What's the Story:
A narrative overview of
community interpreting
in mental health care
in Ireland

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Acknowledgments

Declaration

I hereby certify that this material, which I now submit for assessment on the programme of study leading to the award of Doctor of Philosophy is entirely my own work, that I have exercised reasonable care to ensure that the work is original, and does not to the best of my knowledge breach any law of copyright, and has not been taken from the work of others save and to the extent that such work has been cited and acknowledged within the text of my work.

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Abstract

Interpreting in mental health care is generally considered a consensual activity, whereby all the participants of the interpreter-mediated encounter – the service user client, the service provider mental health professional and the interpreter – are present for the same purpose: successful diagnosis and therapy. Based on this assumption, the current study aims to investigate to what extent narratives in interpreter-mediated mental health care in Ireland are consensually co-constructed at three different organisational levels: (1) the level of stories recounted during the interpreted therapeutic sessions; (2) the level of discourse between the participants of these interpreter-mediated meetings; (3) the metanarrative level of mental health interpreting service provision. The investigation is based on thematic, structural and dialogic narrative analytical methods carried out on data collected during narrative interviews with mental health professionals who have worked with interpreters and interpreters who have experience working in mental health settings. The findings suggest that mental health interpreting is not an obviously consensual activity, and that none of the levels of narrative explored show an even distribution of consensual co-constructive activities. Furthermore, the study proposes that consensual and conflictual narratives may be more helpful in classifying subfields of Community Interpreting than the traditional taxonomies which organise subfields into categories depending on the environment or setting in which they take place.

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List of Abbreviations

CI: Community Interpreting

INT: Interpreter respondent in the current research

MHC: Mental health care

MHI: Mental health interpreting

MHP: Mental health professional respondent in the current research

n.d.: "no date" of publication indicated for the reference

T/IS: Translation and Interpreting Studies

PROLOGUE

The story of this dissertation begins with two of my first interpreting assignments in Ireland. At the time I was equipped with a good knowledge of both English and Hungarian, with training in literary translation, but very little experience and no training in interpreting. Nevertheless, I believed I was reasonably well-educated and socially sensitive enough to deal with various situations on a professional footing. I was soon to find out how little I knew about interpreting in community settings when faced with technical as well as ethical difficulties on the way. I also came to realise that the former were sometimes easier to overcome, while the latter, problems of a moral nature, often stayed with the interpreter and sometimes had a bearing on his or her performance. Both of the series of assignments in question took place in mental health settings. I was interpreting in a range of situations at the time, but the experience with these two particular clients has had a lasting influence on my professional and research career.

One case involved a young woman who had been gang-raped in front of her family, and was suffering from nightmares and obsessive compulsive behaviour and had difficulty with raising her children as a result. Her story was harrowing in itself, and we were very close in age and would have shared a geographical space in our respective home city. What further complicated the case was that not long after a particular session I noticed the same young woman in a public setting – but to my surprise she appeared rather composed and well dressed and showed no signs of the dishevelled almost delirious look I was accustomed to during the interpreted sessions. This experience coupled with the discussion of the advantages of the Irish social welfare system compared to its Hungarian counterpart by her family member at a previous meeting in the waiting room of the psychiatric services threw a different light on the situation. The ambiguities such external experiences added to the situation were difficult to disconnect when interpreting her story during subsequent interpreter-mediated sessions, where I had to make sure that my personal perceptions did not enter the interpreting process.

The other case involved a middle-aged man who was suffering from amnesia following an alleged car accident he had no record of. Various medical examinations, to some of which I also accompanied the client as an interpreter, showed no proof of any of the physiological defects he claimed to have experienced. However, his story

of the accident and the description of the scene was a vivid recollection whether real or imaginary. The discrepancy between the lack of tangible evidence and the consistent accounts he told the psychologist left a trail of uncertainty. Once again, I had to ensure that when interpreting his story I relayed not only the content but also his certainty about the course of events.

These two series of sessions in particular gave the impetus to my interest in research. I became especially drawn to the idea how the interpreter's experience outside the actual interpreter-mediated sessions influenced his or her performance and the interpreting product. I was most fascinated by the stories clients told and how they unfolded not only within the frame of one single encounter but over the course of a series of sessions they attended with a professional. I realised that mental health care was a unique environment where stories had a heightened significance – they were often not only the way to draw up a patient's / client's history, but also a means to therapy. Thus, a question began forming in my mind, and I set off to investigate how interpreting influences the evolution of narratives in mental health care.

My first research plan was to record a series of interpreter-mediated sessions between a Hungarian patient / client and an English-speaking mental health professional. Like many researchers, I ran into difficulties, in my case right at the start. The research plan proved simply unfeasible, for there are very few Hungarians accessing mental healthcare services in Ireland with the aid of an interpreter, and, indeed, there are few other interpreters to carry out the work. Once I had contacted a number of possible services where such sessions might take place, I waited patiently for nearly a year for them to materialise, while familiarising myself with the relevant literature. As time was limited, I decided to change direction and drew up a new research plan for gaining information on the subject from those who have witnessed such events.

The mental health professionals who worked with interpreters and the interpreters who had experience in mental health care who agreed to participate in the project have since confirmed that the issue is worthy of examination. The dissertation has been made possible by their generosity, and what follows here is their stories as well as the story of how the research project evolved. It has been a continuously developing process, which is reflected in the final presentation and the management of the collected material.

1.1. The State of Mental Health Interpreting in Ireland

This research project is set against the background of the current state of mental health interpreting (MHI) in Ireland. The diversity of the service user clients is probably the most important factor to understand in the Irish context. Ireland has seen positive net migration since 1991 when the growing economy began to attract more immigrants than those who were leaving the country in hope of better opportunities abroad. While this trend has recently been reversed due to the economic downturn, there is still a considerable number of immigrants residing in the country, whose needs in a range of areas have to be taken into account. Although their exact number is difficult to gauge, statistics can provide some indication.

According to latest census figures (Central Statistics Office 2006a) nearly 10% of the population was born outside Ireland, compared to the 5.8% non-native population recorded in the 2002 census (Central Statistics Office 2002). While some of the non-nationals included in the figures are English-speakers from Australia, New Zealand, South Africa, the United Kingdom or the United States, and do not need interpreting services, a large proportion of immigrants do not speak English as a first language or well enough to communicate in particular situations. Furthermore, the non-English speaking population is probably underrepresented due to a number of reasons. Firstly, many immigrants were not aware that the census was taking place. Secondly, some immigrants did not consider themselves as part of the population and may not have understood that the census was aimed to establish the number of persons present or residing in the country on a particular day. Thirdly, often fleeing persecution, or coming from formerly mistrustful backgrounds, they did not wish to include their details in a centralised database. Fourthly, they were not aware that the census form was available in languages such as Chinese, Czech, French, Latvian, Lithuanian, Polish, Portuguese, Romanian, Russian and Spanish (Central Statistics Office 2006b). Lastly, they may not have had the linguistic means to communicate about the census.

Similar difficulties arise with figures circulated by other entities concerning the ethnic and linguistic composition of the immigrant population in Ireland. The Department of Enterprise, Trade and Employment (2009) publishes annual figures on work permits issued, which reveal that citizens from over 120 different countries are

in receipt of some sort of a work permit. These figures do not include citizens of European Union / European Economic Area member states who can be employed without a work permit. These numbers also exclude refugees or asylum seekers who are not allowed to engage in employment, but who are represented in the Annual Report figures published by the Office of the Refugee Applications Commissioner (2009).

Information on the nationalities of these migrants does not necessarily reveal the language they speak, and to date we do not have a clear understanding of the immigrants' language needs. In this respect, the statistics are similar to the census figures published by the Central Statistics Office. What is certain is that, according to research carried out by the Language Centre at the National University of Ireland, Maynooth, there are more than 167 languages currently spoken in Ireland (O'Brien 25 March 2006). Some speakers of this great variety of languages arrive with little or no English at all and would need assistance to communicate at the most basic level.

As far as language needs in health care are concerned, the picture is equally discouraging. For the moment it has been best described by the Health Services Executive of the Irish government in their *Intercultural Health Strategy* published in 2008. The summary is so apt that it is worth quoting in full.

> Designing services for the majority of the population may have the effect of inadvertently discriminating against certain groups, including minority ethnic groups, through neglecting to recognise and respond to their particular needs and circumstances. While mainstream healthcare is the primary vehicle through which all service users should be enabled to access care and support, it may be necessary to develop additional programmes that target the specific needs of this group. Interpretation services designed to reduce barriers to communication in accessing and using health services are a particular example. (Health Services Executive 2008 p71)

The account continues later with a detailed depiction of the situation of interpreting in health care in general.

> In a survey conducted by the Irish College of General Practitioners in 2003, GPs identified a lack of interpreters in the health system as the single biggest barrier to offering quality medical care to asylum seekers and refugees.
>
> Subsequent consultations with service users and service providers confirmed the urgency of improving communication between members of minority ethnic groups and service providers.
>
> However, evidence shows that availability of interpreters does not necessarily imply take up by service providers of this option. This is borne out by a preliminary evaluation of a pilot scheme in Dublin mid-Leinster, where GPs did not appear to take maximum advantage of an advertised interpretation service, but tended to rely on informal strategies for communication. In this regard, serious concerns exist around the not uncommon use of children as interpreters.

The complexities around the provision of interpretation services were confirmed in Forum magazine, a journal of the Irish College of General Practitioners, where research findings recommended the urgent development of a comprehensive structure for a statutory interpretation service.

A number of issues exist around the development of quality interpretation services, ranging from training and accreditation of interpretation standards and guidelines for practice in this area, and appropriate codes of practice, to the provision of training for service providers using interpretation services, evaluation of the effectiveness of such services and the provision of support to interpreters involved in particularly emotional interactions.

Proficiency in interpreting medical terminology is an added challenge in this area. The current provision of interpretation services is, as with availability of information discussed above, available on a patchy and fragmented basis across the country, at both hospital and community level, with limited evidence around its quality, effectiveness, appropriateness or service user / service provider satisfaction.

Rural areas in particular experience difficulties in securing quality, timely interpretation services when these are necessary. (p101)

The picture is not much clearer in terms of mental health needs. As new immigration issues are only being recognised now, and research into the mental health needs of immigrants is only beginning, there is little data available on access to MHC services. The biggest problem is that referral to mental health services is processed through primary care: in most cases, the consultation happens without the presence of an interpreter and there is no opportunity to determine more than the physiological symptoms of the patient. As far as service provision is concerned, there is no definitive list of services where non-English speakers are treated in Ireland. A directory of mental health clinics across the country provided by the Health Services Executive (3 April 2008) is a good starting point, but does not include refugee and asylum seeker services, certain regional clinics or voluntary, charitable and specialised organisations. Therefore, it is impossible to know how many clients who access MHC services need an interpreter.

Furthermore, those involved in the interpreting aspect of the MHI service provision are often speakers of particular languages rather than interpreters. In other words, they speak English and another language, but they are not trained or accredited interpreters. Their knowledge of English, or even the language they claim to speak, is often untested. They are often unfamiliar with the work environment and have not acquired the necessary terminology. Additionally, they are rarely aware of the ethical implications interpreting in sensitive settings involves. The current project is set against this backdrop and intends to contribute to the improvement of MHI services by highlighting pertinent issues.

1.2. Terms of Reference

The dissertation is posited in the narrative framework and applies a tiered structure of organisation. The three levels of narrative, as they are referred to throughout the thesis, loosely correspond to the three narrative features which will be discussed in Chapter 2: the story or plot; the prevalence of dialogism or the discourse; and the co-constructed nature of narratives. For ease of understanding and for the sake of consistency, the term "story" denotes the actual narrative which the client tells and which is reproduced by the interpreter; the term "discourse" refers to the dialogic event between participants of an interpreter-mediated encounter; while the term "metanarrative" indicates a paradigm of thought, or an institutional discourse.

Within the framework of the current study, the term "Community Interpreting" (CI) refers both to the practice of interpreting in community settings as well as the scholarly discipline researching the profession. Community Interpreting, rather than the other nominations which are discussed in the Literature Review in Chapter 2, is applied in the current research for four reasons. Firstly, CI has become a well-known term within Interpreting Studies, partly due to the *Critical Link* conference series (Brune et al. 2003; Carr et al. 1997, 2000; Hale et al. forthcoming; Wadensjö et al. 2007). These conferences have succeeded in bringing together sign language interpreters facilitating communication between the Deaf and the hearing, on the one hand, and speakers of indigenous as well as immigrant spoken minority languages on the other (for further information see Pöchhacker 1999). While the framework of the current project does not include users of Irish sign language (ISL) or speakers of Irish (according to the Irish Constitution, the first official language of the State), or Shelta or Cant (the language of the travelling community, the largest indigenous ethnic minority in Ireland), or other sign languages, the use of "CI" acknowledges this inclusivity.

Secondly, the concept of "community" is often associated with empowerment issues, an important concern regarding the lack of language-assisted mental health services in the jurisdiction under study. It implies the communicative nature of the process as well as the power differentials between the service provider and the service user. It differentiates this special form of interpreting from conference interpreting by explicitly naming the community as its setting. It suggests that the difference between the primary speakers is not only linguistic, but also cultural.

Finally, it implies that the communicative encounter between the primary speakers in a communicative activity is only made possible by the use of an interpreter. As for mental health interpreting (MHI), very simply put, it is a subfield of CI, which includes the practice and scholarly research of interpreting between a minority language-speaker client and a majority language-speaker professional in MHC settings.

For the purposes of the current research, the participants in interpreter-mediated encounters are referred to as "the client," "the mental health professional" and "the interpreter" respectively. Despite a few diverse appellations mostly depending on the role definition, there is general consensus about the nomination of the interpreter in the literature. However, the designation of the other two participants requires some clarification. In the current project "mental health professional" refers to any therapist, psychotherapist, mental health nurse, occupational therapist, psychologist, or any other professional working in a service provider capacity in mental health care (Health Services Executive 12 March 2008). The third participant, who is sometimes called the service user or the patient in the literature, is referred to as "the client" throughout the thesis for two reasons. Firstly, the use of the expression "client" rather than "patient" suggests a more active position of the service user and is more suited to the narrative framework of the current study. Secondly, the use of this term also acknowledges service users not only in psychiatric but also in psychological services. As psychology is a social science discipline and, strictly speaking, does not fall under the umbrella term of medical sciences, such a designation seems more suitable for the inclusive approach applied throughout the project.

Another important distinction is to be made between the interpreter and mental health professional participants in interpreter-mediated encounters and the interpreters and mental health professionals who have participated in this particular project. The former individuals are always referred to by the full nomination of their profession throughout the thesis. The interviewed interpreters and mental health professionals, on the other hand, are designated by acronyms referring to their profession. Thus, the mental health professionals who have taken part in the research are represented by the letters MHP, while the interpreters who have contributed to the project appear as INT throughout the thesis. Although Wadensjö (2001b) suggests the use of pseudonyms for research participants, they are denoted by an abbreviation in reference to their profession and a sequential number. Despite the

impersonal nature of such referencing, this choice aims to protect the respondents' identity. In addition, the interviewed INTs and MHPs are collectively referred to as "respondents" within the framework of the current study. The expression intends to signify the dialogic nature of the interviews as well as the active role the respondents have played in shaping the research process. It also facilitates a clear distinction between "respondent" within the research paradigm and "participants" in interpreter-mediated encounters, that is, the persons present when interpreting takes place.

1.3. Contribution to the Field of Community Interpreting

This project, a testimony to the recent upsurge in CI research in Ireland, is the first of its kind on a number of counts. It is the first complete doctoral dissertation in the area of CI provision in Ireland, and it is the first in-depth qualitative study of MHI in the State. To date, this is the only extensive qualitative study on MHI provision in the State which aims to address a wide range of issues. Furthermore, the study covers areas of MHI which have so far received little attention in the literature. In other words, the project includes a wider range of environments within MHC where interpreting for clients with limited language proficiency takes place. To date, MHI research (see, for example, Bot 2003, 2005a, 2005b; Bot and Wadenjsö 2004; Elghezouani 2007; Fox 2001; Fox and Gander 2004; Granger and Baker 2003; Loshak 2003; Messent 2003; Miller et al. 2005; Mudarikiri 2003; Raval 1996, 2003a, 2003b; Tribe 1999, 2005; Wadensjö 2001a) has mostly comprised therapeutic settings and concentrated on interpreting issues in therapy or psychotherapy. The current thesis explores settings outside this traditional research environment and ventures into discussing expectations and possibilities for interpreters in areas such as occupational therapy (which aims at helping "people whose ability to cope with everyday activities is threatened or impaired in some way by physical, psychological or developmental problems" (Health Services Executive 12 March 2008)) or working with mental health nurses.

In addition, the project has grown out of Translation and Interpreting Studies (T/IS), unlike some of the pivotal previously published collections (Tribe and Raval 2003) and monograph (Bot 2005a) which have emerged from a mental health professional background. Finally, the project is innovative in its consistent narrative approach to research. The research is qualitative in nature and goes beyond the simple presentation of opinions expressed by the interviewed INTs and MHPs. This

narrative treatment comprises an overview of the CI and MHI literature through a narrative lens, narrative interviews conducted with respondent INTs and MHPs, a narrative coding process, the application of a variety of narrative analytical approaches and narrative presentation of the findings.

1.4. The Structure of the Thesis

Bearing these initial considerations and the narrative framework in mind, the structure of the thesis is as follows. The **Literature Review** in **Chapter 2** provides a reading of the currently available CI and MHI literature through a narrative lens and introduces the claim this research seeks to explore, namely, that narratives in MHI in Ireland are consensually co-constructed. In addition, the chapter presents the key characteristics of narrative which underlie the current project and offers a tripartite conceptualisation of narrative levels. These concepts include the story or plot, the dialogism or discourse and the constructed nature of narrative.

Chapter 3 offers a thorough introduction to **Methodology** and explains how the narrative framework shaped the research project from its conception to the final analysis. It details the interview design, the respondents' profile, and the recording and transcription process as well as the various stages of the coding procedure. It elaborates on the dual bottom-up and top-down coding procedure using the NVivo qualitative data analysis software and further expands on the narrative dialogic aspects of coding, including the issue of empowering the respondents throughout every stage of the research process. This chapter also discusses the structure and presentation of the analysis chapters in detail.

Chapter 4 concentrates on the actual narrative, that is, the story level, and focuses on **Perceptions around Narratives and Accuracy**. Structured around a research dialogue between the INTs and MHPs, this chapter looks at the respondents' understanding of a narrative as a unit of communication and examines how accurately various levels of communication units are seen to be interpreted. In addition, it discusses practical issues around the training of interpreters and interpreter-user service providers.

Chapter 5 investigates the power-relations at the discourse level of interpreter-mediated encounters and how the respondents view the question of **Control of Communication**. The results are introduced from the perspective of the participants of interpreter-mediated encounters, that is, the client, the mental health professional

and the interpreter. The chapter presents a research dialogue between the only monograph on interpreting in MHC published to date and the findings of the current study. It also addresses employment issues and how the perception of professionalisation may influence who is in control of the communication flow in the interpreter-mediated encounter.

Chapter 6 examines the current state of MHI at the metanarrative level of service provision. It reiterates the significance of the narrative contribution to the research methodology by offering a presentation of the research dialogue between the respondents and the researcher. It concentrates on the issue of **Safety** and related concerns about interpreting support, subjects highlighted by the respondent INTs and MHPs.

Finally, the **Conclusion** in **Chapter 7** summarises the findings of the research and reflects on the research claim. It also provides practical recommendations on how to improve MHI provision and considers avenues for future research.

CHAPTER 2 – A LITERATURE REVIEW OF COMMUNITY INTERPRETING IN MENTAL HEALTH CARE IN IRELAND

2.1. Introduction

The current chapter aims to give a concise overview of the principal issues of community interpreting (CI) in general and mental health interpreting (MHI) in particular with reference to the Irish context through a narrative lens. It takes heed of Gile's (1999) remark that

> lack of space often makes it impossible to cite all previous studies on a particular theme, and choices must be made in favor of the most important ones, or the first ones, or the most recent ones, or the ones most easily accessible to readers. (p30)

Interest in CI and MHI research has grown significantly over the last three decades, which makes selection inevitable. This literature review prioritises works of significance in terms of the contribution they have made to the understanding of CI. The intention is to provide a background to the research claim that narratives in MHI in Ireland are consensually co-constructed. Therefore, this review of the relevant literature briefly discusses the narrative concepts which are regarded as pertinent to the current study. This preamble does not provide an in-depth examination of narrative theories, rather it introduces the features of the narrative framework which inform the dissertation. The chapter then presents the major tenets of CI which underlie the current project and which are considered almost axiomatic in terms of the narrative research framework. Finally, the analysis turns to the more specific area of MHI and the Irish situation.

2.2. Salient Concepts in the Narrative Framework

Narrative theories have recently emerged in various human sciences, including history (Mink 1981; White 1981a, 1981b), philosophy (Ricœur 1988, 1994), communication (Fisher 1984), literature (Bakhtin 1981; Barthes 1972; Herrnstein Smith 1981), psychology (Bruner 1986, 1990, 1991; Labov and Fanshel 1977; Ochs 1997; Ochs and Capps 1996; Polkinghorne 1988, 1995), sociology (Bourdieu 1991, 1998; Foucault 1970, 1977; Geertz 1973) and linguistics and pragmatics (Jakobson 1960; Labov 1972, 1982; Labov and Waletzky 1967). In addition, narrative methodologies have also gained acknowledgement in social sciences (Clandinin and

Connelly 2000; Elliott 2005; Mishler 1984, 1986; Riessman 1990, 1991, 2002, 2004, 2008).

While this research project is posited in the narrative paradigm, it does not rely on one particular narrative theory, but takes a narrative methodological approach. Riessman's (1990, 1991, 2002, 2004, 2008) writings and narrative analytical approaches appeared the most appropriate for a number of reasons. Firstly, her main subject of analysis is the narrative, which is the focus of the current project. Secondly, her main research "examines interrupted lives, where events have disrupted expectations of continuity" (Riessman n.d.), similarly to the narratives told at the heart of our investigation. Thirdly, narrative analysis seems particularly appropriate for the current investigation, as it is useful for studies of small numbers, and the "cases are often drawn from unrepresentative pools" (Riessman 2002 p262). It is very well suited for researching MHI and its effects on the therapy, as it "allows for systematic study of personal experience and meaning: how events have been constructed by active subjects" (Riessman 2002 p263). Fourthly, the "study of narrative does not fit neatly within the boundaries of any single scholarly field" (Riessman 2002 p217), and thus it appears suitable for interdisciplinary research. Finally, Riessman has written extensively on the subject in a concise manner, which facilitates the application and replication of the methodologies she summarises. A detailed description of Riessman's narrative analyses applied in this project will follow in section 3.8.

Narrative theories and methodologies on the whole present the researcher with two difficulties: the disciplines to which they apply may overlap, and there is no agreement upon major principles among the theorists. In a peculiar twist, however, both these difficulties play into the overarching ethos of narrative thinking. Firstly, because interdisciplinary studies follow the poststructuralist argument that there are no clear boundaries between monolithic blocks of various positivist sciences. Secondly, because the underlying concept of narrative theories is a belief in individual perspective and the rejection of one, universally accepted dominant metanarrative.

Nevertheless, a significant problem presents itself when discussing narratives. What exactly do we mean by the word and what synonyms are available? Narrative is often understood simply as a story or sequence of events, but sometimes it is used interchangeably with "discourse," quite often to denote an ongoing exchange of

thoughts. The confusion arises from the fact that "discourse" can also refer to, among others, communication or dialogue. Even Bruner (1991) concedes that there is

> great difficulty in distinguishing what may be called the narrative mode of *thought* from the forms of narrative *discourse*. […] Eventually it becomes a vain enterprise to say which is the more basic—the mental process or the discourse form that expresses it—for, just as our experience of the natural world tends to imitate the categories of familiar science, so our experience of human affairs comes to take the form of the narratives we use in telling about them. (p5)

The word "narrative" originates from the Latin "narrare" (Harper 2001c), meaning "to tell, relate, recount, explain" and is related to "gnarus" or "knowing," also of Latin origin. It is this knowledge and its dissemination that underlie most definitions of the expression, no matter how diverse they first appear. Thus, the most pivotal and most frequently mentioned authors in the literature on narrative, including Bakhtin (1981), Bourdieu (1991, 1998), Bruner (1986, 1990, 1991), Foucault (1970, 1977), Labov (1972, 1982, see also, Labov and Waletzky 1967; Labov and Fanshel 1977) and Ricœur (1988), focus on key characteristics of the narrative dissemination of knowledge. The following sections discuss three of these characteristics which appear relevant to the current project, namely, (1) story and storytelling, (2) dialogism and discourse, and (3) the constructed nature of narratives.

2.2.1. The Characteristics of the Story

Although the expression "narrative" only gained the meaning "a tale, a story" in 1561 (Harper 2001c), it is now often used to denote a story or even a plot. In traditional Eurocentric thinking, which derives from **Aristotle**'s (1996) criteria for dramatic unity summarised in his *Poetics*, there is an action, a temporal and a spatial dimension to the narrative. In other words, a story is made up of a series of events taking place in a particular space organised into a narrative along a certain chronological and / or possibly causal logic. Over two millennia on, **Labov** (1972) found similar organisational principles when studying narratives recounted by Black American youth. He identified six elements of a fully formed narrative, including an abstract (summary of the substance of the narrative), orientation (time, place, situation, participants), complicating action (sequence of events), evaluation (significance and meaning of the action, attitude of the narrator), resolution (what finally happened), and coda (returns the perspective to the present) (Labov 1972 pp362-375). Even though this unity has been successfully disrupted in various art

forms which have grown out of this classical European heritage, such as stream-of-consciousness novels in literature or films employing flash-back narratives in cinema, this structure is still considered the norm and any disruption is still considered a deviation. Consequently, as will be discussed in section 2.5.1., the significance of such disrupted or deviant narratives is of paramount interest to the current research project.

2.2.2. Dialogism and discourse as a feature of narratives

Another important concept of narrative is dialogism, proposed by the Russian philosopher and literary critic, Bakhtin, who is also credited as one of the initiators of discourse studies. It is interesting to note here that while "discourse" and "dialogue" also often appear synonymous, they have complementary but non-identical meanings. Both expressions refer to conversation, but neither denotes an obviously consensual activity. On the one hand, "dialogue" (Harper 2001 a) is often mistakenly thought to have originated from a compound meaning "two speeches" or "conversation between two people." Its etymology means "talking across" and implies a speaker imparting knowledge or voicing their opinion to an audience. On the other hand, the origins of "discourse" (Harper 2001b) suggest that intertwined narratives in a conversation are not always harmoniously running side by side, but they are "off course" or "run about," as the root of the word reveals.

Nevertheless, both expressions relate to the concept that there is an originator of the message or narrative and a receiver of the same, and that these roles are interchangeable between the participants. It refers to the idea that a story cannot exist without an audience and is created with a particular audience in mind, which, in turn, influences the creation of the same (Bakhtin 1981). In addition to the dialogic nature of narratives at the story level, Bakhtin also suggested that works are written in a particular context, taking into consideration what has come before and engaging in a discourse to come (1981). The implications of this concept are discussed in sections 2.4.2. and 2.5.2.

2.2.3. The constructed reality of narratives

Related to the dialogic nature of narratives, insofar as they require an audience whose existence reflexively influences the narrative itself, it appears almost obvious that they are constructed in nature. In the simplest of terms, narrative theories hold

that social realities can be perceived as a construction of a combination of narratives (or stories) told by different narrators (or story tellers). In other words, "we organize our experience and our memory of human happenings mainly in the form of narrative" (Bruner 1991 p3). Given his background in psychology, Bruner's contribution to constructivist thinking cannot be underestimated in a study on MHI. In his ten criteria of narrative, **Bruner** (1991) incorporates the Aristotelian concepts of the unity of time, action and place in his "diachronicity" and "particularity." He reformulates Aristotle's caution for truthfulness in tragedy in his "referentiality." Furthermore, he includes Aristotle's striving for representation of the universal human condition in his "genericness" and "intentional state entailment." Bruner also bows to Bakthin in acknowledging the situated and contextualised nature of narratives in his "hermeneutic composability," "canonicity and breach," "normativeness" and "context sensitivity and negotiability" and "narrative accrual."

On discussing canonicity and the breach thereof, Bruner (1991) remarks that it is "perhaps, what makes the innovative storyteller such a powerful figure in a culture. He may go beyond the conventional scripts, leading people to see human happening in a fresh way, indeed, in a way they had never before 'noticed' or even dreamed" (p12). Bruner introduces the notion of power and *authority* in connection with *authorship*, thus marrying the two etymologically and phenomenologically related concepts. He argues that constructing a new narrative within an already existing context empowers the narrator, a line of reasoning which has gained great significance with regard to the constructed nature of discourses. While Bruner primarily considers these concepts and characteristics at the level of the actual story or account, they feature as governing ideas in narrative theories at higher organisational levels.

The single piece of most important work on narratives in Translation and Interpreting Studies (T/IS), Mona Baker's (2006) discussion of *Translation and Conflict*, also connects individual narratives and higher level metanarratives. Following a thorough introduction to narrative taxonomies, Baker locates the translator and interpreter's work literally on the frontlines and demonstrates how the act of translation and interpreting is a political activity. She illustrates, with a formidable arsenal of examples, how individual pieces of translation and interpreting work transcend their microcosm to constitute higher level discourse. Similarly, she argues that these microsocial acts of a linguistic nature are always posited within

larger scale metanarratives which they cannot escape. She draws attention to the translators and interpreters' responsibility to make conscious choices about what metanarratives they align themselves with and calls on practitioners and academics to constantly challenge dominant discourses of power.

Similarly, power relations take centre stage in Foucault's (1977) treatment of dominant and subjugated discourses and Bourdieu's (1991, 1998) understanding of social organisation in terms of power dynamics. Their ideas and frameworks have been further developed in other fields of study. However, a distinction between the two disciplines which inform the current project, T/IS and mental health care (MHC) related fields, is worth noting here. Certain therapeutic schools and centres (see, for example, Patel 2003; Sarbin 1986; White and Epston 1990) working within a narrative framework akin to the current study take these Foucauldian theories, along with Bateson's "interpretive method" (1972, 1979) as a basis for their models. In contrast, T/IS have applied Bourdieusian concepts extensively, bearing fruit in a special issue of *The Translator* dedicated to the subject (Inghilleri 2005a).

2.3. The narrative organisational levels in the dissertation

These three basic narrative concepts serve as organisational pillars within the framework of this dissertation. They also aid the establishment of a three-tiered structure for the examination of MHI in Ireland. These include (1) the story level of narratives which actually evolve in an interpreter-mediated encounter; (2) the discourse level of the interpreter-mediated encounter as a socially constructed event; and (3) the metanarrative level of service provision and MHI as a profession.

On the one hand, the individual stories recounted during an interpreter-mediated encounter shape the evolution of the encounter, and in turn, the participants' experiences during a series of encounters will influence their involvement in the formation of the metanarrative at the service provision level. The construction of a metanarrative of service provision in MHI, thus, can be illustrated as if based on the support and foundation of the lower organisational levels, namely the encounter-level discourses and the story-level of the client's accounts, as seen in Figure 2.1.
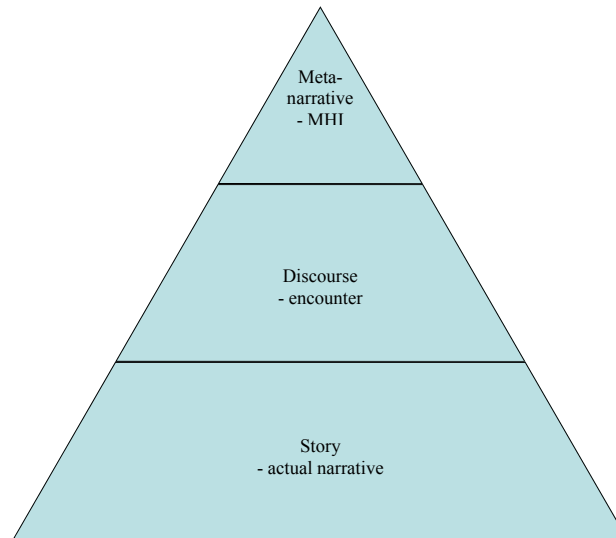
Figure 2.1. The bottom-up construction of the three organisational levels

However, equally, the metanarrative level of MHI has a bearing on the encounter-level discourse of interpreter-mediated encounters, which, in turn, influence how narratives at the story level are constructed by the participants. This top-down organisational understanding is depicted in Figure 2.2.
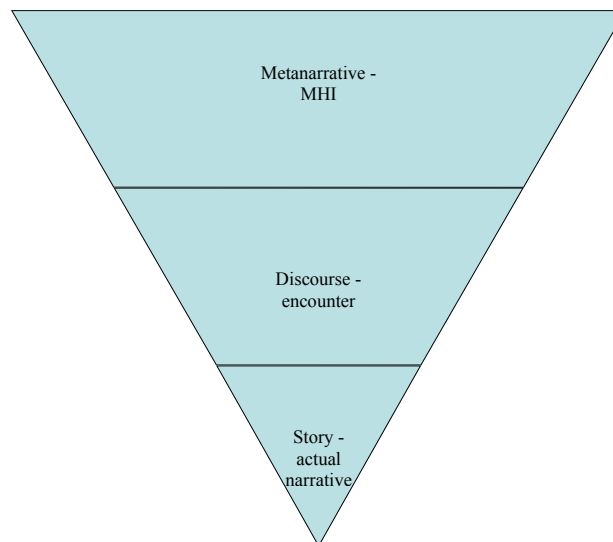
Figure 2.2. The top-down construction of the three organisational levels

Thus, while these levels feature separately for the sake of digestibility, it should be considered that these three organisational levels do not exist in isolation from each other. They are interconnected and are in constant interaction, a concept to bear in

mind throughout the discussion of the three levels in the context of CI, MHI and the Irish situation as well as during the analysis chapters.

2.4. Community Interpreting through a Narrative Lens

CI has been a matter of interest to interpreting scholars for some time and has featured in publications on T/IS as well as on other disciplines. From a T/IS perspective, such articles are accessible in journals, such as *Interpreting*, *Meta*, or *The Translator*. The latter also published a special volume on *Dialogue Interpreting* (Mason 1999a). Further articles have appeared in collections (Erasmus 1999a; Gentile et al. 1996; Mason 2001; Pöchhacker and Schlesinger 2002; Valero-Garcés and Martin 2008) or as conference proceedings, mostly following the *Critical Link* community interpreting conference series (Brune et al. 2003; Carr et al. 1997, 2000; Wadensjö et al. 2007). Monographs on CI issues include Wadensjö (1998a), Hale (2007), Corsellis (2008). Environment-specific monographs are relatively rare but have been published in some, perhaps more prevalent or identifiable areas of CI, such as legal interpreting (Berk-Seligson 1990) medical interpreting (Angelelli 2004), or sign language interpreting (Roy 2000). The fact that these latter publications concentrate on a particular subfield of CI does not detract from their invaluable contribution to empirically-based research and to wider considerations, such as the importance of discourse (Berk-Seligson 1990; Roy 2000) or the significance of ethnographic approaches (Angelelli 2004).

The reason why "community interpreting" is the preferred term in this dissertation was discussed in section 1.2. Nevertheless, the other nominations deserve a mention before moving on to the examination of services in the literature. As Mikkelson and Neumann Solow (n.d.) state,

> Community interpreting is a term that has come into common usage in recent years to describe the kind of interpreting that enables residents of a community to gain access to public services when they do not speak the dominant language of the community. In other countries, this type of interpreting is also known as liaison interpreting (Australia), cultural interpreting (Canada), contact interpreting (Scandinavia), or public service interpreting (U.K.).

The denomination "community-based interpreting" (or CBI), is used in some English-speaking countries. It has been applied by Chesher et al. (2003) in the Australian context or by Turner (2007) when writing on working with the Deaf community in Scotland. This nomination focuses on facilitating access to public

services for those who do not speak the majority language in which these services operate. As Chesher et al. (2003) disclose, this term was originally coined by the then newly established legal interpreting committee of the International Federation of Translators (FIT) to encompass "any interpreting which takes place in everyday or emergency situations in the community. Possible settings include health, education, social services, legal and business" (p276). Similarly, "Public Service Interpreting", a term preferred in the UK (Cambridge 1999, 2004; Corsellis 2008) and in Spain as PST/I (Third International Conference on Public Service Translation and Interpreting 2008; Valero-Garcés and Taibi 2004), also refers to the interpreting environment. It differentiates PS(T/)I from conference interpreting and implies that interpreting is part of service provision and that there is a need for equal access to public services.

Other nominations concentrate on the communicative nature of this activity rather than the situations where it takes place. "Liaison interpreting" and "dialogue interpreting" belong to this category. The latter label has gained wider acceptance through Mason's (1999a, 2001) publications in CI in general, and through Bot's monograph (2005a) and articles (2003, 2005b) on MHI in particular. "Dialogue interpreting" refers to the bilateral characteristic of CI, that is, the interpreter transfers data in both directions. In addition, it simultaneously encompasses the communicative nature of the interpreting process.

The term "community interpreting" applied in the current study has received some criticism for various reasons. As a South-African attendee at the *Fifth Critical Link* conference remarked during a post-paper discussion, the term "community" has been associated with politically deprived minority groups and acquired negative connotations in certain jurisdictions. Perhaps this is why Erasmus and other South-African writers (Erasmus 1999a, 1999b; Marais 1999; Tyolvana 1999; Ulyatt 1999) display a preference for the term "liaison interpreting," which also suggests a critical link between representatives of authority and traditionally powerless service users. After this short explanation of the use of the term "community interpreting" in the current project, the following sections review the CI literature in terms of the narrative features identified in the introduction of the current chapter: the story, dialogue and co-construction.

2.4.1. The story in CI

When discussing the issue of accuracy in interpreting or the question of equivalence, topics of interest in Chapter 4, most CI scholars argue for pragmatic renditions rather than verbatim transfer of the source text utterance (Baker 1992; Cambridge 1999; Hale 1997a, 1997b, 2001, 2007; Mason 1999b, 2001; Roy 2000; Wadensjö 1998a). This would suggest that among other higher levels of textual organisation, narratives should receive attention during analysis. However, to date it is close textual analysis of lower organisational levels which have featured more prominently in CI.

The subject of such research covers a wide range of interests. For example, Napier (2004) investigates omissions in the performance of Australian sign language (AUSLAN) interpreters, while Jacobsen (2003) looks at additions in the court room. Also Jacobsen (2003, 2008), along with Mason (2006) and Mason and Stewart (2001), examine face saving and pragmatics mostly with reference to court interpreting. Hale (2001) writes on legal settings as well, but focuses on the interpreter's interruptions during court cases, while Krouglov (1999) writes on forms of politeness at a police station. On the medical interpreting front, Meyer (1998, 2001) and Meyer et al. (2003) have published their findings on the close analysis of doctor-patient communication. Tebble (1997, 1999, 2007) has also concentrated on discourse analysis in CI in general and medical interpreting in particular.

Despite the fact that a lot of situations where an interpreter's services are required involve stories, for example taking a medical history, giving a witness account at a police station or in court, very little has been published about the interpreting of narratives *per se* in the CI literature. These rare examples include Bot and Wadensjö's (2004) article on MHI, Papadopoulos' (2003) treatment of subjugated narratives also in mental health settings, and Wadensjö's (1998b) paper on the social organisation of remembering. One of the few articles dedicated to the interpreter's involvement in authoring the actual stories the clients tell in fact deals with the interpreter's censorship of the client's narrative rather than its construction. As Jacquemet (2005) reports, interpreters working for the UNHCR in trying to assess the validity of asylum claims in Albania developed a practice of curtailing narrative accounts even before they could materialise. Although the author had access to recordings of the interpreter-mediated events which could have provided an

invaluable insight into the interpreting of story-level narratives, he could not analyse the organisation of narratives, as they were silenced. The material revealed how the interpreters strongly influenced the construction of multilingual encounters. This correlation between the actual stories and the co-construction of events points to the interrelated nature of the narrative characteristics discussed here, and leads on to the examination of encounter-level dialogue and discourse in CI.

2.4.2. Dialogue and discourse in CI

For the purposes of the current investigation the most significant train of thought within the discipline has been the move away from the perception that the interpreter disrupts a communicative dialogue towards a more inclusive and interactive understanding of the interpreter's presence as a person in a communicative encounter. It is now widely accepted that, due to the bilateral linguistic transfer, CI is dialogic in nature. In other words, the *modus operandi* is as follows: the interpreter interprets the service provider's utterance from language A to language B and then the interpreter interprets the service user client's utterance from language B to language A in response. This has been reflected in conceptualised nominations of the discipline discussed above, and the acknowledgement of the triangular relationship between the participants of the interpreter-mediated encounter. The latter is referred to as the "triadic exchange" (Mason 1999a, 1999b, 2001) or the "communicative *pas de trois*" (Wadensjö 1998a) in the CI literature. The emergence of these seemingly nominal concepts has been symptomatic of a significant underlying transfer towards the understanding of the interpreting process as discourse as well as text. In this sense, these developments have placed CI in the narrative framework, where the dialogical / discursive characteristics, as well as the constructed nature of the process, are overtly recognised.

In the 1990s, both of these concepts appeared in the wider area of T/IS (Hatim and Mason 1990) as well as within subsections of CI (see, for example, Berk-Seligson 1990). However, Wadensjö's *Interpreting as Interaction* (1998a) was the first publication to draw attention to these seminal issues with special regard to CI in general. Firstly, she argues that talk during interpreting is both activity as well as text (Wadensjö 1998a pp21-47). Secondly, she claims that the communication process in the activity is both dyadic (for instance, when the interpreter user representing the

authority and their client communicate) and triadic (when the interpreter user professional, their client and the interpreter communicate) (Wadensjö 1998a p11).

Following in Mason and Wadensjö's steps, CI is now considered a discursive and dialogic activity. Roy's (2000) analysis of an encounter between a deaf student and a professor facilitated by a sign-language interpreter reasons that CI is not a purely textual activity and there are non-linguistic, social factors at play. Roy regards interpreter-mediated encounters as speech events, and, similarly to Angelelli's (2000) comparative study of conference and community interpreting, bases her investigation on Hymes' models of linguistic and social interaction. She examines the management talk and turn-taking in communication combining three approaches to discourse, namely interactional sociolinguistics, conversation analysis, and the ethnography of communication. Roy concludes that the primary participants' communication is a complex interaction and that the interpreter is the only participant equipped with "knowledge of the linguistic system, conventions for language use, the social situation, and the discourse structure system" (2000 p99) to manage turn taking.

In possibly the most extensive study in a subfield of CI to date, Angelelli (2004) comes to very similar conclusions. Offering a model of medical interpreting as cross-cultural communication she maintains that, in relation to the idea of the degree of (im)partiality or (dis)involvement, interpreters

> are not only linguistically visible, but […] also visible with all the social and cultural factors that allow them to co-construct a definition of reality with the other co-participants to the interaction. Interpreters enter the interaction with all of their deeply held views on power, status, solidarity, gender, race, ethnicity, nationality, socio-economic status (SES), as well as the cultural norms and societal blueprints that encompass the encounter; they use all of these to construct and interpret reality. The interpreters' views of all of these social factors interact with the parties' views of those same social factors. (p9)

However, while Roy acknowledges external social and cultural factors but calls for strict adherence to rules of impartiality on the interpreter's behalf, Angelelli suggests that interpreters should take on cultural mediation roles to a certain extent.

2.4.3. Narrative construction in CI

In an interesting study of a political interview interpreted live on the radio, Wadensjö (2000) suggests that interpreters sometimes "take on the task of not allowing information about differences in norms and attitudes to surface in discourse, in order to avoid disturbance in interaction" (p245). The fact that interpreter-

mediated encounters are constructed, and indeed co-constructed, by the participants has been accepted as an almost natural extension of the dialogic nature of such communicative events (see, for example, Bot and Wadensjö 2004; Inghilleri 2005b; Wadensjö 1998b, 2000, 2004). Firstly, dialogue is a principal feature of narrative construction, whereby it is acknowledged that social realities are indeed created, and this process is dialogic in nature (Bakhtin 1981; Bruner 1991). Secondly, since the conceptualisation of CI (Roy 2000; Wandensjö 1998a), it has also gained recognition that the interpreter becomes part of the communication process and a third, potentially equal, party to the construction of a socially constructed narrative.

Potentially equal, as the two primary speakers do not participate on an equal footing, either. Power differentials within the interpreter-mediated encounter imply that the client's lack of control deprives them of other rights, too (Leung 2003). Similarly, Bahadir (2001) argues that the client would not be given a "right to speak with a voice of their own" without the help of an interpreter. An extreme historical example of such a power differential, when an interpreter aligned himself with the authority representative primary participant, is presented by Fenton (2001). She analyses the case of Richard Barrett, who acted as an interpreter in the signing of the land deeds between the coloniser of European-descent, or Pakeha, and the traditional land-dweller Maori, who consequently lost their right to most of the land where they had lived. Through the case of Barrett's interpreting it is perhaps easier to understand how individual interpreted events are not only situated in a local socio-cultural context but can also have far-reaching consequences in terms of a greater metanarrative.

Cronin (2002) in his article on the hermeneutic importance of the underrepresentation of non-Western, mostly oral, cultures makes a strong statement on power relations with regard to CI. He says that if "language differentiates the animal from the human, then denying the utterances of others the status of language-that-can-be-translated is to reduce them to the condition of animals" (p59). Although Cronin's discussion mostly concerns interpreting between colonisers and colonised in the land of the former, his warning that languages with no history of literacy receive virtually no attention in T/IS is also valid in terms of language transfer between immigrant or indigenous minorities and majority host communities. As Kent (2007) remarks with regard to sign language interpreting and social construction, if "we consider these two discourses as cultural, as being rooted in particular

experiences of social identity such as being Deaf and being non-deaf or "hearing," then we can imagine the dialogue constructed here as part of a larger discourse about power relations" (p199). It is this understanding of the constructive nature of narratives that aids the conceptualisation of narratives at various levels, and elevates the actual story through the discourse of a communicative event with individual participants to the metanarrative plane of research and service provision.

Perhaps the most prominent proposition of narrative construction in T/IS is the positioning of CI in the area of social sciences. Inghilleri (2006), for example, suggests that the development of the discipline offers a new status quo and has an opportunity to generate a new framework within T/IS. She writes that in

> considering these issues with regard to interpreters and the interpreting profession, I have suggested (Inghilleri 2005a) that interpreting be viewed not as a *field* in Bourdieu's sense but as a "zone of uncertainty", Bourdieu's term for the potentially liberatory spaces within a social structure in which contradictions emerge from a convergence of conflicting world-views that momentarily upset the relevant *habitus*. (p59)

While realising the significance and potential that lies in an emerging discipline, Rudvin (2007) makes more modest claims. Similarly to Mikkelson (2001, 2008), she suggests that CI is now in a position to redefine the practice and theory of Interpreting Studies (IS).

