1 Introduction

According to Article 25 of the Universal Declaration of Human Rights by the United Nations,1 ‘everyone has the right to a standard of living adequate for the health and well-being of himself and of his family’, including medical care. Article 2 stipulates that ‘everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status’2 (my emphasis). In reality though, language often becomes a stumbling block to accessing healthcare. If the care provider and patient do not share a common language, diagnosis and treatment become difficult, if not impossible. This is particularly so in mental healthcare, which relies heavily on the spoken word. An older but still relevant piece of research by Hertog and Van Gucht (2003) showed that 50 per cent of foreign nationals seeking help in Belgian healthcare did need language assistance, suggesting that the numbers are not insignificant. Although the European Union ensures the legal right to be assisted by a professional interpreter in judicial procedures, no such assurance is given in the case of healthcare. In most European countries, easy access to professional interpreters in healthcare is non-existent. In practice, this means that patients who do not speak the same language as the medical professional and require (mental) healthcare are either not treated at all, or receive inferior care with the help of non-professional language assistance (family members, nonmedical staff, etc.). Only few patients receive proper treatment, either by a care provider speaking the language of the patient, or through the assistance of professional interpreters. ENPSIT (European Network for Public Service Interpreting and Translation)3 campaigns for European regulations to ensure proper language services in the entire social sector, comparable with those of the judicial sector, but there is still plenty of work to do.

Mental healthcare in particular is not a suitable setting for working with a nonprofessional interpreter. Mental health issues are usually associated with feelings and behaviour that people may be ashamed of, or with which they do not want to burden others, especially their family members. Despite these issues, the Dutch government, for instance, decided in 2011 to withdraw its central funding for interpreter services in the health sector.
The Minister of Health’s reasoning was that it is the responsibility of each individual to make sure they either understand their care provider or bring their own language help. In practice, it is frequently people with low incomes who require language assistance, which makes acquiring the services of a professional interpreter even more unattainable. As a result, the burden of supplying an interpreter is either left to individual healthcare providers and/or to the institutions they work for, creating extra costs. Alternatively, the patient has no option but to rely on their family members or similar non-professional interpreters. Mental health is the sector within healthcare that makes the most frequent use of interpreters, and, for economic reasons, 85 per cent of these services are done over-the-phone in the Netherlands. Despite this, the use of professional interpreters in healthcare in the Netherlands dropped by more than 75 per cent since this governmental decision.

This contribution deals with the ins and outs of professional interpreting in mental healthcare. It is based on the premise that the primary task of the interpreter is to give a faithful rendition of the words which the therapist and their patient utter; should be neutral and independent; and should refrain from having an input of their own. This is the stance taken by most Codes of Conduct for interpreters, stemming from their work in the judicial realm. Although I personally would support this restricted position of the interpreter, in practice it is impossible to realise. It can even be ‘dangerous’ to believe that an interpreter can ever be of so little influence. Moreover, sometimes a deliberate independent input of the interpreter may enhance the therapeutic process. This means that ‘drawing the line’ is the critical issue here: how much of an independent input is helpful, and when does it go too far, obfuscating the conversation between the primary parties? As in all forms of communication, the key role of the interpreter is to help the healthcare provider and the patient to understand one another. However, it is equally important that they are given the opportunity to find out that they are misunderstanding one another.

This chapter begins with an outline of the main characteristics of therapeutic talk and the interpreting required in this type of conversation, and then discusses the questions of faithfulness, equivalence, and divergence in these settings. The following section provides an overview of the most common critical issues found in mental health interpreting, such as questions, small talk and communicative devices like hedging and modalisation, and uses practical examples to illustrate possible solutions to these problems. The third section introduces the concept of interactive interpreting as a general model for interpreting in mental health settings and discusses situations in which an independent input of an interpreter might become necessary. The chapter briefly touches on the benefits of special training for both therapists and interpreters and ends with a summary of the key characteristics of professional interpreting in mental health.

2 Interpreting therapeutic talk

Throughout this chapter, I use the term therapeutic talk to refer to interactions that take place between a variety of mental health workers (psychiatrists, psychologists, psychotherapists, social workers, etc.) and their patients. Generally speaking, therapeutic talk is about careful listening and understanding in a non-judgemental and open atmosphere. It is also emphatically about interacting and relating, which is conveyed through words and through non-verbal and paraverbal behaviour. Evidence shows that the success of therapeutic work is mostly dependent on the therapeutic relationship
between the therapist and the patient, as well as on the therapists’ attitude and whether they can convincingly explain and implement their treatment methods (see e.g. Wampold and Imel 2015). The key characteristics of a therapists’ attitude in this relationship are described as empathic, accepting, non-judgemental and authentic, based on humanistic-existential approaches to therapy (see for example Feltham and Horton 2006, specifically part V).

