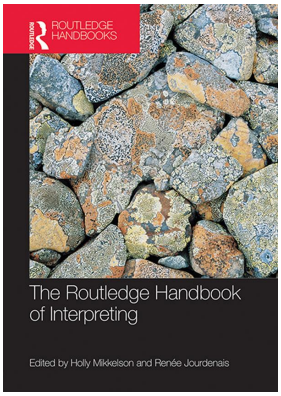

The Routledge Handbook of Interpreting

Holly Mikkelson, Renée Jourdenais

Interpreting in mental health care

Publication details
https://www.routledgehandbooks.com/doi/10.4324/9781315745381.ch16
Hanneke Bot
Published online on: 17 Mar 2015

16
INTERPRETING IN MENTAL HEALTH CARE

Hanneke Bot

Introduction

In mental health care, there is a lively debate about whether this type of help should be adapted for patients who have their roots in 'cultures' outside the borders of the countries they now live in. For several reasons, I will not enter this debate here. First of all, because it is my strong conviction that people will come to understand one another as soon as they are interested in each other and each other's backgrounds. Culture, as a consistent pattern of norms and values, does not determine or cause behaviour. It is at best a pattern that one can detect in someone's behaviour (Verheggen, 2005). Second, related to our topic here, I think that a lot of misunderstanding between people with different national and linguistic backgrounds arises because they literally do not understand one another. Needless to say, you have to have an interest in getting to know each other in order to be willing to bridge the language gap by, for example, engaging an interpreter. The first step towards a (mental) health care that is accessible for all is to establish a well-equipped interpreter service included in insurance-covered care.

This chapter deals with the subtleties of interpreter-mediated talk in mental health care. Interpreting in mental health care is a subcategory of healthcare interpreting (see Chapter 15 on healthcare interpreting). Sometimes there is also an overlap between mental health interpreting and judicial settings (see Chapter 12 on legal interpreting). This happens when patients are admitted to mental health institutions against their will and a judge has to hear the patient and his lawyer in order to make his judgement.

In mental health care, there is hardly any way to diagnose and treat except through language. Not surprisingly, interpreters working in the field of health care are relatively often engaged in mental health sessions. Interpreters are employed in sessions with various mental health providers, each type of session with its own characteristics and demands on the interpreter. This means that interpreters have to adapt their role according to the type of patient and type of session, and also to the idiosyncratic preferences of each individual mental health provider. Constructive cooperation thus depends on the alignment of the mental health provider, the interpreter and their mutual patient. Despite the different styles that are prevalent in the field, the author has a preference for a specific role, based on both theoretical arguments and her own experience, as will become evident in this chapter.

Definition of terms

Interpreting in mental health care is done consecutively with patient-interpreter-therapist taking turns one after the other (see Chapter 6 on consecutive interpreting). Interpreting in mental health encounters can be face-to-face or via the telephone. Video-interpreting is not yet widely available in most countries (see Chapter 22 on remote interpreting). In The Netherlands, more than 75% of interpreting in the medical setting, including mental health care, is done via the telephone. A large number of mental health workers are engaged in sessions with patients: psychiatrists, nurses, psychologists, social workers, psychotherapists, etc. I will mostly use the term mental health practitioner/worker; sometimes I will use therapist as a general term, as this is so much shorter, to cover these different specialisms.

History/early developments

Interpreter-mediated talk in mental health care came into being years after large numbers of migrant workers, their families, asylum seekers and refugees came to live more or less permanently in countries far from their homesteads. In The Netherlands and many other countries, interpreter services started on a volunteer or semi-professional basis in the 1970s; professionalization set in during the nineties or even as late as the first decade of the third millennium, if at all.

In 2005, I described the situation with respect to interpreting in mental health care as governed by several 'schools of thought' (Bot, 2005: 13). Even after the relative explosion of empirical research on interpreting in the medical and judicial field since the 1990s, empirical research, especially research based on recorded sessions, in interpreting in mental health is still very rare. Two meta-studies on the effects of language support for the accessibility and quality of health care by Flores (2005) and Karliner *et al.* (2007) show that, in general, bringing in well-trained and professional interpreters leads to a significant increase in the accessibility and quality of care. However, these meta-studies are based on a limited number of studies, even more so in the case of mental health care compared to somatic health care. To complicate matters further, in these studies quite often no distinction is made between professional interpreters, family members as interpreters and bilingual nurses who also do a bit of interpreting (see for example Aranguri *et al.,* 2006). Thus, lacking an evidence base on which well-founded statements about interpreting in mental health care can be made, there are still various ways of thinking and working with interpreters in mental health care. In 2013, Bot and Verrept come to the conclusion that 'unfortunately, there is no literature that – based on empirical research – shows which approach, under which circumstances and for which groups of patients leads to the best results' (Bot and Verrept, 2013: 118–119).