Furthermore, construction is seen as a double-sided phenomenon, that is, either conflictual or consensual. Such a distinction is present in the wider field of T/IS (Baker 2006) and also in CI, where the field is usually subdivided between the broad categories of the more conflictual, or adversarial, legal interpreting and the more consensual medical interpreting. Mikkelson (2008) states that it "can be argued that medical interpreters should be held to a different standard than their counterparts in legal settings, given the collaborative nature of most healthcare interactions" (p85). Hale (2007) also points out that

> [o]ne major difference between these two settings is that, in the courtroom, participants are bound by the rules of evidence, which stipulate that questions can only originate with lawyers and never with witnesses. In the medical consultation, however, patients feel free to ask questions at any time. Another major difference is that questions asked in the courtroom do not seek new information. For the most part, lawyers ask questions that elicit the answers they need in order to create a story that supports their case. The information is normally already known to the questioner. In the medical setting, physicians are genuinely interested in obtaining information that will enable them to help the patient. (p38)

Later on she continues by saying that

> the private, informal and relaxed nature of the medical consultation makes it more conducive for interpreters to ask for repetition or indicate when they feel there has been a misunderstanding, while still maintaining a detachment and interpreting the utterances accurately. Whereas in the courtroom cross-examiners use tactics to confuse and trip up witnesses in their questioning techniques, the aim of the physician is to be clear and to be understood by the patient, so interpreters can take advantage of the purpose of the interaction to ask for clarifications when needed. However, this does not justify unwarranted interferences from the interpreter... (p46)

Therefore, the distinction can be seen as problematic because it is far too overgeneralising, as, for example, taking witness or victim statements is not an adversarial activity. Furthermore, some authors would argue for the same level of collaboration between service provider and interpreter regardless of the setting. Hale (2007), for example, writes that "it is difficult to understand how medical interpreters can be more helpful to provision of health care by deviating from their role of interpreter and adopting an advocate or gatekeeper role" (p46). Nevertheless, this distinction provides the principal argument of the current study as the basis for the claim, namely, that narratives in MHI in Ireland are consensually co-constructed. The distinction between consensual and conflictual co-construction appears to exist at higher organisational levels as well and features as the metanarrative level of service provision in this study. The claim, which the current project is exploring, that narratives in MHI in Ireland are consensually co-constructed at this level would constitute a client-centered wholesome approach. This would be in line with previous calls for research not only *on* but also *for* and *with* the service user client groups in a consensual manner (Turner and Harrington 2000) and cooperation between clients, practitioners and researchers (Corsellis 2006; Turner 2007).

2.5. MHI through a Narrative Lens

Various subfields of CI are traditionally defined by the environment in which they take place, such as court interpreting, medical interpreting, police interpreting, or educational interpreting (see, for example, Alexieva 1997; Garber 2000). These classifications, however, are not very clearly defined, and there are often overlaps between the categories, such as the case of forensic linguistics which comprises aspects of both legal and medical interpreting. Thus, legal interpreting may comprise court interpreting, police interpreting or interpreting for solicitors during pre-trial consultations, while medical interpreting can include mental health settings, too.

What is certain is that MHI is considered a subdomain of CI, as it shares some basic characteristics, which include the cross-cultural communication facilitative nature of the activity. In other words, MHI also takes place between two (or more) primary speakers, in this case a mental health professional and a client, who do not share a language.

However, MHI also displays particular characteristics which differentiate it from other subfields of CI, not least in terms of the nature of the communication, and deserves special attention. Firstly, verbal communication, or the lack thereof, is the principal means of diagnosis as well as treatment, and physiological symptoms do not always manifest to aid the process. Secondly, an interpreter-mediated encounter in a MHC setting carries additional stress as patients present themselves with a history of trauma not only on a personal, but quite often on a social level, too. Apart from everyday logistics, racism and discrimination (Bhugra & Bahl 1999; Bhui 2002; Vega et al. 1987), clients in an MHI situation also have to battle social isolation, low self-esteem, and feelings of frustration or depression (Fernando 1995; Furnham and Bochner 1986; Torbiorn, 1982;). Some also need special assistance when recovering from torture, mental or physical abuse suffered in their home environment (Drožek and Wilson 2004; Modvig and Jaranson 2004; van der Weer 1998).

The literature on the subject reflects these special characteristics. The only available monograph on MHI, which will be discussed in detail in Chapter 5, was written by a psychotherapist who worked extensively with interpreters (Bot 2005a). The most notable compilation of articles dedicated to MHI to date (Tribe and Raval 2003) is also mostly made up of contribution by professionals from an MHC rather than an interpreting background. This collection of papers ranges from practical advice (Tribe and Sanders 2003) to theoretical frameworks (Patel 2003) and offers a good insight into this emerging field. It contains contributions from health care professionals (Baylav 2003; Granger and Baker 2003; Papadopoulos 2003; Raval 2003b) and language providers (Nijad 2003; Razban 2003) with long years of experience in interpreted therapeutic encounters. However, the volume does not include articles on sign language, psychometric tests or interpretation of assessment instruments. Further articles on MHI can be found in journals within the medical field in general (Green et al. 2005) and MHC settings in particular (Miller 2004;

Miller et al 2005). Additionally, anthologies on migrant populations may also include writings related to the subject (see, for example, Bot & Wadensjö 2004).

2.5.1. The story in MHI

In MHC-related fields, two concepts of narrative theories appear to be paramount: Ricœur's discussion of subjective time (1988 pp104-126) and Bruner's distinction of two modes of thought (1986 pp11-43). What is key to the understanding of therapeutic narratives is the distinction between universal time, historical time (or calendar time) and lived time in Ricœur's writing and the difference between the logico-scientific (or paradigmatic) and the narrative mode of thought in Bruner's analysis. On the one hand, Ricœur's universal time and Bruner's paradigmatic thought can be viewed as the objective world to be described and understood by natural sciences. Meanwhile, Ricœur's lived time and Bruner's narrative mode of thinking, can be seen as an individual perception of the world tainted with previous experience, knowledge and personal circumstances. The latter categories are sometimes seen as a deviation from the norms of the former concept.

Similarly, as discussed in section 2.2.1., narratives normally follow a particular pattern. The significance of diverging narratives cannot be overstated in the MHC literature, where such self-representations are sometimes seen as a sign of disrupted life experiences or alienated selves (Ochs and Capps 1996; White and Epston 1990). Equally, it is not by coincidence that Ricœur's work among the narrative theorists has received so much attention in the fields related to the human psyche. His treatment of time and narrative (1988) and, even more so, his in-depth consideration of the self (1994) are frequently mentioned (Casey and Long 2002, 2003; Hurwitz 2004; Ochs and Capps 1996), sometimes with special reference to immigrants (Papadopoulos 2003; Patel 2003). Thus, the reconstruction of "correct" time-space-action relations through retellings of narrative is often seen as the means as well as the end to the therapeutic process, whereby the narrator regains control over his or her life. Or, the "chronological dimension offers narrators a vehicle for imposing order on otherwise disconnected experiences. That is, chronology provides a coherence that is reassuring" (Ochs and Capps 1996 p24). This concept of coherent narratives, or the lack thereof, underlies the "situational significance of narratives" and the awareness of such issues, which will be discussed in detail in 4.2.2.

Apparent disruption of chronologically or causally coherent narratives is not only a feature of mental health problems. Conventionally acceptable stories are also subjugated by dominant narratives, as can be seen in the case of Afghan settlers (Anonym n.d.) and an Iraqi refugee (Amir n.d.) in Australia. Chafe and his colleagues in the *Pear Tree Project* (Chafe 1980a; Erbaum 2001) also found that narrative is culture dependent, that is, members of different cultures produce varying narratives based on the same visual input. The researchers showed a six-minute film about a pear-picking man who realises that one of his fruit-filled baskets is apparently taken by a group of young children. The authors collected data in a variety of cultural settings and identified differences in narrative organisation (Chafe 1980b; Clancy 1980; Downing 1980; du Bois 1980; Tannen 1980). Thus these divergent narrative approaches are referred to as the "cultural significance of narratives," and will be also discussed in 4.2.1.

If chronological and causal logic may be disrupted in narratives in MHC, and if narratives are differently constructed across different cultures, interpreters in MHI face a double challenge. They need to convey the presence or absence of chronological and causal logic in the client's narrative. Similarly, they have to transfer organisational equivalences in narratives. This two-fold difficulty has given rise to the preliminary research interest introduced in the prologue and which later led to the current study, that is, how interpreting in MHC influences the evolution of narratives.

2.5.2. Dialogue and discourse in MHI

While conflictual situations in MHC occur, for example if a client is psychotic and is unable or unwilling to cooperate, this piece of research is exploring the premise that MHI is generally consensual in nature. This follows from the broad distinction between medical type (consensual) and legal type (conflictual) interpreting settings introduced in section 2.3.3. An inclusive model of cooperation from the MHC literature supports this argument, and, given the narrative focus of the current investigation, merits a reference. White and Epston (1990) in their discussion of narrative therapy argue that narratives are co-constructed and that there is room for more than one therapist or more than one professional in the therapeutic alliance with the patient. This implies that the actual number of the participating practitioners or their professional role in the MHC team is not necessarily problematic. Within their

proposed model, the interpreter is one of these possible professional practitioners, whose position not only does not compromise, on the contrary, it enhances the therapeutic outcome. In such a model, where the ultimate aim is the patient's empowerment, the practitioners engage in a consensual narrative process (White 11 February 2007). Also from a therapeutic background, Bot (2005a) introduces various cooperation models between therapists and interpreters. Although the various possible permutations of her cooperation models signal that co-construction in MHI may have conflictual elements, she also argues for hopeful consensual co-construction.

2.5.3. Narrative construction in MHI

The constructed nature of interpreted narratives goes hand in hand with the dialogic characteristic of the interpreting process. Consequently, narrative construction beyond the level of the actual interpreter-mediated encounters also needs to be considered. It is interesting to note that contributions on service-level co-construction mostly emerge from a MHC rather than a T/IS background (Bate 2004; Harper 2004; Williams 2004). From this viewpoint, language service provision is seen as part of the complete service provision "package," as a subsidiary component of MHC provision. A number of MHC professionals and scholars (Baylav 2003; Raval 2003a) would also like to see the interpreter as a member of the service provision team. Drennan and Swartz (1999) have made similar observations in their research into the role of interpreters in psychiatric settings in South Africa. From an interpreter's perspective this is acceptable, and an in-house interpreting position with its securities is highly desirable, as long as the interpreter is considered a professional in their own right. Conflict may arise if role definitions are confused and the interpreter is expected to perform duties other than facilitating linguistic communication.

2.6. MHI in Ireland through a Narrative Lens

Verbal communication in mental health settings is crucial and those availing of MHC services need a relatively high level of proficiency in the language of the healthcare system provider. Due to the nature of immigration into Ireland, interpreting service provision in MHC is fraught and potentially conflictual with regard to at least two participants of an interpreter-mediated encounter: the client and the interpreter. Firstly, the linguistic, cultural, religious or ethnic composition of the

potential clients in mental health services is very varied. This diversity is difficult to cater for even in countries where the logistics and administration of CI service provision are far more advanced than in Ireland (see further Ozolins 1998). Secondly, a traditionally mostly bilingual Irish society is simply unable to cope with the diversity of language needs of the potential clients or is unaware of the situation. Most interpreters come from an immigrant background, which may also create conflict in an interpreter-mediated encounter either because of the cultural, social, religious or gender differences between the client and the interpreter, or due to the personal history of the interpreter who may have fled a traumatic situation themselves. In addition, a lot of those working as interpreters in Ireland are not trained or accredited to do so, which causes problems in terms of the quality of the services they provide.

2.6.1. The story in MHI in Ireland

Recently there has been some but not extensive interest in narratives and narrative studies in MHC in Ireland (Bracken and Thomas 2006; Casey and Long 2002, 2003; Thomas and Bracken 2004). The same can be said about CI and narratives, which is less unexpected, given the extent of publications on the subject in general. Similarly, it does not come as a surprise that community interpreters have not received much attention in Ireland (Phelan 2001) or are the subject of negative comments in the media (Carolan 25 October 2008; Coulter 10 March 2003; Farrell 5 February 2007; The Irish Examiner 12 October 2007; Lally 30 April 2009; Mac Cormaic 6 October 2008; McInerney 28 January 2007; O'Brien 4 April 2006). Interpreters in MHC have received virtually no mention at all. What little has been written about mental health interpreters has been published in journals on the mental health of immigrants. In their article examining the availability and accessibility of mental health service provision, Kennedy et al (2002) found that "[l]anguage difficulties appeared to be a major hurdle to diagnosis and probably treatment in a substantial minority. Trained interpreters were not readily available, leading to incomplete assessments and probably lack of empathy and treatment in many cases" (p7). Feeney et al (2002) reported similarly negative findings concerning the availability of trained interpreters. They comment that it

is extremely difficult to engage the services of an interpreter in Ireland. […] it is often necessary to rely on the assistance of relatives or friends of the patient, who may also have a limited knowledge of English. This practice also makes it difficult to maintain patient confidentiality and may impede the development of a trusting therapeutic relationship with the mental health team. (p30)

The authors' comments were published in 2002, but seven years later they still ring very true.

2.6.2. Dialogue and discourse in MHI in Ireland

While the perception of the interpreter's role has been studied in various CI environments in Ireland in the form of Masters dissertations, including the Irish courts (Bermúdez Pérez 2000), the asylum determination process (Friel 2002), Refugee Legal Services (O'Byrne 2004) or general settings (Zimányi 2005), the actual performance of interpreters has not featured in publications. This lack of empirical evidence on the dialogic process of CI is due to the difficulty in obtaining access to records of actual interpreter-mediated encounters. It appears that it is not in the interest of service providers to make such records public which could serve to improve the quality of CI services. Thus, on the one hand, there is ample second-hand or anecdotal evidence of how CI is carried out in Ireland (Carolan 25 October 2008; Farrell 5 February 2007; The Irish Examiner 12 October 2007; McInerney 28 January 2007). On the other hand, policy making cannot proceed without adequate evidence and provision cannot be made for efficient services at the dialogue level of the interpreter-mediated encounter.

2.6.3. Narrative construction in MHI in Ireland

Returning to the constructed nature of narratives, it appears that provisions for MHI need to be made at organisational levels higher than the actual interpreter-mediated encounter. In Ireland, this is severely lacking at present, both in terms of MHC provision for immigrants in general and MHI provision in particular. While issues around the mental health of the general population are receiving some attention, there is little awareness of the mental health of immigrants in Ireland. The State is currently operating under the Mental Health Act 2001, which regulates mental health provision and promotion among the general population of the country. In 2006, the Expert Group on Mental Health Policy (2006) appointed by the government published a report, *A Vision for Change*. A subchapter of the Expert Group's report deals with minority groups and mental health care issues. It is interesting to observe

that the report discusses all minority groups together (travellers, gay and lesbian, deaf and immigrants), which does not reveal an underlying organising principle.

Nevertheless, approximately two paragraphs in the over 200-page report is dedicated to interpreting services *per se*, which has been inserted using some of the suggestions made by the ITIA (Irish Translators' and Interpreters' Association 2003) in response to a request for submissions during the compilation process. This short consideration gives laudable recommendations on how interpreters should be able to empathise with the service user clients and how they should interpret in a culturally appropriate manner. It also advises that there should be no ethnic or gender conflict between the service user client and the interpreter and that children or family members of the service user should not act as interpreters. However, the report falls short of including the recommendations of the ITIA for specific training of community interpreters in mental health services, assessment of the interpreters (at least at a basic linguistic level) and some training for service providers, that is mental health professionals.

More recently, the Health Services Executive's *National Intercultural Health Strategy* was launched in March 2008. The report highlighted the provision of "accessible information to service users, together with availability of interpretation and translation services" (Health Services Executive 2008 p10). It also cited the "lack of accessible information in different languages together with unavailability of interpreters" (p77) as a major barrier to accessing services. Consequently, the authors remark that "[s]tandards of clinical governance, together with medico-legal concerns relating to issues of confidentiality and information consent, demand that a professional interpretation service be in place to address such communication issues" (p100). The strategy also names the provision of an appropriate interpreting service as a priority action (p120), which will hopefully be implemented by 2012.

As the latest development in a very specific area of community interpreting related to MHC, it should be mentioned that the Dublin Rape Crisis Centre (n.d.) has published recommended guidelines for interpreters and interpreter users. Supported by government funds, the Centre compiled the handbook (2008) with the assistance of interpreter trainers, mental health services, agencies and interpreters who participated in courses run by DRCC and who all provided feedback for the publication.

3.1. Introduction

Within the subfield of community interpreting (CI) in mental health, the difficulties researchers have to face are two-fold. Firstly, in some cases even secondary data, or basic information on accessibility and provision of services is unavailable in a particular jurisdiction. Secondly, the subject under investigation is highly sensitive, and the environment poses limitations. The mere presence of a researcher could not only affect, but negatively influence the therapeutic outcome, which also explains the difficulty in obtaining informed consent of all involved to participate. This problem has been apparently successfully overcome by researchers who have been able to study primary data. Most notably, Bot (2003, 2005a, 2005b) and Wadensjö (1998b, 2001a) have gained access to interpreter-mediated therapeutic encounters, and also obtained consent not only to audio-tape, but on certain occasions also to video-tape the sessions, which has yielded valuable information on subjects such as the position of the interpreter (Wadensjö 2001a). Bot's (2005a) most comprehensive treatment of mental health interpreting (MHI) to date also used data from video-taped encounters transcribed and translated by Dutch-Dari interpreters.

Unlike Bot or Wadensjö, I was limited by the lack of access to primary data. Due to the unavailability of recorded interpreter-mediated MHC sessions, I decided to concentrate on how these encounters are constructed. The focus of research became the study of not exclusively how narratives are co-constructed at the organisational level of the story, but also how the discourse of an interpreter-mediated encounter is construed. The investigation of these two levels of narrative was then complemented by the examination of MHI service provision in Ireland at the metanarrative level. To this end, I identified the analysis of data collected from semi-structured interviews with mental health professionals (MHP) who have worked with interpreters, and with interpreters (INT) who have worked in mental health settings, as the most appropriate methodological approach.

This chapter discusses methodological issues and describes the methods applied in the current study. First, briefly I position the research within the existing literature in CI and MHI research methodology and I discuss the implications for the current research. Second, I introduce the research design through the stages of data collection and processing, which include interview design, the respondents' profile,

recording and storage of the data as well as the processes of transcription and coding in the NVivo qualitative analysis software program. Finally, I discuss preliminary findings and the analytical considerations I made with regard to analytical tools and the presentation of findings. Bearing in mind the research claim at the heart of the current investigation that narratives in MHI in Ireland are consensually co-constructed, the research design will also remain within the narrative framework.

As an important aspect of a narrative enquiry, I would like to acknowledge my position as a researcher. Reflexivity has been recognised in social sciences, and in qualitative studies in particular, since the 1990s, and has greatly influenced social scientific research in medical environments for the past decade (May 1998; Muck et al. 2002; Richards 2005). With regard to Translation and Interpreting Studies (T/IS), which had followed a more applied linguistics tradition, discursive and narrative approaches have recently become more prevalent, too (see for instance Baker 2006; Cronin 2002; Hatim and Mason 1990, 1997; Turner 2007). CI research, where researchers are often practitioners and where the researchers' own experience gives impetus to particular studies, has been pioneering in this respect (for more on the subject, see Rudvin 2006). Roy (2000), for example, in her analysis of an interpreter-mediated encounter using American Sign Language, describes her relationship with the research participants and explains that their acquaintance played a part in gaining the consent of the teacher, the student and the interpreter to participate in the investigation. Similarly, my experience in MHI was openly revealed to the research participants as the motivation for the study. In relation to the presentation of methodology I will signal this position in the choice of linguistic expressions, especially in the use of an active first person singular throughout the chapter. This will serve to highlight the choices I made and the active dialogue I undertook with the respondents and the existing literature.

Despite the calls for the inclusion of clients in CI research (Bahadir 2001; Leung 2003; Turner 2007), I decided early on in the project against interviewing this group. This was due to an ethical and pragmatic dilemma: in order to interview former (or present) clients, the use of an interpreter would have been necessary. I felt that this would have skewed the results. Another option would have been to interview English-speaking former clients. The problem in this case could be that the former patients may still have limited English proficiency, especially as regards mental-health related subjects. I could also have spoken to Hungarian speakers, which is my

own native language. However, their number is very limited, and there would have been a chance of meeting the same clients I had worked with before. Last but not least, another significant issue was the vulnerability of these clients, a focal point of ethics procedures. With no mental health training or a co-researcher well-versed in the field, it would have been irresponsible to potentially put respondents in a situation neither they nor I would have been able to handle.

It is important to note that there are now ethics committees in place to safeguard the wellbeing and rights of research participants, a subject which emerged in at least one of the interviews (#00:07:24-2#).

> THER4 Wow... I think it's a difficult area an', and, I mean, these... I mean a lot of these patients are... would be perceived as being really quite vulnerable subjects, which, you know... #00:07:12-6#
>
> KZ Mmm. #00:07:12-9#
>
> THER4 whether they can... fully... you know, give [consent]? #00:07:18-2#
>
> KZ [consent?] #00:07:18-2#
>
> THER4 I, I, I... it's is very thorny an' I can imagine you'd... have difficulty gettin' through an ethics committee and... #00:07:24-2#

Even if I opted not to interview clients, but to obtain information from interpreters and mental health professionals, the research heavily relied on the good will and consent of the respondents and their willingness to share their views on MHI. This has been officially recognised by them on signing the informed consent form (see Appendix A) once they had read the description of the research in the plain language statement (see Appendix B). In order to ensure that the research would not put the respondents at unreasonable risk, I submitted the interview schedule in compliance with the regulations of the Research Ethics Committee at Dublin City University (2006), which subsequently approved the project.

3.2. Modest "Musings on Methodology"

Hertog and van der Veer (2006b) in their introduction to a collection of articles on CI methodology caution that "CI research is often found lacking in methodological coherence, all too often misusing research designs of an essentially exploratory nature to generate broad sweeping conclusions at medium or even grand theory level, conclusions thus typically lacking in falsifiablity or even validity" (p14). This fear of limited corpus, contrived research design and a lack of research discipline are

reiterated in another article by Hertog et al (2006), from where this subchapter modestly borrowed its title. This appeal for sound and reliable methodology in the academic research of CI logically follows on from earlier and contemporary calls for the professionalisation of CI as a vocation (Bot, 2005b; Carr et al. 2000; Elghezouani 2007; Mikkelson 2001; Wadensjö 2007; Wadensjö et al. 2007).

At the other end of the spectrum, Inghilleri (2006) in her study included in the same collection of essays on CI methodology advocates a more theoretical approach and draws attention to the fact that within "interpreting studies research, very little attention has been paid to the development of sociologically informed models of professional activity" (p58). Basing her argument not directly on empirical research, but on the findings of previous studies, borrowing from the descriptivist tradition heralded by Toury and "more sociologically and anthropologically informed approaches" (p58) in Translation Studies (TS), Inghilleri provides a sociological-linguistic ethnographic perspective on CI. In a deeply theoretical vein, she follows on from her previous readings of the CI landscape through a Bourdieusian lens (2005a, 2005b) and proposes an active role for the evolving CI profession.

In the same collection, in a similarly extensive and theoretical fashion, Rudvin (2006) provides a highly structured study on the cultural turn in the humanities. She presents a clear argument showing how, in the field of anthropology,

> [f]rom the rationalist, unified absolutes of grand theories through the functionalist analysis of interaction of systems, institutions and practices, mainstream western academia has moved to a more interdisciplinary interpretive/narrative approach in which a reassessment of ideas has redirected and repositioned earlier assumptions. (p22)

This narrative turn influenced other disciplines in the area of humanities and language studies, including Translation and Interpreting Studies (T/IS). Similarly to Inghilleri, Rudvin goes so far as to advance the argument that CI, due to its positioning in a cross-cultural setting, has pioneered this development within the greater area of Interpreting Studies (IS). She also maintains that as a newly emerging sub-discipline, CI has superseded its mother discipline and is now making way for new avenues in IS in general. Current trends in CI, she contends, follow the kaleidoscopic in-between-paradigm wanderings of humanities in general, which is clearly reflected in the CI literature as a whole.

Concerning methodologies applied within the specific field of MHI research, Bot (2006) highlights problem areas in a similar vein to Hertog et al (2006b), namely the lack of rigour in research and the lack of disciplined empirical research.

> Some of the other articles discuss matters that are also of interest to interpreting in mental health care. The nature of most of these publications, however, is problematic: they are highly impressionistic and reflect the sometimes all too personal experiences and opinions of the authors. This often leads to unwarranted statements and to different authors ventilating opposing views based on implicit criteria. Only recently (starting in the early 1990s and encouraged by the international Critical Link Conferences) have studies based on empirical data been published. (p165)

Later on she continues by saying that

> although several research projects systematically analyse empirical data and constitute serious efforts to come to an understanding of the field, they focus on limited aspects of the interaction and they do not offer much more than indications of problem areas and how these problems manifest themselves. (p170)

This may be attributed to the lack of access to primary material and a shortage of supportive background information as well as the absence of previously validated research in the field. While the current project is also limited in terms of access to recorded material, it aims to address issues at the heart of MHI through the data collected in interviews, a process described in the following section.

3.3. The Interview design

3.3.1. Semi-structured narrative interviews

Given the narrative nature of the current project, empowering the respondents was one of the main aspects of the interview design. In the simplest terms, this would manifest itself in allowing them to talk and in not hindering their thought process. While this may prolong the individual interviews, I decided to facilitate lengthier responses in the hope of obtaining valuable data. As Elliott (2005) points out,

> It is widely recognized in the social sciences that the subjects of research are eager to comply with the wishes of the researcher and to provide the type of responses that the researcher is looking for. If the researcher implicitly communicates that narrative responses are not what is wanted, by interrupting the interviewee's stories for example, this in some senses 'trains' the respondent to provide a different type of information. (p31)

On the other hand, I also wished to record the diversity of the respondents' background, and devised a demographic data sheet to elicit quantitative information. While the number of respondents did not allow for an extensive statistical analysis in terms of generalisability, it helped ensure that as wide a range of services, languages,

or professions was included as possible. The demographic data sheets for INTs (see in Appendix C) and MHPs (see in Appendix D) were designed to obtain as much information relevant to the research as possible, as well as to provide material to draw on during the interviews (see also Briggs 1986). Additionally, the date, time and venue of the interview were also recorded.

3.3.2. The main interview themes

I considered the interview design itself in accordance with narrative interview conventions (Briggs 1986; Clandinin and Connelly 2000; Elliott 2005; Mishler 1984, 1986). I constructed the main interview questions around the five main topics I had identified from the available literature and my own experience, keeping in mind the research claim that narratives in MHI in Ireland are consensually co-constructed. These themes included (1) the perception of mental health among the cultural groups of which the respondents had experience; (2) the cultural and situational significance of narratives; (3) the interpreter's familiarity with the evolving narrative and with the participants of the interpreter-mediated encounter; (4) modes of interpreting; and (5) interpreting narratives in mental health care. I also catered for any additional comment or information the respondents might have on (6) MHI, which I framed around "Do you have anything else to say about mental health interpreting?" I phrased the questions with a broad remit to give the interviewees an opportunity to talk about their own experience. In order to have a comparable set of data between the MHPs and the INTs, I presented the five themes identified to representatives of both professional backgrounds during the interviews. The aim was to try and address the same issues with both INTs and MHPs. Nevertheless, the actual questions posed to them varied a little according to their professional background. The interview questions are summarised in Table 3.1 below.

Mental health professionals	Interpreters
Greetings, and administration and ethical issues	
• Introduction to the research, the purpose of the interview • Discussion of ethical issues, confidentiality, and use of findings • Explanation of interview format and length, request for permission to record • Collection of demographic data	
Topic 1: Perception of mental illness	
• What is the perception of mental health and mental illness within the communities where your potential clients come from?	• How is mental health/mental illness viewed in your culture or in the culture you interpret for?
Topic 2: Cultural/situational significance of narratives	
• What importance do you attribute to narratives in therapy and in the particular strand of therapy you practice?	• How important are stories in your own culture or the culture you interpret for?
Topic 3: Familiarity	
• In your opinion, what influence, if any, familiarity with the client or with the emerging narrative may have on the interpreting?	• What influence do you think your familiarity with the client or their story may have on your interpreting?
Topic 4: Modes of interpreting	
• What mode of interpreting (consecutive, simultaneous, whispering) do you prefer when listening to clients and their stories?	• What mode of interpreting (consecutive, simultaneous, whispering) do you prefer to use when interpreting for clients and their stories?
Topic 5: Interpreting narratives in mental health care	
• Can you recall any particular stories from interpreter-mediated encounters in a mental health session?	• Can you recall any particular stories from interpreter-mediated encounters in a mental health session?
• **TOPIC 6: Additional information, views on mental health interpreting**	
• Is there anything else you would like to say about mental health interpreting?	• Is there anything else you would like to say about mental health interpreting?

Table 3.1. The main research themes and interview questions

3.3.2.1. *Theme 1: Perception of mental health and illness*

The primary themes themselves were not randomly selected, but intended to reflect general concerns that may arise in connection with interpreting narratives in MHC. I felt that (1) the perception of mental health and illness, or its variance among cultures, had to be addressed. Cross-cultural psychology and psychiatry are emerging fields which are taking note of such diversity with a growing number of publications (among others *Anthropology and Medicine* or *Cross-Cultural Psychology*) and

articles dedicated to them (Jenkins 1991; van Dongen 2003, 2005). As interdisciplinary domains, they combine areas of anthropology, ethnography, sociology, psychology and psychiatry. It was anticipated that interpreters working in MHC settings might be, if not fully cognisant, at least somewhat aware of these developments in the field related to their professional environment, if they research the area they interpret in.

3.3.2.2. Theme 2: The cultural and situational significance of narratives

Theme (2) on cultural and situational differences as regards narratives aimed to elucidate the significance of narratives in professional and ethnic terms alike. Operating in western paradigms, we tend to think of narratives in a classical tradition, where a narrative has at least some sort of sequence, in the Aristotelian sense, a beginning, a middle and an end. If we also consider Jefferson's (1978, 1985, 1988, 1996) findings in monolingual conversations that reproduction of certain morphological elements of speech in a dialogue influence the other participants, it would be a relatively safe assumption to make that larger units of speech may also have a sub/unconscious effect on the co-participants of a conversation. We can also assume that multilingual encounters are similar in this respect. This would lead us to believe that narratives (or the way the clients tell them) could influence the interpreter's thinking process. Unfortunately, due to the unavailability of analysable encounters, this claim cannot be directly proven. The current research, however, undertakes to corroborate the claim by indirect means, namely, by relying on the MHP and INT respondents' experience.

3.3.2.3. Theme 3: Familiarity

I also identified (3) familiarity as an important issue, as the interpreter could either become too familiar with the client and involved on an emotional level or become too familiar with the story, and become part of the story. The interpreter's influence could manifest itself, for instance, in the interpreter stepping out of the first person narrative and commenting on the client's words, adding information about the cultural background or circumstances, or, even consciously or subconsciously, omitting particular phrases or passages as they do not offer new information compared to what has been said during the same session or previous sessions and is supposedly "taken for granted." An extreme case of familiarity with narrative clues is

reported by Jacquemet (2005), who reveals how interpreters after the war in Kosovo developed an acute sense of how narratives are introduced in a conversation and blocked attempts at further development. The intention of including this theme was to ascertain if familiarity is seen as a problem and how both mental health professionals and interpreters try to eliminate its potential influence on interpreting.

3.3.2.4. Theme 4: Modes of interpreting

There were also practical issues concerning the (4) mode of interpreting, which may pose problems during interpreter-mediated therapeutic sessions. While the client's utterance is being interpreted, the therapist somehow needs to cater for the time lapse – the client may continue without a target language rendition and interpreters have a few options: they can start interpreting simultaneously (maybe whispering), which few interpreters working in MHC in Ireland have been trained to do; they can stop the client in his / her thought process and interpret a chunk, during which the client may become shy, frustrated or confused; they can take notes, which may result in the re-construction or re-organisation of the narrative, but equally this may disturb the client; or they can try to remember everything that has been said in which case they can easily miss some of the story (see also Fox 2001; Pollard 1998). All of these modes, therefore, may involve loss or reorganisation of information, even at a subconscious level and despite best intentions. The purpose of the inclusion of this theme was to investigate if there are any special strategies required and practised to cope with the particular difficulties posed by mental health patients' talk.

3.3.2.5. Themes 5 and 6: Interpreting narratives in MHC

Based on the above enquiries, I was hoping to elicit actual narratives that the respondents could recall from their experience. While such stories could not substitute actual interpreted narratives, and could not serve as a basis for straight narrative analysis, they could hopefully enlighten the study about potential areas of interest (see also Papadopoulos 2003). Therefore, I expected to collect accounts of discrepancies in (5) interpreting narratives in MHC. I included the final questions on the broad subject of (6) interpreting in MHC for the same purpose, to allow respondents to recount their experience or provide additional information I had not anticipated. This last question produced the interview sections most dialogic in nature where the respondents not only brought up issues they considered significant

but could also ask further questions regarding the design and aim of the research project, or my involvement in the area.

3.3.3. *The phrasing of the interview questions*

Nevertheless, there are inherent difficulties with dialogism in narrative research interviews, namely, a heavy reliance on the respondents' willingness to contribute. This problem is also mentioned by Elliott (2005).

> Authors such as Graham (1984), Mishler (1986) and Riessman (1990) have each emphasized that interviewees are likely spontaneously to provide narratives in the context of interviews about their experiences, unless the structure of the interview itself or the questioning style of the interviewer suppresses such stories. Most people like telling stories and with a little encouragement will provide narrative accounts of their experiences in research interviews. [...] However, in contrast to this view that narratives will emerge naturally during in-depth interviews (if only researchers are prepared to hear them), some authors have described situations in which they failed to obtain narratives from respondents even though this was the primary aim of the interview. This raises questions about the most effective ways of encouraging respondents to provide detailed storied accounts of their experiences in interviews. (pp28-29)

In order to elicit answers that would lend themselves to narrative analysis, during the interviews I tried to phrase the questions beginning with expressions of "can you tell me…" or "please tell me…" I was aware that variation among ways of posing research questions across interviews is "endemic and unavoidable" (Mishler 1986 p52). The actual questions asked during the interviews, therefore, were variations of the exact question design. For example, the question on the perception of mental health and illness in the interpreter's ethnic community was posed to INT11 as

> KZ Well, mainly about {name of the country}, because eh... because you've lived in, in {name of the country} as well, if you have any idea. Ehm, my first, first question is: Did you see any difference between... the perception of mental health between Ireland and where your cli', client or the patient you interpreted for come from? #00:08:52-8#
>
> [silence] #00:08:56-2#

In addition, I did not set up a particular order in which to present the questions, as the aim was to allow for the conversation to develop according to the respondent's thought process. Nevertheless, the theme of perceptions of mental illness seemed an appropriate introduction of the main part of the interview, which could lead on from the demographic data of the respondents. This way I could allow the interviewee to affect and actively shape the structure of the interview while making sure that all

themes were covered during the discussion. In turn, this further allowed for a more involved role on the respondents' part and could facilitate a truly dialogic interaction.

3.4. The respondents' profile

The validity of a research project is sometimes measured by generalisability. However, in the case of qualitative studies, in this instance, narrative analysis, the volume of the data is not an exclusive determinant in validating the research. While some previous projects relied on a vast amount of data, as in the case of Angelelli's analysis of medical interpreting (2004), other enquiries, notably Roy's pivotal work on analysing discourse in interpreted encounters, have been based on a single case study (2000).

> For some researchers there is simply a trade-off between depth and breadth, i.e. researchers must make a decision about whether to prioritize detailed descriptions and contextualized data or whether to aim for breadth in the form of large samples of cases which yield more generalizable findings. […] Many would therefore argue that it is mistaken for qualitative researchers to try to produce law-like statements that are expected to hold true across a wide range of historical and cultural contexts. However, it would be clearly pointless to do research if findings were considered completely ungeneralizable. Qualitative research therefore often adopts what we might call a 'common-sense' view of generalizability such that the reader is left to make up his or her own mind as to how far the evidence collected in a specific study can be transferred to offer information about the same topic in similar settings. (Elliott 2005 p26)

The principle behind recruiting respondents was to cover as wide a range of services as possible in the framework of bilingual mental healthcare provision in Ireland. Following Elliott's advice, I aimed to interview respondents from a wide variety of backgrounds within their field, with regard to, for example their profession, extent of experience, the services they had worked in or the cultures and languages they had encountered.

The investigation mainly concentrated on the Dublin area in Ireland, which was found to be representative of the state of MHI provision countrywide, due to the variety of services present in the capital. During the recruitment process, both MHPs who have had experience working with interpreters and INTs who have worked in MHC settings were targeted through various channels to maximise efficiency. As with most research projects, I needed to issue a few rounds of calls for participation before a sufficient number of respondents from a sufficiently varied range of backgrounds were recruited for the study. This can be attributed primarily to the fact that most of the respondents are busy professionals with tight work schedules. However, having agreed to participate, all respondents were more than helpful and gained enthusiasm by the prospect of being able to air their views, voice their concerns and provide suggestions for improved MHI provision in Ireland.

3.4.1. The MHPs' profile

A total of eleven MHPs were interviewed. They include

- four mental health nurses (MHN): who work "within a psychiatric service as part of a health care team. Nurses provide both physical and psychological care to their patients and can also provide essential support and encouragement to the patients' families." (Health Services Executive 12 March 2008);

- one occupational therapist (OT): who provides "services to people whose ability to cope with everyday activities is threatened or impaired in some way by physical, psychological or developmental problems. Occupational therapists can assess and treat anyone (adult or child) who has practical difficulties due to mental illness, accidental injury, arthritis, cerebral palsy, learning difficulties, stroke, and other congenital, developmental, degenerative or neurological conditions. Occupational therapy aims to enable the person to have as independent, productive and satisfying a lifestyle as possible. Treatment can include self care, personal development, mobility and access, skills and training, home management, disability awareness, work preparation, directed play, stress management and compensatory techniques." (Health Services Executive 12 March 2008);

- two psychologists (PSY): who are "trained in the study of human behaviour and [try] to explain feelings, thoughts and behaviour. Psychologists can provide assessment and treatment of a psychological nature that includes personality assessment through a structured interview, assessment of a wide range of psychological problems - anxiety, depression, self esteem issues, psycho-sexual and marital problems. They can also help patients examine the effects their illness is having on their lives and methods of coping with those effects. Bringing a patient closer to an understanding of his or her illness is a key aim of a psychologist. When involved in the area of mental health, the psychologist usually works as a clinical, community or counselling psychologist, and unless also medically qualified, does not prescribe medication." (Health Services Executive 12 March 2008); and

- four therapists/psychotherapists (THER): who engage in psychotherapy which

tends to be more in-depth than counselling. It is based on the idea that the less aware we are of our motives, feelings and actions, the more they control us and the more we stay stuck in old patterns that may be harmful to us. A psychotherapist can help patients to examine their subconscious mind. By bringing any unconscious motives, fears and feelings to light and dealing with them, patients can often get relief from their symptoms. Psychotherapists usually undertake a long postgraduate training that requires trainees to undergo therapy, often twice per week, for several years. The techniques and interventions used by the psychotherapist vary according to the theoretical framework within which he or she is working. (Health Services Executive 12 March 2008)

The participating MHPs were contacted via three different channels: as practitioners in particular services, both mainstream state-run medical facilities and specialised services; as professional acquaintances of other respondents; and following a public lecture addressing the issue of multicultural mental healthcare in Ireland on International Mental Health Day (Irish College of Psychiatrists December 2007).

3.4.1.1. Services: The MHPs' institutional background

The MHPs interviewed work in a variety of services including

Mainstream services (services run by the State or under the aegis of the Health Services Executive for the general population)

- Cedar Ward for female patients and Rowan Ward for male patients, Psychiatric Unit, the Adelaide and Meath Hospital, Tallaght, Dublin (a State run hospital);

- Mental health services at the Cavan-Monaghan Health Services (a State run clinic in the Health Services Executive North-Eastern area, the only service from outside Dublin in the study included because the MHP representing the service engages in collaboration with Dublin services);

- Psychiatric clinic, Connolly Hospital, Blanchardstown, Dublin (a State-run service);

- Jonathan Swift Ward, Psychiatric Clinic, St. James's Hospital, Dublin (a State-run service);

Specialised services (State-run or non-governmental services specialising in providing services for members of minority groups)

- ACCESS – Mental Health Team for Homeless People, Dublin (a service run by the Health Services Executive);

- Balseskin Reception Centre, Dublin (a reception centre, where the initial assessment of the newly arrived asylum seekers occurs including general medical as well as a psychological assessment – some clients are referred to

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the psychology service for refugees and asylum seekers at St. Brendan's Hospital, listed below);

- SPIRASI (Spiritan Asylum Services Initiative) / Centre for the Care of Survivors of Torture, Dublin, "a humanitarian, intercultural, non-governmental organisation that works with asylum seekers, refugees and other disadvantaged migrant groups, with special concern for survivors of torture" (Spirasi n.d.); and

- The psychology service for refugees and asylum seekers at St. Brendan's Hospital, Grangegorman, Dublin (a specialised service within the organisational structure of the oldest State-run psychiatric hospital in Ireland).

There were two services I approached where the professionals were unwilling or unable to participate in the research. In the case of St. Vincent's Psychiatric Hospital, Fairview, Dublin, I could not contact an appropriate person, despite several attempts via the telephone and some email correspondence. In the case of the Dublin Rape Crisis Centre, the timeframe did not allow for the interviews to take place. The professionals there were running a pilot project to train interpreters in working with victims of sexual violence. As I was too late in contacting them, they could not allocate sufficient time to meet.

3.4.1.2. The MHPs' work experience based on the clients' nationalities and languages

In total, the MHPs mentioned thirty-seven nationalities they had encountered. These are Afghani, Algerian, Angolan, Bosnian, Cameroonian, Chadian, Chechen, Congolese, Eritrean, Estonian, Ethiopian, Georgian, German, Ghanaian, Iranian, Iraqi, Italian, Ivorian, Kuwaiti, Kyrgyz, Latvian, Liberian, Lithuanian, Mozambican, Nigerian, Pakistani, Palestinian, Polish, Romanian, Rwandan, Saudi Arabian, Sierra Leonean, Somali, Spanish, Sudanese, Ugandan and Zimbabwean. The seventeen different languages they listed are Arabic, Estonian, Farsi, French, Georgian, German, Italian, Kurdish, Latvian, Lingala, Lithuanian, Polish, Romanian, Russian, Spanish, Swahili and Urdu.

3.4.1.3. The MHPs' work experience with interpreters

As far as the extent of experience of working with interpreters is concerned, there was great divergence among the MHPs interviewed. This division appears to form along the lines of the type of service they work in. Mental health professionals working in what I have termed "mainstream" services for the purposes of this research, that is services catering for the general population in hospitals, outpatient services or State-governed health centres, seem to encounter considerably fewer clients with limited English proficiency. On the other hand, the number of clients who require the assistance of an interpreter in what I have termed "specialised" services within the context of the current project is significantly higher. Professionals working in such facilities, for example special services for refugees and asylum seekers, have reported working with at least 3-5, but often around 6-10 clients per week, who need interpreters. Naturally, the nationality and language profile of clients accessing these services is more varied, too. This difference is most probably due to the fact that they specialise in working with refugees and asylum seekers or immigrants. These organisations mostly operate on a not-for-profit basis and receive some, but not a particularly generous amount of, funding from the State. Additionally, as a most recent development, their funding has been considerably cut due to the recession which began to affect Ireland in 2008.

3.4.2. The INTs' profile

3.4.2.1. Contacting the INTs

With regard to interviewing INTs, a pool of twelve practitioners was considered sufficient to yield enough data and to provide a sample comparable in size and volume to that collected from the MHC professionals. This decision was confirmed by the fact that despite the slight differences in priorities and focus, clear trends among the respondent INTs' views began to emerge after seven or eight interviews. Also, given the time constraints and the nature of doctoral research, more than twenty-three in-depth interviews in all would have exceeded the scope of the project. The participating INTs were contacted via four different channels: an advertisement for volunteers was circulated in the Irish Translators' and Interpreters' Association bulletin (Zimányi January 2008), which is distributed free to subscribers by email and appears on the ITIA website; the same invitation was sent to translation and

interpreting agencies with a request to forward it to the interpreters on their database; the invitation was emailed to participants at a course organised for interpreters by the Dublin Rape Crisis Centre (n.d.); the invitation to participate was also forwarded by the specialised service at the Centre for the Care of Sufferers from Torture (Spirasi n.d.) to interpreters working for the service. In theory, these forums reached more informed interpreters, for example members of a professional organisation. However, it did not mean that all the respondent INTs were trained or experienced, as seen in the following sections.

The overall aim was to recruit a "good spread" of INTs who came from diverse backgrounds and who had very different experiences with regard to their training or introduction to MHC services and MHI. Some of the interviewed INTs are in full-time employment and take on occasional assignments; some are practising interpreters who take on mental health jobs; others are fortunate enough to work for centres or clinics which provide a basic introduction to MHC; and there are also some who work for specific MHC services which offer additional counselling, debriefing, or support to interpreters, if required. However, as most of the INTs work on a freelance basis, they have to divide their time between various types of assignments only one of which is MHI.

3.4.2.2. The INTs' national, linguistic and gender profile

While a more precise matrix of gender, age and language profile cannot be provided for reasons of confidentiality, a list of the INTs' nationalities and languages is available. Among the INTs, there was one Bosnian, one Chinese, one Czech, one Irish, one Italian, two Polish, two Romanian, two Spanish, and one Sudanese interpreter. The languages they speak include Arabic, Basque, Bosnian, Catalan, Croatian, French, German, Italian, Mandarin, Polish, Portuguese, Romanian, Russian, Serbian, Slovak and Spanish. It is worthy of note that they do not interpret into all the languages available to them and they emphasised that their knowledge of certain languages would not qualify them to interpret in that language and that they decline to do so when recruited. Thus, the languages they interpret from and into are Arabic, Bosnian, Czech, Croatian, French, German, Italian, Mandarin, Polish, Portuguese, Serbian, Slovak and Spanish. Ten of the INTs were female, which perhaps is somewhat indicative of the gender representation among community interpreters in Ireland.

3.4.2.3. The INTs' training and educational background

With regard to education in general and interpreter training in particular, the statistics show quite a wide spread. All of the interviewed INTs had tertiary level of education. Most of them had completed their undergraduate studies outside Ireland. Half of the INTs had completed Masters degrees, three in Ireland and three abroad. While this may appear to indicate their ability to conceptualise through the language of their education, and a level of educated proficiency in their first language, this conclusion cannot be reached for two reasons. Firstly, the medium of education may not have been their first language. For example, some of the interpreters completed degrees in philology, sometimes specialising in languages, in which case the language of specialisation could very well have been the medium of education, too. Secondly, their field of study, for example engineering, could be irrelevant to the interpreting environment where they work.

Table 3.2. below provides information on the INTs' training in interpreting.