The presence of an interpreter, whether in person or via telephone or video conferencing, inevitably has an impact on the therapeutic talk. This presence changes a dialogue between two people, i.e. the therapist and the patient, into a conversation between more than two parties. By the act of rendering the words of both the therapist and the patient, the interpreter influences the content of the talk as well as their mutual interaction, inevitably becoming part of the therapeutic relationship. However, in some cases, a neutral and independent stance is not enough for creating the open and empathic environment necessary for a therapeutic session. Some intentional input might become necessary, such as when interpreters have to meta-communicate in order to do justice to the words of the patient or the therapist. As the interpreter should not disturb the formation of a therapeutic relationship, it might also be necessary that the interpreter’s attitude diverges from the neutral stance in order to reflect the attitude of the therapist (empathic, non-judgemental, accepting and authentic) and so to create an atmosphere in which a therapeutic relationship can prosper.

2.1 The importance of understanding ‘faithfulness’

It is difficult to separate spoken words from all the other elements involved in human interaction; gaze, gesture, posture, intonation, facial expression, the process of turn-taking, overlapping speech, etc. are all important in a conversation. Nonetheless, the semantic aspects of an interpreted conversation need to be addressed first, for two main reasons.

First, therapists – and other professionals – decide to involve an interpreter because of the meaning of their words. They can observe their patients, they can see what they look like and see how they behave, but they cannot understand the language in which they speak. Those who commission the services of an interpreter therefore expect them to render the utterances spoken in the unknown language as closely as possible. Healthcare providers without training or experience with interpreting services might even expect the interpreter to give a wholly equivalent rendition. This, however, might be a dangerous expectation, as the following example with a Dutch-speaking therapist and a Farsi speaking patient will show.

Example 1

Therapist: en wat is uw probleem hiermee [. . . stilte] wat betekent het voor u dat u dat nog niet heeft?

Gloss: and what is your problem with this [. . . silence] what does it mean for you that you still do not have it?

Interpreter: Migûyand keh khob moshkel chîh khâh keh masalân kârtetûn tamîdîn nashodeh ya nadârîd cheh moshkeli barâtûn pîsh âmadeh?

Gloss: he says, that it is OK, what is the problem now that for example your permit has not been prolonged, or you do not have it, what problem does it cause you?
In this session, the patient has been talking about the fact that his residence permit has not been prolonged in time. He is worried that he will miss out on social benefits and lose everything he has built up in his new country. The therapist has already asked several questions about the matter and came to the conclusion that the patient has no reason to worry at this moment (a lawyer had already taken the necessary steps for an extension). While rendering the sentence into Farsi, the therapist starts with the word ‘problem’, but, after a brief silence, switches to ‘what does it mean’, seemingly correcting himself. The interpreter, apart from adding a lot more words, some of which have a coordinating function (‘that your permit has not been prolonged’ instead of ‘it’), repeats the word ‘problem’ twice, and does not ask about ‘meaning’ at all. The therapist is looking for a deeper fear but does not arrive there; the patient starts repeating his worries about losing everything. A therapist assuming that the interpreter rendered his question with complete accuracy would ascribe all the answers solely to the patient. He could potentially stop going deeper into the matter with further enquiries, concluding that the patient does not want to, or is not able to do so. This would do injustice to the patient, who had in fact heard a question that was different from the one posed by the therapist, and gave an answer in line with what he heard. This example highlights some of the problems in the concept of an ‘equal’ rendition of the interpreted text, which often disregards the complicated nature of interpreter-mediated communication. It ascribes everything the interpreter says to the original speaker and may thus misrepresent the person for whom they are interpreting.

What happened in reality during this particular session was this: after the episode described above, the therapist returned to the residence permit, acknowledged that he knows about the issue being overseen by a lawyer, and asked whether the patient had trust in these proceedings. This time, the therapist’s utterances, and especially the issue surrounding the lack of trust, were rendered accurately by the interpreter and thus opened a different area of therapeutic talk. The same therapist, when interviewed before the recorded session, offered an insight into his understanding of interpreting. He said he was aware of the fact that a rendition can differ from the original words, and that sometimes you just have to return to a topic to find out if the patient really responded to the question asked or whether any interpreting problem played a role in the interaction. In other words, he had expressed what I refer to as an interactive view of interpreting (Bot 2005a), i.e. the acceptance that the interpreter is more than an invisible go-between and that they interact with the primary parties, thus influencing both the content of the talk and the overall interaction. I call the technique this therapist uses ‘recycled questioning’ (Bot 2005a), which is a strategy that can be used by primary speakers to prevent some of the communicative problems in an interpreted setting.