Current situation/trends

Interpreting is interaction

Interpreting in mental health care is part of community interpreting, and as such fits in the realm investigated by Wadensjö (1998), who concluded that interpreting *is* interaction. Through her work, it became clear that interpreting has to be seen as an interaction involving the interpreter, the mental healthcare provider and the patient. As such, interpreting is a form of cooperation.

A myriad of approaches are used in the field, with varying ideas and practices about training, employment, roles and tasks of the interpreter, medium or mode of working (face-to-face versus via the telephone or videoconferencing). All these different approaches, though, can be

categorized within the interactional paradigm: it is the extent of the involvement in the interaction that differs, and related to that the responsibilities, roles and tasks assigned to the interpreter are different. In fact, the various approaches to interpreting can be situated on a continuum of interactional involvement. The position of the interpreter on this continuum influences and in fact pre-supposes a matching position of the mental health practitioner and even of the patient involved (see also Bot 2005).

The continuum of interaction – role behaviour

The involvement of the interpreter in the interaction ranges across a continuum, with the interpreter as a translation-machine on one end and the interpreter as an independent participant at the other (for further discussion for the evolution and continuum of interpreter roles in other subsectors, see Chapters 7, 13, 14 and 15). In order to simplify matters, I describe a number of positions on this continuum. I distinguish the following positions: the interpreter as a translation-machine (TM), the interactive interpreter (II), the interpreter as a cultural mediator (CM); the interpreter as a co-therapist (ICT) and finally the interpreter as an independent participant (IIP) (Figure 16.1).

I understand there can be some debate about my use of the term 'interpreter' here as beyond the cultural mediator position, there is so much deviation from the original meaning of 'giving new words in another language to what has already been said'. 'Language assistant' might have been a better term if it had not been a term that is not widely used in practice.

The interpreter as a translation-machine

In this position, it is the interpreter's role to make equivalent renditions of the primary speakers' words. The interpreter has no further influence on the communication and holds no other responsibility.

This position implies a monological understanding of language, meaning an emphasis on the everyday, taken-for-granted equivalent meanings of words as they were listed in a dictionary (see Bot and Wadensjö, 2004) and implies the interpreter is an invisible third party who produces equivalent renditions. Based on the communication theories of Watzlawick *et al.* (1967), we know that 'not communicating' in each other's presence is simply not possible. One who tries to do that, communicates precisely that he does not want to engage. The interactional reality cannot be denied. Also, an equivalent translation, in all its subtleties, is an impossible goal to reach, even in written texts, let alone in the oral act of interpreting. The translation-machine model disregards the fundamental issues involved in translation; translation always involves change (Bakker *et al.* 1998). As such, the translation-machine model is an illusion – it can never be reached. Still, some practising interpreters and mental health practitioners adhere to this position and formulate it as a model.

As a conscious effort, it is sometimes justified to strive for an exact, maybe even word-for-word translation, as when appointments – hours, dates – or prescriptions for medication are involved. The conviction that the translation-machine position is a reachable goal, assuming that interpreters

---

TM II CM ICT IIP

Figure 16.1

are translation-machines, is a *dangerous* one, however. This conviction discourages a critical questioning of the quality of the communication. It leads the participants in talk to assume that all interpreters' renditions *are* equivalent and to disregard signs that there are communication problems (Bot, 2005). In my research data (Bot, 2005), I have seen instances where the patients gave relevant answers to the questions they heard from the interpreter's mouth. These questions, however, differed in therapeutic intention from the original questions phrased by the therapists. A therapist working from an interactional stance would say, after an apparently inconsistent reaction of the patient, 'that is not what I meant, I will rephrase my question'. A therapist working from the machine position would not rephrase, maybe would not even notice a communication problem. He would continue his questioning and the session as a whole would end in misunderstanding and an adversarial atmosphere.