	INT 1	INT 2	INT 3	INT 4	INT 5	INT 6	INT 7	INT 8	INT 9	INT 10	INT 11	INT 12
Language related studies												
Bachelors degree in languages	X		X					X				
T/IS – courses run by agencies												
1-day introduction (refugee settings)	X	X		X	X	X		X	X	X		
1-day introduction (court settings)	X	X	X			X					X	
T/IS – tertiary education												
1 T/IS module in bachelors degree	X											
Bachelors degree in T/IS											X	
Bachelors degree in T/IS in Ireland												
Masters degree in T/IS												
Masters degree in T/IS in Ireland												
T/IS – specific CI training												
Grad Cert in CI, DCU, Ireland		**X**						**X**			**X**	
Non-Academic T/IS training												
6-month European Commission T/IS									X			
T/IS – MHC related training												
DRCC 1- day course on rape victims	X		X			X		X	X		X	
Spirasi – torture and trauma victims	X					X				X		X
Background in MHC												
Some studies in psychology					X							
Bachelors degree in psychology									X			
Other relevant training												
Working with refugees							X	X				

Table 3.2. Training background of INTs

Two of the INTs interviewed had undergraduate degrees in translation and interpreting from outside Ireland. One of these INTs and another two interviewed had completed the Graduate Certificate in Community Interpreting (GCCI) at Dublin City University (n.d.), the only university level course in CI in Ireland at the moment. One of the INTs reported having studied interpreting at a six-month training course conducted by an EU organisation. Eight INTs had been involved in one- or two-day training courses run by interpreting agencies in Ireland despite having relevant higher degrees from abroad. While eight out of twelve is quite a high proportion among the participating interpreters, most of them stated that such short

training is insufficient, even within the area of specialisation the course aimed to address. Most INTs had never received any specialised training in the area of MHI. The three who attended the GCCI course had been introduced to the subject. Some of the INTs had taken part in introductory courses organised by particular MHC services. Four of those interviewed had taken part in a training session for interpreting in rape cases organised by the Dublin Rape Crisis Centre (n.d.), while three of the INT respondents had attended sessions on interpreting for victims of torture run by SPIRASI (n.d.).

3.4.2.4. The INTs' experience in MHC services

The experience INTs had in MHC settings is also very varied. Some of them only worked for specialised services, such as SPIRASI, while others engaged in MHI at different locations. Quite a few of the INTs interviewed worked in mainstream hospitals (the Adelaide and Meath Hospital in Tallaght, Connolly Hospital in Blanchardstown or St James's hospital near the city centre). Some respondents worked in specialised services (including the psychology service for refugees and asylum seekers at St. Brendan's Hospital in Grangegorman, or St. Vincent's Psychiatric Hospital in Fairview). A number of INTs indicated venues other than either mainstream or specialised services for MHI, which include Garda (police) stations, the Irish Society for the Prevention of Cruelty to Children, various Health Boards, or the Daughters of Charity (a charitable religious organisation) as venues. This would suggest that MHI situations can arise outside MHC settings, that is, on some occasions, the client may present with mental health issues in unexpected situations.

3.4.2.5. The INTs' CI experience outside MHI

It is worth noting that, as Table 3.3 shows, most INTs who work in MHC settings in Ireland do not exclusively work in this area.

•	• NT1	• NT2	• NT3	• NT4	• NT5	• NT6	• NT7	• NT8	• NT9	• NT10	• NT11	• NT12
• **Med ical**	•	•	•	•	•	•	•	•	•	•	•	•
• **Hos pital**	•	•	•	•	•	•	•	•	•	•	•	•
• **GP**	•	•	•	•	•	•	•	•	•	•	•	•
• **Sch ools**	•	•	•	•	•	•	•	•	•	•	•	•
• **Soci al welfare**	•	•	•	•	•	•	•	•	•	•	•	•
• **Cou rt**	•	•	•	•	•	•	•	•	•	•	•	•
• **Oth er legal**	•	•	•	•	•	•	•	•	•	•	•	•
• **Ref ugee**	•	•	•	•	•	•	•	•	•	•	•	•
• **Gar daí**	•	•	•	•	•	•	•	•	•	•	•	•
• **Pris on**	•	•	•	•	•	•	•	•	•	•	•	•
• **Safe Pass**	•	•	•	•	•	•	•	•	•	•	•	•
• **CSC S**	•	•	•	•	•	•	•	•	•	•	•	•
• **Con struction**	•	•	•	•	•	•	•	•	•	•	•	•
• **Driv ing test**	•	•	•	•	•	•	•	•	•	•	•	•
• **Busi ness**	•	•	•	•	•	•	•	•	•	•	•	•
• **Con ference**	•	•	•	•	•	•	•	•	•	•	•	•

Table 3.3. INTs' work experience in CI

It appears that most of the INTs interviewed, except for INT12 who only works for a particular MHC service on a voluntary basis and does not engage in any other settings, worked in medical settings of some kind, either in hospitals or for GPs or in other unspecified settings. Half of the INTs questioned interpreted in educational settings and also half of them, although not the same individuals, had experience in

interpreting in social welfare. Three quarters of the respondent INTs had interpreted in court, and over half of them in other legal settings as well. Two thirds of the INTs worked with An Garda Síochána (the Irish police force), and over half of them interpreted in prisons. These findings indicate that community interpreters in Ireland usually work in a great variety of settings and find it difficult to specialise.

This diversity is further verified by the fact that two thirds of those interviewed for the project on MHI had also worked in various construction industry settings, such as SafePass (the mandatory health and safety training for construction and other industry workers in Ireland), CSCS (short for "Construction Skills Certification Scheme," which involves training for different specialised areas in the construction industry) or other construction-related settings which may include site-induction or so-called tool-box talks for introducing workers to a particular plant or machinery. One of the respondent INTs interpreted at theory driving tests on the rules of the road, which is part of the process in acquiring a driving licence. Half of those interviewed had experience in interpreting at conferences and two-thirds had interpreted at business meetings. Apart from the settings queried in the demographic datasheet, some of the interviewees also mentioned the following areas where they worked: trade union meetings, RTÉ (the Irish national radio and television provider), the Irish Rugby Football Association, orphanages, homeless agencies, funeral services, manufacturing plants and banks.

3.5. Recording and storage

3.5.1. Setting up a filing system

From the very early stages of conducting the interviews, I set up a file-naming system for easier referencing purposes as shown in Table 3.4. I used an abbreviation to denote the various professions (INT: interpreter, MHN: mental health nurse, OT: occupational therapist, PSY: psychologist, THER: therapist/psychotherapist), and allocated a sequential number to each respondent. I also indicated the type and function of the files in the naming system (REC: recorded digital file with a .wav extension, TS: transcription file with an .rtf extension which the transcription software produced, and an FN file in .doc format containing my own observations and first impressions following the interview in form of an informal field note).

Respondent	Recording (.wav)	Transcript (.rtf)	Field Notes (.doc)
• **INT01**	• REC_int01	• TS_int01	• FN_int01
• **INT02**	• REC_int02	• TS_int02	• FN_int02
• **INT03**	• REC_int03	• TS_int03	• FN_int03
• **INT04**	• REC_int04	• TS_int04	• FN_int04
• **INT05**	• REC_int05	• TS_int05	• FN_int05
• **INT06**	• REC_int06	• TS_int06	• FN_int06
• **INT07**	• REC_int07	• TS_int07	• FN_int07
• **INT08**	• REC_int08	• TS_int08	• FN_int08
• **INT09**	• REC_int09	• TS_int09	• FN_int09
• **INT10**	• REC_int10	• TS_int10	• FN_int10
• **INT11**	• REC_int11	• TS_int11	• FN_int11
• **INT12**	• REC_int12	• TS_int12	• FN_int12
• **MHN01**	• REC_mhn01	• *Equipment fault*	• FN_mhn01
• **MHN02**	• REC_mhn02	• TS_mhn02	• FN_mhn02
• **MHN03**	• REC_mhn03	• *Interviewee had no relevant experience*	
• **MHN04**	• REC_mhn04	• TS_mhn04	• FN_mhn04
• **MHN05**	• REC_mhn05	• TS_mhn05	• FN_mhn05
• **OT01**	• REC_ot01	• TS_ot01	• FN_ot01
• **PSY01**	• REC_psy01	• TS_psy01	• FN_psy01
• **PSY02**	• REC_psy02	• TS_psy02	• FN_psy02
• **THER01**	• REC_ther01	• TS_ther01	• FN_ther01
• **THER02**	• REC_ther02	• TS_ther02	• FN_ther02
• **THER03**	• REC_ther03	• TS_ther03	• FN_ther03
• **THER04**	• REC_ther04	• TS_ther04	• FN_ther04

Table 3.4. File referencing system for data collection and analysis

3.5.2. Audio-recording of the interviews

I audio-taped all interviews using a Creative Muvo Slim MP3 player to digitally record the interviews in a .wav format. According to stipulations by the Research Ethics Committee at Dublin City University, the files were then transferred onto a password-protected computer to which no one else had access. By using audio recording and writing field notes I followed best practice. Elliott (2005), for example, advocates the use of recording equipment for narrative interviews.

> Without tape-recording all kinds of data are lost: the narrative itself, pauses, intonation, laughter. In particular if the interview is understood as a site for the production of meanings and the role of the interviewer is to be analysed alongside the accounts provided by the interviewee, it is important to capture the details of the interaction. Clearly, once an interview is tape-recorded the next set of questions involves how to transcribe the recording in order to preserve an appropriate amount of information about what was said as well as about the interactions as well. (p33)

3.5.3. Interview venues

I conducted the interviews with MHPs at their practices in order to cause the least inconvenience and to facilitate their work schedule. Most of the INT interviews were conducted in public places mainly around the centre of Dublin. One recording took place at the home of the INT in question. Unfortunately, one of the recordings was slightly compromised by the background noise, which made the transcription process particularly difficult. Nevertheless, in most instances the time and location of the interview provided quiet and confidential opportunities for the research. The equipment worked well, although I had a problem with monitoring the recording process, as a result of which only notes and no audio recording survives from the interview with MHN1. In case of MHN3, I had been referred to a number of mental health nurses, who turned out not to have the relevant experience. Therefore, I decided against transcribing the interview. These considerations account for the lack of data in the appropriate fields of Table 3.4.

3.5.4. The length of the interviews

The length of interviews with MHPs and INTs is represented in Table 3.5., where the numbers refer to the length of the recorded file(s) in minutes in the case of each respondent. If recording had to be stopped and re-started for any reason, the sum of the length of the recorded material has been indicated. When calculating the length of the interviews, I have rounded the actual length up or down to the closest full figure in minutes. The shortest MHP interview was 22 minutes long, while the

longest was exactly 60 minutes, and they averaged 36 minutes. Compared to the MHPs, the average length of INT interviews was considerably longer, 53 minutes. This is due to the busy schedule of the MHPs as well as to the extreme generosity of the INTs to give up their time. Despite this increase in length on average, the shortest INT interview at 21 minutes was just shorter than the shortest MHP interview. The longest interview conducted with an INT, however, was nearly an hour and a half, or eighty-four minutes. The overall average length of the interviews was forty-five minutes.

INTs	Mins	MHPs	Mins
int1	34	mhn2	24
int2	45	mhn4	25
int3	32	mhn5	22
int4	57	ot1	39
int5	69	psy1	32
int6	47	psy2	46
int7	66	ther1	23
int8	52	ther2	37
int9	84	ther3	49
int10	21	ther4	60
int11	47		
int12	81		
Average (INT):	53	Average (MHP):	36

Table 3.5. Statistics on the length of interviews

3.6. The transcription process

3.6.1. The extent of detail in the transcriptions

The significance of the transcription of the recorded material cannot be underestimated. The three following stages of the research (transcription, coding and data analysis), which are all part of the data processing practice, are in constant interaction with each other. According to Elliott (2005), it

> is important to recognize that the transcription process is more than a trivial, mechanical task and that decisions about how transcription should be carried out are intimately connected with the type of analysis that is intended. Indeed rather than understanding the transcription process as occurring prior to analysis, it is more appropriate to understand it as part of the analytic process. (p51)

Consequently, the transcription methods used in a particular research project can have implications not only on the following stage of coding, but also on the analysis of the collected material. The transcription needs to suit the investigation and to provide sufficient but not superfluous amount of detail for a transparent analysis. In other words, while transcription will invariably result in loss of information, enough specificity must be retained. As Riessman (2008) cautions the researcher,

> [i]nvestigators must decide, depending on the focus of a project, how much transcription detail is necessary. There is the danger that interview excerpts can become unreadable for those unfamiliar with social linguistic conventions, compromising communication across disciplinary boundaries. (p103)

Transcription conventions of narrative interviews range from so called cleaned up transcripts, which "preserve only the words which were spoken" (Elliott 2005 p52), to detailed transcribing, "when the focus is not solely on the content of the narrative but the way that a narrative is recounted is also salient" (p53). The former tradition may be useful for grounded theory research, or perhaps critical discourse analysis, while the latter is especially suited to conversation analysis. In the current project, which is somewhere between the two extremes of the continuum, I applied a somewhat simplified version of the transcribing convention developed by Jefferson (1985, 2004), whose notation system is considered the starting point for close analysis. I included all details necessary to follow the evolving narratives in the respondents' utterances and my own interaction to capture the dialogic aspect of the narrative interviews. I also recorded long pauses or silences or made references to unusual intonation if the spoken text would carry opposite meaning to what the written text in itself may suggest. However, I did not register any features of body language, as such inclusions would have crowded the already detailed transcriptions and also as the audio-recordings would provide very few clues on non-verbal communication.

3.6.2. The length of the transcription process

The ratio of taped material to transcription time was projected at 1:6/8, that is, one hour of interview material would take six-to-eight hours to transcribe at the first instance. This proved to be a longer process in the end, especially including the proofreading and clarifying stage of transcription. Digital replay and the use of f4 freeware (dr. dresing & pehl GmbH n.d.) along with a foot pedal made transcribing easier and more straightforward, albeit still the lengthiest process of the entire project. A fully transcribed interview (OT1) with the identifiable references removed is available in Appendix E.

3.6.3. The rules applied during the transcription process

Here follows a list of rules I set up and adhered to while transcribing, with examples from the transcript of the interview with OT01.

- I always marked the interviewee by the profession-related abbreviation and the sequential number as explained above (**e.g. INT8** is the eighth interpreter,

MHN5 is the fifth mental health nurse, OT1 is the first occupational therapist, PSY2 is the second psychologist and THER4 is the fourth therapist I interviewed).

- I indicated myself as the researcher / interviewer as KZ.

- I set the transcription freeware f4 to automatically insert a time stamp (in the format #00:00:03-4#), which I later used for referencing and search purposes.

- I included fillers and verbal acknowledgment in the transcript in order to reflect the dialogic nature of the interviews.

> OT1 Uhm. #00:00:04-1#

- I indicated overlaps with the overlapping utterances appearing in square brackets.

> OT1 I had to do this other people myself doing [my masters] #00:00:17-2#
>
> KZ [Oh, God...]

- I indicated inaudible or indiscernible utterances by three question marks in square brackets.

> OT1 [???] that's fine. #00:00:12-8#

- I indicated shorter silences by "…"

> KZ [if] oral... eh, communication was important, or... verbal communication. #00:08:45-1#

- I indicated silences exceeding 1 second in square brackets and in a separate line.

> OT1 degree. So... #00:00:18-3#
>
> [silence] #00:00:19-9#
>
> Yeah, that's fine. #00:00:21-0#

- I included laughter and coughs to account for time lapses (#00:15:34-5#).

> OT1 Ehm... But sometimes they will turn me an' go, They, they, they've just said that blah, And I explained that that's not what you meant. Or somethin' like that. #00:15:27-3#
>
> KZ [Ok.] [Ehm...] #00:15:29-3#
>
> OT1 [Which] I think is good. Because... otherwise you have a couple of over and backs and you're like, Wha', what happened there? [laughs]

#00:15:34-5#

[silence] #00:15:37-1#

- I included laughing or smiling intonation in square brackets to reproduce some vocal information which may aid the analysis.

  KZ I ask anything else. What exactly does an occupational therapist [do] [laughing]? #00:01:00-8#

- I catered for actions pertinent to the interview or accounting for time lapses by the description of action in square brackets.

  [signing consent form] #00:00:32-4#

  or

  [setting up equipment] #00:00:38-9#

- I kept ungrammatical spoken utterances, e.g. "kinda," to reproduce spoken language.

  OT1 [That's] ok. Ehm... I s'pose occupational... therapy... #00:01:06-0#

  or

  OT1 [Maybe] adapt things. Yeah. Kinda it's a very rehabilitative type of... #00:01:45-5#

- I indicated hesitation, mostly in the form of "ehm."

  OT1 Ehm... In mental health? #00:01:56-8#

- I indicated false starts to follow the rhythm of spoken language.

  KZ And... th', you're based in the psychiatry... department of psychiatry [here]. #00:02:38-2#

- If the respondent expressed their wish to exclude a certain part of a recorded interview during or after the recording process, or the conversation took a personal turn, I indicated this by

  [off record]

in the transcripts.

- I introduced direct quotes in speech by a capital letter, but not separated from the main text by quotation marks, in order to reflect the flow of speech, for

example as the respondent's internal quote in the middle of this utterance in
bold script

> OT1 [Ehm...] An' I don't mean that harshly, in a bad way, but... certainly in
> a situation like that... I would feel... I would, I'd feel difficult to say, **Hang
> on, can we just... stop there.** Because... I don't know at what point I'm
> coming into the conversation. If it was an English... #00:21:48-4#

- I marked somewhat uncertain or scarcely audible utterances by one question
  mark.

> KZ It's good.[?] Ehm... I'm just wondering... before... #00:00:56-9#

- In addition, certain references which may be confidential were removed and
  marked between {brackets}.

> Say, I might ask him about football, and he might say a lot, you know,
> something lot bit in {language}, and... the interpreter would turn to me and
> say, He, he says he supports... a particular {nationality} team that is doin'
> well this year. Or something like that. #00:32:45-6#

3.7. The coding process

3.7.1. Initial considerations within the narrative research framework

As previously argued, transcription and coding are both an integral part of the data
analysis process (Elliott 2005; Riessman 2002, 2008). Nevertheless, coding is an
essential phase of the research process in terms of internal validity. The two principal
issues are time and consistency, whereby the more compact the time period set aside
for the actual coding process, the more consistent the coding can be. With regard to
the place of coding within the project as a whole, coding also has to be consistent
with the research framework, in this case a narrative analytical approach. As
described in the previous section, I represented both speakers, that is, the respondent
and the researcher, in the transcript. Following on, I designed coding so that it would
reflect the dialogue between the researcher and the data collected with the
contribution of the respondents, as prioritising either side of this research dialogue
would endanger the internal validity of the project. This dilemma clearly appears in
Elliott's (2005) discussion of the subject.

> Among those with an interest in the use of narratives in research there are two rather different
> views on the relationship between the use of narrative interviews and the internal validity of
> the information obtained. As was discussed above, some researchers have advocated the use

of narrative interviews because they empower the respondent to set the agenda and prevent respondent' experiences from becoming fragmented (Graham, 1984; Mishler, 1986). Both of these considerations imply that interviews that attend to individuals' narratives would produce data that are *more* accurate, truthful or trustworthy than structured interviews that ask each respondent a standardized set of questions.

However, others who are explicitly interested in the use of narratives in interviews stress that narratives are never simply reports of experiences, rather they make sense of and therefore inevitably distort those experiences. While for some this is itself almost an advantage of narrative-based research, as the focus in interest is on the individuals' subjective interpretations and the meanings they make of their lives, others are more concerned that narrative obscures a clear description of life as it is lived. (p23)

In other words, if the coding is top-heavy and is imposed by the researcher, the respondents' empowerment through the interview process would be lost in the coding phase. On the other hand, if the coding only reflects the respondents' views, as is the case in true grounded theory research, the researcher's position does not receive appropriate acknowledgement. Therefore, in order to continue with the dialogic aspect of the narrative approach, I applied two coding systems to the entire data set. Top-down coding, referring to my own imposition as a researcher, reflects the originally identified six themes (perception of mental health, cultural significance of narratives, familiarity between the participants of the interpreter-mediated encounter, mode of interpreting, interpreting narratives, and mental health interpreting), while bottom-up coding reflects the respondents' contribution. As it is possible to utilise different aspects of coding in the NVivo software, I decided to distinguish the two types of coding in terms of tools as well.

3.7.2. Units of coding

Prior to discussing both of these coding systems in detail, it is crucial to clearly identify and consistently keep to units of analysis. Perhaps the easiest way to identify a unit of analysis is to consider the researcher's questions (the six main themes) as clear division lines. Thus, text or interaction between two questions, which mark the introduction of new subject matter, is considered a unit of analysis. Such a unit is then coded or assigned to a "node," a denomination which at first may sound confusing to those who are used to "codes," but which is very simply "the place where the software stores a category" (Richards 2005 p90). This approach can straightforwardly be applied to the top-down coding approach, where the appearance of one of the predefined six themes (perception, cultural significance, familiarity, mode of interpreting, interpreting narratives, or mental health interpreting) signals the opening of a new phase in the discussion, and of a new code. However, in the

case of bottom-up coding, a new topic may be introduced by either the interviewing researcher or the respondent. In keeping with a narrative approach, such introductions on the respondents' behalf were encouraged, and were consequently represented in coding.

The beginning and ending of such units of analysis were more difficult to define in the case of bottom-up coding than in the case of top-down coding. The thematic units were considered complete if the subject was closed, for example, marked by a conversational feature (such as silence, or a sign of acknowledgement mostly by the researcher), or the introduction of a new topic.

The following example from interview with INT2 illustrates how the theme is closed by a conversational feature.

INT2 But if they say, this person mentally illness, ill. So we, we, we're afraid. #00:23:08-4#

KZ Uhm. #00:23:09-4#

INT2 Yeah. #00:23:10-2#

KZ Ok. #00:23:10-7#

INT2 We wouldn't be, wouldn't like to make friends even. #00:23:13-8#

KZ [Uhm.] #00:23:13-9#

INT2 You know, maybe with this, this, this person. #00:23:15-2#

KZ Ok. #00:23:15-9#

INT2 Yeah. #00:23:16-5#

KZ Ehm... So... #00:23:20-2#

[silence] #00:23:22-6#

An example when the introduction of a new subject completes the previous discussion can be seen in the following segment from the interview with INT3.

INT3 [Ehm...] #00:13:02-3#

[silence] #00:13:04-3#

But, eh, the... eh, the... doctor had to... explain... couple of times that it was just eh... normal session to [???] the problem. #00:13:15-3#

KZ And, ehm... when you interpret, is it then different from other... settings? In terms of modes of interpreting, so chouchotage, or, or, or... simultaneous or consecutive. [Or do you use] #00:13:29-8#

3.7.3. Top-down coding

Following the identification of the units of analysis, top-down coding was relatively simple to apply. During the coding process I identified the introduction of the originally defined themes and inserted a short code for the theme in a different style into the document. For example, in the case of the perception of mental health among the community or communities with which the research respondent had experience, the question was posed in different ways.

> KZ Ehm, firstly, because the research is about mental health interpreting... Could you tell me, in your opinion... What... ehm... is the difference, or what are the similarities between the perception of mental health in {country} and Ireland? #00:03:20-7# (INT1)

or

> KZ [Yeah. Yeah.] Ehm... and since you've, you've seen so many different cultures, #00:07:30-8#
>
> THER3 [Uhm.] #00:07:31-3#
>
> KZ [ehm]... would... #00:07:32-2#
>
> [silence] #00:07:34-4#
>
> How do you see... the... cultural, eh... perception of mental illness in different cultures? #00:07:41-8#

In each transcript, I coded these introductions by adding "perception" in the transcript and marking it by a headings style, similarly to an MS Word document. I coded each predefined theme (perception of mental health, cultural significance of narratives, familiarity between the participants of the interpreter-mediated encounter, mode of interpreting, interpreting narratives, or mental health interpreting) in the same manner, as seen here.

perception

> KZ Ehm, firstly, because the research is about mental health interpreting... Could you tell me, in your opinion... What... ehm... is the difference, or what are the similarities between the perception of mental health in [country] and Ireland? #00:03:20-7# (INT1)

However, some of the passages contained additional information with regard to the original questions, and I have separated these sections by the heading "additional info." The introductory section of the interviews collecting quantitative data on the respondents' profile belong here as do my own explanations with regard to the rationale for the research. Once all the transcripts had been coded, I auto-generated codes out of these headings, which the NVivo software facilitates. As a result, all the text or interaction relating to the individual predefined themes became accessible in a single node and could be read or analysed more easily, as displayed in Figure 3.1.
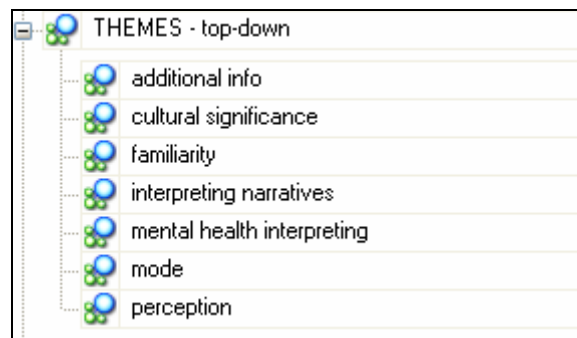
Figure 3.1. Top-down codes based on the original interview themes

3.7.4. Bottom-up coding

In the case of bottom-up coding, the process was more intricate, and involves a process almost identical to traditional thematic coding by hand, with the added advantage of an electronic organisational tool. Lyn Richards, a sociologist by training and also one of the founders of QSR International, the designers of NVivo, in her practical guide to qualitative data introduces three types of coding: descriptive, topic and analytical coding (Richards 2005 pp84-103). Descriptive coding essentially consists of listing attributes under "case properties" in the software. In the case of the current project these, for example, included length of experience in the profession, gender, the INTs' training background or the languages they had worked with. This data can be analysed statistically, if a mixed quantitative-qualitative approach is applied. For example, the average age of the respondents can be calculated, or the extent of the length of their professional experience and gender can be correlated.

Richards' other two categories involve qualitative treatment of the data, where the researcher's involvement and judgement of the collected material comes to the fore. Topic coding is a thematic breakdown of the available material, or "labelling text

according to its subject" (Richards 2005 p88), which is what researchers in the social sciences consider traditional coding, and which is the approach I applied in the case of bottom-up coding. Most of the codes in the present project were so called *in vivo* codes, similar to line-by-line coding in Grounded Theory (Denzin and Lincoln 2000 p515), which means that they arose from the respondents' contribution. A very clear example is a list of nodes which emerged from the replies to the question: How is mental health and illness perceived in the cultures you have worked with? The respondents formulated their answers using expressions such as "crazy," "cursed," "evil spirit," "get on with it," "punishment" or "stigmatised," which I could establish as nodes, as can be seen in Figure 3.2., displaying some of the nodes under "Perception" among the bottom-up coded interview themes.
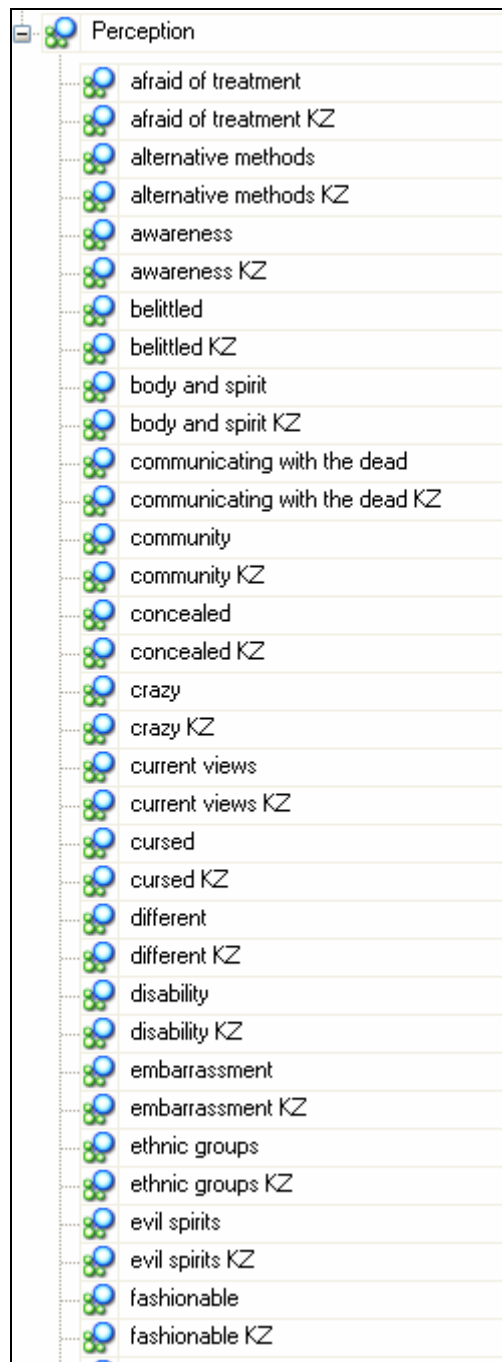
Figure 3.2. An example of bottom-up coding under the interview theme "perception of mental health and illness"

In some instances, however, I made analytical decisions and gave the node a name I thought best described the phenomenon in question. This was the case with regard to "sociogeography." Thus, the node description, a very useful feature of node properties also shown in Figure 3.3., reads "the attitude towards mental health is dependent on socio-geographical factors rather than the country / culture of origin."
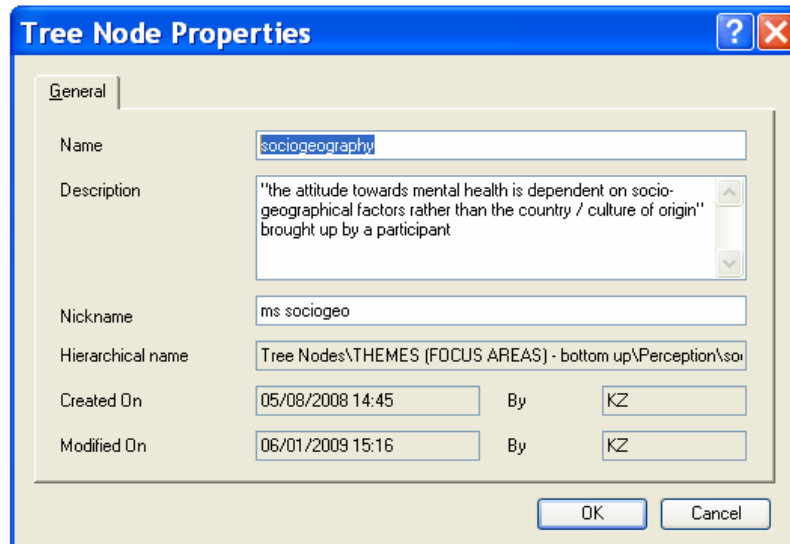
Figure 3.3. Tree node properties pop-up box in the NVivo 8 software

In this example, the respondent noted that the perception of mental health differed not necessarily along national or ethnic lines, it rather depended on whether the client came from an urban or rural background.

Strictly speaking, this latter naming convention counts as intervention on my behalf as a researcher, and falls under Richards' analytical coding category which refers "to coding that comes from interpretation and reflection on meaning" (Richards 2005 p94). This type of coding exemplifies two previously posed arguments. Firstly, it is clear that coding is in fact an integral part of the analytical process. Secondly, it shows that coding in narrative research is a dialogic process, where the researcher organises the emerging concepts into categories and conceptualises the data collected with the contribution of the respondents. Furthermore, this description of the coding process illustrates how working with qualitative analysis software is essentially the same process as coding by hand, except for the added options of nuancing the data for improving searchability and grouping the data at a later stage of the analysis process.

3.7.5. Organising the nodes

3.7.5.1. The tree structure

The latter observation is all the more relevant in the organisation of nodes and levels of coding. From the very beginning of the coding process I started to classify nodes into groups that were thematically homogenous. Thus, the topics mentioned by

the respondents were classified into clusters. This also helped identify the three main themes for analysis, or the foci of the analysis chapters in the dissertation. Additionally, a tree structure with child and parent nodes began to form. For example, the grandparent node "safety" had child nodes "client safety," "interpreter safety" and "professional safety." In turn, "interpreter safety," a child node of "safety" became the "parent node" to child nodes "interpreter physical safety," "interpreter spiritual safety" and "vicarious traumatisation" as shown in Figure 3.4.
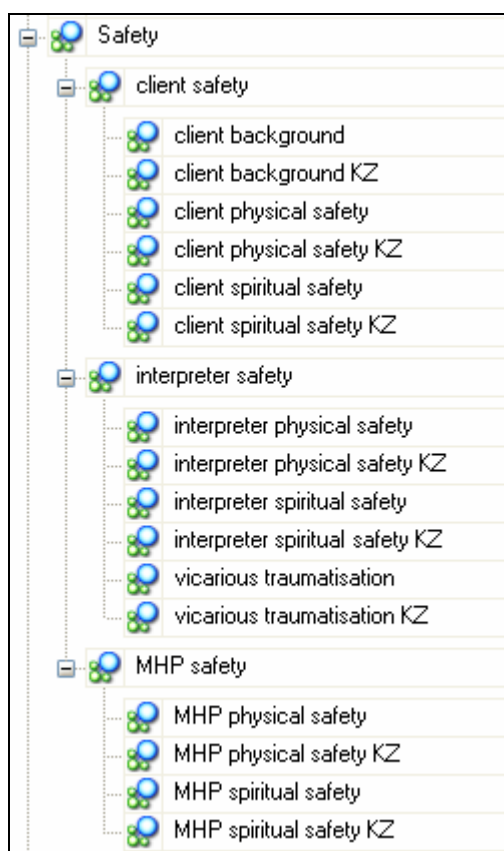
Figure 3.4. Grand-parent, parent and child node examples

3.7.5.2. Differentiating the author of the contributions

Another important characteristic of interviews in the narrative framework which needed to be reflected in the coding structure is that a new topic may be introduced either by the researcher or by the respondent. Thus, either the respondent introduced a new angle to the flow of conversation, or I as the researcher posed a question to move away from or slightly divert from the previous subject. In order to determine what the respondents deemed significant to add to the research dialogue, I believed it was important to mark their spontaneous contribution of introducing new topics.

Therefore for each child node, such as "vicarious traumatisation," I set up a twin node. I assigned one to passages of text or interaction where the subject was initiated by the respondent (simply named as "vicarious traumatisation"). I assigned the other to extracts where I in some manner prompted the introduction of the particular subject (named "vicarious traumatisation KZ"). This separation can be seen in Figure 3.4. above. This distinction became especially salient to the analysis when, in the case of safety which will be discussed in detail in Chapter 6, the relatively high number of references to the subject initiated by the MHPs and the INTs indicated the respondents' preoccupation with a particular topic and confirmed my choice of the subjects as foci for analysis.

3.7.5.3. Topics "brought up by the respondent"

Once again, for the sake of the internal validity of the research project, consistency was required. While it seems apparent that most of the respondents' utterances were in reply to my questions and should, therefore, be coded under "[node name] KZ," this would not reflect the respondents' contribution. With a clear objective to mirror their input and the dialogic nature of the interview process, I established the following guidelines during coding. When conducting the interviews, I aimed to pose the questions as neutrally as possible, and coded the reply as "brought up by the respondent" as I did not suggest a preference of any particular answer over others. An example of this can be seen in the interview with MH05, where it is also clear how I had to phrase questions in lay person's language in order to elicit answers I could later analyse. In this case, the extract is coded under the "consecutive" node with reference to a particular mode of interpreting.

> KZ Ok. Ehm... So when you work with an interpreter, what eh... how does it happen? There's the interpreter, the patient and you, and then... you talk, interpreter interprets, patients talks? or... does the interpreter talk under you? Or whispers? Or... #00:09:09-1#
>
> MHN5 Well, she, ehm... like, for instance, if the pati', sometimes she will... answer back when the patient's here, you know. But, eh... [it depends from the pati'] #00:09:20-3#

I also attributed utterances to the respondent, if the new subject matter was clearly unprompted by me and brought up by them. A very clear indication of such an incident can be observed in the extract from the interview with INT10.

INT10 Yeah. The other thing that I want to mention is #00:16:44-7#

KZ [Yeah.] #00:16:44-6#

INT10 [there's] a lot of... interpreter [sic] now. They're just people, they just... you know. They're not trained. #00:16:50-9#

KZ Yeah. #00:16:51-4#

Finally, I attributed utterances to respondents, if I revisited the subject during the course of the interview, but originally it had been brought up by them. Sometimes these instances are signalled by a short introduction to the question I asked, for example, "And you mentioned…" In the example below, there is a different back-reference to the discussion on whether therapists stop clients in their train of thought if they go on speaking for a long time.

KZ Ok. And, going back to the therapist as well, if they go on for a long time, would the therapist... stop them in the... the, the kind of, ehm... #00:16:29-3#

INT12 Never in my exp #00:16:30-6#

KZ [stream of con] #00:16:31-0#

INT12 It hasn't happened in my, never happened in my experience. #00:16:33-0#

KZ Ok. #00:16:33-3#

This utterance as assigned to "client stopped by professional," which may seem contradictory at first, because the respondent is actually saying that he or she has not experienced such an incident. However, I named the nodes neutrally to include both positive and negative statements on the subject.

3.7.5.4. Topics "prompted by KZ"

In contrast to text or interaction assigned to nodes which were "brought up by the respondent," I considered the utterance as "prompted by KZ" if I made any suggestion or implication in my way of questioning. This was the case in the following extract from the interview with INT4, which I assigned to the "(im)partiality KZ" and and "professional boundaries KZ" nodes.

73

KZ Ehm... does this cause a problem to you if you don't believe the person you're interpreting for? #00:19:38-1#

[silence] #00:19:40-1#

INT4 Hhm. #00:19:40-5#

[silence] #00:19:43-1#

3.7.5.5. Cleaning up the nodes

The last example also reveals that certain passages were attributed to multiple nodes and that I assigned as many codes to a passage as was necessary. In terms of internal validity, the difficulty lay in avoiding overcoding and strictly keeping to codes that were truly relevant to the extract being assigned. This often required referring back to previously coded transcripts as well as to the "description" of nodes, a feature of node properties shown in Figure 3.3. above. This attribute has proven very useful in differentiating between similarly sounding nodes, such as "involved," which is a child node of "mental health interpreting" and is used if "the interpreter in a mental health interpreting situation is more involved than in other environments" and "involvement," which is a child node of "familiarity" and is used if "the interpreter gets emotionally or otherwise involved with the client."

Nevertheless, similarities in the naming of nodes are less problematic during the coding process than similarities between the content of nodes. Prime examples of such overlaps are the nodes concerning the control of communication, a subject explored in Chapter 5. At first sight, it may be difficult to distinguish between the nodes "client keeps talking" or "client allowed to talk by interpreter" or "client stopped by professional," especially if the nominations are intended to be neutral as discussed above. The difference lies in the intentionality and the agency in the control or power exercised by a participant in the interpreter-mediated encounter. Thus, where either the client takes control and cannot be stopped, perhaps due to their mental state, or the interpreter makes a conscious decision to let the client talk or the mental health professional takes an active role in stopping the client in their speech. I have established a number of such node clusters to present a more rounded picture emerging from the collected data.

In order to prevent overcrowding of the nodes, I built in two control measures. Firstly, I only set up a new node if none of the already existing nodes could fully cover the phenomenon under discussion. Even in such instances, I tried to make sure that there was nothing I had previously missed. When I created a new node somewhat similar to previous nodes, I went back to each file I had already coded to confirm that I had not overlooked anything. For example, when I set up the node "family and friend interpreting," a child node of "professional v non-professional interpreters", I searched for particular expressions which may be assigned to the new node and their morphological or typographical roots and potential synonyms, such as "famil," "friend," "child," "parent," "wife," and "husb."

Secondly, during the post-editing phase I eliminated unnecessary overlaps. I examined every node and any similar nodes to them. If there had been a hundred percent overlap between the references, on careful consideration I would have eliminated one of the nodes. Perhaps due to the rigorous coding process in the first place, there was no such instance. However, on a number of occasions, there was only a minor discrepancy between the content of two similar nodes. In these cases I compared the node contents and decided if it was necessary to keep the two nodes. If a merge could be effected, I ensured that all the instances of coding were assigned to the node I decided to retain, and deleted the superfluous node (and its "prompted by KZ" twin pair) from the tree nodes.

3.7.5.6. Additional, non-analytical nodes

This practice clearly demonstrates how coding becomes an integral part of the analysis process, or leads to analysis proper. Another example of analytical coding is the selection of particular passages for later non-thematic analysis. In addition to the thematic codes, I created a parent node for "narratives" and collected segments of the interviews where stories in the Labovian sense, as presented in section 2.2.1., were recounted. In some cases they were told in one single unit of analysis. In others, they re-appeared during the interview, sometimes taking up a narrative thread where it had been left off. In other cases they were repeated in slightly different versions. I considered these stories very important in the research as I believe that they could shed light on how stories might evolve during interpreter-mediated encounters. Naturally, the structural narrative analysis of these segments cannot replace a similar

analysis of actually interpreted narratives, however, they can point to aspects of narrative formation that are useful in interpreter training.

In preparation for later analysis, I also classified these narratives into three categories: "stories told by clients," "stories told about clients" and "other stories." "Stories told by clients" were accounts once told by clients and reproduced by the respondents. "Stories told about clients" included narratives where the respondents recounted events concerning the clients' circumstances and their behaviour within the interpreter-mediated sessions. Finally, "other stories" comprised narratives which the respondents deemed relevant to recall, either in connection with MHI or other related topics. These stories will support the analysis chapters 4, 5 and 6 respectively in an illustratory capacity.

3.7.6. The final node structure

The post editing phase of the coding process clearly bears the signature of the researcher. Following the top-down and bottom-up coding processes, the final tree structure evolved. The main headings included the transcribed extracts coded under the original interview themes during the top-down coding, the stories which were recounted during the interviews and identified as supporting material, and the data selected for the analysis chapters along with practical issues relating to professionalisation of CI. The material selected for the analysis chapters evolved from the bottom-up coding process which reflected the respondents' views and was coded under the titles of the main themes to provide parallel data as discussed in sections 5.3.2. and 6.2. respectively. Three particular subjects emerged based on the MHP and INTs' contribution, who showed particular interest in matters of *accuracy*, the *control of communication* in interpreter-mediated encounters and *safety*. These three topics provided the focus for the respective analysis chapters. At this point, coding seamlessly flowed into analysis proper. I made analytical decisions concerning the organisation of the material and the presentation of the collected data, which I am going to discuss in the following section.

3.8. Riessman's taxonomy

Before the introduction of the three types of analyses, I wish to acknowledge the crucial difference between Riessman's narrative analysis, especially thematic narrative analysis, and the method I propose to apply in the current study. Riessman applies narrative analysis to individuals' personal narratives collected during her career as a psychologist with clients and as a social scientist with respondents. Her interviewees share their experience concerning their private lives and express their lived experience through stories, or narratives in the Labovian sense of the word. In contrast, the current research builds on data collected through research interviews where the respondents offered their opinion on subjects related to their professional life. The framework of the interviews was perhaps less conducive to the development of narratives in the full Labovian sense. Nevertheless, their responses can be considered in the narrative paradigm.

In Labov's (1972) definition, a narrative is "one method of recapitulating past experience by matching a verbal sequence of clauses to the sequence of events which (it is inferred) actually occurred" (pp359-360). This is the definition which I applied when I marked the stories which support the analysis: they are accounts of a series of events and their consequences. For the purposes of thematic analysis, however, I applied a different definition. In Labov's (1972) terms, a *minimal narrative* is

> a sequence of two clauses which are *temporally* ordered: that is, a change in their order will result in a change in the temporal sequence of the original semantic interpretation. In alternative terminology, there is a temporal juncture between the two clauses, and a minimal narrative is defined as one containing a single temporal juncture. (pp360-361)

If we take an even narrower definition of a minimal narrative, we can return to the Aristotelian time-space-action triad of dramatic unity. In this sense, the interviews were full of stories, and experiences that INTs and MHPs had had.

> INT3 Ok, eh... but I would say that, for example, the... ehm... #00:31:37-2#
>
> [silence] #00:31:39-8#
>
> in both, both cases, ehm... [???] I interpreted for, I... never got any... #00:31:44-9#
>
> KZ [Uhm.] #00:31:45-4#
>
> INT3 debriefing, or... anything. #00:31:47-7#

In this sense, a statement "I never had debriefing" could constitute a story, insofar as it locates the (non)action in place (an interpreter-mediated encounters in MHC in Ireland) and in time (during the years the INT had been working in mental health settings). This statement can constitute a story with a temporal, spatial and causal positioning, that is, the INT had never had a session following the assignment in a mental health setting where they would have been offered or could avail of debriefing. This statement, depending on the context, may also imply that they would have needed such support after an emotionally taxing session. However, I will take heed of Riessman's caution not to consider every utterance a narrative (Riessman 2008 p11), and merely posit that I consider these utterances units of analysis for the thematic analysis presented by in the current research.

As discussed in section 2.2., I found Riessman's taxonomy of narrative analysis the most useful to process the collected data. In her encyclopaedic entry on Narrative Analysis writing about "a range of contemporary approaches particularly suited to oral narratives or personal experience" (2004 p706), Riessman offers a four-part typology, which could be represented as Russian nesting dolls, each a little bit larger and containing all the smaller ones. Although Riessman lists the shortcomings of every stage, each kind of analysis can stand on its own and can be useful for various research aims. The first type of narrative analysis Riessman (2004) defines, thematic analysis, underscores the subject rather than the manner of narrative, where the context is outside the scope of the investigation. The following type, structural analysis, concentrates on how the story is told, and thus, language becomes the focus of close investigation. The third type, interactional analysis, involves the consideration of extra-textual relationships and relates to the narrative as a historically and socially situated co-construction of the dialogic partners (see also Bakhtin 1981; Bruner 1986, 1990, 1991). Finally, based on the stage metaphor, the most inclusive approach, performative analysis, also incorporates geographical positions, characters, and is primarily applied for communication practice and identity construction studies.

In her most recent volume on *Narrative Methods for the Human Sciences* (2008), Riessman reconsiders this taxonomy, and offers a slightly different categorisation of thematic, structural, dialogic / performance and visual analysis, in order to incorporate images as the subject of analysis. To enable a clearer understanding of the following analysis chapters, here I present a brief description of the three

analyses (thematic, structural and dialogic / performance) which were applied in this study. As the data under analysis here does not contain visual elements, that is, images or video recordings, Riessman's fourth type of narrative visual analysis is not relevant to the current project.

3.8.1. Riessman's thematic analysis

The definition of **thematic analysis** has not changed since Riessman's previous classification. It has, however, been explained in greater detail. "Investigators in the thematic narrative tradition typically pay little attention to how a story unfolds in a conversational exchange or the questioner's role in constituting it. In other words, readers usually learn little about the local context–conditions of production of a narrative" (Riessman 2008 p58). While this description may sound very unlike a narrative approach insofar as it lacks the dialogic characteristic of narrative theories, Riessman's position of thematic narrative analysis on a continuum between positivist analyses and grounded theory is a convincing argument for thematic analysis to be regarded as a narrative approach.

Riessman (2008) likens thematic analysis to objectivist approaches, when she writes that in

> [...] thematic narrative analysis (and in other thematic coding methods), the language is viewed as a resource, rather than a topic of inquiry. In this respect, the approaches can mimic objectivist modes of analysis where themes appear to be unmediated by an investigators' theoretical perspective, interests, mode of questioning, and personal characteristics. (p59)

On the other hand, she acknowledges the dialogue between the researcher inputting their own concepts into the analysis while empowering the respondents to express their views or tell their story. This discourse is key to narrative approaches and distinguishes thematic analysis from grounded theory "where a priori concepts are discouraged" (Riessman 2008 p66). Also, crucially, thematic analysis, like the other three approaches discussed in the book, takes narrative as the subject of its investigation. This type of analysis is the most prominent in the analyis chapters 4, 5, and 6.