The second reason for the importance of accurate renditions of the therapist’s and patient’s utterances is the need of the primary parties to get a reliable impression of each other’s talk; content, style, register and specific words that are used in a conversation all give information to the listener. Interpreters who adjust the words of a primary speaker to what (they think) the other party wants to know can compromise the mutual understanding of both parties. Primary speakers have to be able to hear that their collocutors use a different register than themselves, that they give answers that do not fit the question which was posed, that they repeat or contradict themselves, etc. The ground rule here is ‘let them (i.e. the primary speakers) sort out their own problems’.

The problem here is of course that interpreting can never produce a completely accurate renditions of the source text. The idea of an interpreter, producing completely equal renditions and nothing else, is as attractive as it is unrealistic. One of the reasons for
The attractiveness is that people want to believe in a perfect world, where things are easy and manageable: one hires an interpreter and all communication problems are solved. The idea of a professional interpreter whose techniques allow for perfect renditions and the metaphor of translator-as-machine are still strong among healthcare professionals.

### 2.2 Rendering therapeutic talk: general issues in equivalency and divergence

Research conducted in the past two decades which compared primary speakers’ utterances with their interpreted renditions in naturally occurring mental health related conversations has yielded interesting results. Bot (2005a), using a bespoke equivalency concept, arrived at an average of 74 per cent equivalent renditions per session (ranging from 56–94 per cent over six sessions) and with marked differences between three interpreters (61–87 per cent, taking into account two sessions per interpreter). Annys (2013), with an equivalence concept derived from Bot’s, found a percentage of 86.3 per cent, and Khawkokgraud (2015), analysing a telephone-interpreted administering of a diagnostic questionnaire and likewise using Bot’s equivalence concept, arrived at 73 per cent equivalent renditions. Wang and Fang (2019) found equivalent renditions ranging from 74–78 per cent in three interpreted encounters in a simulated social service environment. Judging by these results, roughly one-fifth to one-quarter of all renditions in these studies were somehow divergent from their original turn.

Divergence does not necessarily lead to misunderstandings. Just as in a monolingual setting, speech in multilingual conversations is frequently redundant and listeners miss pieces of information, but may also correct obvious mistakes. Systematic divergence however can lead to problems, as it leaves no room for corrective action. The following example from a therapeutic session with a Dutch-speaking therapist and a Dari-speaking patient provides an example of such a situation.

**Example 2**

In this session the interpreter systematically changes religious references (if God permits/gives; God forbid) into secular terms, making the patient secular and also changing the perspective from a patient relying on help and rules from god into a self-conscious acting person.

*Bot 2005a: 214–223*

The interpreter, with whom the transcripts were discussed later, said he had made these adjustments as he considered the religiously inspired utterances to be idiomatic. He thought that if he had rendered them literally, the therapist would have interpreted these words as an expression of extreme religiousness, and he felt that that would not be correct. However, as became clear when analysing the two subsequent sessions in detail, the changes caused the therapist to miss the crucial nature of the patient’s religiousness, and that in turn made him formulate an intervention which offended the patient a great deal. This interpreter opted for a target-oriented rendition, which did not prove to be appropriate.

In my research, I found several issues that led to information loss in interpreted renditions. Many of these were associated with overlapping speech, due to, for instance, not adhering to appropriate turn-taking measures and the therapist not assuming the role of the chair of the session. Bot (2005a) shows that long and grammatically complicated
turns of the therapist and the patient were associated with divergent renditions and could frequently lead to information loss. Some argue that it is important to let the patients produce their narratives undisturbed, especially when the case concerns a traumatised patient at the beginning of their treatment (see e.g. Zimányi 2013). My stance is that it is generally unproductive to let the patient produce a narrative if the therapist is unable to understand it (see Bot 2005a). The therapist, as the ‘chair’ of the session, can nudge the patient into pauses in their speech. They can do this in cooperation with the interpreter, who knows best at what point to pause the narrative. This avoidance of overlapping speech and the use of short turns requires some discipline during the session, and it is helpful for the therapists to be aware of the needs of the interpreter. We see here that there is a strong connection between the faithfulness of renditions, the coordinating of the communication, and the organisation of the sessions.

The frequent use of ‘he/she/they said’ and similar reporting verbs, and the change in perspective (from the first into third person or third into second) usually does not affect understanding, but can lead to a certain degree of alienation (Bot 2005b) with unknown effects on the quality of the therapeutic session. An effort (Bot and Aarts, unpublished) to analyse the nature of the divergence in the material of Khawkokgraud which concerned the administering of a diagnostic questionnaire with the help of an interpreter via the telephone and its influence on the outcome of the questionnaire (i.e. the diagnosis), did not lead to a clear outcome because of extremely low interrater reliability.\(^1\) Wang and Fang (2019) conclude to a very low percentage of unjustifiable omission and distortions, ranging from 3 to 7 per cent; other divergence that they found has either a strategic function or is minimal.