The interactive interpreter

The underlying assumption here is that of the dialogical understanding of language and mind (see again Bot and Wadensjö, 2004), implying that meaning of words is constructed in interaction. It takes into account that 'not communicating' is impossible; it understands that interpreters coordinate talk and meaning (Wadensjö, 1998). Wadensjö's conclusions were confirmed by my own study (Bot, 2005), which found, also based on empirical research, that interpreters not only influence the structure (having every other turn) and organization of the session, but also have an influence on the content of the dialogue:

> It is important for therapists conducting interpreter-mediated psychotherapy to realize that dialogues are influenced by interpreters: through the act of translation, their deliberate choices to diverge in their renditions and through their own cognitions and emotions. This means that the therapist should take care in attributing what happens in the session to the interaction with the patient alone.
>
> *(Bot, 2005: 252)*

There is little discussion about the unavoidability of the interpreter's influence. The interpreter's characteristics (paralinguistic and non-verbal behaviour, appearance) all exert an influence which cannot be erased. On the content level, systemic differences between languages cause inevitable differences between source utterance and rendition, while the understanding of what has been said by the primary partners in talk and thus its rendition are influenced by the interpreter's knowledge, lexicon, emotions, norms, values, beliefs, etc. In my research data (Bot, 2005) the therapists emphasized several times and with different words, that 'talking about one's problems is therapeutic'. Several times these utterances were interpreted properly. But sometimes they were changed into their opposites: 'it is good to keep quiet to protect the family from bad stories'. Baffled by this phenomenon, I questioned the interpreters. It turned out that they themselves felt that 'not talking' was usually better than 'talking'. It seems that their own values crept into their interpreting, and they had not done this consciously.

Knowing that one's own feelings and opinions enter one's interpreting does not always make the extent and content of this influence a conscious one. Interactive interpreters know that 'understanding meaning' is a complicated matter and should not be taken for granted. This allows them to ask questions for clarification, ask for a repetition when they did not hear properly what was said and explain terms that are difficult to translate.

Wadensjö and I (Wadensjö, 1998; Bot and Wadensjö, 2004; Bot, 2005) conclude that in practice interpreting *is* interactive, whether one likes that or not. Thus, this view of the interpreter is undeniable.

The cultural mediator

In this position, 'it is assumed that the interpreter is knowledgeable about matters that are relevant for the healthcare contact and that it will be beneficial to the healthcare encounter if he brings this in. … Without some clarification of the cultural context in which the messages are exchanged, these can sometimes be perceived as "complete nonsense" by both the native healthcare worker and the foreign patient. The intercultural mediation role becomes more important as the languages in question differ more from each other and the cultural and socio-economic distance between patient and healthcare worker is greater' (Bot and Verrept, 2013: 123). In the above-mentioned example about therapists' emphasis on 'talking about your problems' as being beneficial to one's mental health, an intercultural mediator could make a difference if he could explain the underlying idea to the patient to help him enter the therapeutic process. The difference with the interactive model is thus that the interpreter consciously and overtly adds information to the interaction.

This implies that the cultural mediator possesses knowledge about mental health, therapeutic techniques and processes, and about the 'cultural' beliefs and opinions the patient may have. It is still unclear what this involvement should precisely involve and how interpreters could be prepared for this task. 'Ethnic origin alone is not sufficient to have a thorough knowledge of one's cultural group. If intercultural mediators are not sufficiently prepared, one runs the risk that their own opinions, based on their more or less accidental experiences, will be presented as knowledge of the culture' (Bot and Verrept, 2013: 123). It is also complicated because it takes a lot of time and is therefore not very 'economical' when interpreters also have to interpret their own input. The less the 'everything will be translated' paradigm is followed, the stronger the influence of the interpreter on the session will be, with the interpreter making influential choices about what will be or not be interpreted, thus moving even further to the right in the continuum, towards the position of the co-therapist or even the independent participant in talk.

The interpreter as a co-therapist

An interpreter who acts as a co-therapist has, alongside his training as an interpreter, been trained in the areas of social work, psychotherapy or psychiatry. In this position, the therapist and the interpreter-co-therapist work closely together to find acceptable and culturally appropriate ways of working with the patient (see Mudarikiri, 2003).

In situations in which working with a co-therapist is indicated anyway – e.g. family or group therapy or very complicated cases – and language barriers do exist, this could be the working position of choice. The French psychiatrist Moro works with this model in group therapy with migrants in Paris, as can be seen on her DVD *J'ai rêvé d'une grande étendue d'eau* (www.marie osemoro.fr – accessed 17 Oct 2014).