3.8.2. Riessman's structural analysis

While various discursive approaches have been relatively frequently applied within the wider field of CI (see, for example, Bot 2005a; Hale 1997a, 1997b, 2001, 2008; Jacobsen 2003, 2008; Napier 2004; Pöchhcaker and Kadric 1999; Roy 2000; Tebble 1997, 1999, 2007; Wadensjö 1998a), **structural narrative analysis** has yet to be carried out on interpreter-mediated encounters, although it is already being used in some community interpreter training (Winston and Roy 2007). As the name suggests, this most popular and widespread type of narrative analysis is primarily concerned with the organisation of stories. It can take the shape of fiction-like segmentation as described by Labov (1972) or a rather poetic stanza-form as offered by Gee (1986), as illustrated in the Interlogue of this dissertation. Riessman (2008 pp81-100) demonstrates that both methods can reveal the organising principles and rationale behind apparently incohesive narratives, and can help find method in the madness. Larger scale studies applying structural analysis to interpreter-mediated texts could also benefit CI training by continuing in Roy et al's (1998) footsteps in their discursive approach to teaching CI. In Riessman's (2008) words,

> Structural narrative analysis is not suitable for large samples, but can be very useful for detailed case studies and comparisons across a few cases. Micro-analysis of several narratives can build theories that relate language and meaning in ways that are missed when transparency is assumed, as in thematic narrative analysis. Because it takes language seriously, structural narrative analysis provides tools for investigators who want to interrogate how participants use speech to construct themselves in their stories. (p103)

As such an approach can aid the understanding of narratives recounted at ruptures in the narrator's life, it seems a particularly appropriate tool to employ in mental health environments. The method would most ideally suit recorded authentic material of actual interpreted encounters. Here it features in the Interlogue connecting the theoretically and methodologically based Chapters 2 and 3 with the proper analysis chapters 4, 5 and 6.

3.8.3. Riessman's dialogic analysis

Dialogic / performance analysis (henceforth **dialogic analysis** for short) is an approach which can be naturally applied to data collected through interviews. By positioning myself very clearly as an interpreter who had some experience in MHC settings, and by disclosing that this had given the impetus for the current project, I

entered into a dialogue with every INT and MHP who had agreed to take part in the research. Equally, one of the most informative aspects of the study has been the findings that were generated by the respondents on their own initiative. While I accept that to some readers these topics or emerging tendencies may be more evident, they were highlighted to me by the respondent INTs and MHPs. I consider the recurrence of such heuristic moments an important part of the research process, and, therefore, decided to examine them systematically through a dialogic analysis of the interview data. The results of these findings, facilitated by a careful coding process described in sections 3.7., will be presented in Chapter 6 on Safety.

3.9. The presentation of findings

Having discussed the relevance of Riessman's narrative analytical approaches to the current project, I propose that their combination helps develop an argument and validate the research findings. Furthermore, the three types of analytical approaches are not the only tripartite organisation to have evolved. Throughout the research process, concept groups of triads have developed, and these clusters involve more than a simple collection of three items, or triples. The members of each cluster are in constant interaction with each other, and often defy a seemingly obvious hierarchical representation. Therefore, I made decisions to construct the narrative analysis along these clusters of classification.

During the discussion of the CI and MHI literature, I identified three levels of narrative in the introduction to the dissertation. These are 1) the story, that is, the actual narrative recounted by the client in interpreter-mediated encounters; (2) the discourse, that is, the social organisation of such an event; and (3) the metanarrative, that is, the level of service provision, with special reference to MHI in Ireland. Each of these levels of narrative comes to the fore in the individual data analysis chapters, as shown in Table 3.6.

	Chapter 4	Chapter 5	Chapter 6
Level of Narrative	Story	Discourse	Metanarrative

Table 3.6. The organisation of the data analysis chapters and the three levels of narrative

The main subject of the three chapters emerged from the dialogic interviews. The respondents drew attention to particular matters which evidently preoccupied them.

These topics featured so significantly in the interviews that they were easy to identify for further analysis and presentation. The three main topics I chose to focus on are (1) the respondents' perceptions of narratives and accuracy, (2) the control of communication in interpreter-mediated encounters, and (3) safety. Table 3.7. shows how these topics correspond to the data analysis chapters.

	Chapter 4	Chapter 5	Chapter 6
Level of Narrative	Story	Discourse	Metanarrative
Subject of analysis	Perceptions around narratives and accuracy	Control of communication	Safety

Table 3.7. The organisation of the data analysis chapters and the three main subjects of investigation

In addition to the subjects of analysis which I identified from the narrative interviews, the respondents commented on a number of important practical issues concerning the realities of CI and MHI in Ireland. These issues were incorporated into the analysis chapters to highlight the problem areas and propose possible solutions for the improvement of the current situation. The subjects were classified into three main areas as follows (1) training, (2) employment issues and (3) interpreter support, as can be seen in Table 3.8.

	Chapter 4	Chapter 5	Chapter 6
Level of Narrative	Story	Discourse	Metanarrative
Subject of analysis	Perceptions around narratives and accuracy	Control of communication	Safety
Practical issues	Training	Employment issues	Interpreter support

Table 3.8. The organisation of the data analysis chapters and practical issues of interest

The respondents exceeded my expectations in producing some wonderful narratives, which I naturally included in the coming chapters to support their and my

own arguments. I collected these stories while coding and grouped them into three categories, which are (1) stories told *by* the clients and recounted by the respondents, (2) stories told *about* the clients and (3) *other* stories. Since this thesis offers a narrative view of MHI in Ireland, these stories are highlighted in a text box throughout the analysis chapters to help their identification and emphasise their significance. These supportive narratives provide another layer to the analysis chapters, which is shown in Table 3.9.

	Chapter 4	Chapter 5	Chapter 6
Level of Narrative	Story	Discourse	Metanarrative
Subject of analysis	Perceptions around narratives and accuracy	Control of communication	Safety
Practical issues	Training	Employment issues	Interpreter support
Stories supporting the analysis	Stories told *by* the clients	Stories told *about* the clients	Other stories

Table 3.9. The organisation of the data analysis chapters and the types of stories supporting the analysis

Finally, I chose to present the data in the form of internal research dialogues. Thus, Chapter 4 will contrast the INTs' views with the MHPs' opinions, Chapter 5 will present findings of the current research against the backdrop of Bot's pioneering work in the area of MHI and other relevant works in the CI literature, and Chapter 6 will revisit the research dialogue between the respondents and the researcher. These presentational angles, layered onto the previously introduced organisational features, complete the organisational chart in Table 3.10.

	Chapter 4	Chapter 5	Chapter 6
Level of	Story	Discourse	Metanarrative

narrative			
Subject of analysis	Perceptions around narratives and accuracy	Control of communication	Safety
Practical issues	Training	Employment issues	Interpreter support
Stories supporting the analysis	Stories told *by* the clients	Stories told *about* the clients	*Other* stories
Internal research dialogue	INTs and MHPs	Current project and MHI / CI literature	Respondents and the researcher

Table 3.10. The summary of the organisation of the analytical chapters

3.10. Conclusion

The structure of this chapter has reflected the research process insofar as it first summarised the main considerations of the methodological framework, then it gave a detailed description of the various tools and methods used and finally offered an outline for analysis. The reproduction of the train of thought was also intended to illustrate how narrative analysis creates space for the respondents and the data they provide to shape and enrich the research design as well as how useful qualitative data analysis software can aid the organisation of the collected material.

In the name of reflexivity, the chapter aimed to give an insight into the development of a research project with the candid exposure of various decisions a researcher has to make. With regard to the methodological framework, this entailed the involvement of the respondents in a narrative interview process, where the emphasis was on a truly dialogic interaction. This comprised interviews where the responding INTs and MHPs were not restricted to simplistic replies to closed questions, but were encouraged to elaborate on their opinion. Furthermore, they had the opportunity to engage in a bilateral information exchange and question me, the researcher-interviewer, about topics which interested them.

With regard to the data analysis per se, although the full description of the coding process seems very complex at first, I intended to include all the details for reasons of transparency and reproducibility. I aimed to demonstrate how intricate a research network, which certain electronic tools help us construct, can be. In setting up the coding system, I had relied on my previous experience with coding by hand, where I created similarly intricate networks of codes. The added advantage of working with software was the accessibility of the data and the variety of query criteria I could apply to the coded data. However, the process does not differ from manual coding in the sense that the coding process is an essential part of the analysis, during which time and time again the researcher naturally reconsiders the data set and her relationship to the data.

Finally, with regard to analytical decisions, I provided a tripartite organisational structure in order to aid myself and the reader in the analysis of the available data. While this is, obviously, only one of a number of permutations along which the data set could be analysed, I chose this representation as a *bias* or a leading thread in the fabric of the dissertation. Providing a skeleton to an argument is a reflexive process

in itself, which not only reproduces the workings of the researcher's mind, but simultaneously shapes the process of thinking about the project. In this sense, the layering of the levels of narrative, the subjects of analysis and practical interests as well as identifying three different types of narratives and the internal research dialogues supporting the argument in each analysis chapter all aim to mirror the complexity of matter at hand and to provide further cohesion and elucidate the organisational principle behind the thesis.

Before moving on to the analysis chapter, I would like to return to the story of my research project. As explained in the Prologue, my original intention was to examine how the interpreter's presence influences the evolution of stories in interpreter-mediated encounters in mental health care (MHC). Limited access to the interpreter-mediated encounters in Ireland in general and the unavailability of a series of sessions in the Hungarian-English language pair in particular prevented me from pursuing this line of enquiry. Nevertheless, during the course of the study as it eventually materialised, the interviews presented me with numerous stories.

One particular case offered an opportunity to gain insight into the workings of an interpreter's mind with regard to the formation of narratives. The interview excerpts below clearly do not provide evidence as to the actual product of interpreting or the interpreter's performance. However, they offer what we can consider secondary or indirect evidence that stories indeed reappear in conversations whether monolingual or interpreted, and that they often feature in slightly modified versions. The perspective from which they are recounted may be very telling in terms of cultural differences or as regards the storyteller's state of mind. Therefore, the accurate interpreting of these stories with maintaining the perspective of the storyteller is also paramount, as the findings of Chapter 4 will indicate.

In addition, the context in which this particular story appeared and reappeared in one of the research interviews is worth a comment, too. On more than one occasion when the INT brought up the story on her own initiative, and couched it with reference to her own treatment of the story. The INT simply explained how she had reconstructed the storyline by clarifying certain elements with the client and then proceeded to present the "cleaned up" version to the mental health professional. By all accounts, this had happened with the mental health professional's approval and in the best interest of the participants in the interpreter-mediated encounter. Nevertheless, such practices can result in a shift in the control of communication, whereby the mental health professional willingly or unknowingly cedes control to the interpreter. In terms of the credibility of research, while the INT's account can be considered a witness statement describing their experience, it refers to one particular case and therefore, cannot be generalised to any interpreter-mediated encounter. However, as a quasi witness statement it offers interesting evidence and also supports

the findings of Chapter 5 on the control of communication in interpreter-mediated encounters.

Furthermore, the multiple repetition of the story in question by the same INT respondent during the course of one interview also highlights how certain pieces of information and certain narratives affect the participants, in this case, the interpreter. The fact that the INT returned to the same story, sometimes unbeknownst to herself, on a number of occasions is a testimony that stories may have a lasting effect on the interpreter perhaps weeks, possibly months after the assignment. In this respect, the interview also yielded valuable secondary evidence supporting the findings of Chapter 6, which deals with the fallout from emotionally and mentally taxing assignments.

The following excerpts are from the interview with the INT, whose identity shall remain anonymous for the sake of all those involved. Consequently, any potentially identifiable features, such as {dates}, {years}, or {names of countries} have been removed. The excerpts are from two consecutive recordings made during the same interview, which was interrupted for a short while. The story had originally been told by a bereaved woman in a therapeutic environment, about her family, or rather the loss of her family. As the INT repeated the story not once, but at least five times, and in so many different versions, it became clear during the interview that the recurring nature of the account had been a characteristic of the client's narrative in the original therapeutic setting. Such recurrence is a key feature of personal narratives and the reconstruction of the self, which is discussed in detail in sections 2.5.1. and 4.2.2. Here follows a brief structural narrative analysis (Riessman 2002, 2004, 2008) of the various versions of the same story as told by the INT respondent. The relevant passages with the repeatedly emerging narrative are marked in **bold** script.

The first time the story was mentioned during the interview, the INT introduced it from a cautious distance of a third person plural account. The excerpt begins with a discussion on interpreting narratives in MHC. At a certain point in the interview, the INT explained how she clarified vague points in the client's narrative if necessary. During this rationalisation the INT launched into a story, which begins *in medias res* with a reconstruction of an interpreter-mediated encounter. The INT re-enacted their question to the client, "Sorry, I didn't understand. Did you say... It was your husband you lost? (#00:13:57-3#). "Or was it your brother?" (#00:14:07-3#). In Labovian terms (1972 pp263-264), this short "abstract" is actually dramatised and is then

contrasted with a relatively long series of "evaluative" statements by the INT. Here, the INT explained the difficulties of deciphering the distressed client's narrative in a meta-communicative manner (#00:14:07-3# - #00:14:16-4#).

INT Ehm... If I... want to clarify something, if something doesn't make sense, I'll actually ask the client to clarify it. #00:13:52-8#

KZ Uhm. #00:13:53-1#

INT Sorry, I didn't understand. Did you say... It was your husband you lost? #00:13:57-3#

KZ Mmm. #00:13:57-9#

INT Or was it your brother? Sometimes when somebody's telling... ehm... eh, eh, a [???], it's very, well, my experience is that when people get to tell... talking about a particular instance, #00:14:07-3#

KZ Uhm. #00:14:07-6#

INT ehm... and it was very, very traumatic, it can be, what they say can be very confused. #00:14:11-3#

KZ Uhm. #00:14:11-7#

INT And, you, you actually don't know what they said. You know? Or you're not clear that's what they said. #00:14:16-4#

KZ [Uhm.] #00:14:16-5#

INT So... **It's, maybe they're saying... they've lost two children or they've lost six children.** #00:14:20-5#

KZ [Mmm.] #00:14:20-5#

Subsequently, details of a narrative originally told by a female client, who had lost her family, emerged (#00:14:20-5# - #00:14:32-6#). It is here that the distance is created as if generalising the phenomenon in the third person plural. This would lead us to believe that such a retelling by a client is not an isolated incident and that the client's stories are sometimes incoherent. This issues of the situational significance of the client's narrative is further discussed in section 4.2.2.

INT Or... **But in fact... Sometimes what they mean is... They lost two, there are four still alive, but not here with them.** #00:14:28-6#

KZ Uhm. #00:14:29-2#

INT **But they... say I've lost all six. But that doesn't mean all six are dead.** #00:14:32-6#

KZ Ok. #00:14:32-9#

Only a few exchanges later, the INT reproduced a very short version of the narrative, in a "clean" version, as if for the therapist's sake. Once again, the story begins with another evaluation (Labov 1972 pp263-264) on the subject of confusing narratives (#00:14:37-4#). In reply to my probing (#00:14:46-9#), the INT produced an abstract (Labov 1972 p263) in the first person singular (#00:15:01-3#).

INT And so... I do', I'm sure you've had that experience as well. Sometimes they can be very confusing. #00:14:37-4#

KZ Uhm. #00:14:37-9#

INT Ehm... So when it is, I clarify it with them. Just to make sure I got correct what they're saying. #00:14:42-6#

KZ And do you... reflect that confusion in your interpreting? #00:14:46-9#

INT When I'm saying it back? #00:14:48-8#

KZ Yeah. #00:14:49-2#

INT No, usually what I do... So let's say you say... #00:14:52-0#

KZ Uhm. #00:14:52-4#

INT **You know, I have six children and... I've lost six children and my husband and they shot me and they knocked me down.** Some of the stuff that comes out is very confused. It depends on what's coming out. #00:15:01-3#

KZ Uhm. #00:15:01-8#

This is significant as generally community interpreters are trained to interpret the primary speakers' utterances in the first person singular. In mental health interpreting (MHI) this may not always be suitable, especially if the client's speech is very confused (Pollard 1998 pp87-98). This abstract, however, occurred in the context of a research interview and signalled that the INT had possibly internalised the client's story. In addition to general narrative practices, this may well be the consequence of mild secondary traumatisation, especially considering that the INT repeated the same story a number of times during the interview. Therefore, this abstract does not truly reflect how the INT would handle the interpreting of narratives in actual interpreter-mediated encounters. In other words, we cannot draw the conclusion that the INT interpreted the original in the first person singular as well.

However, what follows from here sheds more light on the INT's practices. Once again, she repeated the evaluative statement on how confusing clients' stories can be (#00:15:04-7#), which, by this stage, had almost become a refrain. Then she recreated the process of a question-and-answer session between the client and the

INT (#00:15:16-0# - #00:15:54-0#). The most significant aspect of this re-enaction is not that the INT plays both their own and the client's role in direct speech mode, but that all their questions are closed ones with yes-or-no replies requested (#00:15:32-4#, #00:15:40-1#, #00:15:48-0#). In terms of narrative construction, this can be considered quite restrictive, as the INT determines the course of questioning and limits the flow of narrative. It is clear that in the case the INT referred to during the interview, all this happened with the approval of the professional (#00:15:26-4#). If the interpreter and the mental health professional agree to such practices regarding the control over the evolving narrative, there seems to be consensus between them.

> INT But it really can be very confusing. You don't how many people they're talking about? #00:15:04-7#
>
> KZ Uhm. #00:15:05-2#
>
> INT You don't know if it was their house, you know. So... ehm... I say... ehm... Can I ask you a couple of questions, just so, I just need to clarify what you're talking about that happened on the {date}. Very often #00:15:16-0#
>
> KZ [Uhm.] #00:15:16-5#
>
> INT dates matter a lot. {date}. So I say to the, the... therapist. I just want to clarify a couple of things here, because it's not fully clear. #00:15:24-1#
>
> KZ Uhm. #00:15:24-5#
>
> INT They say, Go ahead. An' so then I'll ask... #00:15:26-4#
>
> [silence] #00:15:27-7#
>
> Was that in {year} that that happened? Or was that the incident that happened in {year} that you were referring to? #00:15:32-4#
>
> KZ Ok. #00:15:33-0#
>
> INT I'll ask them. They'll s', Oh, no, that was {year}. Ok. And did your husband move with you to {country}? Yes, he did. #00:15:40-1#
>
> KZ Ok. #00:15:40-6#
>
> INT Ok. Alright, that's fine. And did you say your daughter came also at that time? Is your still in {country}. [???] #00:15:48-0#
>
> KZ [So...] #00:15:48-4#
>
> INT And then, I would go back, right, **my dau', With my daughter I moved to {country}, and so on.** [That'] #00:15:53-0#
>
> KZ [Yeah.] #00:15:52-9#
>
> INT Yeah. [Ok.] #00:15:54-0#

At the end of this extract, the INT summarised (Labov 1972 p264) the events in a turn which was once again the enactment of what she had said to the mental health professional during the interpreter-mediated encounter (#00:15:53-0#). While the utterance is in the first person singular like in the abstract before (#00:15:01-3#), and thus almost frames the narrative within the interview, this time it reflects the INT's performance. It shows how the complexity of the client's confused story is practically lost for the mental health professional.

The next time the bereaved woman's narrative emerged during the interview, it was again prompted by the INT, who offered to give an example of an incoherent narrative. Apparently, the INT was unaware of the repetition and produced the narrative as if on a first account. It is clear from her retelling that she realised that the client's story was very likely muddled up, both in a chronological and in a factual sense. She took the initiative, consulted the mental health professional and went on to clarify the events which had led to the client's trauma. A number of exchanges took place between the client and the interpreter, who subsequently reconstructed the client's narrative. The interpreter claims that she did so quite consciously, and in order to save time and effort. Arguably, this is in the interest of the client, who could suffer from re-traumatisation if repeatedly questioned about the horrific events. Once again, references to the actual story are highlighted in **bold** within the interview transcript.

INT I can. I remember one specific example #00:30:46-1#

KZ [Ok] #00:30:45-9#

INT of a lady who... ehm... **She... she told a story... that ehm...** #00:30:51-0#

KZ Uhm. #00:30:50-9#

INT **her husband...** #00:30:53-1#

[silence] #00:30:54-6#

eh.. i', i', it seemed as if the story was that her hus', that eh, ehm... #00:30:59-6#

[silence] #00:31:00-4#

militia men came to her home, #00:31:01-5#

KZ Uhm. #00:31:02-0#

INT **broke into the house...** #00:31:03-2#

[silence] #00:31:04-3#

shot her husband... her son, her four children, and she was scooted out the back from [???]. And... #00:31:11-4#

[silence] #00:31:12-6#

her family, paid money... to get her out of the country, and she ended up in Ireland. #00:31:16-9#

KZ Uhm. #00:31:17-4#

INT **And as she continued to tell the story, and she was telling it...** #00:31:22-3#

[an acquaintance arrived, the interview went off the record for a while]

It is interesting to note that this was the only instance during the research interview when the narrative embedded in the INT's account developed in a perfect Labovian structure (1972 pp262-275) including: an abstract (the summary of events #00:30:51-0#); an orientation (the time, place and situation of the narrative #00:30:59-6#); a complicating action (the narrative *per se* #00:31:01-5#); an evaluation (the narrator's comments #00:31:22-3#); until the story was interrupted by the arrival of an acquaintance which left the resolution (the end of the story) and the coda (the return to the present perspective) for a following retelling. It is also noteworthy that the story is recounted in the third person and is introduced by a reporting verb. Thus, the factual account reflects the horror of the events, but not the dysfluent speech and horrified state of the client.

However, if the INT's intention was to cater for the mental health professional, such a linguistic device would be in line with Bot's findings (2005b). Bot argues that change in linguistic perspective, that is recounting the primary speaker's words in the first person introduced by a reporting verb or in indirect speech altogether in the third person, does not necessarily take away from the discourse value of the intended message. Coming from a psychology background, Bot's main focus of interest is clearly the effectiveness of therapeutic communication. If we take into account that the INT had the client's interest at heart by not wanting to expose them to re-traumatisation as well as the mental health professional's benefit by presenting them with a coherent narrative, this version of the story is an example of consensually co-constructed narrative within an interpreter-mediated mental health encounter.

On the other hand, from an interpreting point of view, this means that the mental health professional never got to hear the full story as told by the client, they never experienced the narrative at first hand. While the INT asked the mental health professional's permission to clarify certain aspects of the story, she did not seem to

have conveyed the extent of confusion in the client's narrative. The mental health professional's control over the situation, thus, was restricted, as was that of the client's.

The previously quoted excerpt ended abruptly because the INT asked for the interview to go off record. An acquaintance arrived, apparently someone whom they may have interpreted for in a sensitive situation. The next excerpt begins where recordings recommenced, and the INT was trying to recollect her argument (#00:00:06-4#) and picked up the thread of narrative where she had left it (#00:00:16-9#). Then she continued with points of clarification to the original narrative and provided further details of the events (#00:01:28-8#). The entire narrative was recounted in a clear third person singular form with the distance of an interpreter and the analytical and organisational mind of an outsider.

> INT Now, where are we goin'? |#00:00:06-4#
>
> [silence] #00:00:07-2#
>
> KZ So... #00:00:07-4#
>
> INT The example, #00:00:07-9#
>
> KZ [Yeah, yeah, yeah.] #00:00:08-3#
>
> INT whose stuff they're [???]. Ehm, ehm... so, that would be... So, for, anyway... I', i', is she, eh, eh, actually, she was, she, she told all us that very, very quickly. #00:00:16-9#
>
> KZ [Uhm.] #00:00:17-3#

Although it is clear that such a second hand account cannot be analysed as if it were a transcript of a recorded interpreter-mediated encounter, it is significant that this account has achieved a high level of poetic abstraction.

> INT [But also,] very, very quickly, but also marriage was actually, that no... **her husband... had been taken from her... at least ten years before that.** #00:00:26-5#
>
> KZ Uhm. #00:00:27-5#
>
> INT **They didn't kill her husband in front of her that night.** #00:00:30-0#
>
> KZ [Uhm.] #00:00:30-4#
>
> INT **[Her hus]ban had actually been imprisoned ten years earlier.** #00:00:32-7#
>
> KZ [Uhm.] #00:00:33-6#
>
> INT **[And that] was why... her husband imprison', he was, her husband was**

gone ten years beforehand. #00:00:37-4#

KZ Uhm. #00:00:38-0#

INT **Her son was killed that night. One son.** #00:00:39-9#

KZ Uhm. #00:00:40-2#

INT **But five of her children and her, all of them, were secreted out... by her family.** #00:00:45-8#

KZ [Uhm.] #00:00:46-9#

INT **[They] shot her son in front of her. Not her husband. Ehm... And not her other children. All of them were secreted out of the house...** #00:00:53-5#

[silence] #00:00:54-9#

They got her to Ireland. And her five children, ehm, Red Cross search is out of all five children. #00:00:59-9#

KZ [Uhm.] #00:01:00-7#

INT **[And...] there's no sign of the children, there was no sign of the children as of the last time I met the lady. [???] months ago.** #00:01:05-6#

KZ [Ok.] #00:01:06-5#

INT [Ehm...] So... I don't know what they call those things. International... You know. Anyway. #00:01:10-6#

KZ [Yeah, yeah, yeah.] #00:01:10-9#

INT [A missing person...] [In fact.] #00:01:11-5#

KZ [Yeah, yeah.] #00:01:12-3#

INT **The five children are somewhere in her home country, or somewhere else. She's no idea where. They got separated. And she got to Ireland, and the five kids are... somewhere in the world. Or [???]** #00:01:20-8#

KZ Uhm. #00:01:21-5#

INT **And the searches that are out on them, there have been two searches put out on them now so far, she's that long, and she's in {county in Ireland}.** #00:01:26-2#

KZ [Uhm.] #00:01:26-7#

INT **[In the] reception centre. And, so...** #00:01:28-8#

[silence] #00:01:30-2#

As the woman, she told her whole sto', she all of this in the first kind of... fifteen-twenty minutes, of... her very first session. And eh... She... #00:01:38-0#

[silence] #00:01:39-2#

So... #00:01:39-3#

As a consequence, it is more open to a type of narrative analysis proposed by Gee (1986), rather than the classical structural narrative analysis proposed by Labov (1972) (see also Riessman 2002, 2004, 2008). This retelling resembles a ballad, with constant repetition of the themes, such as (1) the husband's predicament, whether he was (1a) killed or (1b) imprisoned, or (1c) how long before the retelling this story had taken place; (2) the number of children killed or in danger, (2a) with one being shot on the night in question and (2b) the others having escaped; (3a) the client's escape as well as (3b) arrival and stay in Ireland; (4a) the international search for the children; (4b) the unknown place of residence of the children; (4c) the client's separation from her children – a probably cause of her confusion and trauma.

Thus, the first stanza unravels the mystery surrounding the client's husband.

(1) but also marriage was actually, that no... (#00:00:26-5#)

(1) her husband... had been taken from her... (#00:00:26-5#)

(1c) at least ten years before that. (#00:00:26-5#)

(1a) They didn't kill her husband in front of her that night. (#00:00:30-0#)

(1b) [Her hus]band had actually been imprisoned (#00:00:32-7#)

(1c) ten years earlier. (#00:00:32-7#)

[And that] was why... (#00:00:37-4#)

(1b) her husband imprison', (#00:00:37-4#)

(1c) he was, her husband was gone ten years beforehand. (#00:00:37-4#)

The second clearly identifiable passage follows the children's plight.

(2a) Her son was killed that night. (#00:00:39-9#)

(2a) One son. (#00:00:39-9#)

(2b) But five of her children (#00:00:45-8#)

(3a) and her, (#00:00:45-8#)

(2b/3a) all of them, were secreted out... by her family. (#00:00:45-8#)

(2a) [They] shot her son in front of her. (#00:00:53-5#)

There are repeated references to the husband…

(1a) Not her husband. (#00:00:53-5#)

… and again to the children.

(2b) Ehm... And not her other children. (#00:00:53-5#)

(2b/3a) All of them were secreted out of the house... (#00:00:53-5#)

The client's own escape features briefly, almost as a refrain.

(3b) They got her to Ireland. (#00:00:53-5#)

The next stanza offers further explanation of the family's separation.

(4a) And her five children, ehm, (#00:00:59-9#)

(4a) Red Cross search is out on all five children. (#00:00:59-9#)

(4b) [And...] there's no sign of the children, (#00:01:05-6#)

(4b) there was no sign of the children as of the last time I met the lady. [???] months ago. (#00:01:05-6#)

(4b) The five children are somewhere in her home country, (#00:01:20-8#)

(4b) or somewhere else. (#00:01:20-8#)

(4b) She's no idea where. (#00:01:20-8#)

(4c) They got separated. (#00:01:20-8#)

Once again, the client's own story appears as a refrain.

(3b) And she got to Ireland, (#00:01:20-8#)

The children's fate seems to be the principal preoccupation.

(4b) and the five kids are... somewhere in the world. (#00:01:20-8#)

(4a) And the searches that are out on them, (#00:01:26-2#)

(4a) there have been two searches put out on them now so far, (#00:01:26-2#)

The story finishes with the refrain from the client's own story.

(3b) she's that long, and she's in {county in Ireland}. (#00:01:26-2#)

(3b) [In the] reception centre. (#00:01:28-8#)

In the closing excerpt quoted here, the INT gives a final evaluation and gives further justification for her attempts to clarify the narrative (#00:04:15-8# and #00:04:29-2#). It is apparent from the following extract that the INT had the best

intentions to facilitate the mental health professional in understanding the client's narrative and to empower the client in voicing their story (#00:04:20-1#).

> INT12 Ehm... So her way of working... If she's not even actually all that interested... #00:04:11-4#
>
> KZ Uhm. #00:04:12-0#
>
> INT12 in the narrative, actually. #00:04:12-8#
>
> KZ Uhm. #00:04:13-3#
>
> INT12 She's no'. But the only reason I would want to clarify it, #00:04:15-8#
>
> KZ [Uhm.] #00:04:16-2#
>
> INT12 [it's] because... **it's a... deeply hurtful thing... to have all six of your children dead**. #00:04:20-1#
>
> KZ [Mmm.] #00:04:20-6#
>
> INT12 [And] somebody **thinks some of them're alive. Or to have five of your children alive and one of them dead, and somebody thinks...** 'Cause at some stage [later] #00:04:25-8#
>
> KZ [Mmm.] #00:04:26-1#
>
> INT12 in the therapy... it will become clear if I've got that wrong. #00:04:29-2#
>
> KZ Uhm. #00:04:29-7#

Once again, it needs to be emphasised that stories recounted in an interview about community interpreting cannot substitute data for close analysis of recorded interpreter-mediated encounters. The number of recurrences of the same story within the same interview and the manner in which they were repeated, however, suggests that stories do resurface in different versions and that the interpreter becomes as much of a storyteller as the primary speaker. Thus, the brief analysis of the fascinating excerpts confirmed my interest in how narratives are actually interpreted. In addition, it pointed to areas of further investigation which I chose to explore in the following analysis chapters. These include the significance of narratives and the accuracy of their interpreting in MHI, the control of communication within interpreter-mediated encounters, and issues surrounding safety. So, following this brief interlogue, we can now proceed to the analysis *per se*.

4.1. Introduction

The current chapter aims to investigate how the matter of interpreting narratives in mental health care (MHC) is perceived in Ireland. Based on the research claim that narratives in mental health interpreting (MHI) in Ireland are consensually co-constructed, it examines the repondents' views on the significance of narratives and the accuracy of interpreting as well as related training issues.

Level of narrative:	Story
Subject of analysis:	Perceptions around narratives and accuracy
Practical issues:	Training
Stories supporting analysis:	Stories told by the clients
Internal research dialogue:	Interpreters and Mental Health Professionals

Table 4.1. The organisation of Chapter 4

As the chapter outline in Table 4.1. suggests, this first data evaluation chapter focuses on the original interest of the current study, that is, the story level of narrative. The pre-defined interview theme on the cultural and situational significance of narratives will come to the fore. This is essential as the story, the smallest level of narrative organisation, is considered a pragmatic unit of communication within the current framework of study. Perceptions around the accuracy of interpreting, that is the faithful transfer of the intended message, will also receive attention. Finally, the respondents' views on related issues of training will be discussed. The chapter presents findings as a research dialogue between the two groups of respondents, twelve interpreters (INT) who have experience interpreting in MHC, and eleven mental health professionals (MHP) who have experience working with interpreters. In addition, the analysis is supported by *stories by clients* throughout the chapter, typographically marked in text boxes.

4.2. INTs' and MHPs' Awareness of the Cultural and Situational Significance of Narratives

For the purposes of the current study on the co-construction of interpreter-mediated encounters in MHC in Ireland, stories are considered important both from a cultural and a situational point of view. As discussed in Chapters 2 and 3, empirical evidence seems to suggest that, on the one hand, narratives and their disrupted organisation is significant in MHC (Ochs and Capps 1996; White and Epston 1990), on the other,

there are apparent differences across cultures in their ways of storytelling (Chafe 1980a, 1980b; Clancy 1980; Downing 1980; Du Bois 1980; Tannen 1980). Therefore, it would follow that in order to relate these linguistic and cultural variations in formulating narratives, interpreters would need to be aware of their existence and the problems they can present during an interpreting situation. Once aware, interpreters could find pragmatic equivalents to convey them or would be able to signal these cultural differences to the user, here the mental health professional. In the current study, the importance of how narratives are constructed within a MHC framework is referred to as "the situational significance of narratives", while the divergence of narrative styles across cultures is what is termed the "cultural significance of narratives".

   As these concepts would be too abstract to elicit natural answers during the interviews, the questions were phrased in a more accessible manner. They were also posited within the professional framework of the respondents, therefore, INTs were mostly asked about the cultural significance and differences in narratives. For example, the subject was brought up in an extended closed-type question, as in the following extract,

> KZ Yeah, yeah, yeah. And [???] And the other thing I meant to ask is ehm... #00:28:50-3#
>
> [silence] #00:28:52-1#
>
> eh... #00:28:52-5#
>
> [silence] #00:28:53-2#
>
> How, I don't know how familiar you're with... stories in different cultures, but {country of origin} definitely. #00:28:58-3#
>
> INT7 [coughs] #00:28:58-8#
>
> KZ Are stories told the same way, or similarly, or differently? #00:29:03-0#

or in an open-ended question, which is a characteristic of semi-structured interviews. As seen here, the questions were sometimes rephrased, a technique also suggested by Mishler (1986 pp52-65).

> KZ Ehm... something totally different. How... How important do you think stories are in {country of origin} culture? Stories or story-telling. Or... #00:20:47-7#
>
> INT11 [Uhm.] #00:20:47-8#
>
> KZ [How] people... relate to stories, or how they tell what's happening to them? Or...

How important or ho', or is it different from Ireland? Or is it similar to Ireland? #00:20:59-1#

INT11 Storytelling? #00:20:59-7#

KZ Uhm. #00:21:00-4#

On the other hand, MHPs were invited to talk about the situational significance of narratives. As Mishler suggests, meaning is jointly constructed in research interviews, and discourse develops "between the interviewer and respondent as they try to make continuing sense of what they are saying to each other" (1986 p54). This can be clearly observed in the following example, where a question posed in an unbiased manner is not only rephrased by the MHP, but it is also reframed within MHP's own professional paradigm as well as within the narrative research framework (#00:09:01-8#).

KZ Ok. And, eh, b, I've asked you already #00:08:38-8#

OT1 [Uhm.] #00:08:39-0#

KZ [if] oral... eh, communication was important, or... verbal communication. #00:08:45-1#

[paper noise in the background] #00:08:45-3#

OT1 [Vital.] Vital, absolutely. In this job, anyway. #00:08:48-1#

KZ Yeah. And, ehm.. How important are stories in your area? So not necessarily psychiatry or [not for] #00:08:54-8#

OT1 [Uhm.] #00:08:54-9#

KZ a psychiatrist. But for you as an occupational therapist. Do they mean anything? Or... #00:08:59-5#

OT1 You mean somebody's, somebody's own narrative? [Or] #00:09:01-8#

KZ [Yeah.] #00:09:01-8#

OT1 personal story? #00:09:02-6#

KZ [Yeah, yeah, yeah.] #00:09:03-1#

This re-moval of a deliberately discipline-neutral phrasing to the more abstract level of the researcher's plane was more prevalent among the MHPs than among the INTs. This already signalled an awareness of narrative issues among the respondent MHPs, which will be discussed in the following sections investigating the levels of awareness regarding the cultural and situational significance of narratives and their adequate rendition.

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4.2.1. The respondents' views on the cultural significance of narratives

Interviews with the two groups of professionals yielded comparable but diverse results on the predefined interview theme of the significance of narratives. As far as cultural significance, that is the divergence of narrative styles across cultures, is concerned, the distribution of the number of respondents commenting on the topic is 27 references by INTs and 17 by MHPs, as displayed in Table 4.2. The table shows the nodes under which the respondents' views have been coded in the dialogic coding process presented in section 3.7. The themes, and therefore the node names, emerged from the respondents, and each theme constitutes a pair of nodes, depending on whether the participant brought up the subject themselves (e.g. the "circular" nature of some narratives) or whether the idea was prompted by the researcher (e.g. suggesting that narratives are sometimes constructed in a "circular KZ" manner). The figures refer to the number of times each theme was mentioned during the interviews.

	INTs	MHPs
Circular	1	0
circular KZ	0	1
cultural phenomena	7	5
cultural phenomena KZ	1	0
culture-specific	4	3
culture-specific KZ	3	1
Details	2	1
details KZ	0	0
Dramatisation	0	2
dramatisation KZ	0	0
explicit - implicit	1	1
explicit - implicit KZ	0	0
individuality	2	1
individuallity KZ	0	0
lack of stories	2	0
lack of stories KZ	0	0
memory	0	0
memory KZ	0	0
particular subject	2	1
particular subject KZ	0	0
stories as archetypes	1	1
stories as archetypes KZ	0	0
time and place	1	0
time and place KZ	0	0
Total:	**27**	**17**

Table 4.2. The number of references to "the cultural significance of narratives" by MHPs and INTs

4.2.1.1. INTs' views on the cultural significance of narrative differences

A narrative thematic reading of the data reveals that INTs showed awareness of cultural differences and pointed out a few examples with regard to stories, such as the symbolic representation of reality among Sub-Saharan Africans (INT8, INT12). Another INT commented on the lack of detail in Arab clients' descriptions of events (#00:08:31-4#). The sequential number referring to the interpreter has been removed from the following extract, as the corresponding information in other sections of the dissertation could lead to their identification.

INT I find that, because of... Arabics are very conservative. #00:08:20-3#

KZ Uhm. #00:08:20-8#

INT So then they're tell telling their stories, they don't express themselves

#00:08:24-3#

KZ [Uhm.] #00:08:24-6#

INT really well. They don't get... eh... like, if you ask anybody how they're tortured, #00:08:29-6#

KZ Uhm. #00:08:30-1#

INT they wouldn't go into details. #00:08:31-4#

KZ Uhm. #00:08:31-8#

INT you know what I mean. Eh... But in... #00:08:34-3#

[silence] #00:08:36-2#

you know like to help them, you have to go... with #00:08:38-3#

KZ Uhm. #00:08:38-9#

INT actually... ehm... to get it out of them, it's very difficult. It takes time. #00:08:42-9#

KZ [Uhm.] #00:08:43-3#

INT Especially Arabic people. #00:08:43-7#

KZ [Uhm.] #00:08:44-4#

INT [I don't] I don't know about other nationalities. #00:08:46-3#

INTs working with European clients, on the other hand, claimed that storytelling was essentially the same across the cultures of which they have experience. Perhaps the only difference mentioned is that in Ireland only the elderly are inclined to tell stories (INT11). One INT commented that in Poland most stories trace their origins back to WWII, as seen in the following passage. Once again, the sequential number has been removed for reasons of confidentiality.

INT Eh... #00:21:07-9#

[silence] #00:21:11-8#

Like I think there would be eh... #00:21:13-6#

[silence] #00:21:14-7#

INT there would be a... a.. #00:21:16-2#

[silence] #00:21:17-3#

INT11 certain a... #00:21:18-3#

[silence] #00:21:19-3#

INT I don't know. A certain ehm... #00:21:22-0#

[silence] #00:21:27-1#

pattern... as far as storytelling is concerned. Eh... If I were to begin with anything that would be the war. And all the stor', stories that have to with, with war, with the war. #00:21:39-7#

On a number of occasions, the question concerning culture-dependent narrative differences prompted answers regarding cultural and linguistic differences, and did not relate to the actual organisation of stories. According to the INTs interviewed, for example, there is no clear equivalent of the distinction between brother and cousin in Chinese; or that the expression "black" [negrinho] actually denotes mestizo in Brazilian Portuguese. The same interpreter explained that "married" may refer to common-law partnership in certain contexts (#00:19:08-6#). Similarly to the examples listed above, the passage appears without the identifying sequential number of the INT.

Ehm... if you always relate to... to your family, or to... the person who... say would... I suppose, ehm... the fam... it's differen'... the differen' for example, in Brazil, ehm... when you, you use the word marriage... but, but, for example, my husband, I'm married to this person, you use this word for somebody who... perhaps you're not... in, legally married [to] #00:19:08-6#

KZ [Uhm.] #00:19:08-7#

INT But... you say, your life's... second [?], and that's the word we use in Portuguese. #00:19:13-7#

KZ [Uhm.] #00:19:14-1#

INT casado, casado means that you're... like. Now, this is... not the same... in Ireland. Because... when... somebody questions you and say, Are you married to this person and you say yes, and they check your passport, and basically you're not married to this person #00:19:27-8#

KZ [Uhm.] #00:19:27-8#

INT there's a type of misunderstanding. #00:19:29-5#

KZ [Uhm.] #00:19:30-0#

INT But that means that... this is... are you lyin'? I'... #00:19:34-4#

KZ [Uhm.] #00:19:34-7#

INT An', and this is to do with the... the culture, because they use... that's what the people... say... Not [e]specifically married, but the word married means... that you are... you're married means that you're, you share this life. This is, #00:19:48-2#

KZ [Uhm.] #00:19:48-9#

> INT is you', like your partner. Ehm... happen all', I mean, misunderstanding sometimes. #00:19:53-9#

Other INTs commented that Roma react more emotionally to certain situations than the settled population in certain Eastern-European countries, and that they relate to child-rearing differently (#00:03:52-5#), too, as the following extract illustrates.

> INT Ehm... No, it's, it's never the men who looked after the children. So it's always the women. #00:03:26-2#

> KZ [Uhm.] #00:03:26-9#

> INT Or... unfortunately... the daughter, you know. The ten, eleven, twelve year old daughter. #00:03:33-6#

> KZ [Uhm.] #00:03:33-6#

> INT Who, by the way, at twelve they would get married anyway, so #00:03:37-1#

> KZ [Uhm.] #00:03:37-6#

> INT [They'd] be out of the, the house. Eh... But... No, it's, it's not because of that. Because... #00:03:44-4#

> [silence] #00:03:47-6#

> what the parents would value and observe normally in a child, doesn't have much... #00:03:52-5#

> KZ [Uhm.] #00:03:53-4#

> INT [im]portance, you know, in Roma culture. #00:03:55-6#

One INT remarked that cultural practices, such as shaving a baby's head, may be mistaken for some abnormal post-natal depression syndrome in Western societies while accepted elsewhere (INT7 #00:54:41-5#). A few INTs stated that family concepts and communal links are stronger in certain ethnic groups than in their Western counterparts (INT8, INT10, INT12). One INT revealed how the perceived lack of "fala" (or "hazing," as the initiation process which is mostly practised in the armed forces and involves humiliation of rookies is referred to in English) encourages Polish criminals sentenced to imprisonment to opt for incarceration in Ireland rather than in their home country where they fear they would face a harsher initiation into prison life. Such examples confirm that the INTs interviewed are not fully aware of the narrative as an organisational unit of communication. This is significant if the aim of interpreting is to achieve pragmatic equivalence between the source and the target message.

Nevertheless, one INT pointed out structural differences in narrative organisation from work experience in a human rights watchperson capacity in Latin-America. Once again, the sequential number has been removed for reasons of confidentiality in case of cross referencing.

> INT [...] To go back to this... It was very interesting in Guatemala. #00:31:05-3#
>
> [silence] #00:31:07-7#
>
> Even when people spoke Spanish... #00:31:09-3#
>
> [silence] #00:31:10-3#
>
> noticed that they had a different way of... thinking altogether. #00:31:13-7#
>
> KZ Uhm. #00:31:14-2#
>
> INT [coughs] In Guatemala the difference is... there really were, and I noticed it sometimes because of that. They do not have a linear way of telling things. #00:31:22-8#
>
> KZ Uhm. #00:31:23-3#
>
> INT But in Guatemala it was quite definite that they start from... somewhere in the middle, and they... went back an' forth and back an' forth, and you just... thou'... I, I took the... complaint as it were... #00:31:35-8#
>
> [silence] #00:31:37-2#
>
> And then... #00:31:37-9#
>
> [silence] #00:31:39-3#
>
> I had to reconstuct... the narrative of the events. #00:31:42-5#
>
> KZ [Uhm.] #00:31:43-2#
>
> INT [Bec]ause it was not... in a... from A to B to C. There wasn't a chronological... #00:31:47-7#
>
> KZ Uhm. #00:31:48-1#
>
> INT And that was very common in Guatemala. They wouldn't have that kind of linear... #00:31:52-3#
>
> [silence] #00:31:53-7#
>
> way of thinkin' that we have. They kinda want to go around... #00:31:56-4#

The fact that the INT had not given much thought to the story-level of communicative organisation, which is the focus of the current chapter, does not mean that they are unaware of the concept of pragmatic equivalence. They clearly show an understanding of transferring meaning, as seen in section 4.3.

4.2.1.2. MHPs' views on the cultural significance of narrative differences

Similarly to INTs, MHPs often mentioned customs rather than discussing the formation of stories when asked about the cultural significance of narratives. For example, they referred to somatisation as a cultural practice in some parts of Africa, which is different from Western mental health practices (MHN2, PSY1, PSY2, THER2, THER3), as can be seen in the following short passage.

> THER2 But, for example, in some of the African countries, people present them, sometimes are much more inclined to find physical symptoms #00:12:09-0#
>
> KZ Uhm. #00:12:09-2#
>
> THER2 They'd be much more, I think, emotionally open, an', and much more demonstrative, and sometimes would behave in much more dramatic fashion than, you know, make it seem and look a little bit different to how it might look in, in a different, in a different person, eh, from a person from a different culture.

Some MHPs also pointed out that (both male and female) Muslim clients are unable to express experience of sexual violence (MHN1, PSY1, PSY2, THER3). Most of these issues across various cultures were summarised by one MHP, as can be seen in the following extract.

> PSY2 Ehm... let me see... #00:12:15-9#
>
> [silence] #00:12:19-6#
>
> Middle-Eastern peoples [sic] are... are more ehm... geared towards telling you the whole stories with the details and they go through everything. Every time they talk to you, ah, for the men, for example. The women are much more, ehm... they'll tell you stories, but they're much more reserved [???]. They have to build a, a, a rapport. #00:12:44-0#
>
> KZ [Uhm.] #00:12:44-6#
>
> PSY2 [Eh...] The men as well, but the wo, women take longer to build a rapport. The man, the men will tell you stories easier. #00:12:52-1#
>
> KZ Uhm. #00:12:52-8#
>
> PSY2 Ehm... #00:12:54-3#
>
> [silence] #00:12:57-5#
>
> When they build a rapport with you, it will, when it's easier for them to start saying things. But I, I, I don't know, Middle-Eastern peop', I'm thinking about the Iranians, Iraqis. #00:13:07-9#
>
> KZ Uhm. #00:13:08-0#
>
> PSY2 Algerians. They feel more comfortable in... letting you know what happened. It is very difficult to put things together with... in my experience, with Somalian woman,

women, and Sudanese women. #00:13:23-9#

KZ Uhm. #00:13:24-5#

PSY2 They, they don't tell you the story. It's just, ehm... something very ehm... it looks very dramatic. It's just a lot of upset, and a lot of crying and ehm... and you can't... you can't possibly put things together. And it's, it's very somatic. #00:13:46-0#

KZ Uhm. #00:13:46-6#

Once again, references to customs rather than narrative organisation suggest that MHPs, similarly to INTs, are not fully cognisant of the cultural significance of narratives.