3 Rendering therapeutic talk: critical issues

As stated in the previous section, the relationship between a therapist and their patient, and the way in which this relationship develops, is a very important aspect of the treatment process. This is reflected in the therapeutic language and leads to some specific issues that frequently pose difficulties in interpreting the therapists’ words. Amongst these are hedges and phatic communication (Albl-Mikasa et al., 2015; Bot 2005a; Iglesias-Fernández 2010), modalisations (Bührig and Meyer 2004), questions and brief introductory phrases (Bot 2005a), but also small talk, cultural issues and problems pertaining to patients with severe mental health problems that affect their speech. The following section will look at each of these subjects in an interpreted setting and provide practical suggestions on how to avoid some of the reoccurring problems.

3.1 Hedges, phatic communication and modalisations

Omitting hedges (typically adjectives, adverbs or tags used to signal caution and probability) and phatic communication (social or polite phrases) can leave out important information; while hedges play a role in showing empathy, phatic communication is crucial to relationship building. Modalisations (linguistic options used to express levels of certainty) are important in searching for hidden feelings, dealing with ambivalence, etc., in phrases such as ‘is it possible that…?’ At the beginning of an intervention, therapists often use phrases like, ‘as you have said previously’, ‘do I understand correctly that you mean….’ or ‘I might be wrong, but didn’t you just …’. These phrases involve mutuality. They emphasise that the therapist and patient are working together, and that the therapist is building
on the words of the patient. If these phrases are considered phatic (or ‘fringe’, as an interpreter once said to me) and are omitted during the interpreting process, the therapist can come across as someone who ‘already knows’ and who ‘is the expert’, instead of someone who is looking for answers together with the patient. The same applies to false starts or other unorthodox parts of the conversation, including ‘Freudian slips’ and other unintentional utterances from both the therapist and the patient. Leaving these out, as some interpreters tend to do, may mean that important information is omitted. Therapists sometimes ask the interpreter not to interpret these utterances, such as when they feel that they made a mistake or said something rude or reflective of themselves, as I know from training sessions with interpreters. I do not think this is correct behaviour. It poses a dilemma for the interpreter (follow the request of the therapist or the official Code of Conduct) and places the therapist into a ‘superior’ position. Therapists and patients should be aware that everything they say will have to be rendered.

3.2 Questions

In many cases, therapeutic talk necessitates letting the patient talk in a scenario where the therapist assumes a ‘not-knowing’ position. For this reason, therapists will often ask questions, leading the patient to reflect upon what they have said or delve deeper into their emotions. However, when these questions are rendered as statements, the therapist is moved from a not-knowing position into a knowing one. The question ‘So, you were angry?’ is completely different from the statement ‘So, you were angry.’ and the difference should ideally be replicated in the rendition. Bot (2005a) found that questions are often changed into statements or their content is altered in the process of interpreting.

3.3 Small talk and self-disclosure

Small talk and self-disclosure, usually present at the beginning and the end of a session, are an important part of the therapeutic relationship. Self-disclosure usually involves the therapist sharing personal information with the patient (such as marital status or questions about their family) and is nowadays seen as an acceptable part of a therapy session, provided it contributes to the wellbeing of the patient (van Meekeren, 2017). Not disclosing such information and not indulging in small talk can lead to an alienation between the therapist and the patient; the same applies, to an extent, to the interpreters. For example, a therapist mentioning something along the lines of ‘educating adolescents is not easy’ suggests that they are speaking from experience; a nod by the interpreter could be a welcome supporting gesture in such a situation. However, both small talk and self-disclosure have their boundaries. Therapists receive training about what is appropriate to disclose in which circumstances, and interpreters should follow their example.

Example 3

The patient in this example is very mistrustful of people from his country of origin and asks the interpreter where he comes from. The interpreter renders the question to the therapist. The therapist, knowing that the interpreter is of Dutch origin, agrees that the interpreter can disclose this to the patient. However, the information is immediately followed by a lively exchange (about food, as it turns out later) between the interpreter and the patient.
While the interpreter, as part of their professional conduct, consults the therapist about the patient’s initial request for information, the following discussion about food goes beyond the bounds of an acceptable interpreter intervention. Therapists are trained to ‘never volunteer information’, i.e. to answer requests for personal information briefly without adding anything that has not been asked for. Here the interpreter and the patient have overtaken the conversation by sharing more information than necessary, as well as taking the lead in the conversation, which is not part of the interpreter’s role.

### 3.4 Cultural issues

Another aspect that is often mentioned in research about interpreting in general is the question of cultural differences. The Dutch Code of Conduct for certified interpreters notes that interpreters should make sure there is ‘complete and effective communication between the two parties […] and if necessary to intervene actively to correct (culturally defined) misunderstanding’. However, what is meant by ‘culturally defined’ is not further elaborated upon. This can take the form of the interpreter intervening in a session to give information about some specific practice or expression, but it can also lead the interpreter to adjust their renditions to how they think the receiver of their rendition will understand the other person’s words (target-text orientation). These changes can again lead to various issues in the interpreting process.