The interpreter as an independent participant

The end position on the continuum of interaction is the interpreter as an independent participant. In such cases, interpreters insert their own comments, stemming from their personal experiences or knowledge. It is a position that gets little attention in training and literature, as it is never included in the role and task of the interpreter. It is ostensibly non-existent, but it is a position that any interpreter sometimes assumes. This role can be played in a way that relates to the session, for example when a new appointment has to be made and the interpreter checks his or her own agenda. But it also happens that comments are an independent addition to the session,

related or not related to the topic at hand, interpreted or not to all participants in talk. An example of this stems from my own experience: in a session my patient was crying a lot and the interpreter took the initiative to console her, gave her a tissue, patted her on the arm, and said comforting words. If I had felt the same, it would not have been too much of a problem. But I felt that the crying was excessive and should stop as it was an impediment to constructive work. The interpreter's behaviour made it difficult for me to follow my strategy.

Discussion

The different positions on the continuum suppose a difference in responsibility for the communication in the mental health encounter. In the translation-machine position, the emphasis is on therapist and patient 'to sort out their problems'. A translation-machine interpreter would not rectify an obvious error nor even point it out. Mental health practitioners and patients have the responsibility to notice any problems that occur, and they are able to do so because the interpreter gives equivalent translations. Therapist, patient and interpreter all have clearly defined and separated roles.

Moving along the continuum to the right, the influence of the interpreter increases as the interaction becomes more and more three-party talk. The input of the interpreter could be restricted to its inevitable influence on the content of the conversation through the interpretation and the interpreter's very presence; a step further is in explaining certain words or terms which do not have a direct equivalent in the target language. It can further stretch out to include statements about habits, norms and values that are related to the patient's or the health system's background; and can go all the way to the interpreter making independent therapeutic interventions and adding personal remarks. The more the interpreter moves to the right on the continuum, the more two-faceted the role becomes: as someone who interprets everything that is said and at the same time as someone with autonomous input. The more one moves to the right, the more complicated the situation becomes, especially because the more independent input the interpreter has, the less it will be possible to render all that was said to all participants.

In theory, one can distinguish the various positions as models and specifically find a separation between the interactive interpreter and the cultural mediator. There is a gap between the un- or semi-conscious interaction of the interactive interpreter and the fully conscious and explicit interventions cultural mediators and independent participants make. Interpreters and the institutions they work for usually select a certain position on this continuum: their official model of working. In practice, though, interpreters move along the entire continuum, and these roles are more blurred, even in a single session. For example, interpreters working from an interactive stance do sometimes throw in a remark, in addition to what was said, or sometimes even a personal supplement. Because of this, I prefer to see it as one model: an interactional one, in which one can distinguish different positions.

The interpreter and the mental health practitioner

Interpreters always work together with other professionals and their patients/clients. They have to select their way of working in conjunction with their participants in talk. Bot (2005) emphasizes the importance of the interpreter and the mental health practitioner working in the same position along the continuum. If expectations about one another's roles do not match, irritation will ensue. Mental health practitioners work in very different styles. In fact, they have their own continuum of interaction.

The classical Freudian position is the therapist as a 'therapy-machine'. That is to say: sessions are carried out focussing on the problems and feelings of the patient while the mental health practitioner abstains from any personal involvement. Of course, therapists are not machines either. In practice, their own feelings and (unconscious) cognitions and norms do influence their interventions; every therapist will have a different interpretation of the prescribed ways of working (see: interactive interpreter). Especially in the treatment of asylum seekers and refugees, some mental health practitioners, overwhelmed by the number of traumas and the often miserable social situation of their patients, show an involvement that goes much further than official professional standards (the therapist as an independent participant). Therapists have contact with patients outside the official settings, make phone calls for them, lend them money or give them amulets, et cetera (see for a good example of these practices Mirdal *et al.,* 2012). Whether or not these transgressions of formal boundaries are acceptable, they occur in the daily practice of mental health work. Matching ideas between therapist and interpreter about how to carry out their jobs is a prerequisite for constructive cooperation in the session (Bot, 2005). To complicate matters even further, therapists may also move along their own continuum, even in one session.