4.2.2. The respondents' views on the situational significance of narratives

Apart from cultural differences, divergence in narrative styles may carry significance within the MHC situation, and provide clues as to the client's mental state. Consequently, discrepancies in narratives among migrants whose life has been disrupted have been well documented. These may be induced by displacement alone (see, for example, Barsky 2005; Maryns 2005) or by aggravating circumstances, such as post-traumatic experiences (see, for example, Cohen, 2001; Herlihy et al 2002). The distribution of responses between INTs and MHPs with regard to the situational significance of narratives, that is the understanding of how narratives are constructed within a MHC framework, shows a far more quantifiable difference between the two respondent groups, as displayed in Table 4.3. Once again, as in Table 4.2., the nominations in the first column refer to the node pair based on the emerging themes either brought up by the respondent (e.g. "careful"), or prompted by the researcher (e.g. "careful KZ").

	INTs	MHPs
careful	0	2
careful KZ	0	0
important	1	6
important KZ	1	0
narrative in psychiatry or psychology	0	2
narrative in psychiatry or psychology KZ	1	0
part of diagnosis	0	1
part of diagnosis KZ	0	0
storying lives	0	5
storying lives KZ	0	0
Total:	**3**	**16**

Table 4.3. The number of references to the "situational significance of narratives" by INTs and MHPs

4.2.2.1. INTs' views on the situational significance of narratives

As the figures in Table 4.3. show, MHPs commented on the subject over five times more than INTs, which is a telling result in itself. A narrative thematic analysis of the data in the following sections also confirms these findings. While altogether three INTs commented on the significance of narrative in MHC, only one INT displayed awareness of situational differences in narratives styles.

INT7 People would tell, you know, it's not that they would tell... things essentially differently. It's, you know, you'll always have some details that emerge... that they might think that they were not important but they're important for the legal case. #00:29:26-6#

KZ [Uhm.] #00:29:27-2#

INT7 [And if,] But why you didn't say that before? #00:29:28-5#

KZ [Uhm.] #00:29:28-9#

INT7 [Well,] but I didn't think it was important. #00:29:30-2#

KZ [Uhm.] #00:29:30-5#

INT7 Or even disclose your some... traumatic events, you wouldn't have been... at the first meeting #00:29:37-4#

KZ Uhm. #00:29:37-2#

INT7 it would take a while before it comes out, you know. #00:29:40-1#

KZ Yeah. #00:29:40-6#

Furthermore, INT7 pointed to the role of power relations and how authoritative narratives are often superimposed on subjugated discourses. The INT's attention to such subtleties may arise from her background as a case worker in refugee appeals procedures.

> INT7 Some of the asylum seekers may have a different way of... inventing as well. And again that's in a linear way. So basically... what you were doing really was posing... #00:32:40-3#
>
> [silence] #00:32:42-5#
>
> the narrative of the legal process onto what they... they were saying, because you know... you knew what they were gonna ask you. #00:32:48-8#
>
> KZ Uhm. #00:32:49-3#
>
> INT7 There are some things they want to know. #00:32:51-1#
>
> [silence] #00:32:52-0#
>
> You know. They have things that has to ma', you know. Then you essentially have to say to them... You have to make sense of your story the way we would understand it. #00:33:00-6#
>
> KZ Uhm. #00:33:01-1#
>
> INT7 Because that's the only way that you get a chance. D'you know what [I mean?] #00:33:04-9#

Another INT commented on the differences in opportunities for the client's story to evolve. INT8 explained that during the initial assessment at the Centre for the Care of Sufferers of Torture run by Spirasi, the client is restricted to providing factual information and is often halted in his or her attempts to tell his or her story. Therapeutic sessions, however, allow for such communicative expression of the client's behalf. As seen in the extract, in the case of more administrative-type encounters, interpreters may have to act as a buffer in a more conflictual situation, where the client is trying to tell their story, and the MHP is trying to gather data. In therapeutic encounters, on the other hand, time allows for a more consensual co-constructive activity. The consequences of such conflict is examined in relation to the discourse level of interpreter-mediated encounters in Chapter 5.

> INT8 In Spirasi, sometimes, you have to go to the point... in medical assessments. #00:20:36-2#
>
> KZ Yeah. Yeah, yeah, yeah. #00:20:37-2#
>
> INT8 But they don't... just the client can't. [laughs] You know it's in their... some, sometimes, there's a bit of a tension there. Because they won't. They have to tell the

whole story. So the doctor gets a bit unease [sic] sometimes. And you're there in the middle. [laughs] #00:20:55-5#

KZ And what do you do then? [smiling] #00:20:56-6#

INT8 [laughs] #00:20:57-5#

KZ Like when you're... #00:20:57-9#

INT8 Breath deeply. [laughs] #00:21:00-2#

KZ So wh', for instance, when you do a medico-legal re', they're doing a medico-legal... assessment, #00:21:04-5#

INT8 Yeah. #00:21:05-0#

KZ report. Yeah. #00:21:05-7#

INT8 Usually it's not a medical legal report, because medical legal report, it has to be very thorough. #00:21:11-7#

KZ Yeah. #00:21:12-4#

INT8 So they have to tell the story with every detail. But, eh, the first time they go to Spirasi, they do like a medical assessment. #00:21:19-1#

KZ Uhm. #00:21:19-4#

INT8 Which assess what... services, eh... they should, eh... get. And that's done, it's an hour. #00:21:27-1#

KZ Uhm. #00:21:28-1#

INT8 Usually. And, eh... they're not meant to say the whole story. Just few bits, so the doctor... can point them, point them out to their services which are more suitable. But they go on and they think it's an interview again. So they go on an' tell details. And sometimes the doctor may get a bit... eh... tense. [laughs] #00:21:50-2#

While INT7 and INT8's understanding of the social construction of narratives at the story level is exemplary. Ideally, all interpreters should be aware of this organisational level of communication in addition to their knowledge of meaning transfer at a level higher than that of the word, as discussed in section 4.3.

4.2.2.2. MHPs' views on the situational significance of narratives

In comparison to INTs, MHPs showed a higher awareness of the situational significance of narratives. Some of them confirmed the researcher's initial assumption based on the literature that in MHC narratives are an integral part of both diagnosis and treatment. In the following extract, the respondent MHP mentions both of these aspects.

THER4 Ehm... and... ultimately, I s'pose... a belief I would hold. Not profe', you know, it's not held by every member of my profession, would be very often when people have been... damaged or traumatised, that very often the story remains unfinished. #00:34:58-3#

KZ [Uhm.] #00:34:58-8#

THER4 That even though they were abused... ten years ago... that story hasn't ended. They're still in exile, they're still upset, they're still distraught, and there's no real closure. #00:35:12-4#

KZ [Uhm.] #00:35:12-9#

THER4 So, that kinda personal narrative... therapeutically, you would understand for the symptoms to be relieved... if for them to have a face... conclusion to that narrative. It's the safe starting point for the rest of their life. #00:35:29-2#

KZ [Uhm.] #00:35:29-6#

A prime example of such positive narrative is a *story by a client* about their locality of origin, which the MHP decoded in a Biblical metaphor.

THER1 For example, the, the, the, the, one lad who's extremely... made a number of suicide attempts. And over the last several weeks we've gotten him into talking about his home town. And he comes from a, a, a, a, a, a, a, a, a, a, an agricultural area, I won't give you the, the bio... #00:06:46-3#

KZ No, no, no, no, don't, don't. [speaking over each other] #00:06:47-4#

THER1 But he's like, his eyes light up, you see. #00:06:51-1#

KZ Hmm. #00:06:51-7#

THER1 and his smile's very strong, and he talks about this agricultural area, and it's like a, it's like, you know, in, in, in Biblical terms the garden of Eden or a paradise. #00:07:02-9#

KZ Oh-kay. #00:07:03-0#

THER1 And he fills, his whole body fills up with that. So, we have been, and, and he's begin to talk about now his friendships, young with and his old friends, now that's a bit more difficult, he gets, he gets sad then, because of what happened. #00:07:19-9#

KZ Hmm. #00:07:20-3#

THER1 But those stories are very enhancing, very enriching, and very resourceful, and resourcing to the client. And, yeah, love to hear those. #00:07:31-9#

There are two interesting trends among the MHP responses with regard to the situational significance of narratives. These tendencies are displayed in Tables 4.4. and 4.5., where the first column indicates the pair nodes denoting themes whether brought up by the respondents (e.g. "careful") or prompted by the researcher (e.g.

"careful KZ") during the narrative interviews. Firstly, Table 4.4. shows that three quarters of the responses on the subject came from MHPs working in specialised services, while only one quarter represents those working in mainstream hospital settings. Considering that the latter group is in a slight majority of 6 to 5 compared to the former category, this constitutes a noteworthy result. It is difficult to determine whether these professionals are more aware of narrative issues because they work with immigrants or they work with immigrants because they subscribe to such views. This may also be due to the differences in their training background in theoretical approaches, but such considerations are outside the scope of the current study.

	mainstream	specialised
careful	0	2
careful KZ	0	0
important	2	4
important KZ	0	0
narrative in psychiatry or psychology	1	1
narrative in psychiatry or psychology KZ	0	0
part of diagnosis	0	1
part of diagnosis KZ	0	0
storying lives	1	4
storying lives KZ	0	0
Total:	**4**	**12**

Table 4.4. The number of references to the "situational significance of narratives" by MHPs with regard to their institutional background

The other important finding is that an overwhelming majority of those who commented on the subject come from a "therapeutic" rather than a "logistical" background, as presented in Table 4.5. This means that, even though all the pre-identified research themes were put to all the respondents, occupational therapists, psychologists and therapists, who are involved in therapy *per se*, commented on the narrative significance fifteen times more often than mental health nurses, who mostly provide logistical services.

114

	Logistics	therapy
careful	0	2
careful KZ	0	0
important	1	5
important KZ	0	0
narrative in psychiatry or psychology	0	2
narrative in psychiatry or psychology KZ	0	0
part of diagnosis	0	1
part of diagnosis KZ	0	0
storying lives	0	5
storying lives KZ	0	0
Total:	**1**	**15**

Table 4.5. The number of references to the "situational significance of narratives" by MHPs with regard to their types of services

Although the numbers only represent instances and do not reveal if the respondent in any way subscribes to the use of narratives in their practice, the difference is considerable, if understandable. Those working in logistical services, such as mental health nurses, have very distinct roles from those working in therapeutic services.

The other issue is the matter of operational limitations. MHPs mentioned time as the biggest constraint, which appears to divide mainstream from specialised services as well as therapeutic work from work of a more logistical nature. Time is what separates a "sticky-plaster" [*sic*], meaning quick fix but only short-term solution, (THER4 #00:38:09-7#) and "problem-solving... brief intervention approach" (THER4 #00:39:23-4#), which is characteristic of the mainstream and logistical settings, from "psychological therapies" (THER4 #00:39:23-4#). Consequently, the characteristics of the interaction between the service user and the service provider will differ greatly. Therefore, details on the type of assignment are very important from an interpreter's viewpoint: s/he can prepare not only for the subject but also for the communicative style of the upcoming encounter if given the right information.

In sum, it appears that neither INT nor MHP respondents are fully aware of the combined significance of the organisation of the story across cultures and situations. Since such an understanding is seen as a prerequisite for the harmonious co-construction of the client's story, the research claim has been shown to be unfounded. In other words, with regard to the situational and cultural significance of stories, narratives in MHI in Ireland are not necessarily consensually co-constructed.

4.3. The Respondents' Views on Accuracy

Given the apparent lack of awareness among INTs concerning the narrative content, the question follows as to how efficient interpreting at the narrative level of the story in such situations can be. Since recorded material of actual interpreter-mediated encounters in MHC is unavailable for the current research project, the views of INTs and MHPs on the issues of accuracy provide evidence. While narrative organisation as a pragmatic unit of transfer is not apparent to the INTs interviewed, equivalence at the level of smaller organisational units such as phrases and clauses is more evidently considered desirable. Anecdotal evidence in the current study on misdiagnosis (PSY2), and in the CI literature on misinterpretation of details (Pöchhacker and Kadric 1999), informational loss in medical situations (Cambridge 1999), or miscarriage of justice (Hale 1997a) all sound familiar to the interpreter's ear. The following *story by a client* in support of the thematic narrative analysis is illustrative of such problems.

INT7 Another thing, you know, you've mentioned, you know... eh, I don't know if I mentioned to you a case eh... again about a woman, who had been... #00:40:08-8#

raped, and... [coughs] beaten up in prison, she was. But she developed a person... #00:40:14-9#

KZ Uhm. #00:40:15-5#

INT7 a number of diseases, and she suffered from depression, anyway. But during the appeal she [???] basically the interpreter did not interpret... the right, you know. She, she translated a... #00:40:25-7#

[silence] #00:40:27-2#

the French term "angine" as... angina. #00:40:30-0#

KZ Uhm. #00:40:30-8#

INT7 But she was refused on the basis that... although she was treated for all other com', health complaints, that she wasn't treated for angina, which was quite serious. #00:40:40-8#

KZ Yeah. #00:40:41-2#

INT7 And, as it turned out the woman's angina was "angine," which is eh... you know... #00:40:46-0#

KZ Throat. #00:40:47-1#

INT7 You know, when you have... #00:40:47-2#

KZ Yeah. #00:40:48-0#

INT7 Swallowing... you know like... #00:40:49-0#

KZ Tonsils. [Yeah.] #00:40:49-8#

It is clear from this example that accuracy of interpreting is an issue of great importance and also emerged from the interviews as one of the key interests. Table 4.6. provides a comparative display of the number of instances INTs and MHPs have mentioned issues (e.g. "addition and omission" brought up by the respondent or "addition and omission KZ" if prompted by the researcher) that were subsequently coded under the umbrella term of "accuracy".

	INTs	MHPs
addition and omission	11	7
addition and omission KZ	1	1
asking for clarification	6	1
asking for clarification KZ	0	0
client incoherent	13	1
client incoherent KZ	0	0
client incohesive	6	1
client incohesive KZ	0	0
client register up	7	1
client register up KZ	1	0
client repetition	3	1
client repetition KZ	0	0
explanation or elicitation	12	6
explanation or elicitation KZ	0	0
first person	7	1
first person KZ	0	0
Interpretation	2	8
interpretation KZ	0	0
lost in translation	0	1
lost in translation KZ	0	0
mental health issues	2	0
mental health issues KZ	0	0
non verbal interpreting	2	5
non verbal interpreting KZ	0	0
post factum correction	1	0
post factum correction KZ	0	0
professional register down	9	0
professional register down KZ	1	0
Rearrangement	2	1
rearrangement KZ	1	0
Remarks	1	3
remarks KZ	0	0
Slang	0	3
slang KZ	0	0
speech difficulties	1	0
speech difficulties KZ	0	0
Speed	2	0
speed KZ	0	0
Summary	3	9
summary KZ	1	2
Swearing	1	1
swearing KZ	0	0
Truth	2	1

truth KZ	0	0
unacceptable content	1	3
unacceptable content KZ	0	0
Verbatim	12	12
verbatim KZ	0	0
Total:	**111**	**69**

Table 4.6. The number of references to "accuracy" by INTs and MHPs

Even if we consider that certain passages are coded into multiple nodes within the broader issue of "accuracy," and this would apply to both practitioner groups anyway, the proportion of 111 INT instances compared to 69 MHP instances constitutes a notable difference. The following sections discuss subjects which received the most attention and / or where the discrepancy between the number of references made by INTs and MHPs is the most significant. These subject clusters include "interpretation," verbatim interpreting" and "addition and omission" as well as register-related issues.

4.3.1. The MHPs' concern with accuracy

4.3.1.1. The issue of "interpretation"

Perhaps some of the most telling findings appear when the trends are reversed, and a particular topic, coded under a pair node, shows a higher number of references made by the MHPs than by the INTs. Such an example is the theme of "interpretation," which the MHPs mentioned four times more often than the INTs. The concerned MHPs saw a difference between translation and "straight translation" (THER1 #00:01:31-5#) and interpreting / interpretation and "presenting a cultural bias deliberately" (MHN4 #00:14:43-4#). They also expressed a clear preference for the former, which they apparently communicate to the interpreters with whom they work. This can be seen in the following extract, where the issue is presented in a narrative frame of reference.

> MHN4 Ehm... And say, look, I know, I don't want, I don't want an interp', I don't need [you] to interpret what they're saying for me, you only need to translate it. I want to know the words they're using. And if they're sometimes they're important, and sometimes they're less so, I s'pose. But yes, if you're looking at the... eh... a sto', story can become... perverted #00:17:25-6#
>
> KZ Uhm. #00:17:26-4#
>
> MHN4 [by] a third party. #00:17:27-4#

One particular MHP touched on the subject at the very beginning of the interview when signing the informed consent form to participate in the research and generated a discussion on the subject (#00:01:38-6#). The long passage illustrates the evolution of a narrative research interview and the dialogic nature of the process (#00:02:30-0#). It also points to simple pieces of information, such as the T/IS definition of translation and interpreting (#00:02:44-4#), which can be passed on to interpreter-users in training sessions for easier professional cooperation during actual interpreter-mediated encounters.

> THER4 Ehm... jus', jus' a, eh, just eh, just one point to kinda, kinda clarification. Just... #00:01:31-0#
>
> KZ Uhm. #00:01:31-4#
>
> THER4 [reading from the plain language statement] "The research study investigates the interpreting of the personal accounts of the person using a therapeutical service." So that's the... #00:01:38-6#
>
> KZ The patient. So I'm... tryin' to see how, what the patient says is interpreted to, to the therapist. [Does that make sense?] #00:01:50-0#
>
> [silence] #00:01:51-7#
>
> THER4 Ah, so, it's just the word interpret, interpreting in, in, in... in, in, in, in... in, interpreting... might mean... interpretation of language. #00:02:03-3#
>
> KZ Mmm. #00:02:03-8#
>
> [silence] #00:02:05-1#
>
> That's a... #00:02:05-5#
>
> THER4 And interpretation may also mean... #00:02:07-6#
>
> KZ Understanding or... rendering. #00:02:09-4#
>
> THER4 [Ehm...] [Ye...] Yeah. #00:02:10-2#
>
> KZ Mmm. #00:02:10-6#
>
> THER4 Providing an understanding or feedback #00:02:12-8#
>
> KZ Yeah. #00:02:13-2#
>
> THER4 [to] somebody. Say, so... someone tells me, eh... you know, I've got distressed about this, that and the other thing and you may interpret that #00:02:21-8#
>
> KZ Yeah. #00:02:22-3#
>
> THER4 Or it sounds like... something like this is happening. #00:02:25-4#
>
> KZ Yeah. #00:02:25-8#

THER4 And so you're interpreting... this, you're interpreting the narrative. #00:02:30-0#

KZ Yeah. [Ehm.] #00:02:30-5#

THER4 [Ehm...] #00:02:31-6#

KZ Well, eh, what it's... eh... professionally, from my professional point view, it's, strictly speaking the difference between translation and interpreting is that translation is written work, and interpreting is oral... #00:02:44-4#

THER4 Ok. #00:02:45-3#

KZ [translation.] #00:02:45-8#

The following *story by a client* is an example of how the individual interpreter's presentation of the client's message can have serious consequences in an environment where verbal communication is the essecial means of gaining medical information.

MHN4 In fact, ehm... where the interpreter was, was ehm... presenting a cultural bias deliberately where they felt that there was things that were unacceptable that the patient was saying. And didn't want to pass them on to us. #00:14:43-4#

KZ So [face-saving, or]? #00:14:44-6#

MHN4 [Word for word.] #00:14:44-8#

Eh? #00:14:45-7#

KZ Face-saving? Or... #00:14:47-5#

MHN4 To a certain extent, but wasn't, wasn't willing to... wh' where the patient was, or, the patient, or client whatever [he was] talking about ghosts. And ehm... #00:14:58-8#

KZ Ok. #00:14:59-5#

MHN4 And the interpreter didn't like the idea of bringing up spirits #00:15:03-6#

KZ OK. #00:15:03-9#

MHN4 and, ehm... ghosts of the families... #00:15:06-4#

KZ Uhm. #00:15:07-0#

MHN4 because it was[,] seemed to be disrespectful. #00:15:08-6#

KZ Uhm. #00:15:09-4#

MHN4 And, ehm... interpreted it as... voices, or, you know, so... Where somebody may have talked of a dead relative in such a way that might seem strange to you or I #00:15:21-2#

KZ Uhm. #00:15:21-4#

MHN4 I don't know, ehm... in a very open way. For... it didn't, it was culturally unusual. #00:15:29-5#

KZ Uhm. #00:15:30-2#

MHN4 And the interpreter didn't want to say that I'm, that they we' talking to the dead family. #00:15:34-2#

KZ Uhm. #00:15:34-7#

MHN4 An', and sort of talked about, ehm... "voices." #00:15:39-2#

KZ And did you #00:15:41-2#

MHN4 [And, ehm...] talking to voices. Well, we didn't cop this for a while. We didn't know what we were talking about. And we didn't know what we were hearing it was, it was interpreted to us like, if th', they're hearing voices, there's something clearly wrong. When, in fact, from a cultural point of view that was so, something appropriate. [???] But, but, it's it's strange. #00:15:59-8#

KZ Yeah, bec' #00:16:01-5#

MHN4 And somebody, she made a judgement. #00:16:03-4#

KZ Uhm. #00:16:04-3#

MHN4 About what was, what was right for us to hear and what wasn't. So held back certain information but presented others in a different way which was, m', m, seemingly more acceptable to us or maybe what we wanted to hear. #00:16:16-0#

The issue at hand is clearly more complex than finding the equivalent expression between two languages or even considering cultural appropriateness. The example is all the more intriguing as the interpreter probably provided a word-for-word translation as often required by interpreter-user professionals. This word-for-word rendition apparently led to a situation whereby the fact that these voices are a cultural rather than an auditory phenomenon remained unexplained.

4.3.1.2. The issue of "verbatim" interpreting

It is also telling that mentioning "interpretation" often coincides with "verbatim interpreting" among MHPs. The same MHP who dwelled long upon the definition of "interpreting" also juxtaposed these two concepts, as can be observed in the following extract.

THER4 or [???] that. An' I think... particularly if it is structured in... as I sai', I explained to you... that you're actually wanting word for word transl'... not the... #00:52:18-2#

KZ Yeah. #00:52:18-9#

THER4 the interpreta', you know, not the... you want the translation. Not the interpretation. #00:52:24-5#

KZ Uhm. #00:52:24-9#

It is interesting to observe that, although INTs refer to "verbatim" interpreting the same number of times as MHPs, they do not make the connection with "interpretation." This seems to indicate that in the MHPs' perception a word-for-word oral translation is desirable and understood as professional interpreting. This is in clear contrast with findings of Interpreting Studies, where it is acknowledged that inexperienced interpreters may try to find the word-level equivalent, but with training they acquire skills to transfer the message across faithfully at a pragmatic level. As Hale (2007) remarks, only "the most competent interpreters will convert the message pragmatically, taking the top-down approach, understanding the text as discourse rather than as words or sentences strung together" (p23).

Out of the nine MHP respondents and the twelve instances relating to the "verbatim" node not one shows an understanding of the intricacies of interpreting between two languages. However, while T/IS have greatly benefited from research in pragmatics and moved away from the concept of equivalence at word-level to a broader concept of equivalence at various communicative levels (see, for example, Angelelli 2004; Baker 1992; Hale 1997a, 1997b, 2001, 2007; Hatim and Mason 1990, 1997; Wadensjö 1998a), this significant shift in the understanding of cross-linguistic communication has not yet come to the fore among many service providers who work with interpreters.

In comparison, INTs seem to be aware of the distinction between a word-for-word rendering and conveying the intended meaning (#00:20:05-1#), as is exemplified in the following example.

INT4 at... And I do understand professionalism when it comes to interpreting as translating what is said. #00:20:01-2#

KZ Uhm. #00:20:02-2#

INT4 Not verbatim, because that can't be done. #00:20:05-1#

KZ Uhm. #00:20:05-2#

INT4 But trying to, sort of, rela', you know, relay, or, or, or, or, you know, ehm, convey #00:20:11-6#

KZ Uhm. #00:20:12-6#

INT4 the sense of, eh, what, what's been said. #00:20:16-0#

This is confirmed by Hale (2007), who comments that "very rarely will a literal translation produce an accurate rendition" (p42).

4.3.2. The INTs' concern with accuracy

4.3.2.1. The issue of "addition and omission"

If MHPs appear to insist on "verbatim" interpreting, or rather translation, INTs display a passion for making sure there is no "addition or omission" in their interpreted output. The following example, a contribution from a trained community interpreter, is representative of most INTs' responses on the subject.

INT3 Ehm... not necessarily [?]. I normally, cause I, I... try to be really... strictly follow the... the, the rules. Try not to... involve, or... or add information. #00:25:48-2#

All twenty comments on addition and omission, whether brought up by the respondents or prompted by KZ, appear in the negative. That is to say that neither INTs, nor MHPs find addition or omission acceptable. The high representation of "addition and omission" may be due to the fact that these expressions appear in codes of practices across the globe (see, for example, Australian Institute of Interpreters and Translators n.d.) and despite the fact that "often additions and omissions are needed in order to achieve accuracy" (Hale 2007 p112). It is quite likely that these are the terms INTs use to describe the fact that they aim at transferring the entire message without modification to content rather than using scholarly terms such as "pragmatic equivalence." Thus, they do not refer to a lack of understanding on the INTs' part.

Although both INTs and MHPs agree that addition and omission are undesirable, some MHPs reported negative experiences in relation to the subject. One of the MHPs reported an extreme experience, which supports the argument of the current chapter as one of the *stories told by a client*.

> THER3 So that right again, at the very beginning... there's... there needs to be... a lot of work on clear boundaries, clear understanding, clear contracts, clear expectations. An' you're doing all that through the interpreter. And when there's a male interprete', one male interpreter said to me recently, ehm... I'm sorry sometimes that my people... my people meaning just the people who speaks their language, 'cause that's different country, but he... indicated that was glad I didn't understand everything they said. #00:15:27-1#
>
> KZ [Mmm.] #00:15:27-5#
>
> THER3 Which is interesting. #00:15:28-2#
>
> KZ Wh', what d'you mean by that? #00:15:30-4#
>
> THER3 Well, I, I think it was in relation one day specifcally to... a client talk about eh, eh... in the mental health service. #00:15:38-4#
>
> KZ Uhm. #00:15:39-1#
>
> THER3 And the doctor h' saw. And... I, I know from the innuendo tha' the, the interpreter didn't actually, I'd say, #00:15:47-5#
>
> KZ Uhm. #00:15:48-1#
>
> THER3 interpret to me #00:15:49-5#
>
> KZ Uhm. #00:15:49-8#
>
> THER3 exactly what he said. But, ehm... i'... the remark could've been taken as a racist remark about, ehm... a black doctor. #00:15:59-6#
>
> KZ OK. #00:16:00-1#

In this case, the interpreter made a value judgement and relayed part of the information only after the end of the interpreter-mediated session by muting it during the course of the actual interpreter-mediated encounter.

4.3.2.2. *The issue of register*

Finally, the interrelated issues of style and register deserve a more detailed discussion, as these themes have been the ones most frequently mentioned by the INTs in comparison with the MHPs. The related subtopics include the nodes "coherence," "cohesion," "client's register up" and "professional's register down," and for the purposes of the current study, they are referred to under the umbrella term "register." The inclusion of cohesion and coherence in this classification may appear questionable at first. However, registers can develop due to cultural, situational and socio-economic reasons. If the client does not speak the institutional discourse whose

services s/he is trying to access, s/he may be considered incohesive, if not incoherent. As the values in Table 4.7., showing node pairs depending whether the theme has been brought up by the respondent (e.g. "client incoherent") or prompted by the researcher (e.g. "client incoherent KZ"), suggest, MHPs made very few comments on these subjects. Although the MHP respondents seem to be somewhat aware of difficulties when interpreting slang (MHN5), swearwords (THER3) or unacceptable content (MHN4, THER3), they show little awareness of register issues.

	INTs	MHPs
client incoherent	13	1
client incoherent KZ	0	0
client incohesive	6	1
client incohesive KZ	0	0
client register up	7	1
client register up KZ	1	0
professional register down	9	0
professional register down KZ	1	0
Total:	37	3

Table 4.7. The number of references to register-related issues by INTs and MHPs

Incomplete transmission of register has been documented previously in the CI literature. As the case study by Pöchhacker and Kadric (1999) indicates, a post-session introduction of the professional to a discourse-analysed transcript revealed that they had no sense of their message being miscommunicated and were quite apprehensive about the prospect.

> Following a review of the interaction on the basis of the transcript, the therapist in charge (Tania) found the interpreter's initiatives to reassure, question and advise the client(s) totally unacceptable and was greatly disconcerted by the way in which the interpreter's rendition often blunted the point she had meant to bring across. From her informed professional perspective, the mediated interaction is judged as embarrassingly dysfunctional, even in the absence of an obvious breakdown of communication. With the cleaner-interpreter covertly shaping the content and form of their discourse, the therapists have in fact lost control of their professional (inter)action to such an extent that they can no longer ensure the quality and effectiveness of their work. (Pöchhacker and Kadric 1999 pp176-177)

However, the current study revealed that apart from the content of the client's original linguistic utterance, the (mental health) professionals' lack of access to the client's part of the communication precludes them from judging various other linguistic elements. Thus, it is possible that they do not realise that the client's speech is incoherent, that is it does not make sense, or that the client's speech is incohesive, that is the client does not reply to the mental health professional's

question or follows a line of logic different to that pursued by the professional. The respondent MHPs' lack of awareness of these issues, similar to the example in Pöchhacker and Kadric's study, is evident from the lack of references found in the interviews, as can be seen in Table 4.7. above.

This lack of access transpires clearly from a *story by a client* seen through the eyes of an interpreter.

INT7 So... #00:07:27-6#

[silence] #00:07:29-1#

Of course... the, the patient wasn't hundred percent well. Otherwise, you know... well. But [???], the thing is they didn't really wanna talk about... mental health, you know. What they were completely missing out on is... that this patient is with her background... eh... a kind of class and educational background she was coming from, that she wasn't... an eejit, or... a simple person. #00:07:56-3#

KZ Uhm. #00:07:57-3#

The reason why MHPs are unaware of potential stylistic and register differences between the primary speakers' original utterances and the interpreter-mediated versions may be that they simply do not have access to the client's form and style of discourse.

4.3.2.2.1. The issue of register – definition and remit

While it is clear that style, genre and register are somehow inherent to issues of accuracy and equivalence, the discussion of register poses two distinct difficulties. Firstly, its definition is rather elusive. Secondly, the term is not used consistently in the CI literature, either. As for a definition, the most quoted ones have been provided by Halliday and his colleagues across the span of the last three decades. According to Halliday and Hasan (1989), a

> register is a semantic concept. It can be defined as a configuration of meanings that are typically associated with a particular situational configuration of field, mode and tenor. But since it is a configuration of meanings, a register must also, of course, include the expressions, the lexico-grammatical and phonological gestures, that typically accompany or realize these meanings. (pp38-39)

Although this definition has been slightly updated and worded as "a functional variety of language [...] the patterns of instantiation of the overall system associated with a given type of context (a **situation type**)" (emphasis by the authors) (Halliday

and Matthiessen 2004 p27), it has been successfully applied to register-based analyses in T/IS. These projects include literary translation (Marco 2000) or advertising (Steiner 1998) as well as CI studies by Sandra Hale (1997a) and Helen Tebble (1999).

However, it is telling that Tebble consistently refers to "style" rather than "register," and Hale (1997a) combines features of what "Halliday and Hasan call 'tenor of discourse' (involving the relationship between participants) and social dialect (the variety of language used by member of a particular social class)" (p43). This working definition seems more fitting within the current research context, where respondents would probably agree that "register […] relates specifically to levels of formality and education" (Hale 1997a p43). This approach is also evident in the researcher's choice of node nominations and the assigning of the coding of register-related extracts in the interviews to "client register up" and "professional register down" nodes. These subtopics constitute the core of the present discussion of "register."

The quantitative difference between the two groups of practitioners is significant in itself. While raising the client's register for the benefit of the professional and lowering the professional's register for the benefit of the client receives fifteen mentions from six INTs, only one MHP discusses the subject to any degree at all. Even in that one particular case, the discussion was prompted by the researcher and did not yield an analysable response, insofar as the content value was minimal. Consequently, the following sections on analysing issues of register concentrate on the INTs' responses.

4.3.2.2.2. Raising the client's register

The INTs' responses on the subject of register have confirmed Hale's (1997a) findings in Australian courtroom situations that there

> […] are two clear tendencies in the data analyzed in this study: one relates to raising the level of formality when interpreting into English, the language of the courtroom, and the other relates to lowering the level of formality when interpreting into Spanish, the language of the powerless participants in this context. (p46)

An extreme example of such discrepancy between the register of the client and the professional is the following story, which was recounted by an INT and is presented here in support of the argument. The respondent recalled how a *story told by a client* in a very simple language caused merriment among the professionals involved.

INT6 Let's say once at the hospital. I don't wanna call out the name of the #00:07:25-2#

KZ Yeah, yeah. #00:07:25-7#

INT6 [hospital.] It was a... emergency department, you know. It was in the evening and I got a call to go there. So when I arrived there I knew... when I saw this woman... she was about, eh, sixty-nine... or something like that. #00:07:38-3#

KZ Ok. #00:07:39-3#

INT6 And then she was laying [sic] in the bed. You know, I, I, I... recognised her straight away, because I met her before with the, with the social worker.... #00:07:48-2#

KZ Uhm. #00:07:48-7#

INT6 And then doctor asked me, Ok... ask her what, what she wants, how does she feel? what's wrong? You know... And she started complaining about her sexual appetite.... #00:07:57-5#

KZ Ok. #00:07:58-5#

INT6 [laughs] It was funny, you know... And she was explaining, like, you know, eh... the way, you know... the way her pussy, eh... #00:08:05-2#

KZ [laughs] #00:08:06-0#

INT6 react, you know, and... eh, you know. She used the same simple language. So I had to, eh, so, the poor doctor, eh... she would understand only every two word was sex, sex. Because repeating sex every two word during speak, [???] patient in {language}. #00:08:19-1#

KZ Alright. #00:08:19-3#

INT6 And... [laughs] and, like that, yeah? But the end I told that she was mentally sick, you know. So they brought, like, psychiatrist, to speak to her. And he make, like, about twenty question ask them, she goes... we can't help you. You're not mad, you know. So I don't know what's wrong with you. We can't provide you man here, you know [laughs] #00:08:39-6#

KZ Yeah. #00:08:40-1#

INT6 You should go home. So here. Sometimes that's why, you know, and she, she used simple, very simple language, you know. And the way she described, you know, when the, when a man... entering her, or whatever. You know, [???] And nurse was, What? [laughs] laughing at me and the doctor. #00:08:56-5#

As for raising the level of the client's register, some INTs explained their professional choices and the rationale behind them. They disclosed that they do not trust the professional to be able to deal with the client's "simple language" (#00:05:45-6#, #00:05:59-4#). This attitude is clearly exemplified in the following extract, where an untrained INT talks about their experience in medical interpreting:

INT6 Sometimes I have a patient, like, you know, ehm... with very poor education. #00:05:38-3#

KZ Uhm. #00:05:38-7#

INT6 They wouldn't understand the... medical phrases. #00:05:41-0#

They wouldn't understand what is the injection, why they have to receive the injection, you know. Stuff like that. #00:05:45-6#

KZ Uhm. #00:05:46-2#

INT6 So then... I ask to the doctor [sic] if I could clarify it with the patient, if I could explain in very... simple words, you know... and things like that. And it takes like a sentence or two more. Than it would usually take, you know, with a normal patient. You know. #00:05:59-4#

KZ And what do you, do the doctors say then? #00:06:01-8#

INT6 They say that's fine. They'd like to [???] make them understand why it's important, you know. Or, you know... #00:06:07-4#

KZ Ok. And do they rephrase the question then? Or do you... #00:06:11-2#

INT6 They do rephrase, alright, the... I rephrase the... you know the, [the interpretation]. #00:06:15-8#

KZ Interpreting. #00:06:15-6#

INT6 But maybe it's easy for the pa', the patient to understand. #00:06:19-8#

KZ Yeah. Ok. Ok. Ehm... #00:06:23-1#

[silence] #00:06:23-9#

And when you talk back, when the patient something, obviously their language will be quite simple as well. #00:06:29-1#

INT6 Yes. #00:06:30-0#

KZ Ok. Would you... use that simple language to the doctor then? #00:06:34-7#

INT6 No... [laughing] not really because the doctor wouldn't understand, like. #00:06:39-3#

KZ Uhm. #00:06:39-9#

INT6 You know. If I... I would try, the doctor... would say, What? You know... Wouldn't understand like that... that kind of language. So it's part of my profession to... make doctor understand how he or she feels, like, you know. #00:06:52-7#

The INT's reasoning is somewhat fraught, insofar as communication between a highly educated professional and a lesser educated client is not restricted to cross-linguistic encounters. As a result, responsibility should not fall on the interpreter to iron out such discrepancies. Furthermore, there are inherent dangers to this routine, the most obvious one being the misrepresentation of a primary speaker (see further Cambridge 2004 p6). In addition, register changes on the interpreter's part may stem from an insecure or insufficient knowledge of the environment. Although such comments have not been representative in the current study, this phenomenon is discussed by Drennan and Swartz (1999) in their study of institutional roles for psychiatric interpreters in post-apartheid South-Africa.

4.3.2.2.3. Lowering the mental health professional's register

It also transpired from the interviews, that INTs not only elevate the client's register, but they also often downplay the professional's style in order to make it more easily accessible for the client. Once again, there seems to be a rationale behind such decisions (#00:03:42-9#), as explained by an INT with a degree in languages but no formal CI training.

> INT1 So... #00:03:28-9#
>
> [silence] #00:03:30-7#
>
> That's one of the reasons why I kind of quit interpreting, to be honest, because, I just couldn't deal with the... #00:03:35-2#
>
> [silence] #00:03:37-4#
>
> simple language. I, I, I didn't feel able to... #00:03:40-0#
>
> [silence] #00:03:42-4#
>
> to interpret. #00:03:42-9#
>
> KZ Yeah. #00:03:44-1#
>
> INT1 Sort of the tools, of... of the person. So... #00:03:48-3#
>
> [silence] #00:03:49-4#
>
> KZ So you were actually analysing it while you were... doing it? #00:03:51-8#
>
> INT1 Yeah, 'cause I, I sensed that, but... I'd #00:03:53-9#
>
> [silence] #00:03:55-8#
>
> most of the times I couldn't adapt to that register because, just I didn't have it.

#00:03:59-6#

KZ Yeah. #00:04:00-1#

INTs may also use particular strategies (such as explanation and elicitation) to either one of the participants of the interpreter-mediated encounter while trying to make sure that everyone is aware of the differences in communication style (#00:19:05-0#), as can be seen from the following view put forward by one of the INTs, who does not have formal CI training.

INT5 […] Try not to... #00:18:43-1#

[silence] #00:18:44-5#

even if the question is very... #00:18:46-2#

[silence] #00:18:47-2#

technical an'. I mean the language in which is put... #00:18:49-8#

[silence] #00:18:51-3#

try to put it... so that people understand. 'Cause there's no point... in translating something. I mean you can tell your... psychologist or the person you're working with... #00:19:00-0#

[silence] #00:19:01-0#

I can... translate your question exactly, but they won't understand it. #00:19:05-0#

KZ Uhm. #00:19:05-4#

INT5 So if you wish, I'll translate it first the way you said it, and then I'll elaborate... so they can understand. #00:19:11-5#

KZ [Uhm.] #00:19:12-2#

INT5 [Because...] if the... #00:19:13-5#

[silence] #00:19:15-1#

You need... your client to understand what you're asking... #00:19:18-6#

KZ [Uhm.] #00:19:18-6#

INT5 in order to... #00:19:19-7#

[silence] #00:19:21-0#

to get somewhere. #00:19:21-4#

Clearly, these strategies display a judgement of the client on the INT's behalf, which is best left up to the professional. As argued above, mental health professionals are accustomed to clients from all walks of life and are well equipped to make such assessment.

Thus, with regard to register issues, the research claim that narratives in MHI in Ireland are consensually co-constructed, has been found unjustified. If interpreters modify the register of the utterance, the primary parties form an unrealistic image of their communicative partners respectively. As a result, the story becomes distorted, and co-construction is not fully consensual.

4.3.2.2.4. INTs' strategies as regards register and style

It is worth noting that informing the other primary party of the interpreter-mediated encounter about register differences mostly occurs towards the (mental health) professional, while explication is offered to the client. The nature of such information exchange or information provision seems to align the interpreter with the mental health professional and would need to undergo further analysis of recorded data, where available, to draw reliable conclusions. Also, not all INTs modify the primary speakers' register and some place trust in the professionals with whom they are working. Some INTs are aware that MHPs modify their language for the purpose and, considering that such sociolectal differences may occur in monolingual exchanges as well, choose their interpreting strategies accordingly. One of the INTs, with no substantial training in CI but training in conference interpreting, explains as follows.

> INT9 [Say,] for example, somebody has... panic attacks. And even if I know... what it is, #00:34:20-4#
>
> KZ [Uhm.] #00:34:20-8#
>
> INT9 based on my education, I... I think I should not translate it. Ehm... I'd say, Explain it to him, #00:34:26-3#
>
> KZ [Uhm.] #00:34:26-8#
>
> INT9 [because] it is interfering, so I translate it back to the professional, and let him explain. #00:34:31-2#
>
> KZ Uhm. Sorry, so... you use the... equivalent of a panic attack towards the patient, and the patient asks, What's that, and you ask back to the... therapist? #00:34:42-4#
>
> INT9 Yes. Uhm. #00:34:43-4#

KZ Mmm. #00:34:43-9#

[silence] #00:34:46-2#

And then... he or she can explain it? #00:34:48-3#

INT9 Yes. Uhm. And I do that because, ehm... #00:34:51-7#

[silence] #00:34:53-3#

Well, I really think you should... translate accurately. #00:34:56-4#

KZ Uhm. #00:34:56-7#

[…]

INT9 So, I let the... professional do the explaining... #00:35:51-9#

[silence] #00:35:53-7#

and... #00:35:54-1#

[silence] #00:35:55-1#

I think that's... #00:35:55-6#

[silence] #00:35:56-8#

that's, that's better. #00:35:58-0#

The views expressed by INT9 are clearly in line with the ideals of impartiality and neutrality, which are included in the code of ethics (Irish Translators' and Interpreters' Association 2009) which provide the guidelines for interpreters in Ireland. These codes were conceived in a western cultural paradigm with a tradition of professional codes of ethics underlying professional practices. As Rudvin (2007) argues, often there is an irreconcilable conflict between the cultural attitudes of the client and the service provider. Regardless of where the interpreter would prefer to see themselves in terms of these cultural faultlines, working in systems which are of the individualist paradigm the interpreter is expected to abide by such code of ethics. Clients, to a certain extent, are also expected to behave according to these unwritten rules. In other words, they are given the chance to ask for clarification if they do not understand what a professional says. What happens if the client, embedded in his or her own culture, does not feel he is in a position to do so and the interpreter, sensing this, crosses the boundaries of neutrality and impartiality by modifying the primary speaker's register would constitute an interesting study. For the purposes of the current research, however, this falls outside the scope of the investigation.

All in all, it appears that some INTs interviewed modify at least one of the primary participants' registers during an interpreter-mediated encounter. Their self-professed aim is to facilitate communication by neutralising the primary parties' register. As Hatim and Mason (1990) write,

> [i]n addition to geographical and the temporal dimensions, social differentiation is also reflected in language. Social dialects emerge in response to social stratification within a speech community. As translators and interpreters, we are here up against problems of comprehensibility with ideological, political and social implications. Principles of equivalence demand that we attempt to relay the full impact of social dialect, including whatever discoursal forms it may carry. Yet liaison interpreters working with interlocutors of vastly different social status (e.g. barrister and accused person) find themselves tempted to neutralise social dialect in translation for the sake of improved mutual comprehension, and to avoid appearing patronising. (p42)

Rather than using a neutral or standard dialect, however, INTs reported adjusting to the register of the participant they interpret for. These findings confirm Hale's (1997a) observations of Spanish-English interpreters' attitudes in Australian courts.

> […] the four interpreters here tend to imitate the communicative style of the participant they are addressing at any given time rather than opt for an unmarked register overall. […] Although this strategy may be used with the best of intentions, it clearly has serious consequences in court and, as has already been illustrated, can in fact jeopardize rather than enhance a witness's credibility. (p52)

Arguably, clients feel disempowered in clinical situations, and all the more so if they have to communicate with the aid of an interpreter. As a result, they may not feel fully comfortable to ask questions and may also be disinclined to do so depending on their cultural background.

4.4. Training of Interpreters and Interpreter Users

It is worthy of note that training and accuracy issues appear to go hand-in-hand in the CI literature. Articles on quality or various levels of equivalence often feature training aspects (Cambridge 1999; Meyer 2001; Napier 2004; Pöchhacker and Kadric 1999), while studies on training frequently discuss the problems surrounding accuracy (Cambridge 2004; Fowler 2007; Niska 2007; Roy et al 1998; Russo 2004). As also suggested during the discussion of accuracy-related issues, a simple recital of the code of ethics is not sufficient to work well as an interpreter. A thoughtful application of the guidelines would be desirable, and, as Hale (2007) suggests, it is only through appropriate training that a full comprehension of CI issues can be attained. In relation to the usefulness of codes of conducts she writes that such

an understanding can only be achieved through careful study and debate on what each principle means in practice the reason for upholding each of the guidelines and the consequences of not doing so. However, an academic debate of the issues must be accompanied by practical training to acquire the necessary knowledge and skills. Much more than the mere existence of a code of ethics is needed in order to ensure quality of interpreting services. There is large contradiction between the high standards expected of interpreters, as outlined in the code of ethics on the one hand, and the total absence of any compulsory pre-service training, low institutional support and poor working conditions to allow interpreters to meet those standards on the other. (2007 p105)

Ozolins (2007) concurs, and draws attention to the fact that the "majority of interpreters in community settings may have received *no* training for their work" (p123). This is true in the case of Ireland, where only three of the interviewed INTs have specialised third-level training in CI, all of whom had already completed university courses in T/IS or applied language / linguistics training. As can be seen in Table 3.2. reproduced in Table 4.8 below, only two other INTs interviewed have any tertiary training in T/IS issues, which are of a conference interpreting nature. While three of the others received specialised training in how to interpret for victims of sexual violence and / or sufferers of torture, five of the INTs interviewed have not received more than a one-day introductory session into interpreting for refugees or interpreting in courts.