**Example 4**

A therapist reported that during a session with a patient, the interpreter intervened by commenting ‘you should know that there are arranged marriages in his (i.e. the patient’s) country’. The therapist was surprised – it distracted him from the topic of the session, and, more importantly, he felt offended by the interpreter; ‘how stupid does he think I am; does he really think I do not know this?’ The experience took him completely off the course, he said.

Here we have a situation in which an interpreter, possibly with good intentions, purposefully and openly adds information he feels will contribute to the session, but ends up affecting the interaction negatively. The cultural adjustments from Example 2, with the interpreter systematically changing religiously inspired terms into secular ones, changed the overall impression of the patient. The interpreter in Example 2 made a cultural adjustment, adapting what he considered to be a culturally-impacted statement from the patient so as to be appropriate for the therapist. Such an intervention of the interpreter is very difficult to detect as neither the therapist nor the patient know that these changes are being made and subsequently cannot interfere. The responsibility for this kind of problem lies with the interpreter and it is imperative that they are aware of this danger and keep as close to the source text as possible.

‘Culture’ is a concept that appears frequently in discussions about treating migrant patients; interpreting agencies advertise that ‘we solve language and cultural barriers’ or ‘we connect cultures’. However, ‘culture’ i.e. a meaningful combination of norms and values, is a group concept. Especially when it concerns groups that one has not chosen deliberately (such as national or ethnic groups), its members relate very differently to these norm and values (Bot 2020). There is no such thing as ‘certified cultural
information’ on which the interpreter can rely. Interpreters connect people, not cultures, by interpreting faithfully and thus allowing the primary speakers to find differences, cultural or otherwise.

3.5 Psychotic patients

The utterances of severely psychotic patients can sometimes diverge from regular speech patterns or grammatical norms. They may repeat themselves, use words that do not exist, talk without pausing, speak in a sequence of seemingly unrelated words, etc. An interpreter cannot be expected to give a faithful rendition of such speech patterns. Here the interpreter has to take an active role, initiating meta-communication and explaining to the therapist how the patients is communicating, such as their use of grammar and general speech patterns, the topic of their talk, or their use of non-existent words. In these cases, it is helpful for the interpreter to know what kind of language issues the therapist is looking for (see the section on training below).

3.6 Other factors influencing therapeutic work

Therapists influence the therapeutic process just by being there for the patient. The same goes for interpreters and their very presence may have an impact on the process, even if they work remotely, e.g. via telephone. The interpreters’ prosody, idiolect, fluency, pitch, and – in face-to-face interpreting – their appearance, can have a decisive impact on the atmosphere and even the success of the session. These factors can determine whether the patient feels reassured and safe enough to speak openly, whether the patient or the therapist feel criticised in any way, and whether they perceive the interpreter as interested in what is being said during the interaction. Therapists report on the importance of factors such as minor facial movements, gaze, posture, and changes in intonation or pitch. When they perceive that the interpreter does not agree with what they are doing, they feel inhibited in doing their job (Bot 2005a). The interpreter cannot prevent having an influence, but they can make sure they use this influence in a way that benefits the session (see also Iglesias-Fernández 2013). Ideally, the therapist and interpreter are working together towards a common goal, i.e. understanding what the patient wants to convey, while supporting each other’s roles (Bot 2005a). Patients too report on the influence of the interpreters’ attitude on their feelings of safety during the sessions (Bot 2005a).

Example 5

In my own clinical work as a therapist, I once worked with an interpreter who frequently laughed when hearing the patient’s words before rendering them to me. Not only did I feel left out (‘Apparently there is something to laugh about, do you care to enlighten me?’) but I also did not think there was anything to laugh about after receiving the rendition.

Here we see a situation where the interpreter sets the tone for the upcoming statement (indicating ‘this is something to laugh about’) and taking charge of the session, which should be the role of the therapist. Although the interpreter’s laughter annoyed the therapist and the situation might have created negative feelings that could potentially disturb...
the session, the therapist in this case was able to intervene and make the situation more constructive. In similar situations, the therapist could also follow up on the issue and discuss whether the patients’ statements are indeed something to laugh about or not, and why. Although this may not be what the therapist wanted to talk about, at least they can thus avoid negative emotions and may arrive at a meaningful conversation. On the other hand, an interpreter choosing not to laugh while both the patient and the therapist do may cause them both to feel as if they are being looked down upon or snubbed. That is, there are times when the interpreter can come across as ‘too neutral’, but, on the other hand, their openly shared opinions on the matter at hand may harm – or support – the sessions.

