to guarantee a smooth sequence of events. During such courses, audiovisual recordings of interactions with child patients could be analysed to provide learners with further understanding, provided that necessary ethical hurdles could be overcome and permissions obtained. Such training for interpreters would ideally be complemented by a continuous evaluation mechanism, including debriefings after a session and regular feedback by experts (i.e. interpreters as well as professionals from related fields).

An interdisciplinary approach to training is also supported by van Schoor, Balogh and Salaets (2015: 22). Training in interpreter-mediated communication with children is not only the concern of interpreters, but also of other professionals. Doctors, nurses and psychologists should also have competence related to the particular characteristics of interpreter-mediated communication with children and be taught the basic principles of working with an interpreter. Van Schoor, Balogh and Salaets (2015: 22) suggest that these principles can be practised in joint role plays, imitating a real interpreted child interview. Similarly, these principles can be practised in role plays including doctors, nurses and psychologists.

These are, of course, important suggestions, but I would rather argue for specialised training for interpreters and for users of their services who work with children in the public sector in general. The components of working with children are the same across all public sectors; what differs is the context. It is no less important in healthcare that the interpreters and users of their services know, for example, how to ask developmentally appropriate questions of children, than it is in the court rooms or in investigative interviews. It is important across all sectors to have knowledge about the specifics of children's language use and the most constructive way in which to relate to children.

5 Recommendations for future research

There is a need for more research-based knowledge on interpreting in public service meetings with children from linguistic minorities, and in particular, research that relates to healthcare. Themes that emerged as important from this review highlight some of
the differences between interpreting for children and for adults. One theme is trust, and several researchers refer to the importance of establishing rapport and connection through non-verbal communication. Another theme is the need for cooperation between healthcare workers and interpreters, and the clear separation of their roles. We need to know more about the types of situations in which there is a need to interpret for children in healthcare, and how to facilitate interpreter-mediated communication with children in healthcare settings. We also need to know more about good practice and about the multilingual practices currently taking place in encounters with children and their families in public sector services (Nilsen 2015: 129).

Kanstad and Gran (2016) show that interpreting may be important to safeguard children’s rights to express themselves, to participate in interactions, and to prevent social exclusion resulting from a lack of shared language with others in the kindergarten. These aspects of interpreting are important in healthcare, for example so that the children can contribute to the dialogues about their own health and express their pain and/or concerns. In their study on paediatric healthcare, where the participants had interpreted in multi-party bilingual consultations that included children, Granhagen Jungner et al. (2018) observe:

Participants described experiences of interpreting between healthcare personnel and the family (parents). However, the participants did not mention experiences of including the child in the multi-party consultation. Thus, further research is needed exploring the complexity of multi-party consultations that includes children, especially from the child’s perspective.

Granhagen Jungner et al. 2018: 661

Balogh and Salaets (2015) note that interpreter-mediated communication with children is, intrinsically, an interdisciplinary research topic; thus, the research methods or perspectives employed should also be interdisciplinary. Balogh and Salaets’ project CO-Minor-IN/QUEST survey could serve as a good example of such an interdisciplinary approach.

Research into interpreter-mediated communication with children inevitably presents particular challenges relating to ethical issues, due to the vulnerability that goes with young age and the considerable imbalance of power between adults and children. At different ages, children have varying cognitive capacities to make decisions about their own involvement in research, to express meaningful assent or to refuse to participate. However, only one of the studies mentioned above (Nilsen 2013) discusses ethical issues, and then only cursorily. In that study, the experiments conducted with very young children were, for example, set up in such a way that they would cause as little stress as possible to the children (Nilsen 2013: 17). The author notes that one of the children may not have fully understood the differences between the primary speaker and the interpreter, and also that he or she may not have had a clear understanding of the interpreter’s role. The child’s lack of understanding of the interpreter’s role as a translator did not, however, seem to hinder the communication, although the situation may raise certain ethical concerns (Nilsen 2013: 20–21).

6 Conclusion

In this chapter, I have presented a literature review of interpreter-mediated communication with children. The review shows that communication through an interpreter is a skill that must be learnt. Of particular importance is an understanding of the intersection
between the interpreter’s and the public servant’s areas of expertise, which means that training for interpreters and users must be synchronised in order to avoid contradictory modes of operation.

The review shows that extant research generally relates both to the (lack of) competence of interpreters and to those who use their services, and to the training of these two professional groups. There is a need to train interpreters and interpreter users in how to handle interpreter-mediated communication with children of different ages, and there is a need for more knowledge about what to teach the interpreters and users. In turn, this knowledge will help to improve meetings in the public sector services with children who have not mastered the language spoken or who have limited linguistic skills. Most of all, there is a demand for more knowledge about the best practices related to interpreter-mediated communication with children of all ages in healthcare, as well as in other public service areas. In that respect, it is important to note the asymmetry of the relationship in interpreter-mediated communication involving children – children are less able to assert their rights due to their status as minors and their generally less advanced communicative skills.

Based on the literature review this chapter has also provided some recommendations for future research. In particular, I would like to highlight the fact that interpreter-mediated communication with children is an interdisciplinary research topic. Hence, the research methods or perspectives employed should also be interdisciplinary.

Notes


Further reading


The book addresses the challenges in interpreting for minors during an interview as part of (pre-trial) criminal proceedings.


These two articles focus on interpreting in Swedish childhood cancer care.

This article discusses interpreter-mediated communication with children based on knowledge from research on multilingualism.


The report is based on testimonies of 170 migrant and refugee children from 36 nationalities in reception centres and schools. The children talk about their experiences in their country of origin and their new environment, the disaster they fled from, the trials they endured on the way, their joys and sorrows.

**Related topics**

Healthcare Interpreting Ethics, Remote (Telephone) Interpreting in Healthcare Settings, Community/Liaison Interpreting in Healthcare Settings

**References**


Children in healthcare settings