	INT 1	INT 2	INT 3	INT 4	INT 5	INT 6	INT 7	INT 8	INT 9	INT 10	INT 11	INT 12
Language related studies												
Bachelors degree in languages	X		X					X				
T/IS – courses run by agencies												
1-day introduction (refugee settings)	X	X		X	X	X		X	X	X		
1-day introduction (court settings)	X	X	X			X					X	
T/IS – tertiary education												
1 T/IS module in bachelors degree	X											
Bachelors degree in T/IS											X	
Bachelors degree in T/IS in Ireland												
Masters degree in T/IS												
Masters degree in T/IS in Ireland												
T/IS – specific CI training												
Grad Cert in CI, DCU, Ireland			**X**					**X**			**X**	
Non-Academic T/IS training												
6-month European Commission T/IS									X			
T/IS – MHC related training												
DRCC 1- day course on rape victims	X		X			X		X	X		X	
Spirasi – torture and trauma victims	X					X				X		X
Background in MHC												
Some studies in psychology					X							
Bachelors degree in psychology									X			
Other relevant training												
Working with refugees							X	X				

Table 4.8. The training background of INTs

4.4.1. The respondents' views on training in general: some quantifiable findings

Issues concerning training interpreters as well as interpreter users, or the lack thereof, received considerable interest throughout the interviews, which shows the respondents' preoccupation with the subject. However, as a brief quantitative analysis of the figures in Table 4.9. reveals, the total number of references coded under some aspect of training interpreters is significantly higher than training professionals. This difference is probably due to the main focus of research, that of interpreting, and perhaps also the fact that most of the MHPs have received no training on working with interpreters. Nevertheless, the proportion of the disparity

would be worth exploring further in a future study on the perception of professionals working together in the area.

As shown in Table 4.9. on the number of instances the respondents mentioned training issues, both INTs and MHPs discussed training of interpreters just over three times more often than training of mental health professionals. During coding, the latter combined category included the specific themes of "cultural training for professionals," "guidelines for professionals working with interpreters" and "training professional" in pair nodes, depending on whether they were brought up by the respondent (e.g. "cultural training of professionals"), or prompted by the researcher during the narrative interviews (e.g. "cultural training of professionals KZ"). As there is only one overlapping reference in one source text where the same passage is coded under "guidelines for professionals working with interpreters" and "training professionals," this does not significantly skew the results presented.

	INTs	MHPs
training interpreters	20	19
training interpreters KZ	2	6
Total:	22	25

cultural training for professionals	2	0
cultural training for professionals KZ	0	1
guidelines - working with interpreters	2	1
guidelines - working with interpreters KZ	0	0
training professionals	3	5
training professionals KZ	0	1
Total:	7	8

Table 4.9. The number of references to the training of interpreters and mental health professionals by INTs and MHPs

4.4.2. INTs' views on training issues

4.4.2.1. INTs on the lack of interpreter training

On closer inspection it transpires that trained INTs are acutely aware of the lack of training in the area. One particular INT comprehensively touched on all the aspects of training that were discussed across the interviews by the INTs. These include continuous professional development (#00:40:52-3#), paid for by the employer or contractor (#00:41:35-1#), as seen in the following extract. In the middle of the passage the INT refers to Lionbridge (#00:41:53-8#), a multinational localisaiton company whose main profile comprises software localisation, but whose European

headquarters in Dublin has been a significant player in CI provision in Ireland trading under Berlitz, Bowne Global Solutions and Lionbridge over the years.

KZ What else do you think would help the interpreters? #00:40:49-8#

[silence] #00:40:51-8#

INT9 Training. #00:40:52-3#

KZ Uhm. #00:40:52-9#

INT9 Well... you see that's... I think that's the problem. That many people think if you require training, it's perhaps a weakness. #00:41:00-1#

KZ Uhm. #00:41:00-7#

INT9 If a person says, I need more training, it's kind of feels if you do it, it's up to you. #00:41:05-3#

KZ Uhm. #00:41:05-3#

[silence] #00:41:07-3#

INT9 Ehm... #00:41:07-7#

[silence] #00:41:09-3#

I really think that training should be ongoing. In every job. #00:41:12-5#

KZ Uhm. #00:41:13-2#

INT9 And just because you had training before, even if it was a thorough one, it doesn't meant that you... that you're not gonna be training again. Because you should really update it. And methods change. And you might forget something. Policies change. #00:41:29-2#

[silence] #00:41:30-5#

So I really believe that training should be ongoing. #00:41:32-9#

KZ Ok. #00:41:33-9#

INT9 And that it should be paid for. #00:41:35-1#

KZ By? #00:41:36-6#

[silence] #00:41:38-6#

INT9 Ehm... #00:41:39-1#

[silence] #00:41:42-6#

By your employer, or by the service provider. #00:41:44-9#

KZ Uhm. #00:41:45-6#

[silence] #00:41:48-6#

INT9 See, for example, when I said, eh, we had a one-day training at Lionbridge, and I didn't learn anything there. #00:41:53-8#

KZ [Uhm.] #00:41:54-5#

INT9 [And] I asked will there be any further training? And they said, No, what for? You had your training already. Well, a one-day training is not a suitable training. #00:42:03-1#

KZ No. #00:42:03-7#

INT9 Ehm... #00:42:05-2#

[silence] #00:42:06-9#

Well, I just said that every... body was looking at me... eh, eh, What does she mean, like, we, we just finished our training? And how can a person... Like I actually had vast experience compared to some interpreters, how can somebody that like that request some additional training? But I really think you should, you know. It's like doctors, it's like lawyers. They all have ongoing training. I think it's very, very important. Because you can get stuck in a rot as well. Or you can make some minor mistakes... but they continue all the time. #00:42:35-9#

KZ Uhm. #00:42:36-6#

The same INT also elaborated on the necessary knowledge of vocabulary and environment-specific terminology in MHI (#00:48:15-8#), ethics and etiquette (#00:49:45-3#), and interpreting techniques (#00:49:57-5#).

INT9 And then training. #00:48:13-1#

[silence] #00:48:14-2#

So first of all... vocabulary. #00:48:15-8#

[silence] #00:48:16-9#

So you'd have to learn a lot about... #00:48:18-6#

[silence] #00:48:19-9#

emotions, #00:48:20-4#

[silence] #00:48:22-3#

different shades of... expressing emotions. For example... #00:48:25-8#

[silence] #00:48:26-6#

what is... rage... as opposed to... #00:48:29-5#

[silence] #00:48:31-0#

as opposed to fear. What is being upset as opposed to be anxious or nervous. All the different shades. Otherwise you just translate very general. Like, I felt bad, or something. Kind of generalistic. And that's not good. #00:48:42-7#

KZ [Uhm.] #00:48:43-2#

INT9 ['Cause] [???] you have to be precise. #00:48:44-6#

[silence] #00:48:46-3#

Ehm... #00:48:48-0#

So you have to... #00:48:48-4#

[silence] #00:48:49-6#

know... #00:48:49-7#

[silence] #00:48:51-5#

You have to have this vocabulary in both languages. In the source and target language. Then, second... you have to know some medical vocabulary. Some specialist vocabulary. Like you have to know what is... #00:49:03-6#

[silence] #00:49:05-3#

ju', just different things, like what is... #00:49:06-9#

[silence] #00:49:07-9#

PTSD is post-traumatic [stress disorder]. #00:49:10-3#

KZ [Strees disorder] [Uhm.] #00:49:10-4#

INT9 [Say] things like that. So ehm... I'm not going to have to have the background in medicine or psychology, but you should have, let's say... #00:49:18-5#

[silence] #00:49:20-0#

a few hours' or few week's training... #00:49:21-6#

[silence] #00:49:23-1#

so that you know the basic... #00:49:24-3#

[silence] #00:49:25-3#

sometimes the basic diseases you might be dealing with. #00:49:28-1#

[silence] #00:49:31-9#

Ehm... #00:49:32-4#

[silence] #00:49:35-4#

Then you should have, ehm... training in etiquette. So you should know... that you... should introduce yourself first. Explain your policy about confidentiality. #00:49:45-3#

[silence] #00:49:47-6#

And... objectivity and so on. #00:49:49-5#

[silence] #00:49:51-9#

And then just... general interpreting techinques. Such as taking notes... memory technique and so on. #00:49:57-5#

[silence] #00:49:58-1#

It's very important. #00:49:59-3#

[silence] #00:50:01-8#

In addition, INT9 drew attention to the prerequisites of training, which should include the knowledge of both (or all) working languages at an excellent level. INT9 also commented on the dangers of the lack of training, such as possible misdiagnosis. Finally, the INT said that supervision and quality assurance should go hand in hand with training. These findings are in line with the general CI literature (see, for example, Bell 1997; Bendalozzi 2007; Gamal 1998; Hamerik and Martinsen 1998; Vonk 2003). Valéro-Garcés and Taibi (2004) propose that professionalisation of community interpreting necessitates the development of a training programme for interpreters and awareness raising among service providers. Villareal (2001) also highlights the significance of training and certification procedures when discussing the professionalisation of Chicago area court interpreters. She describes their training, which includes an assessment process, a 36-hour orientation, shadowing, the development of listening skills and memory exercises, a mock trial, and a follow-up mentoring program consisting of an observation phase and a supervised performance phase.

Interpreters working in MHC should also receive some MHI-specific training. Such programs are already available abroad (Pollard 1998). Continuous professional development or introductory sessions have also been made available to interested interpreters in Ireland. The Dublin Rape Crisis Centre (2008), for example, ran a series of workshops for interpreters on how to work with sufferers of sexual abuse and published a booklet on the same. Spirasi (n.d.) also offers ongoing training and support to interpreters working with the service, which mainly specialises in helping survivors of torture.

4.4.2.2. INTs on their own limitations due to the lack of training

In general, INTs with at least a degree in languages or T/IS qualifications were more vocal about training issues which can ensure accurate, impartial, confidential and professional interpreting as prescribed by professional codes of conduct, for

example the Association of Visual Interpreters of Canada (n.d.), the Australian Institute of Interpreters and Translators (n.d.), the Institute of Translation and Interpreting (n.d.), the National Register of Public Service Interpreters (n.d.), the Irish Translators' and Interpreters' Association (2009), and especially legal interpreters' associations, such as court interpreters in Finland (The Finnish Association of Translators, (n.d.) or the National Association of Judiciary Interpreters and Translators in the US (n.d.). Nevertheless, it is reassuring to note that one untrained interpreter clearly expressed awareness of their own limitations caused by the lack of appropriate training. This admission was entirely unprompted (#00:25:23-9#) and came about when discussing modes of interpreting used in MHI.

KZ Modes of interpreting. It's consecutive, or, whether... what would be [more appropriate]. #00:25:13-4#

INT12 Simultaneous. I mean I don't know what would you need for simultaneous? I need flippin'... I don't know, ehm... #00:25:17-7#

[silence] #00:25:18-8#

earphones, and... #00:25:19-3#

KZ Yeah #00:25:19-6#

INT12 Well, you'd need much, much, much more skilled interpreters than me, anyway. You wouldn't be dealing with the likes of me. #00:25:23-9#

KZ Yeah, eh... #00:25:24-9#

INT12 You'd be in a different, you're into a different ball game. You're into #00:25:27-6#

KZ [Yeah.] #00:25:27-7#

INT12 [people] who're correctly trained. #00:25:28-5#

It appears that without adequate training it is difficult for interpreters to appropriately carry out their work whether at the level of story or any other level of organisational unit of communication. In their own words, INTs expressed that very often they lacked such adequate training. Therefore, once again, the research claim that narratives in MHI in Ireland are consensually co-constructed has been found to be unsubstantiated.

4.4.2.3. INTS on training interpreter user mental health professionals

Furmanek (2004) reports how her students developed guidelines for the particular services they had worked for during their professional internship as interpreters. The exercise proved successful not only in educating interpreter users but also raised awareness of professional collaboration with their colleagues among the interpreter trainees. Such practices could possibly be followed in Ireland, if internships were available for trainee interpreters. Based on the interviews, it appears that INTs are not only aware of the lack of training and their own limitations, but they are also cognisant of the apparent differences between MHPs who have been trained to work with interpreters and those who have not received such information.

According to the INTs interviewed, mental health professionals should at least have some basic information on the cultural background of their client (INT5, INT10), as suggested in the following extract.

INT10 But you see, the Irish people, they cannot relate at the beginning. #00:10:42-0#

KZ Uhm. #00:10:42-4#

INT10 And I find it very ehm... very difficult when I'm doing interviews. #00:10:45-8#

KZ Uhm. #00:10:46-6#

INT10 That the interviewer has no experience, and they're not prepared. #00:10:51-6#

KZ Uhm. #00:10:52-0#

INT10 And they haven't been... doing any homework. #00:10:55-6#

KZ Uhm. #00:10:56-1#

INT10 You know what I mean. It's a job for them. And that's very bad. #00:10:59-1#

KZ Uhm. #00:10:59-4#

INT10 Because, you have to know... what the country is a background. The people. #00:11:05-1#

KZ Uhm. #00:11:05-6#

INT10 An' everything. #00:11:06-3#

KZ Uhm. Ok. Ehm... #00:11:09-1#

This information should come from training rather than individual "on-site" education by the interpreter colleague.

4.4.3. MHPs' views on training issues

4.4.3.1. MHPs on training interpreters

A close inspection of the MHPs' responses opens up trends comparable to the INTs' views on training. While MHPs acknowledged the interpreter's contribution to their work, they emphasised that training, or the lack thereof, is "noticeable" when working with interpreters (MHN5, PSY2 #00:37:34-8#). PSY2 also commented on how the interpreter's training affected their work (#00:37:56-3#).

> PSY2 [And] you notice. When, when, when we work... or I work. #00:37:34-8#
>
> KZ [Mmm.] #00:37:35-2#
>
> PSY2 [I] notice the difference straight away #00:37:37-7#
>
> KZ [Mmm.] #00:37:38-1#
>
> PSY2 [to] who's trained and who isn't. It's the posture, the listening. They don't make eye-contact with the interpre'... eh, with the client. #00:37:45-4#
>
> KZ Mmm. #00:37:46-4#
>
> PSY2 All these things. It's very, very noticable. #00:37:48-7#
>
> [silence] #00:37:50-0#
>
> And, and that, you know... they know what they're doing. #00:37:52-8#
>
> KZ [Uhm.] #00:37:53-7#
>
> PSY2 [And eh...] It makes a difference to my work. [smiling] #00:37:56-3#
>
> KZ Yeah. Yeah. #00:37:57-6#

THER3 also commented that training could improve the professional co-operation between the service provider mental health professional and the interpreter. The findings on training confirm those regarding the significance of narratives and accuracy. Thus, MHPs working in specialised services seem to have more experience, thus seem to be more aware of problems surrounding interpreting or have more opportunities and time to consider such issues than their colleagues working in mainstream services.

Unsurprisingly, those MHPs who can see how significantly the lack of training affects interpreting, also advocate training of interpreters on mental health issues. A training programme developed by Pollard (1998) explicitly deals with such matters, which include confidentiality (#00:17:34-0#), boundaries (#00:17:41-6#), secondary

traumatisation (#00:17:55-4#) and co-operation with the mental health professional (#00:18:06-4#), which are all mentioned by PSY1 in relation to training.

KZ If we s... spoke about training, what would you expect the interpreter to be trained? Or... wha' #00:17:10-3#

PSY1 Ehm... #00:17:11-2#

KZ What would you be your needs of... #00:17:13-2#

PSY1 Yeah. Ehm... #00:17:14-8#

[silence] #00:17:18-7#

I suppose, ehm. First of all the issues that, ehm... we're, we're in the process now of drawing up some of, of [what] #00:17:26-3#

KZ [Uhm.] #00:17:26-3#

PSY1 we would require for, for this small service. #00:17:28-7#

KZ [Uhm.] #00:17:29-0#

PSY1 And they'd be issues that we've mentioned: confidentiality, eh... ehm... #00:17:34-0#

[silence] #00:17:35-6#

boundaries, say, say, working within the service. That, that, ehm... respect for the... the difference... #00:17:41-6#

KZ [Uhm.] #00:17:42-6#

PSY1 Ehm... #00:17:42-8#

[silence] #00:17:46-3#

So they're, I think they're the really, the issues that need to be addressed, ehm, in training. And also an awareness for the interpreter of the issues of vicarious traumatisation. #00:17:55-4#

KZ [Mm.] #00:17:56-3#

PSY1 Ehm... And the need, ehm... #00:17:59-9#

[silence] #00:18:00-8#

for the health professional to, to, eh, work with, with the interpreter, an', and that area. #00:18:06-4#

Once again, the subject of vicarious traumatisation and boundaries, which will be discussed in detail in Chapter 6, were only mentioned by respondents who work in a therapeutic setting rather than in the logistical aspect of MHC provision, that is therapists, psychotherapists and psychologists. Additionally, of the MHP respondents

who commented on these issues all bar one work in specialised services rather than in mainstream services.

4.4.3.2. MHPs on training mental health professionals

Perhaps it is significant, that apart from Furmanek's (2004) report on her students trying to educate interpreter users while serving their interpreter traineeship, there is little published on this side of the equation. This is all the more surprising as Bischoff's (2006) findings on their project on medical interpreting in Switzerland reveal that "communication between primary care physicians and FLS [foreign language speaker] patients, as rated by the patients themselves, may be improved by specific training sessions delivered to physicians about how to deal with FSL patients" (p183; see also Bischoff et al. 2003). With regard to their own training on how to work with interpreters, MHPs also commented on the lack of training possibilities in Ireland (PSY2). Most of the MHPs who have been trained to work with interpreters received their instruction elsewhere or are building on their own experience gained outside the geographical area under study. Seven out of the eleven MHPs interviewed have experience working with interpreters overseas, a knowledge-base they could transfer to their practice in Ireland. As a short extract from an interview with MHN4 below illustrates, the explanation of basic concepts does not take a long time and information sessions on interpreting could be incorporated into the training of mental health professionals.

> MHN4 Right, yeah. No, I don', I don't think so. Ehm... I... I'm, I'm always interested in... ehm... eh... the... the element of... or the difference between interperting #00:31:50-9#
>
> KZ Uhm. #00:31:51-4#
>
> MHN4 and translating. #00:31:52-1#
>
> KZ O', officially, interpreting is oral, translation is written. #00:31:56-4#
>
> MHN4 Right. #00:31:57-2#

In this respect the research claim that narratives in MHI in Ireland are consensually co-constructed has been demonstrated to be without foundation, as without a basic understanding of the workings of interpreting on the mental health professional's part it is not easy for an interpreter to consensually co-construct the client's story.

Nevertheless, some MHPs pointed out that such training is now also becoming available and is being built into the curriculum at least on certain courses.

> THER2 Ehm, pressure of time. And I don't... Certainly at the start. I don't think... we, we weren't, I, I never trained, and I'm sure lot of the psychiatrist of my ilk and my age haven't trained in working through interpreters. It's, it's completely, obviously, coming in now, I s'pose, I mean, it's something that's paid attention to in training of, of, of undergraduates now. So, maybe, we would've thought it's only after you've done the first few cases #00:18:07-6#
>
> KZ Uhm. #00:18:08-0#

The respondent may be referring to elements of third-level educational courses that have now incorporated at least intercultural dimensions into their curriculum.

Psychiatric nurses, for example, training at Dublin City University receive information on mental health interpreting as part of their intercultural awareness training (Dublin City University 2008/09). Social workers studying at University College Dublin have also been introduced to working with interpreters (PSY2). Spirasi has recently offered training to their new mental health professional staff (THER3) and in-house training sessions have been given at some mainstream hospitals, as MHN1 confirmed. These initiatives, along with recently published guidelines for health professionals in general (Health Services Executive 2007) based on best practices abroad (see, for example, Miletic & al 2006; Tribe and Thompson 2008; Turner, Greg 2008), are a step in the right direction and a concerted effort could yield even better results in the future.

4.5. Conclusion

The current chapter set out to examine the claim that stories in interpreter-mediated encounters in MHC in Ireland are consensually co-constructed. At first, an investigation into the respondents' understanding of narrative issues and the significance of story-level narratives was carried out. Following on, the question of accuracy emerged to gauge how the transfer of the message at various organisational levels of communication takes place. As the findings displayed an uneven awareness of these issues among the respondents, the next step was to identify ways of improving the situation. Consequently, the respondents' views on practical issues with regards to training were explored.

In summary, it appears that there was no consensus with regard to the significance of narratives and accuracy-related issues among the respondents across the board. In

terms of the research claim, this means that narratives at the story level are not fully consensually co-constructed. On closer inspection, there was much variance across the two groups of practitioners. MHPs seem to be aware of the situational significance of narratives, that is how narratives are constructed within a MHC framework. However, except for two INTs, neither group showed a full awareness of the cultural significance of the organisation of stories, that is, the divergence of narrative styles across cultures. This is also supported by the observation that most responses to the questions regarding cultural differences across narrative styles actually concerned differing customs across cultures. This is a significant result, especially for interpreters, who would need to be aware of a wide range of organisational units of communication.

Preoccupation with lower organisational levels of communication also featured in the respondents' discussion of accuracy-related issues. Thus, MHPs emphasised that they expect a "verbatim" translation rather than the interpreter's personal rendition, and INTs often equated accuracy with "no omission or addition." While these two general responses share the same expectation for impartiality, they do not include concepts of pragmatic equivalence and do not recognise the interpreter-mediated encounter as a communicative rather than a text-only event. Recognition, or at least awareness, of these issues is less likely in the case of MHPs than in the case of INTs, who are present in interpreter-mediated encounters as facilitators of communication. The lack of understanding in both cases, however, can be remedied by appropriate training.

As far as training mental health professionals is concerned, the respondents pointed to the desirability of raising awareness about and accessing practical information on how to work with interpreters. As the focus of the study is interpreting, comparatively more detailed discussions on interpreter training took place. Findings show that both MHPs and INTs who commented on the subject agreed that training of interpreters in specific situations is required. In the case of MHI, these comprise mental health problems, professional boundaries and vicarious traumatisation, as suggested by both the interviewed MHPs and in the relevant CI literature.

However, the most significant result of the thematic analysis of the respondents' views on the significance of narratives and accuracy is that clear trends emerged with regard to the respondents' background. As regards MHPs, two clearly identifiable tendencies evolved. On the one hand, there is an understandable distinction between

therapeutic and logistical services. Respondents working in services where the emphasis is on therapy displayed greater awareness and awareness of issues not only related to their own profession, such as the situational significance of narratives, but also of interpreting-related topics as well. This may well be due to the fact that they work with narratives more often than their colleagues in logistical services.

The other apparent faultline formed between MHP respondents working in mainstream services and those working in what are referred to as specialised services within the framework of the current study. The difference between these two groups in terms of understanding the processes of interpreting, how to work with interpreters and interpreters' needs is considerable. Those MHPs interviewed who work in specialised services displayed a greater comprehension of not only the situational but also the cultural significance of narratives as well as the basic concepts of T/IS, such as the distinction between translation and interpreting. While this may be due to the fact that they have more experience working with non-English speaking clients through an interpreter, and indeed are perhaps more predisposed to seek out such services, this result is momentous in terms of the current project.

Consequently, it appears that there is greater effort needed in training mental health professionals working in mainstream services on how to work with interpreters. From the interpreter's point of view these findings also mean that while the interpreter can expect a mental health professional working in an specialised service to have an understanding of the interpreting process and create a space for consensual co-construction of the communicative event, this is not the case in mainstream services. As a consequence, the interpreter may need an even higher level of alertness when interpreting in a mainstream setting than usual.

As regards INTs, those respondents who have training in CI or at least some third-level education in T/IS showed far greater awareness of the three issues (the significance of narratives, accuracy and training) than the INTs who have no or very little training in the area. This outcome confirms the calls for appropriate training for community interpreters widely promoted in the CI literature. Based on the findings of the current study, such training should also include raising awareness of narrative events in MHC and different expectations across mental health settings, with special reference to the specialised versus mainstream and the therapeutic versus logistical divide.

CHAPTER 5 – CONTROL OF COMMUNICATION IN INTERPRETER-MEDIATED MENTAL HEALTH ENCOUNTERS

5.1. Introduction

This chapter examines how the participants of multilingual settings take control of the communication flow. As shown in Table 5.1, it contrasts the research respondents' views in Ireland with experience outside the geographical framework of the current research. Keeping in mind the research claim that narratives in mental health interpreting (MHI) in Ireland are consensually co-constructed, it concentrates on the discourse level of actual interpreter-mediated mental health encounters.

Level of narrative:	Discourse
Subject of analysis:	Control of communication
Practical issues:	Employment issues
Stories supporting analysis:	Stories told about the clients
Internal research dialogue:	Current project and MHI / CI literature

Table 5.1. The organisation of Chapter 5

Following an introduction to the concept of control and the sources of data analysis, the sections on client control, mental health professional control and interpreter control examine who manages communication in interpreter-mediated encounters in mental health care (MHC). The thematic narrative analysis (Riessman 2000, 2004, 2008) then extends to the respondents' views on employment issues in MHI and community interpreting (CI) in Ireland. Similarly to Chapters 4 and 6, the sections on the primary subject of interest as well as on practical matters comprise the opinion of the interpreters (INT) who have worked in mental health settings and mental health professionals (MHP) who have experience working with interpreters. The findings of the current research based on the interviews are presented in a dialogue against the backdrop of Hanneke Bot's (2005a) monograph on dialogue interpreting in MHC and the wider area of the CI literature. The line of argument is supported by *stories about clients* which emerged during the interviews and which appear in a text box for the purposes of easier identification.

5.2. The Sources of the Research Dialogue

5.2.1. *The sources of the research dialogue in Bot's Treatment*

At the time of writing, the only available monograph on MHI was *Dialogue Interpreting in Mental Health* by Hanneke Bot (2005a). Given that this is the most comprehensive single piece on the subject, it forms the basis of the research dialogue underpinning the current chapter. At the heart of Bot's analysis is the involvement of the interpreter, a topic akin to the focus of the current investigation, which is the interpreter's influence on narrative construction in MHI in Ireland. Furthermore, while it is not explicitly stated in her monograph, the two-tiered research design Bot applies is dialogic in its nature, and in this respect, it is similar to the current research project. The two stages of Bot's methodology include the development of an intricate concept map and the analysis of video-recorded interpreter-mediated therapeutic sessions. Bot's first stage of research is dialogic, as it relies on her research participants' (RP) involvement to a significant degree. This complements her own research input and comprises a bottom-up approach, where the researcher (Hanneke Bot, initials HB) empowers the RP. The chronological narrative of Bot's research process can be presented as a dialogue as follows:

> **RP:** The seven therapists, eight interpreters and five ex-patients generated statements to complete the sentence "Interpreter-mediated psychotherapeutic conversation proceeds best when…"
>
> **HB:** Cleaned up the generated statements by removing any overlaps or repetitions.
>
> **RP:** Prioritised the remaining 55 statements and divided them into five groups of 11 statements (with group 1 comprising the least salient and group 5 the most important statements).
>
> Simultaneously, RP also categorised the same 55 statements into ten clusters according to subject matter with no guidelines for or restrictions on cluster-size (that is, regardless of the number of statements in each cluster).
>
> **HB:** Organised the clusters into four subjects for investigation, including management of sessions; patient security; the interpreter's attitude; and interpreting techniques, which she incorporated into a concept map.
>
> Based on these findings of the first stage of the investigation, HB defined two models of co-operation: translation machine and interactive interpreting.

During the second stage of her research project, Bot analysed six video-taped sessions between a Dutch therapist, a Dari Persian-speaking patient and an interpreter. The first stage of the analysis did not yield a clearly defined scope for the

investigation, therefore Bot decided to continue the research dialogue with her participants. During this process, she availed of existing literature on the subject, advice from practitioners and constant revisited her interview transcripts as well as the video-taped interpreter-mediated sessions. She finally identified two of the clusters, which were prioritised by the research participants, as the focus of her investigation. These two topics, "the translation of therapeutic sessions" and "the management of a session," then formed the basis of her data analysis. The former subject is the focus of Chapter 4, while the latter takes centre stage in the current chapter.

5.2.2. The sources of the dialogue in the current research

In this research project the data collected through narrative interviews with a comparable number of mental health professionals (MHP) and interpreters (INT) subsequently underwent a coding process. Throughout this pre-analysis stage, clusters of topics began to emerge. One of these clusters was coded under the umbrella term "trialogue," which represented the triadic co-constructed nature of interpreter-mediated encounters. Due to the amount of information collected during the interviews, the presentation of all the available material would be beyond the scope of this research. In order to provide an insight into the wealth of ideas which the respondents shared during the interviews, I opted to concentrate on the control of communication, a subset of the data coded under "trialogue".

During the bottom-up coding process, described in detail in section 3.7.4., the respondents' views on control were coded into three main child nodes of the parent node "control of communication." As shown in Figure 5.1., these three child nodes include "client control," "mental health professional control" and "interpreter control," a tripartite structure which also provides the organisational background to the current chapter.
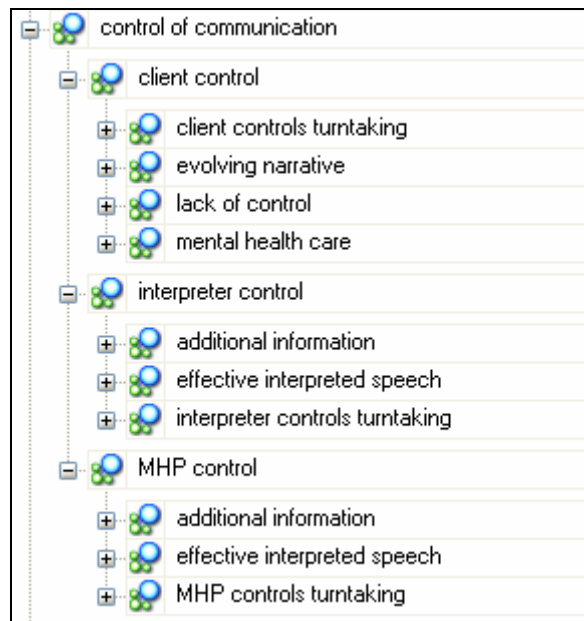
Figure 5.1. Node structure of "the control of communication"

Each child node contains further sub-nodes, referring to, among others, turn-taking, evolving narratives, effective interpreted speech, additional information or control by the individual participants. Further subcategories of these grandchild nodes include, for example, "client keeps talking," "interpreter adapts to client," or "client lacks control" under "client control;" "interpreter informs mental health professional," "mental health professional unaware of original," or "mental health professional stopped by interpreter" under "interpreter control;" and "mental health professional in control," "mental health professional instructs interpreter," or "client stopped by mental health professional" under "mental health professional control." Thus, an actual piece of interview extract / transcribed text on how a psychologist manages the situation with an emotional client (INT3 #00:26:47-6#) is coded under a great-grandchild node in the following manner: control of communication\mental health professional control\mental health professional controls turn-taking\client stopped by mental health professional, as seen in Figure 5.2.

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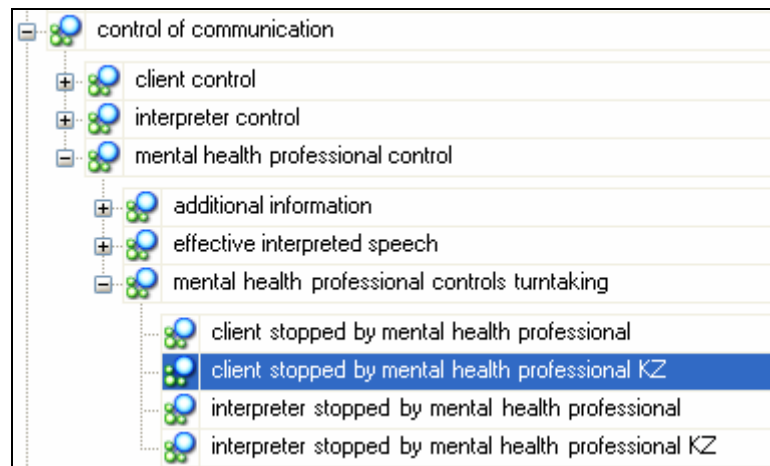
Figure 5.2. Node structure detail on "the control of communication"

5.3. The Concept of Control

5.3.1. The concept of control in Bot's treatment

In order to comprehend the models of session management in Bot's work, a brief discussion of her models of interpreting and cooperation is required. First, she identified two basic interpreting models based on the interviews she had conducted. These two interpreting models are the interpreter-as-translation-machine model referring to an interpreter "who walks in and translates" (Bot 2005a p75), and the interpreter-as-interactive-translator model. Second, she compared these models to therapeutic models in psychology. These models are one-person psychology where "the relationship that develops between patient and analyst is seen as a manifestation of the patient's psychology alone" (p76); two-person psychology which holds that "[w]ithout a relationship, there can be no therapy" (p77); and three-person psychology approaches which "explicitly pay attention to the context in which the patient-therapist dyad functions. The external is not only included in the therapeutic space as it is experienced, but also in behavioural, real, terms" (p78).

Finally, Bot drew up models of cooperation between the two professional practitioners by aligning the interpreting and the therapeutic models. Subsequently, she stated that interpreters operating in a translation-machine model work well with therapists who subscribe to the one- or two-person psychology models, while interpreters from an interactive-model background can work well with therapists who prefer a three-person psychology approach. Bot named the former cooperation model the "translation-machine model" and the latter cooperation model the "interactive

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model" for short (p87). In her thesis she argued that the two cooperation models are shaped by the attitude of the interpreter and the therapist as well as by the interpreter's skills, and in turn, influence the security of the patient and the management of the session. In terms of the current project, this means that ideally, the therapist's and the interpreter's attitudes are comparable, that is their construction of the communicative event is consensual.

5.3.2. The concept of control in the findings of the current research

The current research has built on the understanding that the role of the interpreter is crucial in the construction of interpreter-mediated encounters. Consequently, the interpreter's familiarity with the client and their narrative has been identified as a central topic of the investigation. The concept of familiarity, therefore, encompasses issues around the discourse of the encounter which is the main topic of this chapter as well as narrative construction at the level of the actual story, which was the subject of Chapter 4. Table 5.2. shows the total number of references each of the main interview themes, defined in section 3.3.2., have received during the bottom-up coding described in section 3.7.4. During the bottom-up coding process, issues brought up by the participants were organised into emerging clusters along the main interview themes by the researcher.

It is apparent that familiarity has received the most attention with 224 mentions, while interpreting narratives is at the other end of the scale with only 41 references.

	References
Perception of Mental Health	94
Significance of Narratives	123
Familiarity	224
Modes of Interpreting	74
Interpreting Narratives	41
Mental Health Interpreting	222

Table 5.2. The number of references coded under the six main interview themes as "Focus Areas"

According to these figures, familiarity seems to have emerged as a significant concern among the respondents of the current research project.

However, it is interesting to note that most respondents ignored the story-level narrative, and replied to the question with regard to the encounter-level instead. In other words, the respondents commented on how familiarity between the participants influenced their relationship and the therapeutic outcome (#00:28:13-1#), but they rarely remarked upon how their familiarity with the actual stories told by the clients

could affect their interpreting of the retelling of the same stories (#00:28:03-2#). Nevertheless, some respondents made the distinction when specifically asked about these two aspects of familiarity. The excerpt below illustrates such an incident, where the passage begins with a reference to a previous topic of conversation.

KZ Ehm... so... if you were talking to this lady, in the corridor, and you saw her later... #00:27:38-0#

INT2 I saw her what? #00:27:39-9#

KZ Later, with the doctor. #00:27:41-2#

INT2 Ok. #00:27:41-5#

KZ Later you were interpreting for the doctor. Does the fact that, the fact that you knew how she got sick. Or ill. #00:27:49-9#

INT7 Yeah, I can [???]. Yeah. #00:27:51-4#

KZ Ehm... you became familiar with her... history. #00:27:55-2#

INT2 Yes, I do. #00:27:55-9#

KZ And... ehm... does that have any effect on... on how you interpret or what you say? Or... #00:28:03-2#

INT2 Yeah. Probably it'll be easier. And the doctor also, wants to use the same interpreter. #00:28:07-8#

KZ [Uhm.] #00:28:08-6#

INT2 Also, yeah. The doctor prefer to use the same interpreter. For the same patient. #00:28:13-1#

KZ Why do you think is that? #00:28:14-8#

INT2 Because you are... One thing is for confidential... #00:28:18-8#

KZ [Uhm.] #00:28:19-5#

INT2 [reasons.] And another thing is for... because an e... because you know patient and the illness history #00:28:25-5#

KZ [Uhm.] #00:28:26-2#

INT2 And sometimes ehm... don't make a lot of sense to you... when the patient says something. #00:28:32-1#

KZ [Uhm.] #00:28:32-5#

INT2 And you could interpret it properly. Ehm... to the... to the... to the doctor. #00:28:37-4#

This lack of observation by the participants is probably due to the MHPs' incomplete understanding of the interpreting process as well as the INTs' lack of awareness of narrative issues, as suggested in Chapter 4. As a result, the respondents' views on the relationship of the participants and on the control of communication of interpreter-mediated encounters in MHC feature independently of their views on familiarity with evolving narratives. While Bot suggests that both session management and communication control are intrinsically linked to the interpreter's underlying role and their relationship to the primary participants of interpreter-mediated encounters, the respondents of the current research apparently did not make a connection between the interpreter's familiarity with the client and with their narrative.

5.4. The Client in Control

Traditionally, the client is seen as the powerless participant in interpreter-mediated encounters (Brennan 1999; Patel 2003). This is the case in clients in MHC, especially survivors of torture. As Smith (2000) remarks, it "is important to tell the alleged victim that he/she [sic] has the right to stop at any time or to take a break or not to answer any particular question(s)" (p25). Her comment on the empowerment of traumatised patients in monolingual situations can be extended to interpreter-mediated encounters. Wherever an interpreter's assistance is required, clients usually face the representative of an authority or institution. Furthermore, they are deprived of language as a tool of communication as well as rights of access. In addition, once they have been provided with an interpreter, they may feel they are required to attend the consultation, which deprives them of the choice to decline. The following sections discuss Bot's comments and the findings of the current research on the client's control, or the lack thereof, in interpreter-mediated encounters in mental health care.

5.4.1. The client in control in Bot's treatment

Bot (2005a) involved former patients of therapeutic encounters in the first stage of her research, whereby former patients contributed to the development of her concept map in the exact same manner as the therapist and interpreter participants in her study. They were involved in the same process, generated statements, and participated in the interviews, the aim of which was to clarify the development of a

concept map. By acknowledging the presence and input of the patient, Bot aimed to counterbalance the general lack of service-user perspective in the literature. However, the findings on the subject of investigation during the second phase of her research, that is the analysis of six video-recorded interpreter-mediated sessions, could not fully parallel this research methodology.

During the second phase of her research, Bot (2005a) taped two sessions with three different groups of participants each. As is apparent from the following short quotations, the client's control of communication flow is always subject to the therapist's, and to some extent also to the interpreter's, will to facilitate such control.

> The multiple turns of the three patients show a similar pattern. In all three cases, there are many opportunities for the therapists to take a turn after renditions of patient's words. As they do not take it, they thus give room to their patients to talk more. These consecutive turns by the patient, intersected with renditions from the interpreter, do not have the structure of projected discourse units. (p121)

What Bot implies here is that the clients can only carry on with multiple turns because the mental health professionals decide not to interrupt them. They are not in a position to plan such uninterrupted multiple turns, or, in Bot's terms, "projected discourse units."

This observation is confirmed in the analysis of a particular group of participants, group C, of Bot's (2005a) research.

> During the sequence the therapist does not give any indications of wanting to take the turn – turn transfer is a matter between the patient and the interpreter. The changes in therapists' non-verbal behaviour seem to be a preparation for turn transfer [sic] to him. As soon as he takes the turn, both the patient and the interpreter yield.

> Again, here the therapist seems to give the floor to the patient. As soon as the therapist takes the turn, he gets it. (p121)

From Bot's research findings it seems that the control of communication is rarely, if at all, in the hands of the client.

5.4.2. The client in control in findings of the current research

Respondents of the current research acknowledge the fact that without the client, there would be no interpreter-mediated encounter.

> OT1 The're, the're, they're the most, I mean not the most important person in the room. But they're the person in that room that it all revolves around. #00:30:05-8#
>
> KZ [Mmm.] #00:30:06-5#
>
> OT1 I mean, it, it should be the client, and it s', I mean it is the client, but... neither the client [sic] or the therapist is anything without the middle... #00:30:14-5#
>
> KZ [Mmm.] #00:30:15-2#

Nevertheless, it appears that once the session begins, the client loses control over the situation. Perhaps the only time the client is in full control is by giving his or her consent to participate at all. As the following *story about a client* in support of the argument presented here illustrates, some clients exercise such control to great affect.

> PSY2 Ehm... I, I had a situation of a {nationality} client... who I had to book... three or four interpreters before I could work with him. 'Cause he comes, he would come here very early. Like half an hour before the... appointment. #00:24:19-1#
>
> KZ Uhm. #00:24:19-6#
>
> PSY2 See the interpreter comin'... and then leave. The three times I never had the opportunity to talk to him. The fourth time... he, he stayed because he didn't know the interpreter. So, obviously, those... those communities are very small. #00:24:37-3#
>
> KZ [Uhm.] #00:24:37-8#
>
> PSY2 And they all know each other. #00:24:39-2#
>
> KZ Yeah. #00:24:39-9#
>
> PSY2 So he would be very afraid that this person that he had seen somewhere would go out and tell their story. An' I don't, I talk about confidentiality, and say, and they say, Yes, yes, yes, but I don't know. #00:24:50-0#
>
> KZ Mmm. #00:24:50-7#

Both INTs (INT1, INT8, INT10 INT11) and MHPs (MHN5, OT1, PSY1, PSY2, THER3, THER4) commented on the fact that the client sometimes needs an opportunity to develop a full narrative, that is, the client needs to take control over the communication flow. The following abstract well illustrates this view within a narrative framework presented at the MHP's own initiative.

THER4 An', ehm... try to be conscious... not to have too many questions or... confusing questions or... double questions or treble questions. Ehm... to try an' keep it simple. But to try an' keep it... ehm... #00:44:00-7#

[silence] #00:44:03-0#

as clear... a communication between me and the patient... as possible. #00:44:09-0#

KZ Uhm. #00:44:09-3#

THER4 Eh, and that often requires repeating questions. Coming back to questions. Because that's what often happens... without an interpreter. That the patient [???] what you're looking for. Ehm... it's... I mean, again, that sounds a little bit mechanistic. Ehm... I mean at the outset you w'd... try and give the person the opportunity to give so much of the account and you let them explain. You know, you, you may orientate the person, eh, how you hope to run the session. And you might say [???], you know, I would like you tell me in your own words what would happen, and, you know, your understanding of being here and how I might be able to help. And I'll try not to interrupt or ask any questions. An'... try an' allow... that to... given the person and the framework, to tell... their story. And... for it to be punctuated by... the interpreter, telling me... and me kinda... facilitating to continue to give #00:45:18-0#

KZ [Uhm.] #00:45:18-0#

THER4 [that] account. Pretty much without that interruption or direct question-asking. I mean... in any clinical interview... interrupting people or asking questions... is not usually productive.... facilitation. Ehm... tryin' to kinda... make emphatic statement as to How they might be feeling about discussing [???] is what folds... story out. So, so... y... mm... you know my... so I'm asking, so [???] I might be reflecting back, when the interpreter finished. I'd say, that must have been... a dreadful experience for you. #00:45:55-1#

[silence] #00:45:57-3#

Eh... you know. #00:45:58-0#

KZ Uhm. #00:45:58-3#

Nevertheless, such allowances on the therapist's part are restricted to therapeutic rather than logistical encounters, a differentiation emphasised in Chapter 4. In other words, while the client may be allowed to continue with their story in a therapeutic setting, they cannot develop further than straight answers to straight questions in, for example, medico-legal interviews (INT8) (for more, see Hale 2007 p38). Certain other factors, such as the lack of informed consent (#00:09:25-3#), can further aggravate the lack of empowerment and control, as can be seen in the following extract.

INT3 Yes. The... first, ehm... [???] I had... as I say... that was a few years ago, ehm... the... #00:09:16-1#

[KZ adjusting the recorder] #00:09:22-2#

INT3 the patient, he was not fully informed #00:09:25-3#

KZ [Uhm.] #00:09:26-1#

INT3 that he was... in fact, visitin' a psychiatric... #00:09:28-4#

KZ [Uhm.] #00:09:28-9#

INT3 He didn't know. He didn', he knew he was a doc', that [that person] #00:09:33-3#

KZ [Uhm.] #00:09:33-5#

INT3 was a doctor, but he was not informed... #00:09:35-3#

KZ [Ok.] #00:09:35-7#

INT3 that it was psychiatry. I mean that's... is it, a kind of a difficult situation, because... ehm... he had to answer lot of questions, like a questionnaire. #00:09:44-8#

KZ [Uhm.] #00:09:45-1#

INT3 And... he felt sometimes... a bit lost. #00:09:49-8#

The client's narrative may also be restricted if they are underage (#00:27:31-5#) and the information flow is controlled by the parents (#00:27:59-7#), as INT5 commented.

INT5 It's much harder, because... #00:27:26-9#

[silence] #00:27:28-1#

your client... #00:27:28-8#

[silence] #00:27:29-8#

is not your source of information. #00:27:31-5#

KZ Uhm. #00:27:31-9#

INT5 So... #00:27:32-5#

[silence] #00:27:33-6#

you're losing... information through... the translation, through the... the... being sort of... #00:27:40-9#

[silence] #00:27:43-6#

overly formal... set-up. #00:27:45-6#

KZ [Mmm.] #00:27:46-4#

INT5 [Because] you have... the psychologist, you have an interpreter. It's not in your language, you feel a bit intimidated. Loads of people in the room. #00:27:53-7#

[silence] #00:27:55-1#

So you lose through that, and you lose through... the way parents seeing what their child [does] #00:27:59-7#

KZ [Mmm.] #00:27:59-8#

INT5 So, I mean it's a different perspective. I mean, it could be totally... you know... eh, wrong, eh. Or, eh... unobservant, or... or #00:28:08-8#

Once again, as also seen in Chapters 4, there is also a difference between mainstream services and specialised services (INT8, THER3, THER4). In the case of the former, the mental health professional is sometimes forced to end the client's control of communication due to time pressure.

However, as discussed in section 4.2.2. on the respondent's views on the situational significance of narratives, not every school of thought considers stories or even speech equally important. The following *story about a client*, in support of the argument of this chapter, shows the frustration and internal conflict an INT experienced in relation to a particular therapeutic session where the client's narrative was completely muted by the mental health professional who opted for art / occupational therapy and left very little control with the client.