The issue of turn transfer also impacts the quality of a session. Although the therapist should be in charge of the session, they often cannot manage the turn transfer adequately without the help of the interpreter, who knows what is being said and whether a turn transition point has been reached. The turn transfer not only influences the quality of the translation, but also the feelings of the participants. It has an impact on, for instance, whether the patient has enough time to express themselves, whether they feel hurt when they are interrupted, and whether the therapist feels their turn comes at the right time and they are still in control of the session. A successful turn transfer combines the practical needs of the interpreter and takes into account the feelings of the primary participants, making sure their statements are acknowledged and taken seriously.

4 Interactive interpreting

As the examples above have shown, a successfully interpreted therapy session usually requires the interpreter giving accurate renditions of the utterances while paying attention to coordinating turns, as well as being mindful of their own personal presence at the session. I have called this the stance of the ‘interactive interpreter’ (Bot 2005a) and it implies a close cooperation between the therapist, the interpreter and the patient. The following section outlines what this stance looks like.

4.1 Rendering faithfully

As in all interpreted settings, the language competency of the interpreter, including their use of relevant medical vocabulary, plays a crucial role in ensuring the success of a therapy session. However, the other participants also carry a responsibility for the smooth running of a session. The use of clear and grammatical sentences and the avoidance of jargon and long turns can help the interpreter immensely in providing proper renditions of what has been said. Preferably, the therapist assumes the role of the chairperson for the session (Bot 2005a). They are in charge of the turn transfer, although they may need some help from the interpreter. It is the therapist’s role to intervene when there are problems in the communication. The therapist intervenes when the patient takes very long turns and/or produces overlapping speech. When the chairperson of the session is performing their duties correctly, the interpreter can focus on giving accurate renditions.

Even with these precautions, we know that interpreters’ renditions are a form of reported speech; the interpreter constructs a dialogue which is based on the words of the primary speakers, but is biased by their translation choices and influenced by their worldview, i.e. in this case, ideas and opinions about ‘what mental health talk is about’ and about proper behaviour in general terms (Bot 2005a and 2005b). For example, the interpreter might think that it is best not to talk about traumatic experiences (‘do not stir it up’)
and resist when the therapist emphasises that talking about these issues is at the core of any trauma treatment. In these cases, it is important that the therapist, and preferably also the patient, make use of the technique of ‘recycled questioning’, i.e. rephrasing questions or formulating new ones when there seems to be a misunderstanding. By keeping short turns, both the patient and the therapist receive feedback from one another, thus promoting mutual understanding. Furthermore, interpreters have to be fair in acknowledging possible mistakes on their part and use meta-communication as an ‘emergency-buoy’ for detecting these issues.

4.2 Independent input

Depending on the setting, the interpreter might deviate from a neutral stance and choose to offer an independent input in order to fit into the overall atmosphere of the session. Neutrality does not mean being aloof or distant. Empathy is essential in mental health sessions and interpreters may have more success if they are in tune with the feelings expressed in the sessions. In fact, in order to create a good working relationship, interpreters should ideally shadow the expressions of the therapist to some extent, e.g. if the therapist laughs, the interpreter smiles (Bot 2005a). The same applies to the expressions of the patient; when the patient shouts, the interpreter may also raise their voice, but to a lower level. As far as the treatment strategy is concerned, the interpreter should follow the therapist as the chair of the session. An interpreter siding with the patient as in the example below may seem like a supportive gesture but is in fact anti-therapeutic. If a patient asks the interpreter for help, for example when they disagree with the therapist or dislike them, the interpreter should encourage the patient to discuss this directly with the therapist.

Example 6

The therapist encouraged the patient to become more independent and helped her prepare for important conversations with the social services, which she was later supposed to manage on her own. Afterwards, the therapist discovered that, on the patient’s request, the interpreter had accompanied the patient to the social service encounters, as the interpreter felt that the therapist expected too much from the patient.

In this example, the interpreter is going against the therapist’s strategy. The action undermines the relationship of trust between the therapist and the patient, as the interpreter and the patient are effectively acting behind the therapist’s back. This is a case where the interpreter acts as an independent participant. However, this problem could have been avoided. When the patient asked the interpreter for help, the interpreter could have said something along the lines of ‘I understand your feelings. If you do not feel ready to do this on your own, you should speak to your therapist and see what can be done about it.’ In this way, the interpreter validates the feelings of the patient but also refers the patient back to the therapist. If the interpreter really thinks the therapist is not helping the patient, they could discuss the matter with the therapist first, in order to understand their reasons for this decision. If this is not sufficient and the interpreter remains feeling bad about the sessions, it would be best for them to stop interpreting in these sessions. The basis of an effective cooperation is the mutual trust between the therapist and the
interpreter, including their trust in each other's professionalism. The following example shows the complexity of this relationship.