Cooperation

Both interpreters and mental health workers use various ways of working with patients; both professionals can be more or less involved as persons in the interaction. Depending on the type of patient, the type of institution and its philosophy, and the therapist's own idiosyncrasies, a method of working will be selected and the interpreter will be expected to match it. It is important that therapist and interpreter manage to adjust their styles to one another.

Here is an example of how this cooperation takes place and how the balance can become disturbed. A therapist, dedicated to the interactive interpreter model, tells me she can deal with brief interruptions, related to difficult-to-translate terms or the interpreter not immediately understanding or hearing what was said. From this position, she can also deal with an interpreter who inserts explanations of what the patient just said. Her usual reaction would be to react with 'the interpreter just said … how do you feel/think about that?', and ask the interpreter to translate that. But the balance gets disrupted when, in a session, the interpreter inserts his or her own comment – which sometimes happens. She tells me that this completely throws her off balance, the focus on the patient is disrupted, suddenly there is someone else's input; there is another line of conversation next to that with the patient.

On the other hand, interpreters sometimes feel stifled by their role as 'translators'; they feel they have so much knowledge the session may benefit from and feel frustrated when they cannot intervene. They focus on the cultural mediator position and are disturbed when a therapist does not welcome their input. Therapists wanting to know whether the behaviour or feelings of their patients are related to their background ask interpreters for information and feel irritated when the interpreter is not willing to give this. An interpreter who leans toward the translation-machine position may be unsettled when a therapist inserts an 'off-the-record remark' or asks the interpreter a question; this may pose a dilemma – interpret or not? – for the interpreter. An interpreter told me that he had been engaged in a systems therapy session with a 12-year-old child, his mother and the therapist. When talking about musical instruments to raise the boy's interest in playing music, the therapist asked the interpreter 'what other instruments does one have?'. The interpreter felt ill at ease, answered the question but felt bad about that later on. He felt he should have refused to answer. But that might have disrupted the flow of the session.

We see that a mismatch between mental health practitioner and interpreter leads to 'trouble': irritation, loss of concentration, 'feeling bad' afterwards and the like. Fine-tuning between the two professionals can happen when both understand these dynamics and are willing to adapt.

Empathy, emotions, attitude

In the previous section I examined the overt role behaviour of interpreters and therapists. Whether a mental health session and cooperation between therapist and interpreter 'works' is, however, also shaped by their paralinguistic and non-verbal behaviour. One may call it attitude and the overall 'fit' of the relationship. In general, empathy with the patient is the guiding tone in the mental health encounter: empathy with his situation, his feelings, his strengths, his inadequacies and weaknesses, etc. Empathy is shaped in the words the therapist speaks, but it is also formed by paralinguistic and non-verbal behaviour. Therapists are trained to pay attention to these aspects of the communication; for interpreters, however, this is much less the case. It is important that interpreter and therapist are also fine-tuned in this respect. It is hard to outline precisely what this entails, but at the same time it is clear that this is a delicate and important issue.

> A committee dealing with complaints about interpreters in asylum hearings concludes that most complaints dealt not so much with inadequate 'translations', but with issues of 'attitude'. It became apparent that 'the boundary between a friendly intended smile and a grimace, between helpful and interfering behaviour, was dangerously thin'.
>
> *(Hyams in IND, 2009; my translation)*

Interpreters should be aware of their body language and, especially when working via the telephone, their intonation, diction and other paralinguistic factors, as they are very important in shaping the 'feel' of the encounter.

For therapists and interpreters to cooperate, it is necessary, as far as expressions of emotion are concerned, that the interpreter and therapist are consistent (Bot, 2005). It becomes confusing for the patient and in general not conducive to effective therapy when, for example, the interpreter laughs about something the patient says while the therapist feels there is nothing to laugh about. Not to mention even the confusion that occurs when interpreters make clear in non-verbal behaviour that they do not approve of the therapist's interventions.

The words – translation in mental health encounters

Words are important in mental health care: diagnosis and treatment is largely based on the words exchanged between care practitioner and patient. In general, in order to interpret the words in an encounter well, one should have knowledge of the encounter's interactional purposes and the specific conversational techniques that will be used to meet this purpose. The mental health field is vast and differentiated, so it is difficult to list, within limited space, what all this entails.

In order to give an overview, I divide the field into two parts: psychological therapies and communication with psychotic patients.

Psychological treatment

Very, very generally, the psychological field can be divided into two parts: the structured, so called protocolized treatments and the more unstructured counselling therapies. The structured therapies include, among other forms, cognitive behaviour therapy (CBT) and eye movement

desensitization and reprocessing (EMDR); counselling therapies consist of psychodynamic and experiential/client-centred therapies.