INT12 It was a lady again from the {name of country}, young woman. And I have no idea to this day what experiences she had. You could sort of tell by her... way of behaving everything, that she was very, very traumatised... And we went in, and we would sit down, me and the art therapist and her... And eh... #00:19:29-6#

[silence] #00:19:31-1#

There was almost no talking at all. For a whole hour. We'd go in, we'd sit down. And eh... #00:19:35-6#

[silence] #00:19:36-9#

Hello, how are you today? [mimicking slow speech of the therapist after speaking incredibly fast] #00:19:38-4#

[silence] #00:19:39-4#

I'd say in {language}. How are you today? How are you feeling? #00:19:42-0#

[silence] #00:19:43-2#

I'm ok. I'm ok. [???] #00:19:46-6#

KZ [Yeah, yeah, yeah.] #00:19:47-2#

INT12 [With the {language} bit] alright? Ehm... #00:19:48-6#

[silence] #00:19:49-6#

KZ [???] #00:19:50-2#

INT12 Are you feeling better? Or... #00:19:52-0#

[silence] #00:19:53-8#

Worse than the last day? [pretending to talk in another language] Are you feeling better [???]? #00:19:56-4#

[silence] #00:19:58-7#

The same. #00:19:59-1#

[silence] #00:20:00-3#

The same. #00:20:00-7#

[silence] #00:20:01-6#

And then... #00:20:01-9#

[silence] #00:20:03-3#

and hour later... it would be ehm...Silence for an hour... Three of us would sit there, in silence. Or every now and again the therapist might say Would you like to make something? And this lady would woke up, would be... Well, not really. #00:20:12-9#

KZ Mmm. #00:20:13-6#

INT12 And she'd say, Well, maybe do, maybe you find you can express... something of what you're feeling in... Oh, no she can' fuckin' express what she's feelin' by playin' around with a lump of dough. Or purple paint. No, it's not gonna... #00:20:23-3#

[silence] #00:20:24-3#

Anyway... #00:20:24-4#

[silence] #00:20:25-5#

So, she would go over, and she would pick a piece of do', the gir', this is the client, and she'd sit down and she'd mess around with this... #00:20:30-1#

[silence] #00:20:30-9#

You wouldn't. Which I thought was a mistake. #00:20:32-5#

KZ [Mmm.] #00:20:33-1#

INT12 I thought we should all do it. #00:20:33-8#

KZ Mmm. #00:20:34-4#

INT12 Made the woman feel extremely uncomfortable. She's sittin' there... messing about with this, we're both sittin'... staring at her. #00:20:38-9#

[silence] #00:20:39-7#

Ehm... Very uncomfortable... #00:20:40-8#

KZ Mmm. #00:20:41-0#

INT12 position to put somebody in. Lady was very uncomfortable. #00:20:43-3#

[silence] #00:20:44-0#

Silent. For the hour. And at about five to the hour, a couple of minutes before we were due to finish, it was... [imitating the therapist again] Well, don't know... Perhaps we can... Ehm.. Let's see how you're feeling next time. #00:20:54-0#

[silence] #00:20:54-8#

Two thirty, Wednesday the 11th. Ok. Thank you very much. [turning away as if talking to an interpreter] Thank you very much, {name of INT}. And we'd go home. #00:21:01-1#

[silence] #00:21:01-8#

And we'd come in two weeks' time, we'd do the same thing again. #00:21:03-7#

KZ [Mmm.] #00:21:04-2#

INT12 [The wom]an never spoke. She never said anything about her life, she... The therapist knew her name. #00:21:08-1#

[silence] #00:21:09-4#

The country that she was from... #00:21:10-3#

[silence] #00:21:12-7#

She never spoke. The whole hour. And the therapist never asked a single question. #00:21:15-6#

[silence] #00:21:16-6#

KZ [???] #00:21:16-9#

INT12 She [never said]... #00:21:17-2#

KZ [asked anything.] #00:21:18-1#

INT12 Never. #00:21:17-7#

KZ [Mmm.] #00:21:19-0#

Notwithstanding the type of services or the school of therapy, INTs reported that they would only put a stop to the client's narrative due to their difficulty in following the story, or being afraid of losing some details (INT4, INT7, INT8, INT9, INT11). In this respect there seems to be an agreement among INTs, regardless of their training background. The practices of negotiating space for the client's control (#00:13:38-9#) is shown in the next excerpt.

INT12 Well, ehm, eh... If I need to.. well, you see, I'm doin' this for ages, I suppose, but the inter', the therapist're always used to using interpreters. So they do it... #00:13:33-5#

KZ [Yeah.] #00:13:33-3#

INT12 bang on. Like they know... #00:13:34-7#

KZ Uhm. #00:13:35-3#

INT12 when to stop an' when. The others don't. And the others do get used to it, though. They do. #00:13:38-9#

KZ Yeah. #00:13:39-1#

INT12 Afte a while they actually realise that... and they themselves... But I don't tell them that, you know. #00:13:43-6#

KZ Yeah. #00:13:43-9#

INT12 I let them find it that way themselves. Ehm... If I... want to clarify something, if something doesn't make sense, I'll actually ask the client to clarify it. #00:13:52-8#

KZ Uhm. #00:13:53-1#

Nevertheless, even if some interpreters inform the client about the routine of turn-taking prior to the start of the session (INT4), such interruptions are a clear sign of the client's lack of total control. As seen in Bot's discussion and in the broader CI literature, control seems to be awarded to the client only within the mental health professional's framework. It is apparent that even with best intentions to empower the client, interpreters and clients are informed about how the therapist "hopes to run the session" (THER4 #00:45:18-0#).

5.5. The Mental Health Professional in Control

Some believe that it is the interpreter user service provider who should be in control of commnicaiton in an interpreter-mediated encounter. As Clark (1998) reports, the speech pathologists she interviewed perceived their control to reach even beyond the actual interpreter-mediated sessions.

> Not surprisingly, there was consensus that the speech pathologist should be the person 'in control' of an assessment session, in accordance with their expertise and professional responsibility in the medical context. Furthermore, this sense of control is evident in the behaviour of speech pathologists: they are responsible for booking the interpreter, for determining what information the interpreter receives about the patient and for deciding what tools will be used to assess the patient. Further, they instruct the interpreter about tasks to be undertaken, about the aspects of speech or language to focus on, in addition to generally setting parameters for accuracy and conduct within which the interpreter is expected to work. (1998 p4)

The following sections reveal Bot's findings on the mental health professional's control and also how the respondents of the current research view the subject.

5.5.1. The mental health professional in control in Bot's treatment

According to Bot (2005a), therapists operating within the translation-machine framework consider the interpreter as a mere mouth-piece to facilitate multilingual communication. Therapists subscribing to the interactive model, on the other hand, recognise the interpreter's position as a full participant in interpreter-mediated encounters (p141). Therefore, only therapists and interpreters working in the translation-machine model would hold that the mental health professional is in full control of the communicative event and the flow of information. Based on the information she derived from interviews with the three therapists and the three interpreters who participated in the six video-recorded therapeutic sessions in her study, Bot found that one particular therapist fully subscribed to the translation-machine model, and consequently, preferred to keep strict role boundaries for the interpreter (pp141-143).

Bot (2005a, 2005b) analysed the turn-taking as well as the gesture and gaze patterns as means of controls of communication, or session management as she terms them. She found that the three groups of interpreter-mediated triads had very different communication management control patterns from each other, making use of verbal and non-verbal clues to a varied extent. "The turn transfer in group A usually takes place after a short moment of silence, in group B gaze direction and gesture are important and in group C overlap dominates" (Bot 2005a p141). Nevertheless, she made observations which were true of all the encounters across the board. She noticed that the gaze pattern was different from what is considered normal in monolingual talk, and that "the three therapists gaze at the patients when they listen to the renditions of the therapists' turns and they often do not gaze at the interpreters when they are speaking" (p140). As a result, the fact that mental health professionals are responsible for the overall control of the interpreter-mediated encounters cannot be ignored. As Bot remarks on the basis of her evidence, "the interpreters and patients in this material tend to yield whenever a therapist indicated that he wants to take the turn. This may mean that the therapists <u>can</u> take charge of the session, even though in practice they do not always do so" (emphasis by the author, 2005a p143).

5.5.2. *The mental health professional in control in the findings of the current research*

The diversity of approaches to interpreting and control are evident from the respondents' views. As discussed in sections 4.3.1.1. and 4.3.1.2., there appears to be a distinction between respondents who view "translation" as opposed to "interpreting" as the primary function of the interpreter in multilingual therapeutic encounters. On the one hand, this distinction, made mostly by MHP respondents, highlights the mental health professional's preference for Bot's translation-machine model. On the other, and perhaps as a cause or a consequence of this preference, such comments also reveal the MHPs' discomfort at not being fully aware of the nuances of communication. Therefore, it appears that MHPs who make comments along these lines evidently prefer clear role boundaries for the interpreter.

As a result, some MHPs try to exercise gentle control of communication. For example, if the client is going around in circles, if their speech is pressured (MHN2, PSY2), or if they are excitable (MHN2), the mental health professional will try to regain control. MHN5 summarised the situation as follows,

MHN5 [W', w', well] #00:17:50-7#

KZ [word] by word, #00:17:51-2#

MHN5 if the patient keeps talking, we, like, we'd nearly know ourselves, like, that... you'd nearly guess, like, if, if he has said, said that too much. #00:17:59-1#

KZ Aha, ok. #00:18:00-1#

MHN5 You know. Or, the', the', the, the, the interpreter'd give you, eh... some idea, you know. #00:18:04-1#

KZ Ok. #00:18:04-4#

MHN5 Like, we'd, we', we, we couldn't, like, we couldn't let them talk forever. #00:18:07-7#

KZ Ok. #00:18:08-2#

MHN5 We, we'd never get through our work then. But like when, when, when there's a set period, I mean, if it goes on beyond that then we... we say to the patient, Or just hold on for a sec. Just want to hear what the interpreter says. #00:18:20-3#

KZ Ok. #00:18:20-9#

MHN5 And we mightn't need any more information. Might have got in, in that bit, you know. But there are times when you have to stop, because... Patient come in, and depends what mental state they are, so they can be very excitable... have... eh... pressured speech #00:18:35-0#

KZ Uhm. #00:18:35-6#

MHN5 and all that. And you, you have to stop them, you know. #00:18:37-9#

Strategies for the mental health professional to assert their authority can involve, for example, turn-allocation to either the client or the interpreter (INT3, MHN5, OT1, PSY1, PSY2). Such interruption is sometimes necessary, especially when there is more than one non-English speaker present "when all members speak together or try to make themselves heard" (Fox and Gander 2004 p5). This is well supported by the following *story about a client* and their family.

OT1 Ehm... So those were a couple... maybe of things... that were kind of... an, w', just, I s'pose, very last thing was... when things can get... not out of hand, but... somebody is communicating anger through sign lan' [laughing], thro', through an interpreter. Ehm... Or when a conversation just simply goes.. . Where, say, you've got two people having again, like, maybe a client an' a family member, an' it's happenin' through the interpreter, an' it's, an' it's gone. There's been... five or six interchanges of conversation, #00:21:16-9#

KZ [Uhm.] #00:21:17-2#

OT1 there's obvious high... high emotion, high tension, you know... there's bangin' on the table, that kind of stuff, an' it's like Wha'... wha', what happened there? And you lose... so much of that without the language, you know. #00:21:28-2#

KZ And do you think you lose... [a lot]? #00:21:30-6#

OT1 [I think] so. I think what you probably lose is your authority. #00:21:33-3#

KZ [Uhm.] #00:21:34-3#

OT1 [Ehm...] An' I don't mean that harshly, in a bad way, but...certainly in a situation like that...I would feel... I would, I'd feel difficult to say, Hang on, can we just... stop there. Because... I don't know at what point I'm coming into the conversation. If it was an English... #00:21:48-4#

KZ [Uhm.] #00:21:49-1#

OT1 [conver]sation... I would hear maybe a natural break... in a conversation. A natural pause between subjects. An' I'd come in and go, Ok, you know, I've heard that. It's time to, maybe, can we just bring it back to #00:22:00-6#

KZ [Uhm.] #00:22:00-7#

OT1 what we were talkin' about earlier. Bu' without that... I could be comin' in in the middle of a really traumatic story, that... #00:22:06-6#

KZ [Uhm.] #00:22:07-1#

OT1 I... I don't want them to not... talk about, but... You know, it's kinda difficult to know where to break that stuff... That's just another challenge, I guess. #00:22:17-2#

Similarly to Bot's findings, some MHPs realise that they have to concede some of the control over the therapeutic session, albeit not always willingly. Some have experienced losing control when working abroad and being the non-majority language speaker in a therapeutic setting (#00:06:52-2#), as the following excerpt illustrates.

THER3 Is that probably in my own language environment, here, #00:06:16-0#

KZ Uhm. #00:06:16-5#

THER3 there's probably more structure and control. Whereas... in my experience in... particularly in {country}, #00:06:23-8#

KZ Uhm. #00:06:24-2#

THER3 where I would've worked in a centre for domestic violence, very often we would have a number of family members. Because that was the model [???] #00:06:33-6#

KZ Uhm. #00:06:34-1#

THER3 where... you know, you just didn't work with the client who came with the issue. It often extended into... the elders coming. #00:06:41-2#

KZ Uhm. #00:06:41-6#

THER3 Ehm, so there was very... so there was much less control, because... sometimes I would have... a member of my team... you know therapeutic team working with me in that context. #00:06:52-2#

KZ Uhm. #00:06:52-7#

THER3 So her or she... would have the... local language. #00:06:56-0#

KZ Uhm. #00:06:56-8#

THER3 And therefore I'm depending... on that individual. To either interpret all, or some, or the... you know, less. #00:07:05-9#

KZ Yeah. #00:07:06-5#

THER3 So maybe that... yeah, that', that probably would be true. That I would've probably felt less, less in control. Because I would be the, certainly, the minority. #00:07:15-6#

Finally, in the respondents' opinion, ultimate control appears to rest with the mental health professional (INT6, INT8, INT9, INT12, OT1, PSY2, THER3, THER4), as appropriately put by THER3 (#00:17:07-3#).

THER3 Well... the whole aim in the therapeutic work would be that everything that the, that the therapist is if you like guides it and controls the session #00:17:07-3#

KZ [Uhm.] #00:17:07-8#

THER3 and I'm using control in the best way. #00:17:09-1#

KZ [Mmm.] #00:17:09-8#

THER3 But somebody has to be in charge of a session. #00:17:11-4#

KZ Uhm. #00:17:12-0#

It is worth noting that most of these examples, which are representative of the data collected during the interviews, originate in a specialised and / or therapeutic setting, as opposed to mainstream and / or logistical setting, a distinction discussed in further detail in Chapters 4 and 6. That is to say, MHPs working in these services seem to be more cognisant of issues around session control.

5.6. Interpreter in Control

The interpreter's control of communication of interpreter-mediated encounters can manifest itself in turn-taking management by verbal interruption (Hale 2001), hand gestures and / or gaze (Bot 2005a), overlapping talk (Bot 2005a), hedging (Wadensjö 2000) or answering questions for the primary speaker (Qian 1994). *In extremis*, it can even involve halting asylum seekers' developing narratives (Jacquemet 2005). Further examples comprise the conscious or unintentional choices of what is interpreted, or rather what is left out, that is zero-rendition of the primary speakers' utterances (Wadensjö 1998a p108), or non-renditions (Wadensjö 1998a p108), where communication other than the oral translation of the primary speaker's words is initiated by the interpreter. Both types of interpreter interference influence the construction of interpreter-mediated encounters, as clearly demonstrated by Amato (2007) in her analysis of medical consultation with the parents of brain-injured children. Differences in register variations, as discussed in section 4.3.2., also result in an often undetected change in the control of communication. The following sections present Bot's results and the findings of the current research on the interpreter's control of interpreter-mediated encounters.

5.6.1. The interpreter in control in Bot's treatment

Bot considers the matter of session management in terms of models of cooperation rather than from the viewpoint of the individual participants. Her findings on the therapist's control suggest that there is no one single way to model session management. Therefore, it is unsurprising that she cannot detect a general pattern for

the interpreter's taking control. What is interesting, however, is that on a number of occasions Bot (2005a) discusses the interpreter taking control over the communication flow in terms of struggle for control.

> From the interviews it has become clear though that interpreters occasionally disagree with the course set out by the therapist and therapists state that interpreters sometimes make this clear non-verbally. Whenever interpreters disagree with the therapist's strategy, this does however not lead to mutual consultation between the two professionals about the course to be followed: it remains the therapist's responsibility to determine this. However, in the discussion the participants emphasise the importance of the interpreter and therapist agreeing with each other. (p65)

In terms of the current study, this implies that occasionally the mental health professional and the interpreter disagree, in other words, the co-construction of the interpreter-mediated event at the discourse level is not fully consensual.

Following on from her suggestion to distinguish between the translation-machine and the interactive cooperation models, the issue of interpreter control could indeed cause conflict between the therapist and the interpreter. If a mental health professional who subscribes to the one- or two-person psychology models shares a session with an interpreter who works in the translation-machine model, they would be in consensus that interpreter control is undesirable. A therapist of the three-person psychology persuasion and an interpreter operating in an interactive model would equally agree that the interpreter, at least occasionally, could take control over the flow of communication. However, a therapist working in an interactive model would be halted in their efforts in trying to allow for occasional interpreter control by an interpreter from a translation-machine model. Within Bot's taxonomy, and as seen from the narrative viewpoint of the current research, probably the most conflictual situation is if a therapist from a one- or two-person psychology background and an interactive interpreter are trying to fight for control.

Notwithstanding the cooperation models between the therapist and the interpreter, possibly the most interesting finding in Bot's research is the realisation that the client's relationship or attitude towards the therapist can also affect their cooperation with the interpreter. Reporting on one of the six video-taped sessions Bot (2005a) remarks that the

> feeling of being in control that the patient reported is showing [sic] most clearly in relation to the interpreter. […] I would like to relate this to the content of the session: the patient is angry with the therapist. The session is saturated with this emotion and I think that leads the patient to disregard the interpreter. The therapist does not intervene to help the interpreter to get the turn – which would have been an appropriate thing to do being the manager of the session.

> The interpreter has to fend for himself and overlap is a powerful means to get his turn. He clearly self-selects to become the next speaker. As the patient does not always yield to him quickly, the patient and the interpreter seem to struggle for the floor in several instances. Again, it shows that for turn transfer to happen, a current speaker has to yield and any control is always a shared control between the current and the following speaker. (p127)

This example clearly shows that some power rests with each of the participants to control the flow of communication. It also refutes the research claim that interpreter-mediated encounter-level narratives in MHC are consensually co-constructed.

5.6.2. The interpreter in control in the findings of the current research

As also discussed by Bot (2005a, 2005b), the respondents in the current research believe that one of the most apparent aspects of the interpreter's control is the fact that the MHP is not aware of the intent, content or manner of the original utterance (INT1, INT2, INT4, MHN1, OT1). Despite a general understanding of the mental health professional's disadvantage at following the information flow, some respondents have expressed their surprise at the realisation, as can be seen from the following extract. This short passage also illustrates how the interview provided an opportunity for bilateral information exchange. In other words, respondents could take advantage of my presence and make enquiries in turn for their assistance with the research process, while I, the interviewer, sometimes became the data provider.

> MHN4 [Yeah,] from now I know, yeah. So you could be telling me a whole, whole load of hogwash? Do you? #00:20:19-4#

> KZ Yeah, exactly. #00:20:20-1#

Similar contributions generated reponses on the mode of interpreting. This original interview theme received relatively little attention during the interviews and there was no consensus on the most frequently used modes or best practices. Some respondents suggested that the interpreter should interpret in simultaneous mode in order to minimise information loss (INT8, INT9, INT11, INT12). This is well demonstrated in the next passage where a trained INT voices concern over the loss of information (#00:16:31-8#).

> INT11 For this particular case. Ehm... #00:16:19-3#

> [silence] #00:16:20-6#

> But ehm... If it is possible, I think, simultaneous would be best. Because... it allows you to... interpret exactly everything that is being said. So you just, you follow all the words of the patient. #00:16:31-8#

KZ [Uhm.] #00:16:32-3#

INT11 [And then] you can convey everything one hundred percent. Whereas, ehm... #00:16:36-3#

[silence] #00:16:37-4#

whereas ehm... with consecutive interpreting, if the patient... let's say, they won't stop, because they just don't know, and you cannot really... like, you know, advise them, could you please pause, especially... like, that's, that's obvious, So, eh, yeah, I think, it would, it would be best... to, to interpret simultaneously. #00:16:55-4#

KZ [Uhm.] #00:16:56-1#

INT11 [In] this... instance. #00:16:57-3#

The other frequent proposal was that interpreters should take notes (INT9, INT12) in order to preserve as much of the communication of the primary speakers in their rendition as possible. INT9 argues that by taking control over the message transfer, the interpreter empowers the primary participants to follow their own rhythm in the communicative event (#01:09:22-8# - #01:09:52-1#).

INT9 Well, again, the quality of interpreting comes in again. 'Cause if you are fluent in interpreting, you won't [???] eh... ehm... #01:08:42-0#

[silence] #01:08:43-2#

interrupt people in the middle of the sentence. Because you can handle that. You can take in... a good bit of infor', of information. You can memorise it. Or if not, you can take notes. Or if you see, you just can't cope with it, then you, then you say so... to the patient. But if you don't know how... how to prepare... how to deal with that, then you, then you just interrupt people. And most people... don't like that, especially if it's about an emotional matter. #01:09:10-8#

KZ Mmm. #01:09:11-0#

INT9 [???] #01:09:12-6#

KZ [???] #01:09:14-0#

INT9 Yeah, but it happens very often in the middle of the sen, sentence. It isn't really. And some interpreters who are not very experienced... ehm... #01:09:22-8#

[silence] #01:09:24-7#

they don't adjust to the rhythm of the patient. #01:09:27-5#

[silence] #01:09:29-4#

They, they adjust to the rhythm of their own memory. Where, whereas you should really adjust to the patient and to the professional. This is what... what I'm trying to do anyway. Because if they don't feel they're, they are here to cooperate with the interpreter. But that they feel... they're here... for... a psychological assessment really. Not just to make things easier for the interpreter. #01:09:52-1#

However, notetaking is sometimes viewed as problematic in mental health care (see, for example, Fox 2001 p20), where clients may perceive it as an institutional imposition and it may aggravate their symptoms, especially if they are already suffering from paranoia or paranoid conditions (INT10, INT12, PSY2).

The following *story about a client* concerns their fear of recording their communication and supports the argument presented in the current chapter. It illustrates how taking notes sometimes has to be clarified to the client and how the interpreter sometimes takes control over the recording and final disposal of the information the client may perceive as threatening.

> INT12 That's what I always say to them. I always say to them, I have a notebook here... #00:17:23-5#
>
> KZ Uhm. #00:17:23-9#
>
> INT12 I'm gonna be taking notes of what you come up with, it's just so that I don't forget anything that you say, #00:17:27-5#
>
> KZ Uhm. #00:17:27-9#
>
> INT12 or don't leave anything out. When this meeting is over, I destroy these notes and throw them in the bin. #00:17:31-7#
>
> KZ Uhm. #00:17:32-2#
>
> INT12 Ehm... Is that alright with you? And... The', it's usually totally fine. It's, it's that you mightn't be retaining information about them #00:17:38-4#
>
> KZ [Yeah.] #00:17:38-5#
>
> INT12 [some]times that disturbs some of them. Or... What are you gonna do with this afterwards? Then sometimes... there was one woman who... was a very frightened lady. And I actually destroyed them in front of her. #00:17:47-2#
>
> KZ Mmm. #00:17:47-7#
>
> INT12 I said, I'm throwing them, I'm tearing these up now, putting them into the bin here. #00:17:50-1#
>
> KZ [Yeah.] #00:17:50-3#
>
> INT12 [Right here.] And I tore them first. #00:17:51-7#
>
> KZ [Uhm.] #00:17:52-2#
>
> INT12 And just take the page out. [???]. I only had to do that once. #00:17:55-8#
>
> KZ Ok. #00:17:56-4#
>
> INT12 Just once. With a young woman. #00:17:57-8#

Note-taking as well as simultaneous interpreting is also difficult in some MHC situations, where therapy does not take place in the confined space of an office or clinic. In the case of occupational therapy, for example, the interpreter may have to take over communication entirely and produce non-renditions. After all, if the therapist cannot communicate with the client when they are about to run out in front of a bus, the interpreter will most probably not wait for the occupational therapist to produce an utterance to be interpreted (OT1). This example also highlights the difference present in settings traditionally viewed as therapeutic encounters, and the variety of environments an interpreter may find themselves in MHC in Ireland.

In general, INTs reported that before they begin the first session they explain to the client how the interpreting process works – mostly following the consecutive mode (INT3, INT4, INT6, INT9, INT12). This can be achieved by different means. The following extract illustrates a straightforward explanation by an untrained INT.

> INT4 I do, I do remember, because, eh, [???] it was no different. I mean. In, in the beginning, you know, I did a lot of, eh, interpreting. I always tell them, the people, before the start, Listen, it goes like this, I mean, you say few sentences, you will talk half a minute, and then, and I give you a sign, with my hand. #00:16:01-7#
>
> KZ Uhm. #00:16:02-4#
>
> INT4 And you stop and I'll interpret what you've, 've just said. #00:16:04-8#
>
> KZ Uhm. #00:16:05-6#
>
> INT4 So... #00:16:05-8#
>
> KZ And did you tell the psychologist the same thing? #00:16:08-6#
>
> INT4 Eeh, yes. More or less yeah. #00:16:10-5#

INTs said that they would stop the client if necessary (INT4, INT5, INT7). This usually happens if they have not finished interpreting the previous primary speaker's whole utterance (#00:27:33-1# - #00:27:41-3#), as recounted in the following extract by an INT with CI training.

> INT3 [Mmm... some]times, ok, I would say that, ehm... the way I... I will control the situation, not only in, in, ehm, mental health, but in other case, is, ehm... tryin' to make aware... or tryin' to... establish the rules... when the doctor... finished with his, statement #00:27:33-1#
>
> KZ [Uhm.] #00:27:33-8#
>
> INT3 [I] have the interpreter, and I ask... the person to listen until I finished. Otherwise... [...] get mixed up all the time. #00:27:41-3#

KZ [Uhm.] #00:27:41-9#

INT3 [An'] I... have to really... say it this way. So, for the patient, [???] expect... people #00:27:50-1#

KZ [Uhm.] Or you clear that at the beginning? #00:27:52-7#

INT3 Ehm... yes. But I always try to... that... the message is bein'... #00:27:56-7#

KZ You mean entire message? #00:27:57-9#

INT3 Yeah. Otherwise, sometimes, eh... in the middle of the conversation the... the patient, eh, interrupts. #00:28:04-2#

KZ [Uhm.] #00:28:04-8#

INT3 [An'...] you're not finished with the... interpreting... previous message. An'... #00:28:09-8#

Other INTs commented that they would never stop the client, mainly for two reasons. Firstly, during the initial sessions the client often has a need to produce an uninterrupted, even if unintelligible narrative, where the focus is on the activity of telling, rather than on the full reception on the listener's part. In other words, mental health professionals do not necessarily find it problematic if they do not fully understand what the client is saying as long as the client, who is very often traumatised, has an opportunity to relieve their pain (INT8, INT12, THER4). Secondly, some respondents have commented that clients eventually get used to the concept of interpreter-mediation, and allow the interpreter to take turns, and carry out the interpreting of what they have just said (INT12). A MHP suggested that this problem is not significant as the client would behave differently anyway, once an interpreter is present.

KZ And what if, for instance, the patient goes on for like five minutes? Ehm... Because, in... terribly... I, I would've thought he was allowed and to go on #00:24:19-3#

THER2 Yeah. #00:24:19-9#

KZ for five minutes. #00:24:19-9#

THER2 Yeah. I... you would, but I don't think, you see... Because of the interpreter's presence, there's far more pausing, you know. There's far more stopping, and all. Because, I think even if somebody's very sick, they appreciate that somebody's, going to have to relay the information. #00:24:37-6#

KZ Ok. #00:24:38-1#

THER2 [...???] Nobody could contain ten minutes' information [...???]. #00:24:42-1#

Although the INTs reported stopping the client in their tracks on a regular basis, there are very few mentions of the interpreter interrupting the mental health professional. This may be due to a perceived power differential between the mental health professional and the interpreter, but it may happen because the interpreter believes they should mirror the mental health professional's attitude for the client's sake. On a more practical level, it is also possible that mental health professionals simply make shorter utterances which the interpreter does not need to interrupt. As Fox (2001) remarks,

> Some clinicians are tactile and effusive and we greet and say goodbye to our clients with lengthy and warm hugs and kisses. Others are formal and reserved, avoiding body contact beyond a handshake. Most of the time I try to align my body language to that of the clinician as in most cases my relationship to the client is similar to the one the clinician has with the client. Successful therapy is often determined by a smooth and open teamwork between all concerned in which the bonds and boundaries are well defined. (p19)

Also, in line with Bot's findings, mental health professionals do not appear to concede control over communication entirely. While they are aware that they cannot manage and monitor linguistic communication, final responsibility rests with them, as we have seen in section 5.5.2. on mental health professional control. Moreover, if linguistic communication does not go according to the mental health professional's expectations, they may resume control by non-verbal means, by, for example, raising their hand (INT4, PSY2). It is also to be emphasised that the interpreter can only make and follow up on such decisions in the relatively consensually co-constructed settings of specialised services rather than in mainstream provision.

INTs who allow for such developments believe that rather than being in control of the session, they are a tool of communication, serving the two primary speakers (INT9, INT12). It is interesting to note, however, that the two particular respondents who have commented on the service nature of their profession hold very different attitudes towards the interpreter's role. An untrained INT will try and build trust and assume responsibility for trying to make sense of the primary speakers' intended message and will keep asking to clarify their utterances before continuing interpreting (INT12). An INT, on the other hand, with training in conference interpreting and psychology will keep to the role boundaries and take a purely impartial, uninvolved stance which allows the two primary speakers to work out their comprehension problems (INT9).

The interpreter's control is perhaps best illustrated by a *story about a client,* in support of the present argument, where the INT explained their practices during the interview. The INT elaborated on whether mental health professionals have a tendency to interrupt clients' narratives (#00:29:24-6#). Then they spontaneously returned to the topic of clarification (#00:29:35-2#) before going on to explain how they used the consecutive mode of interpreting (#00:29:43-2#). In reply to my query on their clarifications (#00:30:03-3#), the INT reasoned that they needed to clean up the narrative, otherwise it would not make sense (#00:30:25-8#). The INT's reference number and any identifiable details have been removed for confidentiality reasons.

INT So, yeah, and I would every single time... you know, I will... #00:29:28-3#

[silence] #00:29:30-8#

Maybe when I'm tryin' to kinda clarify facts, will I interjected my own voice, most of the time I just, you know... #00:29:35-2#

[silence] #00:29:37-0#

I repeat exactly what the person says... #00:29:38-3#

KZ [Yeah.] #00:29:38-3#

INT And then I repeat what the therapist says. And then I repeat what the client says. [laughs] #00:29:42-1#

KZ Yeah. #00:29:42-3#

INT You know. #00:29:43-2#

KZ 'Cause that's exactly what I was go', gonna go back to... the.. eh, the clarification. What you said that... you actually used the word narrative. That when it's their narrative, #00:29:51-5#

INT Uhm. #00:29:51-8#

KZ And you don't necessarily... wait for the therapist to clarify things, but you kind of... clarify it with them, and they're... sort of clear up the narrative towards the therapist. #00:30:03-3#

[silence] #00:30:04-6#

INT Yeah. And you'd have to. Because otherwise... you're... you're saying things that makes absolutely no sense. #00:30:11-0#

KZ Yeah. #00:30:12-5#

INT You, d'you know what I mean? You know, you're, you're, you're #00:30:14-0#

KZ [Yeah.] #00:30:14-1#

> INT you're, you're, you know, by the end of... the sentence you've given the woman three husbands. #00:30:17-3#
>
> KZ Uhm. #00:30:17-8#
>
> INT And she's not married. Or, or, you've, you know, she's talking about her friend's husband. Or d', d'you... It's, it's, it's to do with the level of confusion... #00:30:23-8#
>
> KZ Uhm. #00:30:24-3#
>
> INT of the story that has come out. #00:30:25-8#
>
> KZ Ok. #00:30:26-5#
>
> INT You know. I don't know if that makes any sense at all. #00:30:28-6#

Sharing of control between the MHP and the interpreter, however, does not necessarily entail consensual co-construction. Respondents agree that a balance between trust among the participants (INT7, INT8, INT9, INT10, INT11, MHN2, MHN4, OT1, PSY1, PSY2, THER3) and boundaries among them (INT7, INT9, INT10, INT12, PSY1, PSY2, THER1, THER3, THER4) is the key to successful therapeutic relations. These two sides of the same coin were of particular interest to one of the MHPs (#00:23:31-4#, #00:23:40-5#), as can be seen in the following extract.

> PSY1 I think it can, ehm... it obviously makes a big difference if the... if the client is comfortable. #00:23:12-1#
>
> KZ [Uhm.] #00:23:12-5#
>
> PSY1 [With] the interpreter. #00:23:13-2#
>
> KZ [Uhm.] #00:23:13-6#
>
> PSY1 Ehm... #00:23:14-6#
>
> [silence] #00:23:16-0#
>
> And... you know when I, I spoke about boundaries earlier on. That is, is one of the issues that... obviously, if the interpreter is someone who speaks the client's language and the client doesn't have anybody else who speaks that language... they may develop a, a relationship outside of the... therapeutic #00:23:31-4#
>
> KZ [Uhm.] #00:23:31-5#
>
> PSY1 relationship. So... That can... #00:23:34-8#
>
> [silence] #00:23:37-0#
>
> it can be helpful, because the client is then very relaxed with that person. #00:23:40-5#

KZ [Uhm.] #00:23:40-8#

The next passage shows how the same idea was reiterated by another MHP (#00:27:09-8#, #00:27:22-1#).

THER3 Well, I s'pose... there's two things, I would say here, in my experience just here. One is I'm aware that it can be a huge influence for the positive. #00:27:01-0#

KZ Uhm. #00:27:01-6#

THER3 In that it builds the safety, and the security that we need for therapeutic process to work. #00:27:09-8#

KZ Uhm. #00:27:10-4#

THER3 And having the same interpreter who's calm, and who's safe and who does the job professionally #00:27:15-8#

KZ [Mmm.] #00:27:16-5#

THER3 holds the boundaries. That, that, that really actually increases the speed of the work. #00:27:22-1#

KZ [Uhm.] #00:27:22-5#

THER3 Even though, we'll always know that using an interpreter is very sl, it's, it's slow part. #00:27:26-3#

KZ Uhm. #00:27:27-0#

Respondents maintained that, on the one hand, "the most important for you is kind of the rapport and con[tact]" (MHN2 #00:21:56-5#) for the therapy to be able to begin. However, they also emphasise that over-familiarity "blocks the relationship between the therapist and client which is the foremost" (THER3 #00:29:04-8#).

Thus, it appears that while the interpreter is expected to take responsibility of the meaning transfer between the primary speakers, the ultimate control of the interpreter-mediated event in MHI in Ireland rests with the mental health professional. As the definition of meaning transfer and overall communication are sometimes undefined and the boundaries are often unclear, the overlaps can result in the mental health professional and the interpreter battling for the control of communication. Therefore, the research claim that narratives in MHI in Ireland are consensually co-constructed has been found to be untrue with regard to the discourse level of interpreter-mediated encounters.

5.7. Issues of Professionalisation

As seen in sections 5.5.2. and 5.6.2. on the mental health professionals and the interpreter's control of communication, the respondents remarked that interpreters should keep professional boundaries in order for successful communication to develop. Sometimes they also elaborated on what they meant by profession and boundaries in their comments. The following discussion presents these findings and continues with a research dialogue between the respondents' views and the CI literature. As the issues mentioned in relation to professionalisation are wider than the remit of MHI, the referenced literature moves away from the strict focus of Hanneke Bot's work in the previous sections and also includes general CI works. Similarly, the scope of analysis broadens and ventures from the encounter level of discourse to a higher organisation level of narrative. Thus, it will lead on to the next chapter, where the metanarrative of service provision comes to the fore.

5.7.1. Profession as a concept

5.7.1.1. The concept of profession in the CI literature

Mikkelson in her article on the professionalisation of community interpreting quotes Joseph Tseng's argument on the evolution of the profession. Tseng (1992 in Mikkelson 1996) examines the status of the profession in Taiwan and posits that the four stages of the evolution of a profession comprise I) market disorder; II) consolidation of the profession and consensus about professionals' aspirations; III) ethical standards; and IV) public acknowledgement. The main areas which, in Tseng's view, are necessary for professional development, are training, professional association, and control of access into the profession.

Ozolins (2000) proposes that there are four stages in the evolution of service provision from the denial of the existence of communication issues, through reliance on ad hoc services, then generic language services where "usually governments, but sometimes charities or private providers, have attempted to introduce broader-based language services that make some attempt to cover public sector needs" (p25), to fully comprehensive responses. He also offers the criteria along which particular countries can be placed on the continuum of the above spectrum. This list of primary standards includes organised language services, training and accreditation (pp25-26).

Similarly to Roberts (1997), Pöchhacker (1999) begins his argument with the discussion of the definition and denomination of community interpreting. Pöchhacker, however, makes two significant distinctions. Firstly, he emphasises the difference between interpreting for the deaf and for spoken migrant and indigenous minority languages. In agreement with Ozolins (2007) who remarks that the "sign language (SL) interpreting field, as with so many other issues, may be further down the road on this than spoken language interpreting" (p129), Pöchhacker also states that the former is in a far more advanced state of provision than the latter. Secondly, Pöchhacker contrasts "authority-driven" or legislated service provision and training / accreditation systems, such as the practice in Australia and Sweden, with profession-based systems, such as the ones in operation in the UK and the US. The author concludes that, while the heterogeneous nature of CI service provision allows for little generalisation, "typically, interpreting services 'get organized' (by institutions or community agencies) before practitioners get themselves organized, if at all, to actively and collectively shape their professional terms of reference" (Pöchhacker 1999 p136).

Wadensjö (2007) in her introduction to the proceedings of the Stockholm conference quotes two historical definitions of "profession." In the 1960s, a professional was seen as emotionally neutral, as someone who provides services for the collective good, gains professionalism through training and upholds certain ethical norms. In the 1970s, professionalisation was viewed as a struggle "between conflicting interests of groups and societies" around issues such as "the role of theory for the development of the profession, the relation between a profession and the (welfare) state, and professionalisation and higher education" (p2).

Arguably, all service provision should be organised around the good, that is the welfare and benefit, of the client. A substantial proportion of the literature further contends that this can only be achieved by collaboration between the service providing parties, in CI terms, the service provider and the interpreter. Elghezouani (2007), the author of the only article specifically dedicated to the professionalisation of MHI in particular, arrives at the same conclusion (p223). Like Rudvin (2007), he draws attention to the dichotomy between the Western and Eastern paradigms. However, within the MHC framework, he draws on the distinction also made by Kaufert and his colleagues (Kaufert 1990; Kaufert and Koolage 1984; Kaufert and Putsch 1997), on the difference between bioethical and ethno-psychiatric approaches.

Elghezouani's contribution is also significant as he has a double perspective of being a practising psychologist and an experienced interpreter.

5.7.1.2. The respondents' views on the concept of profession

The respondent INTs and MHPs were far less conceptual and abstract about the idea of profession than it appears in the CI literature, and they mainly associated the notion with "professional behaviour" in terms of time-keeping or appearance. Nevertheless, the three areas most often brought up, that of professional interpreters, employment concerns and moral obligations, are intrinsically intertwined. The respondent INTs' complaints reflect this interconnection. They repeatedly remarked that they find it difficult to get work because untrained interpreters, who are unaware of and may act against professional guidelines laid down in codes of professional conduct, are preferred by the agencies (INT9, INT10, INT11). INT10, for example, drew attention to the fact that some people are contracted to interpret who are still in the asylum process (#00:16:55-6#). Asylum seekers are not allowed to engage in employment. Given their status and the ensuing feeling of insecurity, they can hardly be expected to provide impartial professional services.

INT10 Yeah. The other thing that I want to mention is #00:16:44-7#

KZ [Yeah.] #00:16:44-6#

INT10 [there's] a lot of... interpreter now [sic]. They're just people, they just... you know. They're not trained. #00:16:50-9#

KZ Yeah. #00:16:51-4#

INT10 They are... being in processing asylum themselves. Know what I mean. #00:16:55-6#

KZ [Yeah.] #00:16:55-7#

INT10 And they have no experience whatsoever. #00:16:58-3#

KZ Yeah. #00:16:58-9#

INT10 And I really find it very disgusting... you know that... #00:17:02-0#

KZ [Yeah.] #00:17:02-5#

INT10 I find some of the interpreters, I did interpretation for them. And they became interpreter after that. #00:17:07-1#

KZ [Uhm.] #00:17:06-9#

INT10 Without training, without even... the language they have no... control over the

language. #00:17:12-5#

KZ Uhm. #00:17:13-0#

The fact that some agencies do not check for credentials or do not seek to employ trained interpreters is highlighted in the following passage by another INT.

INT9 Well, as you know, agencies are just recruiting... #00:57:18-1#

[silence] #00:57:20-0#

speakers #00:57:20-1#

KZ [Uhm.] #00:57:20-9#

INT9 of different languages. Not really interpreters. So there's no emphasis on quality. And I think that's quite important. And... #00:57:30-5#

Some MHPs also mentioned that they had negative experiences with certain agencies and prefer to book their interpreters through a particular agency (#00:13:23-3#), which is sensitive to issues of trust and confidentiality between the client and the interpreter (PSY1, PSY2), as the following passage suggests.

KZ Yeah. How do you... find your interpreters? Or how do you recruit them? Obviously, if you know them... for a while, but... if you ne', need a new language, [for example?] #00:13:14-7#

PSY1 [We, we] use a, an interpreting service. #00:13:16-9#

KZ Ok. Interling, or? #00:13:18-6#

PSY1 We use Interli', well, I tend to use Interling. Ehm... Obviously, I use some other... #00:13:23-3#

KZ [Ok.] #00:13:23-7#

PSY1 [services] as well. But I, I would... I'd have a trust in Interling. #00:13:27-5#

KZ [Ok.] #00:13:27-9#

PSY1 [I've,] I've used services, and really, you know, have had very unsuitable interpreters. #00:13:33-1#

KZ [Ok.] #00:13:34-0#

5.7.2. The specific issue of family and friends acting as interpreters

5.7.2.1. The CI literature on family and friends acting as interpreters

Internationally, perhaps the most contentious issue around professional versus non-professional interpreters' employment is the use of friends and family members, especially children, as interpreters. The CI literature is highly divided on the matter:

while some argue for the employment of professional interpreters (Abraham and Fiola 2006; Bullock and Harris 1997), others clearly do not consider friends and family, even children, interpreting for their loved ones as necessarily problematic (Edwards et al. 2005; Green et al 2005). Researchers who promote the use of professional interpreters base their argument on findings of discourse analysis of recorded interpreter-mediated encounters (Meyer 2001). Those who subscribe to the idea of using family or friends as interpreters quote results of surveys or interviews with service users and interpreters, children among them (Green et al. 2005). The background of the researchers also seems to influence their attitude towards such issues. Scholars in Translation and Interpreting Studies (T/IS) usually uphold the view to engage trained interpreters (Bullock and Harris 1997; Meyer 2001), while experts from other disciplines who encounter interpreters during their work accept the use of family and friends (Green et al 2005).

Simply put, the two principal arguments revolve around familiarity on the one hand, and confidentiality, traumatisation and linguistic competence on the other. In other words, the advantage of working with friends and family members is that they may speak the client's special dialect, and may be more trusted than a stranger (Green et al 2005). However, the converse may also be true, that is the client prefers to work with a stranger, whereby confidentiality can be guaranteed (Abraham and Fiola 2006; Rudvin 2007). Furthermore, friends and family members may also be traumatised and find it emotionally difficult to interpret, especially in cases of serious medical problems (Jacobs et al 1995).

5.7.2.2. The respondents' view on family and friends acting as interpreters

Findings of the current research confirm that trust is a salient issue and sometimes the client accepts no one else but the relative to interpret for them.

> INT7 And of course, for example, for this couple... the wife always went to counselling with the husband who was interpreting for her. Although his English wasn't great, but... she wouldn't accept anybody else. #00:19:33-7#

> [silence] #00:19:34-9#

MHN2 commented that rapport is essential and in times outside the therapeutic session the client is precluded from general everyday conversation or small talk with the mental health professional due to the language barrier. In these circumstances, mental health nurses are pleased if family members or friends can help them

communicate with the client. The MHN argued in the following excerpt that in the case of in-patient services where the clients spend days or even weeks in the care of MHC services, not to be able to communicate is highly frustrating to both parties, and any help with keeping contact is welcome (#00:21:56-5#).

> MHN2 Or eh, eh, sometimes as well, if somebody's [???] if maybe people, if their friends coming in. #00:21:34-7#
>
> KZ Uhm. #00:21:35-0#
>
> MHN2 we kind of would get them maybe to interpret for the person. Kind of informal #00:21:40-3#
>
> KZ Ok. Just to keep kind of contact? #00:21:44-0#
>
> MHN2 Yeah, like, say friends or family, if they speak English. We can, we get them to interpret. Ehm.. #00:21:51-0#
>
> KZ Hm. #00:21:51-4#
>
> MHN2 Ok, so, kind of, the most important for you is kind of the rapport and con[tact]? #00:21:56-5#
>
> MHN2 Yeah, to kind of establish a rapport with the person. #00:21:58-8#
>
> KZ Yeah. #00:21:59-5#

In contrast, confidentiality is brought up as the main reason for not employing friends or family members as interpreters by two MHP respondents, who have confirmed that such practices are highly undesirable, as the following passage suggests.

> PSY2 But #00:34:33-7#
>
> KZ [Uhm.] #00:34:34-3#
>
> PSY2 that people can't access, ah well, sometimes the GPs ask them to go with a friend that speaks English. I think that's even worse. #00:34:41-4#
>
> KZ Yeah. #00:34:42-3#
>
> PSY2 There's, where is the confidentiality gone? For, for, you know... So I think that is... I, I find that very, very... hard to... swallow. #00:34:53-4#
>
> KZ Uhm. Uhm. #00:34:54-7#

One of the respondent INTs remarked that if there is no female interpreter available for a gynaecological examination, having a male interpreter working behind a screen is preferable to having the husband or any other family member to do the job (INT6). The INT also added that, generally, it is hospital policy not to work with family

members as interpreters (#00:10:30-6#), as can be seen in the following extract when referring to Blanchardstown Hospital.

> INT6 But they didn't have female interpreter. So I have to do interpreting. You know, of course, I didn't look at the, you know, at the... #00:10:04-8#
>
> KZ Yeah, yeah. #00:10:05-1#
>
> INT6 at the... I was speaking through the... #00:10:06-4#
>
> KZ the screen, yeah. #00:10:08-2#
>
> INT6 yeah, or whatever. You know. But... they accepted, the patient accepted me as the interpreter. #00:10:13-3#
>
> KZ Uhm. #00:10:13-7#
>
> INT6 You know. She agreed me to do the interpreting. #00:10:15-9#
>
> To work out. #00:10:17-3#
>
> KZ [sighs] Ok. #00:10:19-0#
>
> INT6 [laughs] #00:10:19-4#
>
> KZ Ehm... well, much better than having the... #00:10:22-3#
>
> INT6 Oh, yeah. #00:10:22-4#
>
> KZ the husband, or son, eh... or someone in the family. #00:10:26-1#
>
> INT6 Oh, yeah. They can't do that. By the.. by the policy. Hospital policy. Family members can't do the... #00:10:30-6#
>
> KZ Yeah. #00:10:30-7#
>
> INT6 interpreting. #00:10:31-4#
>
> KZ Yeah, yeah. #00:10:31-9#
>
> INT6 Only emergency cases. Usually they have to provide them the interpreter. You know? #00:10:37-2#
>
> [silence] #00:10:38-8#
>
> KZ Ok. #00:10:39-1#

5.7.3. *Employment conditions: Rates of payment and agencies, the undesirable middlemen in service provision*

The use of untrained interpreters is interrelated with employment conditions on the market. The two focal points with regard to employment issues mentioned by the respondents, mostly the INTs interviewed, are rates of payment and the subject of agencies. In State-run institutions or mental health services, interpreters are usually

commissioned through translation agencies on an individual case-to-case basis. There is only one NGO, Spirasi, which uses "in-house" interpreters, although these interpreters, for financial reasons, do not work exclusively for this service. The professionals working at the psychology services for refugees and asylum seekers run by the State also try to make sure that they employ the same, experienced, interpreter with the same patient. But by and large, MHC services or the larger hospital units have either issued a tender for translation and interpreting provision, or are in a service-level agreement with a particular agency, or simply look up agencies in the phone book.