**Example 7**

Therapist and patient have been working with the same face-to-face interpreter for a long time, and the patient emphasises in an interview that the interpreter is very important to her: it is her interpreter. The interpreter encourages her, saying supportive things like ‘you’re doing very well’ and ‘you’ll get over all this, I’m sure’. Then there is a change in therapist. The new therapist does not like the way the interpreter behaves towards the patient and, moreover, she feels that the patient’s Dutch is quite good. She decides to continue the therapy without an interpreter. The patient is very angry and upset about this but continues with her treatment. In an interview conducted in Dutch some years after the therapy was successfully concluded, the patient acknowledges that it had been a good decision to stop the involvement of the interpreter. She liked having the support of the interpreter, but she would not have become as independent as she is now, had she continued to rely on the interpreter’s help.

In this example, we see the complex nature of the matter. The first therapist was aware of the interpreter’s personal involvement but showed no objection to them going beyond their designated role. The second therapist did not approve of this relationship and, being aware of the increasing language proficiency of the patient, stopped using the interpreter during therapy sessions. The outcome was ultimately evaluated positively by the patient; we can only guess at how the therapy would have ended if the interpreter had continued to accompany the patient. We also do not know how the therapy would have proceeded had there been a less overtly supportive interpreter at the beginning of the sessions. We only know the outcome after the change: the patient learnt to speak Dutch, overcoming her shyness and worries about making mistakes, and ultimately became much more independent. It shows the importance of a careful deliberation on the part of the therapist in regard to the interpreter’s involvement, as well as of the flexibility of the interpreter, who has to adjust to different therapists’ methods within the limits of their professional involvement.

**5 Training**

In this chapter, I mentioned several times that coordination and cooperation between therapist and interpreter is important for the proper course of a session. Personally, I think it would be best if therapists and interpreters had some training in each other’s trade. Some of the problems that I have discussed above might be prevented with such training. Interpreters should not become (co-)therapists, but some background knowledge about what mental health talk stands for in general will help them to interpret faithfully. The topics that should be included concern the differences between the various kinds of therapists and the overall way mental healthcare is organised; the major categories of mental illness and the specific problems these represent in the way patients talk and relate; some of the major treatment techniques and their specific ways of wording interventions; and managing severe stress and emotions. Training of skills in dealing with these problems (meta-communicating; dealing with questions directed at the interpreter
or with inappropriate requests, intense emotions, etc.) should be an important part of such training.

Therapists are usually very ill-informed about what interpreting entails and often foster the naive notion of the interpreter as a translation machine. In training sessions, I often get disappointed reactions when I tell therapists that they have to adjust their conversation techniques in order to make the complicated communication work. In general, therapists should know what the role and task of the interpreters entails and be familiar with their training and Code of Conduct; have some insight into the difficulties of interpreting and what ‘faithful’ interpreting means; make sure they construct their interventions carefully and in a grammatically correct way; allow time for the interpreter’s work; and take into account that the interpreter’s words are not the patient’s words. They also need to be aware of the dynamics in this three-party talk and use it to the benefit of the treatment, understand that, although they are ‘the chair’ of the sessions, they have to delegate the coordination of turns to the interpreters, and also accept that the attention of the patient will be shared with the interpreter.

I have conducted this type of training for both interpreters and therapists. Although the feedback I receive indicates that participants find it useful and that it brings benefits to both interpreters and therapists, it should be noted that these findings are as of yet not confirmed by any large-scale data, and much more research is needed both into the question of training and into interpreting in mental health settings in general.

6 Conclusion

Interpreting in mental health settings is a complex issue that includes not only interlingual exchange, but also verbal, non-verbal and paraverbal aspects that require careful coordination of the sessions. Its success also relies on building a solid relationship between the interpreter and the therapist, who have to coordinate their actions based on mutual trust in each other’s professional abilities. Although any list of rules for mental health interpreting will be necessarily incomplete, the following hopes to give some guidance on successful interpreter-mediated (psycho)therapeutic sessions.

Accurate renditions are important: they are the raison d’être of interpreters, allow the primary speakers to understand (or misunderstand) one another and ultimately to solve their own communication problems. In order to help the interpreter in successfully executing their work, the primary speakers could:

- Organise the conversation, keep turns relatively short (while allowing for feedback) and avoid overlapping speech
- Talk in properly phrased sentences that are grammatically correct, avoiding complicated constructions or jargon

In practice of course, not all primary speakers will be able to follow these guidelines. Interpreters should focus on accurate renditions, but both interpreters and the users of their services should be aware that a fully accurate translation is not possible, even when the above-mentioned guidelines are followed. As a result, the following should also be observed:

- Acknowledging that renditions may not have been what the primary speaker intended to convey; the willingness to provide alternatives is important
• Using recycled questioning by primary speakers
• Source speech orientation by the interpreter
• Meta-communication, both by the interpreter and by the primary speakers when they are not able to hear or understand the message