All therapies are based on a theory – a set of assumptions – which are translated into treatment practices. Structured therapies usually use specific terms to instruct their patients, to phrase interventions and to measure progress. Counselling therapies emphasize the importance of the working relationship between therapist and patient and the importance of re-wording experiences. Both types may focus on the patient's own experiencing of feelings.

In general, therapists explain their way of working and its rationale to the patient. This also helps the interpreter to understand the purpose of the session. Of course, interpreting is facilitated when interpreters are aware of certain specific terms that are being used and have familiarized themselves with their rendition in the target language. I analysed a corpus of six video-recorded interpreter-mediated counselling sessions (Bot, 2005) and found that a number of problematic renditions were most probably due to the fact that the interpreter was unaware of the general goal of this type of session (see example 'talking' versus 'not talking').

Psychotic patients

Not surprisingly, there is no empirical research about interpreting in sessions with psychotic patients. Often these sessions are not planned ahead, and the patients are in no position to consent to participate in research and have the session recorded. It is thus very difficult and maybe even impossible to conduct research while adhering to ethical standards. There is, however, much psychiatric literature about the ways that psychotic patients talk, distorted from the 'ordinary' in both content and formulation. Psychotic patients' talk can be disorganized, incoherent; the patient has difficulty organizing his thoughts, he may skip from one thought to another, losing the thread of his story; he may be highly associative, for example linking words not because of their meaning but their sound (which, of course, is usually not the same in the target language). Another problem can be that the patient uses uncommon words or expressions or even neologisms and expressions that do not exist. Also, patients may repeat themselves, or repeat what the interpreter just said. It is beyond the scope of this chapter to describe in any detail all the different ways in which speech can be distorted. One thing is certain: the mental health practitioner is interested to hear what the patient has to say and how he says it, and the interpreter will have great trouble making equivalent renditions.

In these cases, it is inevitable for the interpreter to meta-communicate: to describe the patient's talk. By doing so, the interpreter moves considerably to the right on the continuum of interaction, and necessarily so.

Conclusion

As stated above, lacking vast quantities of empirical research in which interpreted sessions using the various positions are investigated, it is not possible to give evidence-based advice about which position is best to adopt in which type of talk (see also Bot and Verrept 2013).

Based on theoretical grounds and on my own experiences in practice, I do have a preference. The starting point is that, although of course interpreters have their own professional responsibility, the health practitioner is ultimately responsible for the treatment of the patient. On top of that, I do not favour a cultural stance: I believe such information should be obtained through contact with the individual patient. As stated in Bot and Verrept (2013: 125) I 'see potential problems for cultural mediators in the *mental* healthcare sector. … One can expect healthcare workers … to be curious about the patient's background, his views about his symptoms and his feelings about the appropriate remedy for them. Providing an explanation on one's work methods,

flexibility and the ability to adjust to the patient and his needs and circumstances – as well as being able to work eclectically – is also all part of good healthcare provision.' A cultural mediator would thus be superfluous; it is the therapist who, through contact with the patient, learns about his background, habits, norms and values. The treatment is best served with an interpreter who stays close to the source language structure and who calls attention to any problems in hearing and understanding which can subsequently be solved by communicating about them with all parties involved.

Therefore, my preference is that both therapist and interpreter strive for the left side of the continuum: knowing that of course they have a personal influence and incorporating that in their cooperation, but trying hard to maintain the role division of the patient talking about his life and problems, the therapist making therapeutic interventions and the interpreter interpreting everything that is said. In this way, therapist and patient can find out to what extent they understand one another and sort out their communication problems themselves. If there are problems in understanding one another because of differences in background, education, socio-economic status, habits and the like, these will become apparent in the interpreter's renditions. The therapist can then make a choice about how to deal with these differences. Interpreters should take pride in their role of interpreting closely, acknowledging that their renditions are never completely equivalent and leaving the content of the session as much as possible to the therapist and the patient.

Only rarely, for example in communication with severely disturbed patients, should the interpreter adopt another role, i.e. a more active, meta-communicative role. Also in this role, the interpreter should focus exclusively on the language part of the job, explain how the patient uses language. The interpreter is a language and communications expert, not a habit, values and norms expert.