Particularly in mental health settings, the interpreter also needs to pay attention to the overall atmosphere of the conversation and be attuned to the emotions expressed in the session. This sometimes means leaving behind the professionally ‘neutral’ stance (which could come across as ‘too neutral’ and thus inhibiting to the free flow of the conversation) while being aware of the interpreter’s own influence on the outcomes of the session (‘interactive interpreting’). Some points to keep in mind in this regard are:

• Following and remaining a little behind the emotions expressed in the session – ‘shadowing’ the therapist who determines the flow of the conversation
• Steering away from giving opinions and information that go beyond language-related issues, even when asked, and referring those questions back to the primary speakers
• Meta-communication by the interpreter to explain words or concepts that are difficult to translate, preferably in interaction with the primary speaker who used the word
• Including some small talk and self-disclosure, in close cooperation with the therapist

It is clear that both the interpreter and the therapist have their individual responsibilities during a session. Their mutual respect, as well as some knowledge of each other’s fields, can greatly contribute to a successful outcome. This means that the interpreter should have some basic knowledge of the field of mental healthcare (how it is organised; what the various disciplines stand for; general knowledge of therapeutic aims; strategies and wording of therapeutic interventions) and that the therapist should know what interpreting entails and what they can do to facilitate the work of the interpreter. The patient usually does not receive any training in interpreted conversations and should, of course, be allowed to speak freely. The therapist, however, can inform the patient about the rules of the organisation of the talk via the interpreter by pointing out the importance of keeping short turns and the avoidance of overlapping speech. In interpreter-mediated mental healthcare, coming to an understanding is always a three-party responsibility.

Notes
2 Ibid.
3 www.enpsit.org.
5 Oral communication, TVCN (Dutch Interpreter and Translation Service) 2018.
6 Oral communication, TVCN (Dutch Interpreter and Translation Service) 2013.
7 The term ‘therapist’ is used throughout this chapter as a generic term including psychiatrists, psychologists, psychotherapists, social workers and the like.
8 Unless stated otherwise, all examples of interpreted dialogue in this chapter were collected as part of a PhD thesis (Bot 2005a) but not all of them were published or published in this format. All therapists are speaking in Dutch, interpreters in Farsi or Dari (transliterated into Latin alphabet), and the English glosses were translated by the author.
9 Thanks to Marina Sleptsova for this clear and precise wording offered at a symposium in Lausanne, 11–12 November 2009.
10 Hermans related this to ‘the longing for the security of the womb, before the rupture of translating appeared’ (Hermans 2004: 40, translation by the author).

11 In order to compare the original turns of the therapists with their renditions, I designed an equivalency concept which consisted of three parts: conservation of information, conservation of the perspective of person and conservation of the therapeutic perspective (Bot 2005a: 145–149). For the analysis of the therapeutic perspective, I used the Hill Counsellor Verbal Response Category System, revised for the Dutch language (Lietaer et al. 1995). The Hill system focuses on the ‘syntactic or grammatical structure of language which implies a relationship between communicator and recipient, e.g. a question’ (Hill 1986: 132). If the therapist’s utterance and its rendition were scored in the same category, they were seen as equivalent.

12 The original research consisted of an assessment of the quality of renditions in a telephone interpreted administration of a diagnostic questionnaire with a French-speaking patient and a Dutch speaking therapist. In order to assess the effect of the rendition on the outcome of the questionnaire, a Dutch translation was made of the interpreted original, which was scored by two certified psychologists. Of the 20 diagnostic questions, 16 were scored differently by the two psychologists; one psychologist gave ten items the same score as the psychologist with the interpreter, the other one only four. The exercise seems to say more about the reliability of the administration of the diagnostic instrument than of the work of the interpreter.

13 This example stems from the clinical practice of the author.


Further reading


The rendering of hedges and phatic tokens is important in interpreter-mediated psychotherapeutic sessions as these linguistic features help to build rapport and emphasise the cooperative nature of the session. The article shows that interpreters have difficulties in interpreting these phenomena.


This article shows how rapport in healthcare encounters is shaped and how interpreters can render these characteristics.


This publication consists of five articles on discourse-based research on healthcare interpreting, as well as a number of book reviews. The research studies show what happens in real interpreter-mediated healthcare sessions and are food for thought for practising interpreters.


In this article I focus on what is usually referred to as the rule of ‘interpreting in the first person’. Based on naturalistic data, I conclude that interpreters very often neglect that rule, but this decision does not seem to compromise the quality of the understanding of the primary parties. Specifically, the use of a reporting verb (such as ‘he says’ before a rendition) as a ‘mental space builder’ seems to enhance the understanding by the primary parties about ‘who is talking’. 
Related topics
Healthcare Interpreting Ethics, Community/Liaison Interpreting in Healthcare Settings, Remote (Telephone) Interpreting in Healthcare Settings

References