With respect to paralingual, non-verbal behaviour and the expression of emotions, I think it is reasonable to say that the interpreter should closely follow the therapist.

All this implies that both therapists and interpreters should have knowledge about the dynamics of their cooperation. On top of this, therapists should understand that interpreting has little to do with word-for-word translation and understand the intricacies of interpreting; interpreters need background knowledge about mental health care – diagnoses, terminology, treatment practices and their objectives – in order to be able to interpret well.

At present, many an interpreter and nearly all mental health practitioners lack education and training in how to move along the continuum of interaction in their cooperation. They also lack background knowledge about their respective areas of expertise. Therapists are often shockingly unaware of the 'trade' of interpreting – they verbalize translation-machine ideas while at the same time they do not shy away from using the interpreter as a co-therapist or informant. As a result, finding a matching position on the continuum is often difficult. Both professionals lack the words to define their cooperation. The challenge for the future lies in training both interpreters and mental health practitioners in this area. In the training of healthcare practitioners a lot of attention is paid to communication – as it is understood very well that good communication lies at the basis of good healthcare. 'Bridging the language gap' should be part of that training. Likewise, interpreters should be trained in the principles of (mental) health care.

Further reading

Bot, H, 2005. *Dialogue Interpreting in Mental Health*. Amsterdam & New York: Rodopi Publishers.
One of the few sources exclusively dedicated to interpreting in mental health.

Mirdal, G.M., E. Ryding and M. Essendrop Sondej, 2012. Traumatized refugees, their therapists and their interpreters. Three perspectives on psychological treatment. In: *Psychology and Psychotherapy: theory, research and practice*, 2012: 85:436–455.

Wadensjö, C. 1998. *Interpreting as Interaction*. London / New York: Longman.
One of the seminal works in interpreting studies.

References

Aranguri, C., B. Davidson and R. Ramirez 2006. Patterns of communication through interpreters: a detailed sociolinguistic analysis. In: *Journal of General Internal Medicine* 2006: 21: 623–9.

Bakker, M., C. Koster and K. van Leuven-Zwart, 1998. Shifts of translation. In: Baker, M. (ed.) *Routledge Encyclopedia of Translation Studies*, London & New York: Routledge, 226–31.

Bot, H, 2005. *Dialogue Interpreting in Mental Health*. Amsterdam & New York: Rodopi Publishers.

Bot, H. and H. Verrept 2013. Role issues in the Low Countries: interpreting in mental healthcare in the Netherlands and Belgium. In: C. Schäffner, K. Kredens and Y. Fowler 2013. *Interpreting in a Changing Landscape. Selected papers from Critical Link 6*. Amsterdam & Philadelphia: Benjamins. p.117 –31

Bot, H. and C. Wadensjö 2004. The presence of a third party: A dialogical view on interpreter-assisted treatment. In: Drosdek, B. and J. Wilson, *Broken Spirits: the Treatment of Traumatized Asylum Seekers, Refugees, War and Torture Victims*, New York: Brunner-Routledge, 355–78.

Flores, G. 2005. The Impact of Medical Interpreter Services on the Quality of Health Care: A Systematic Review. In: *Medical Care Research and Review* 62: 255–99.

IND (Immigratie and Naturalisatiedienst) 2009. *Klachtenadviescomissie Tolken, verslag 2006 – 2009 en eindrapportage*. Den Haag.

Karliner L.S., E.A. Jacobs, A.H. Chen and S. Mutha 2007. Do professional interpreters improve clinical care for patients with limited English proficiency? A Systematic Review of the Literature. In: *Health Research and Educational Trust*, 42 (2): 727–54.

Mirdal, G.M., E. Ryding and M. Essendrop Sondej, 2012. Traumatized refugees, their therapists and their interpreters. Three perspectives on psychological treatment. In: *Psychology and Psychotherapy: Theory, Research & Practice*, 2012: 85:436–55.

Mudarikiri, M.M. 2003. Working with the interpreters in adult mental health, in: Tribe, R. and H. Raval, *Working with Interpreters in Mental Health*, Hove & New York: Brunner-Routledge, 182–97

Verheggen, T. 2005. *Culture Alt Delete*. Open University Nederland.

Wadensjö, C. 1998. *Interpreting as Interaction*. London/New York: Longman.

Watzlawick, P., J.H. Beavin and D.D. Jackson 1967. *Pragmatics of Human Communication*, New York: Norton & Company.