Contracting interpreters through agencies which operate as business entities in itself should not pose a problem. What is questionable is the quality of provision, which varies a lot across the different companies. In Ireland the agencies' organisational structure is telling of their commitment: one is a branch of a big multinational company providing language services, interpreting among them, and has substantial infrastructural support; another has grown out of a university department and is very quality and ethics conscious; a few have very good long-standing translation practices, mainly due to the fact that their managers come from a trained and educated translator / interpreter background. However, a lot of these agencies have been set up by individuals who have worked as interpreters and translators but have no training in the area. The problem is that hospital staff often assume that if they are paying for a service, then the service is professional and the interpreters are qualified.

5.7.3.1. The CI literature on employment conditions

Writing on employment conditions and the role of agencies, Ozolins (2007) points out that there "has been scant examination of how agencies themselves shape expectations of professionalism among end-users, or how they enhance or inhibit professional practice among interpreters" (p122). He describes the market *status quo* as the "central peculiarity of interpreting agencies," which he defines as "their service is often misunderstood by their clients (the purchasers of language services), *and* misunderstood by interpreters, *and* not infrequently misunderstood by agency employees as well" (p122).

Ozolins then lists a number of problems which are characteristic of the agencies (pp123-129):

- no quality control of interpreters by the agency;
- no mention professional codes of ethics by agencies;
- no understanding of the nature of interpreting among agency management and staff;
- no standards for remuneration;
- no appropriate communication between interpreter and agency (on cancellation policies, complaints, etc.);
- no support for INTs from agencies.

5.7.3.2. The respondents' view on employment conditions

Some INTs pointed out that agencies have little or no awareness of issues around interpreting, a matter also mentioned by Ozolins (2007). Consequently, possibly the most frequently quoted problem, apart from payment issues, is the carelessness about booking interpreters and providing continuity (#00:45:41-1#), especially in a setting as sensitive as MHI. The following extract is a clear example of such complaints.

> INT9 So ehm... Just getting back to it, I think that the same interpreter should be booked for the same case. #00:45:41-1#
>
> KZ Uhm. #00:45:41-8#
>
> INT9 And ehm.. #00:45:43-8#
>
> [silence] #00:45:44-8#
>
> Because it's a question of trust and confidentiality. And sometimes clients requested that. #00:45:49-3#
>
> KZ Uhm. #00:45:50-1#
>
> INT9 Like patients. They... #00:45:51-5#
>
> KZ [Yeah.] #00:45:52-0#
>
> INT9 [request]ed that. And the professional requested that as well. #00:45:54-8#
>
> [silence] #00:45:55-8#
>
> But the agencies, they don't really care about that, and they just... [???] assign whoever is available. #00:46:00-5#
>
> KZ Uhm. #00:46:01-1#

Quality and resources, or the lack thereof, go hand in hand, and the way rates are set seems to undermine the professionalisation of CI in Ireland. As INT respondents pointed out, mental health professionals, like other service providers in general, are

unaware of the fact that unprofessional, that is untrained and unqualified, interpreters receive the same remuneration as their professional counterparts (INT9, INT10). As one disillusioned INT commented, "if you pay peanuts, you get... monkeys. Pretty much so." (INT9 #00:58:05-3#).

The situation in Ireland will hopefully improve when a code of ethics for corporate entities is drawn up by the Irish Translators' and Interpreters' Association to promote the use of qualified interpreters whenever possible with appropriate remuneration, payment and cancellation procedures among others. This is in progress at the time of writing, and the Community Interpreting subcommittee have submitted a draft version of the code of ethics for corporate members to the Executive Committee. If approved, the code will have to be endorsed by members of the Association at the next AGM.

5.7.4. Ethical consideration

Several respondents, mostly INTs, also mentioned the lack of ethical standards associated with non-professional interpreters and the agencies which seem to control the market in Ireland. Related issues have been on the CI agenda for decades. The following sections examine the findings of the current research against the backdrop of the CI literature.

5.7.4.1. The CI literature on ethics

Abraham and Weston (2004) take a human right stance regarding the professionalisation of CI and quality interpreting service provision in Ontario. They posit that limited language proficiency speakers should have a right to quality interpreting services, and that standards which allow for such services should be facilitated by legal means. Building on a metaphor suggested by Pöchhacker (2004) in a contemporaneous study, they suggest that financial support to develop a service-user training programme within an anti-domestic-violence campaign is "a pebble at the centre of the ripple" (Abraham and Weston 2004 p2). While they emphasise the importance of such initiatives, they voice their fear that "it may unfortunately take a major tragedy, such as a loss of life, to trigger a change in public policy" (p8), a stark warning that there is more to the professionalisation of CI than meets the eye.

From a slightly different perspective, Rudvin (2007) warns that the concept of ethics is culture-bound and that confidentiality may also prove a fluid notion and a

difficult one to transfer between cultures and languages present at interpreter-mediated encounters (p65). Albeit solidly positioning herself in the Western tradition, Rudvin draws attention to the anomaly between the collectivist background of some interpreters and the individualist expectations of their work environment. She remarks that

> it *is* important to clarify and indeed separate one's professional role as an interpreter and private identity in order to function successfully in the workplace, clients and interpreters from more holistic philosophical and professional traditions are likely to be far less willing to make that separation, unless they decide over time to internalize those particular host-culture values. (p64)

The inherent paradox in the comment is rooted in the fact that it is based within the Western paradigm where such separation is indeed desirable, which confirms the author's self-confessed stance, too.

Kermit (2007) in his analysis of the concept of ethics in interpreting proposes that community interpreters can only be good if they fulfil their duty in both definitions of the Aristotelian sense of *good*. He suggests that interpreters need to be useful in what Aristotle coins *poiesis*, "an act as a means to accomplish an end, where this end is something different from the act itself" (p245). At the same time, Kermit argues, interpreters also have to understand that their professional position could allow them to exert power over the course of the interpreting process. Some would consider that this approach goes beyond the impartial role of the interpreter and involves advocacy on the interpreter's part. However, Kermit further argues that interpreters have a moral obligation not to abuse such power and earn the trust of the service user. This is what Aristotle refers to as *praxis*, "an act that is both a means and an end" (Kermit 2007 p245).

5.7.4.2. *The respondents' views on ethics*

Interpreters who see language assistance provision as a human right would be highly aware of what Kermit introduces as Aristotle's *praxis*. In other words, they would forego certain prescriptive guidelines if they felt there was a serious risk to the health or life of the patient. An example would be a surgical trauma patient refusing to give informed consent to be administered medication, while unaware of running the risk of limb-amputation as a possible consequence (INT7). Another is the apparent risk of suicide, where an interpreter would feel obliged to step outside the strict ascribed role and breach confidentiality with the patient by informing the

mental health professional of the imminent danger, as can be seen in the following passage.

> INT3 But, eh... I would say that this does not... speci', specifically apply in a situation of danger of human life. An' an exception should be made, [???], for example in a mental health situation. #00:15:26-4#
>
> KZ Uhm. #00:15:26-7#
>
> INT3 From part', for exam', eh... when there's a... there's a risk of eh suicide. #00:15:30-5#

Most INTs considered crossing the boundaries of confidentiality unethical in cases other than an emergency. This is a practice INTs associated with unprofessional colleagues (INT10). According to the respondents, confidentiality is still the single most important aspect of the code of professional conduct (INT3, INT5, INT7, INT9). INT3, an interpreter with CI qualification, commented on the issue (#00:14:52-6#).

> INT3 I suppose for me... the main difference, eh, and I mentioned this before, is to do... in relation to the code of ethics, ehm... it's do with the issue of confidentiality. #00:14:52-6#
>
> KZ Uhm. #00:14:53-2#
>
> INT3 Ehm... I suppose that, ehm... any information obtained... in the course of your interpreting work. #00:15:01-8#
>
> KZ Uhm. #00:15:02-4#
>
> INT3 Must not be... divul'... It cannot be released to any third party. #00:15:09-3#
>
> KZ [Uhm.] #00:15:09-7#
>
> INT3 cannot be disclosed to people. There's an agreement. #00:15:11-9#
>
> KZ Yeah. #00:15:12-4#

These codes published by professional organisations (see, for example, the Association of Visual Interpreters of Canada (n.d.); court interpreters in Finland (The Finnish Association of Translators, (n.d.); the National Association of Judiciary Interpreters and Translators in the US (n.d.); the Standards for Performance and Professional Responsibility for Contract Court Interpreters in the Federal Courts also in the US (Federal Court Interpreter Programme n.d.); or the Irish Translators and Interpreters' Association (2009) among others) serve as a compass to interpreters as well as a protecting shield when they feel compromised in their professional role and identity. Codes of conduct, or codes of practice as they are sometimes called,

symbolise the values that interpreters should aspire and adhere to, as exemplified by this short extract from an interview with INT3.

> INT3 Tha', tha', tha' had happened before and I suppose that's part of the... following the the code of ethics, ehm... it's... similar to the case... #00:16:39-8#
>
> KZ [Uhm.] #00:16:40-3#
>
> INT3 with the... eh, the approach... and advice the... the doctor. Eh, eh, the... it says in the code of conduct you should not have any... #00:16:51-3#
>
> KZ [Uhm.] #00:16:51-6#
>
> INT3 contact... previously with the... with the patient. #00:16:55-1#
>
> KZ [Uhm.] #00:16:55-5#
>
> INT3 And this applies not only for mental health interpreting, but applies to many other issues, but... I suppose in... in ehm... mental health interpreting it's specifically very important because of the... situation. #00:17:08-6#

A number of INTs (INT3, INT5, INT7, INT9) commented that awareness of and adherence to the code of ethics, mostly acquired through training (INT3, INT9), is what differentiates professional and non-professional interpreters. As one of them remarked, ignorance of these codes may have serious consequences.

> INT5 Because... you can actually cause damage, if you bring... a person who's totally oblivious to any sort of... you know... professional conduct, or #00:08:44-5#
>
> KZ [Yeah.] #00:08:45-0#
>
> INT5 [any]thing.

Thus, the findings suggest that some of the INTs interviewed consider ethics a much more tangible and pragmatic issue than it may seem at first.

5.8. Conclusion

The current chapter has focused on the encounter-level narrative set against the research claim that narratives in MHI in Ireland are consensually co-constructed. Following an investigation into how the individual participants of interpreter-mediated encounters take control of the communication, it appears that there is not one person who claims continuous full control. Evidence from Bot's study (2005a) and the current study also suggests that sometimes there is disagreement over and struggle for communication control, therefore, the research claim has once again been found untrue.

As regards professionalisation, a great proportion of references to professionalisation were made in connection with unprofessional interpreters and the resulting lack of quality assurance by contracting professionals and non-professionals. Unsurprisingly, INT respondents showed more awareness of quality issues and complained about the fact that there is no distinction between qualified and unqualified interpreters. What the INT respondents meant by qualification is rather unclear, but probably refers to years of experience (INT10). In other cases, quality denotes sufficient training, knowledge of skills and awareness of ethical issues (INT1, INT3, INT9, INT11). MHPs, on the other hand, almost equate professionalism with keeping boundaries, that is building trust while keeping a professional distance from both the client and the mental health professional (PSY1, PSY2, THER1, THER3).

The feasibility of such interpreting service provision is not always evident. In Ireland, for example, it would be practicable for languages spoken by a relatively large proportion of the population and where general education and specific interpreter training has been available, such as Polish, Russian or French. This cannot be guaranteed in the case of lesser spoken languages or where the language is not used as a vehicle of education in the home country, and where there is no tradition of interpreter training. Additionally, an interpreter is not always available at the venue where the interpreting takes place. In remote areas in case of emergency, for example, service providers could use telephone interpreting.

The findings of the current research with regard to the control of communication by the mental health professional are similar to those of Bot's research (2005a), discussed in section 5.5.2. That is, 1) there is not one single model of control; 2) mental health practitioners of the translation-machine persuasion try to exercise full control and keep interpreter role boundaries; 3) practitioners subscribing to an interactive model realise that they do not have full control; and 4), ultimately, the mental health professional is in a position to take control.

Findings on the control of communication also corroborate the evidence presented in Chapter 4 insofar as there appears to be a distinction between mainstream and specialised services as well as between logistical and therapeutic services in terms of their approach to consensual co-construction. Firstly, a therapeutic environment is more facilitating towards consensus. Less constrained by time than logistical settings, therapeutic sessions can truly allow for the ideal interpreter-mediated mental

health encounters, where all participants have one aim, successful therapy for the client. Secondly, specialised services, unlike mainstream hospitals, can also afford such luxuries, which creates a very different premise for interpreters. The inherent risks of the physical and psychological effects of interpreting in MHC on interpreters are the subject of the following chapter.

6.1. Introduction

This chapter tests the research claim that narratives are consensually co-constructed at the highest organisational level, the metanarrative. As shown in Table 6.1., it aims to present how important aspects of this metanarrative level, safety and interpreter support, were brought to the researcher's attention by the respondents. From the qualitative analysis which follows here it also transpires that it was not only the proportion, but also the manner of the responses which warrants special attention. I intend to demonstrate how the respondents approached the subject of safety on their own initiative within the narrative interview framework.

Level of narrative:	Metanarrative
Subject of analysis:	Safety
Practical issues:	Interpreter support
Stories supporting analysis:	Other stories
Internal research dialogue:	Research respondents and the researcher

Table 6.1. The organisation of Chapter 6

Consequently, the findings are introduced in an internal research dialogue between the respondents and the researcher. The argument is presented using dialogic and thematic narrative analytical approaches as proposed by Riessman (2002, 2004, 2008), which are detailed in Chapter 3. This entails the presentation of how the originally identified interview themes were actually phrased during the course of the narrative interviews (often in bold script throughout the chapter in order to highlight the variations on the original theme) as well as how the respondents availed of the opportunities to introduce subjects they felt strongly about.

This methodological approach illustrates the dialogic relationship between the researcher and the respondents, where the latter had the opportunity to raise issues which are significant in their experience. In order to best represent this ongoing dialogue, the current chapter relies heavily on the respondents' contribution by presenting extensive quotes which portray the nature of the research dialogue. The views of participating mental health professionals (MHP) and interpreters (INT) are also prioritised in terms of a more low-key presence of the community interpreting (CI) and mental health interpreting (MHI) literature relative to the other two analysis chapters. Furthermore, the other participant to the research dialogue, the researcher appears in the first person singular. This syntactic device, also deployed and

explained in Chapter 3, serves to further reinforce the researcher's position in the narrative research framework. Additionally, stories from outside the actual therapeutic encounters recollected during the research interviews support the argument. During the coding process these narratives were identified in a separate category, under *other stories*, in order to distinguish them from stories *told by clients*, supporting the findings of Chapter 4, or narratives recounted *about clients*, supporting the findings of Chapter 5. They appear in text boxes throughout the current chapter.

6.2. Safety as a Concept

While the concept of safety is not a novel one in the MHI literature (see, for example, Bot 2005a; Bot and Wadensjö 2004; Fox 2001; Fox and Gander 2004; Pollard 1998), it did not originally feature among the main interview themes for the current research. This was due to the fact that the study aimed to concentrate on the formation of narratives at various levels in MHI in Ireland. However, as the respondents introduced the subject into the research dialogue without much prompting on my part on a number of occasions, it soon became apparent that they deemed safety to be central to the nature of MHI and the mental health care (MHC) service environment. This is clearly illustrated in the comparative Table 6.2. below, which displays the number of references coded under Issues of Interests (the core data for the analysis chapters), on the one hand, and on Safety (a particular Issue of Interest), on the other. In other words, the left-hand section of the table under the "General" heading displays how many sections or instances of the transcribed interviews were coded into any thematic node. In comparison, the right-hand side of the table under the "Safety" heading illustrates how many references the individual respondents made to issues relating to safety. Both sub-tables are divided into the number of responses which were brought up by the individual respondents in reply to a question in the "respondent" column, and the number of references the individual respondents made that were prompted by the researcher in the "KZ" column. The totals and the percentages are given cumulatively.

General	respondents	KZ
INT01	28	10
INT02	36	4
INT03	31	1
INT04	43	4
INT05	45	10
INT06	30	11
INT07	60	4
INT08	38	15
INT09	48	13
INT10	25	0
INT11	25	5
INT12	36	8
MHN01	29	1
MHN02	24	3
MHN04	14	6
MHN05	24	11
OT01	31	3
PSY01	31	8
PSY02	25	4
THER01	15	6
THER02	16	5
THER03	18	1
THER04	30	2
Total:	702	135
%	83.87%	16.13%

Safety	respondents	KZ
INT01	0	0
INT02	0	0
INT03	0	0
INT04	0	0
INT05	1	1
INT06	1	0
INT07	4	0
INT08	2	0
INT09	5	1
INT10	5	0
INT11	1	0
INT12	2	0
MHN01	4	0
MHN02	0	0
MHN04	1	0
MHN05	4	1
OT01	1	0
PSY01	4	0
PSY02	4	0
THER01	2	1
THER02	0	0
THER03	12	0
THER04	1	0
Total:	54	4
%	93.10%	6.90%

Table 6.2. The overall number of references compared to the number of references to safety in terms of the generator of the comment

In general, the results of the query presented in Table 6.2. demonstrate that the narrative framework successfully allowed for the respondents' input to feature strongly. This means that 83.87% of the responses were brought up by the respondents in their reply to one of the original interview themes while only 16.13% of the responses were prompted by me, the interviewer / researcher. However, the results of the same query with regard to the issue of safety show an even higher proportion of the responses originated by the respondents. These results confirm my observation which developed during the course on the interview process and suggest that safety is an issue which has been highly prioritised by the respondents.

During the coding process, I classified the respondents' comments on safety into three subcategories, which include "client safety," the "interpreter's safety" and the "mental health professional's safety." These nodes have further child nodes, which generally relate to physical and psychological safety, and an additional node in the case of client and interpreter safety each. Thus, the full list of nodes under the parent node "safety," displayed in Figure 6.1., include: "client background," "client physical safety," "client psychological safety," "interpreter physical safety," "interpreter psychological safety," "vicarious traumatisation (which refers to the interpreter's secondary traumatisation following an internalisation process while relaying the client's utterances)," "mental health professional physical safety" and "mental health professional psychological safety." The nodes each have the "brought up by the participant" and the "prompted by KZ" distinction. As 93.1% of the responses have been coded in the category "brought up by the participants," most of the views quoted in the current chapter are under these nodes.
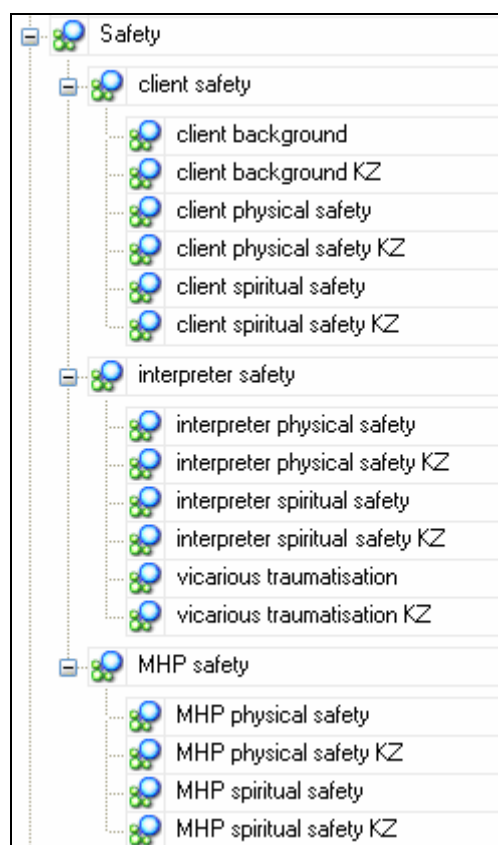
Figure 6.1. Node structure on "safety"

The findings are presented here as if in reply to the original interview themes in order to replicate the sense of dialogue between the researcher and the respondents. To recapitulate briefly, the interview themes include:

- Interpreting narratives: whereby respondents are asked to recall any particular stories or narratives from their practice;

- Perception: with regard to the perception of mental health among the cultural groups the respondents have worked with;

- Mode: the mode of interpreting employed during MHI sessions, for example, consecutive, simultaneous, whispering, or comments on note-taking practices;

- Cultural significance of narratives: the importance attributed to narratives in the therapeutic framework in which the MHP is working and / or the significance of narratives in the client's culture;

- Familiarity: the interpreter's familiarity with the client or their evolving narrative, and the consequences of such familiarity on the therapeutic outcome; and

- Additional information and / or mental health interpreting: the phase of the interview eliciting quantitative data, for example the types of services the INTs have worked in or the list of languages the MHPs have encountered during the course of their work, or the closure of the interview with the open-ended question enquiring if the respondents have anything to add in relation to their experience in MHI.

These themes are listed and shown in Table 6.3. in the order of significance, that is, according to how much attention they received from the respondents. They are not to be confused with the bottom-up coding results displayed in Table 5.2. in section 5.3.2 which shows how I classified the respondents' contribution based on the content of their views rather than on the basis of the interview themes.

	interpreting narratives	perception	mode	cultural significance	familiarity	additional information	mental health interpreting
Client							
background	0	1	0	2	0	0	0
background KZ	0	0	0	0	0	0	0
physical safety	0	2	1	0	1	0	0
physical safety KZ	0	0	0	0	0	0	0
psychological safety	2	2	1	6	3	0	3
psychological safety KZ	0	0	0	0	0	0	0
Interpreter							
physical safety	0	0	2	0	0	0	3
physical safety KZ	0	0	1	0	0	0	1
psychological safety	0	0	1	0	4	0	6
psychological safety KZ	0	0	0	0	0	0	0
vicarious traumatisation	1	0	1	0	3	2	13
vicarious traumatisation KZ	0	0	0	0	0	0	2
Mental health professional							
physical safety	0	0	0	0	1	1	0
physical safety KZ	0	0	0	0	0	0	0
psychological safety	0	0	1	0	0	0	0
psychological safety KZ	0	0	0	0	0	0	0
Total:	3	5	8	8	12	3	28

Table 6.3. The number of references coded under "safety" children nodes according to the original interview themes

6.3. The respondents' views on "safety"

6.3.1. Safety issues in response to "Interpreting Narratives"

Based on the idea that gave impetus to the current project, namely, how narratives in MHI influence the therapeutic encounter, I included a question among the interview themes to inquire about the respondents' experience of interpreted

narratives. As seen in Chapter 4, findings of the current project demonstrate that respondents are less aware of narrative and narrative construction than originally anticipated. Out of the three replies to the question which were coded under safety issues, two relate to the client's psychological safety and one to the vicarious traumatisation of the interpreter. This seems to suggest that stories have relevance as far as psychological safety is concerned.

6.3.1.1. The client's safety

The following extract shows my question (in bold) and the respondent MHP's reply.

KZ I guess [???] Ahhm, were there any particular stories that you remember that were very... either very successful or very sad that they told and either helped them to get through it or just brought them through the [???] #00:14:34-3#

THER1 [sighs] Whenever they get into the trauma, #00:14:39-4#

KZ Hmm. #00:14:39-9#

THER1 that bring them down. We try and avoid that. #00:14:43-3#

KZ Hmm. #00:14:43-8#

THER1 I don't know if you know about the steps in trauma, but if they aren't, if they don't have asylum status #00:14:50-9#

KZ Hmm. #00:14:51-8#

THER1 as much as possible you avoid getting into any traumatic memories. #00:14:55-7#

KZ Hmm. #00:15:11-2#

The MHP then went on to recount a *story* which evolved in a monological, non-interpreted session, reproduced in support of the the argument presented in this chapter below.

THER1 Hmm… ahhm, I mean I had a guy, who was, he was very depressed. This guy, he used to, ahmm, he'd get up in the night and had have to open the window [...] choking. #00:15:22-9#

KZ Hmm. #00:15:23-8#

THER1 He was suffocating. Ahhm, when we got into, he was a marksman in the army. #00:15:30-0#

KZ Hmm. #00:15:30-9#

THER1 And when he got into hunting, and he talks about hunting, you could see his whole body you know became alive, because that was a competence he had. So he'd talk about being a hunter, and he hardly spoke at all in the sessions. But he spoke a lot about being a hunter. #00:15:47-4#

KZ Hmm #00:15:48-2#

THER1 And going on the hunt for animals, you know. So there's, those kinds of things are enhancing [?], those kinds of memories're enhancing. #00:15:57-8#

Concerns about the client's psychological safety are reinforced by another respondent (OT1) in relation to the question on interpreting narratives. Both quoted MHPs agree that the client should leave the session in a "safe space," and OT1 confides feeling ill-equipped to enter into a narrative construction and "would be afraid of leavin' the person quite raw" (OT1 #00:10:36-7#). Such fears seem to be confirmed by a story recounted below about an incident which happened outside the therapeutic safe space. In this case, the *story* is about a refugee who has been granted asylum in Ireland. Thus, in theory, he is officially recognised as a resident whose legal status has been resolved and who has, literally, found refuge in the host country. However, the granting of refugee status may take years in Ireland and between the time of entry to the country and official resolution, the individual is considered an asylum seeker with no right to be employed and the constant sense of insecurity and fear of possible detention hanging over his or her head.

> THER3 Now. Because it's a refugee. So he's very safe in the country. But the minute any mention of the past and detention [coughs] or even... an incident that he wanted to work on... recently, you know, somebody coming into his family's house because they need some special aids. And something that this man said... #00:40:16-7#
>
> [silence] #00:40:19-0#
>
> He just flipped. #00:40:20-5#
>
> KZ [Mmm.] #00:40:21-6#
>
> THER3 'Cause the guy said something like... why did you come to Ireland? Simple question, like. #00:40:26-6#
>
> KZ [Uhm.] #00:40:26-9#
>
> THER3 But it sparked off in him huge stuff. So, so, immediately the shakin' starts off. So... but he, but he wants to tell his story to me, because he's got his asylum... And... but he's never actually told in depth other than injustice when he just felt that was a... #00:40:45-6#
>
> KZ [Mmm.] #00:40:46-3#
>
> THER3 procedure. But he never felt that he could tell and grieve, and cry, and all of that. #00:40:52-0#
>
> KZ [Mmm.] #00:40:52-4#
>
> THER3 So, we're working with small pieces of it... So, we've only got to before detention. Can't even imagine what detention would be about. #00:41:01-5#
>
> KZ [Mmm.] #00:41:02-9#

This seems to indicate that MHC provision aims to provide a safe and consensual environment for the client against the backdrop of his or her everyday insecurities and possible conflicts. However, this does not conclusively confirm or dispose of the research claim that narratives at the metanarrative level of service provision in MHI in Ireland are consensually co-constructed.

6.3.2. Safety issues in response to "Perception of Mental Health Care among Client Groups"

We have seen that safety issues have not featured significantly in relation to interpreting narratives, and they have received similarly little attention in relation to the perception of client groups on MHC. All five comments in this category belong to the client's safety nodes and have all been made by the same respondent.

INT7 has remarked that therapy is often too abstract a concept for the clients and that they are more concerned with finding a haven, or a "safe place" than psychological well-being in a western biomedical sense. This difference in attitudes, documented by Kaufert and his group (Kaufert 1990; Kaufert and Koolage 1984; Kaufert and O'Neil 1995; Kaufert and Putsch 1997), is also evident from the INTs' comments on the usefulness of therapy (#00:18:55-1#).

> INT7 But for some of them counselling worked to some extent. But then... for them it was more important... #00:18:41-8#
>
> [silence] #00:18:43-6#
>
> should become safe here, to have residency here, in some form or shape and then they could just get on with their lives. And that was more important than... #00:18:51-7#
>
> [silence] #00:18:52-7#
>
> I'm not sure to what extent individual counselling helps. #00:18:55-1#

Nevertheless, the client's real or perceived safety is an important consideration in the client's country of origin as much as it is in Ireland. Indeed, paranoia frequently features as a symptom of mental health problems. This is quite evident from the following extract where the sequential number of the respondent has been removed for reasons of identifiability. As one of the *stories* from outside interpreter-mediated sessions in support of the argument in this chapter, it appears in a text box.

> INT Eh... for example... ehm... #00:24:30-1#
>
> [silence] #00:24:31-4#
>
> ehm... when I... one sec, I can't remember any'... Let me see... Uhm... Look... One person... I met in {name of hospital}... Ehm... #00:24:42-8#
>
> [silence] #00:24:45-5#
>
> Once she... now, ok. Once, once she said she's, she... I said, How did you become ill [?] ehm, doctors, I think doctor asked her, I can't remember who asked her. How did you become ill? You know. #00:24:56-4#
>
> KZ [Uhm.] #00:24:56-7#
>
> INT Ah, once I was in, I was in corridor. I met her. She, she told me she's telling me that. At that time, because she on medi', medi', she was ok. #00:25:05-2#
>
> KZ [Uhm.] #00:25:05-7#
>
> INT [She] was sayin' things, even though she... her actions kinda very numb. And not

very flexible. #00:25:11-2#

KZ Uhm. #00:25:11-7#

INT [...] But she [???]. I said How... how come that you become ill? #00:25:18-3#

KZ [Uhm.] #00:25:18-8#

INT And she said that because she... eh... she said her... the husband... they're live in the country side in {name of country}. Her husband is butcher. #00:25:27-2#

KZ [Uhm.] #00:25:28-2#

INT [Butcher.] An' her husband is butcher. And eh... and she keeps cutting... pigs. #00:25:32-7#

KZ [Uhm.] #00:25:33-2#

INT And, eh... he, she... ehm... she... tha', at the time I think she always spreading bad words about people. #00:25:41-8#

KZ [Uhm.] #00:25:42-2#

INT And she felt guilty something like that. #00:25:44-5#

KZ Oh, she was... telling rumours? Or spreading rumours? #00:25:48-5#

INT [Yeah, somethin'] #00:25:48-5#

KZ [Aha.] #00:25:48-7#

INT like that. I'm not quite sure. She said... and the people just hated her, or somethin' like that. #00:25:53-4#

KZ [Uhm.] #00:25:53-6#

INT Ehm... She become ill. #00:25:55-0#

KZ [Uhm.] #00:25:55-9#

INT And suddenly she become ill. #00:25:57-1#

6.3.3. Safety issues in response to the "Mode of Interpreting"

The responses concerning safety issues to my enquiries regarding the modes of interpreting relate equally to client safety, interpreter safety and the safety of the mental health professional.

6.3.3.1. The mental health professional safety

In the last category, the only reference involves an interpreter, who felt that they had to protect the MHP from "bad language" used by or painful stories told by the

client (THER3). The respondent has attributed such face-saving exercises, also discussed by Mason and Stewart (2001), to the specialised mental healthcare setting as opposed to other environments, where the interpreter expects and accepts the conflictual nature of the assignment. The extract contains references to the Office of the Refugee Applications Commissioner (ORAC) and the Irish police or garda station (#00:19:04-6#).

> THER3 So... it's not about... I'm goin' to take this personally, or that... they're there to protect me from what... is being said. #00:18:44-6#
>
> KZ Uhm. #00:18:45-5#
>
> THER3 And I think... there's often... ehm... probably a little bit of misunderstanding 'bout that. Because you see they're... often interpreting, the interpreter's maybe interpreting in the courts, #00:18:56-1#
>
> KZ [Uhm.] #00:18:56-6#
>
> THER3 [or] in ORAC, an'... in the garda station, or in with the prison officers, whatever... So they're often put in situations that are highly stressful. #00:19:04-6#
>
> KZ Uhm. #00:19:05-0#
>
> THER3 [An'] you wonder... are they afraid maybe... the consequences of what they interpret? #00:19:10-0#
>
> KZ [Uhm.] #00:19:10-0#

This remark suggests that metanarratives at the level of service provision in Ireland are not always consensually constructed in MHI, and that MHI cannot be considered a homogenous environment.

6.3.3.2. The interpreter's safety

As regards interpreter safety, the issue of physical safety was raised as a result of a misunderstanding of my initial question on the mode of interpreting. While I was enquiring whether MHN5 expected the interpreter to interpret consecutively or simultaneously, or perhaps in the whispering mode, the respondent replied by quoting their briefing for the interpreter. According to the MHP, the briefing includes a warning in case of aggression.

MHN5 You know. Like I mean, he may not like to hear it [in his] #00:10:26-9#

KZ [Uhm.] #00:10:26-8#

MHN5 like we do get very paranoid people, you know that could be violent, you know. #00:10:30-1#

KZ Uhm. #00:10:30-6#

It is worth noting at this point that the respondents made no mention of the interpreter's physical safety outside the sessions. This problem is far more severe in areas of conflict, as posited by Thomas (2003) in his article on the protection of interpreters in Kosovo following UN withdrawal. While it is possible that some interpreters may feel threatened if meeting clients outside the session, they did not voice such concerns.

6.3.3.3. The client's safety

Similarly to MHN5 quoted above, THER3 brought up the issue of violent or hyper-aroused clients who may pose a danger to the interpreter's physical safety (#00:23:39-3#). However, in reply to my query on the mode of interpreting, the respondent in the following extract connects this to the more pertinent problem of the client's psychological safety and that the situation has to be managed by the MHP (#00:23:45-5#), an issue discussed in Chapter 5. The phrasing of the question (in bold) also demonstrates that I return to a point previously raised by the respondent, thus following on from their lead in the dialogic research process.

KZ And you've said that you would have your own ways of slowing the, the patient down, or slowing the client down. Ehm, have you ever had any experience where the interpreter... kind of, ehm... took it onto themselves to solve that problem let's say by, whispering interpreting simultaneously, or using different techniques of interpreting... to allow the patient... to, to continue? Or... does it make any difference if it's an interpreted situation? Or would you actually slow down an English-speaker as well? Or... #00:23:32-5#

THER3 Yeah. [Yeah.] I would slow down... ev', anybody I s'pose in that hyper-arousal state. #00:23:39-3#

KZ Uhm. #00:23:39-8#

THER3 That would be part of our... you kn', that would be part of the process, I suppose, is containing... #00:23:45-5#

KZ Uhm. #00:23:45-8#

THER3 you know, the person's window of tolerance of where they either go up or down, or out of that window #00:23:50-5#

KZ [Uhm.] #00:23:50-9#

THER3 of tolerance, you know, to, to what's... you know, being processed. So I, I would say there's actually no great difference in the work... as the therapist. However, it could be helped if interpreters had a fuller understanding #00:24:05-5#

KZ [Uhm.] #00:24:05-9#

THER3 of what was going on, and that they were also able to sit back. Be more relaxed. And mirror what the therapis's tryin' to mirror, and that is more calmness. An' that's by, very often by slowing the process we'll actually [bring?] the client a little bit. #00:24:22-7#

KZ Uhm. #00:24:23-3#

The point THER3 made regarding the interpreter reflecting the mental health professional's calming effect on the client is an interesting one in terms of possible training instructions for interpreters. It is also in line with Bot's (2005a) suggestion on how psychiatrists who subscribe to a three-person psychology model and interpreters working in an interactive framework can work well together (pp89-90).

6.3.4. Safety issues in response to the "Cultural Significance of Narratives"

My questions on the cultural and situational significance of narratives drew an equal number of references as the mode of interpreting discussed in the previous section.

6.3.4.1. The client's safety

Similarly to sections 6.3.1. and 6.3.2., these responses mainly concern the client's safety. As another *story* from outside the therapeutic encounters recounted in the text box below shows, most of the insecurity arises from the client's background and history.

> THER3 I was tryin' to resource somebody one day and I was askin' this young guy, 22, What did he remember... you know, before all his troubles started, as being detained. #00:37:42-3#
>
> KZ Uhm. #00:37:42-8#
>
> THER3 He was tryin' to think. But he'd been detained for many times since he was eight years old. The only good time was, we had a good, good talk about it, he drew it. An' it was one part of the prison, where he felt more safe than the other. #00:37:56-9#
>
> KZ [sighs] #00:37:58-1#
>
> THER3 That was his resource. #00:37:59-1#
>
> [silence] #00:38:03-1#
>
> So, I realised... he didn't remember anything before the age of eight. Nothing. But it was, it was like... generations of trauma. #00:38:12-7#
>
> KZ Uhm. #00:38:13-1#

Some of the MHP respondents confirmed that narratives play an important part in their therapeutic work (PSY1, PSY2, THER1, THER3). This is mostly the case in specialised and / or therapeutic services rather than mainstream and / or logistical services, which confirms the findings presented in Chapters 4 and 5 where the divide between various types of services was discussed in detail. In reply to the interview theme of the cultural significance of narratives, THER3 drew attention to culturally appropriate concepts of safety (#00:42:01-8#), too – and the boundaries mental health professionals have to keep in order to help the client (#00:42:26-1#). The introductory lines of this extract (in bold) also illustrate how the respondent took an active role in shaping the course of the interview, as they freely referred back to a subject discussed earlier in the course of the meeting.

> **THER3 Yeah. So... so, I s'pose, ehm... just goin' back to somethin' on the cultural difference... for... I am very aware working with Muslim women, for example, and men... #00:41:48-9#**
>
> KZ Uhm. #00:41:49-4#
>
> THER3 ... any kind of sexual violence in their torture... is not a good place to go. #00:41:54-7#
>
> KZ Uhm. #00:41:55-2#
>
> THER3 And the person wants to forget that. Our understanding would be to work

through it, and heal it. #00:42:01-8#

KZ Uhm. #00:42:02-3#

THER3 [Their]... belief is... pretend it's never happened. Because it's too shameful, it's too awful to go [there.] #00:42:10-3#

KZ [Mmm.] #00:42:10-5#

THER3 And I've worked with a man for two years... And we haven't gone nearly into anything... But I know... he has been raped. #00:42:20-7#

KZ Uhm. Uhm. #00:42:22-2#

THER3 Not something they want to go. But we've done a lot of work other than that. #00:42:26-1#

KZ [Uhm.] #00:42:26-4#

THER3 Around grief and all. [???] and on coping skills... Around integration, you know? #00:42:34-5#

[silence] #00:42:36-1#

But... you know... the telling of that... wouldn't be... #00:42:41-0#

KZ Uhm. #00:42:41-5#

This safe place also concenrs the client's environment outside the session, as the following *story* about a female client illustrates.

THER3 And how the process of doin' that, it [???] so traumatisin' and sometimes the re-traumatisation can kick over into psychosis. We had a person here, who came in, who was psychotic after her ORAC. I really believed, and I only met her twice before, and I recommended that she wouldn't have her interview. #00:45:02-7#

KZ Uhm. #00:45:03-2#

THER3 Because I felt... she'd be traumatised, and was very much borderline #00:45:07-8#

KZ Uhm. #00:45:08-3#

THER3 mental health, I s'pose, just is like that. It would, could go either way. #00:45:11-9#

KZ Uhm. #00:45:12-4#

THER3 And she'd come in here, and wanted, she was waiting to see me unscheduled. Appointment. Ehm... She just flipped it in the... in the kitchen. Canteen. Went totally out of control, an'... went back into... all her past stuff, and... you know the village bein' burnt, and... She was actually there. She was there. And it was two things. There was a [???] that happened the day before, #00:45:37-9#

KZ [Uhm.] #00:45:38-5#

THER3 which I'm aware of that. That, which, which I became aware of that. #00:45:40-9#

KZ [Uhm.] #00:45:41-5#

THER3 Because I knew there had to be some... strong triggers. #00:45:43-9#

KZ Uhm. #00:45:44-9#

THER3 And it was to do with the smell of burning in the hostel. Which... you know #00:45:50-0#

KZ Mmm. #00:45:50-5#

THER3 somebody... smoking something. Ehm, so, you know, all of those things #00:45:52-9#

KZ [Uhm.] #00:45:52-9#

THER3 later went on to discuss the conflict such an approach poses in relation to their own beliefs of effective therapy. They explained that they believe that recounting a trauma is a therapeutic process, and this is in stark contrast to some clients' faith, which is to avoid talking about what happened. However, while conflict may arise between the therapist's professional beliefs and the client's cultural sensitivities in MHC, especially in therapeutic situations, there is generally a

consensus that the main purpose of the sessions is to work towards the client's wellbeing. Therefore, some MHPs are willing to sacrifice the situational significance of narratives, that is how important they believe stories are or the way of telling stories is, for the cultural significance of narratives, that is, how important their clients believe such stories or their non-telling is. These MHPs try to create a "safe place" for their client, "wherever the person can cope best" (THER3 #00:44:13-8#). This approach is also promoted by the interpreter-user training video by The Violence Against Women Prevention Interpreter Program (2000) as well as by Pollard's MHI training material (1998). In this sense the research claim that narratives in MHI in Ireland are consensually coconstructed appears only partly confirmed.

6.3.5. Safety issues in response to "Familiarity"

The interview questions concerning the interpreter's familiarity with the client as well as with the client's narrative solicited responses on the safety of all three participants.

6.3.5.1. The client's safety

A number of replies to my original question on the interpreter's familiarity related to the client's physical safety, which is closely connected to the client's psychological safety (#00:11:09-1#), as seen from the following extract. Once again, this interview excerpt also exemplifies how the respondents actively shaped the interview process and how I could return (in bold) to subjects introduced by them at an earlier stage of the interview.

KZ You mentioned that some of the interpreters, or some of the clients, have had problems with particular interpreters. Was that as you said because of a, ahhm, let's say tribal differences or cultural differences, or personal differences, or... #00:10:33-2#

THER1 There was, there are political differences. #00:10:37-4#

KZ Hmm #00:10:37-7#

THER1 Especially if they're coming from different tribes, they won't even, you'd imagine , I used to imagine that they're in Ireland, they met somebody from their own country, isn't that terrific? #00:10:49-1#

KZ Hmm. #00:10:49-4#

THER1 They won't say a word. Because if they're coming from countries that are,

you know, a police kind of state, #00:10:58-3#

KZ Hmm. #00:10:59-2#

THER1 then they're afraid for their own families at home. #00:11:02-0#

KZ Hmm. #00:11:02-7#

THER1 So, those interpreters, ahhm, are, are that would be dangerous. #00:11:09-1#

KZ Hmmm #00:11:09-5#

As far as distance is concerned, THER3 emphasises boundary issues. The MHP's preoccupation with the subject is apparent from the fact that out of the nine comments on the client's psychological safety, which is a record number made by the same individual among the respondents, four are related to boundary issues. In the first instance, the reply came to my original question on "familiarity" (in bold).

KZ […] Do you... have you ever had any experience, or if they come from... it's the same culture, or similar culture, where their knowledge, as you've said they're privy to the, their cultural background. Where that knowledge, or the knowledge of the, the client themselves, ehm... has interfered or has influenced their interpreting or the therapy itself? #00:26:47-9#

THER3's response introduces the subject of boundaries (#00:27:22-1#), which clearly has not been a part of my query.

THER3 Well, I s'pose... there's two things, I would say here, in my experience just here. One is I'm aware that it can be a huge influence for the positive. #00:27:01-0#

KZ Uhm. #00:27:01-6#

THER3 In that it builds the safety, and the security that we need for therapeutic process to work. #00:27:09-8#

KZ Uhm. #00:27:10-4#

THER3 And having the same interpreter who's calm, and who's safe and who does the job professionally #00:27:15-8#

KZ [Mmm.] #00:27:16-5#

THER3 holds the boundaries. That, that, that really actually increases the speed of the work. #00:27:22-1#

KZ [Uhm.] #00:27:22-5#

THER3 Even though, we'll always know that using an interpreter is very sl, it's, it's slow part. #00:27:26-3#

KZ Uhm. #00:27:27-0#

Later on THER3 returned to the same subject connecting boundary issues to the client's safety twice, in both cases in reply to my question on their views on MHI in general. The fourth and last time the MHP mentioned the interconnection of boundaries and the client's psychological safety was in relation to the cultural significance of narratives, which was discussed in section 6.3.4.1. of the current chapter.

6.3.5.2. The interpreter's safety

The other three comments on the client's physical safety are more related to the psychological safety of the client as well as that of the interpreter, which does not come as a surprise in a MHC environment. Among these replies issues of transference and boundaries are heavily represented. While there has been a tradition of acceptance of the impact of therapeutic encounters on therapists (Clarkson 1995; Flaskas & Perlesz 1996; Kitron 1992; Lavender 2003), similar effects of countertransference on interpreters have only recently been acknowledged (Granger and Baker 2003; Papadopoulos 2003; Tribe & Morissey 2003). Transference is a complicated phenomenon, which Pollard (1998) explains in lay terms for interpreters as follows,

> Typically, patients bring painful emotions into psychotherapy to talk about them and, often, a history of unhappy or unsuccessful relationships. But then, the patient forms a relationship with the therapist and begins to have emotions about the therapist and the therapy process. Quite often, the patient's painful emotions, and their memories and habits from old relationships begin to get mixed up with the new therapy relationship and therapy emotions.
>
> When this happens, the patient's thinking and emotions about the therapist can be based on the patient's past emotions and relationships, and not on the things that are "real" about the therapist. When that happens, it's called transference. (p107)

Pollard continues to discuss the dangers of the transference process on the therapeutic relationship between the patient and the therapist, and also extends the argument to the interpreter's involvement, who is not trained to deal with such complex emotional response. He then draws attention to further emotional complexities which can cause difficulties when an interpreter is concerned.

> Countertransference is essentially the same thing as transference, but this time, it is feelings and ideas that the *therapist* begins to have *about the patient*, based on the *therapist's* past emotions and relationships. […] countertransference can happen for the interpreter, too, that is, the interpreter can begin to have thoughts and feelings about the patient (or the therapist) that are based on the interpreter's past emotions and relationships. Countertransference is not the same thing as simply having feelings or opinions about what takes place in therapy

sessions. Those feelings or opinions are normal and common; countertransference is more complex. [italics by the author] (Pollard 1998 pp109-110)

Bot and Wadensjö (2004) also offer a clear definition of their application of these two related concepts, saying that they "take (counter)transference here as the experience of feelings that are evoked during the session, but which have their origin in relationships of the persons concerned with important others in the past" (p370).

In the following extract MHN4 explains how mental health professionals are trained to deal with the phenomenon known as transference (#00:29:54-6#) in reply to my original question regarding familiarity.

MHN4 Yes. You have to worry about transference. You have to... be careful about losing your neutrality as far as stories go, and being involved with people. #00:29:23-4#

KZ Uhm. #00:29:24-1#

MHN4 Ehm... and... so yeah, a, a therapist would often have their own partner separated and out of the room, say for instance, family therapy, behind a screen... who will call the therapist out every now and again, sort of talk about things, say, Look, you're going a certain direction. #00:29:40-1#

KZ Uhm. #00:29:40-4#

MHN4 Y' need to pull back from that. I'm worried about... you know, what she's saying to you, you seem to be... maybe getting sucked into this... kind of thing. So you would have... a, as the therapist, if you like, a fall-back position, a safeguard, somebody watching your back. #00:29:54-6#

KZ Uhm. #00:29:55-2#

MHN4 Almost literally. Whereas an interpreter, you may not have that, or they may not have that, eh... safeguard. #00:30:01-3#

KZ Yeah. #00:30:01-9#

MHN4 Ehm... and... if it was a continuous... over a continual period, continuous period, sort of, you know, weeks, months, s's', I think there's certainly a danger of... sort of becoming over-involved or over-invested in the life of somebody else, or a story, or the problems of somebody else. #00:30:19-1#

While emotional response, either empathy or aversion, toward the service user client or the service provider professional, can develop in other CI settings as well, it is a principal attribute of MHI. Following on from Pollard's argument, thus, it is crucial that the interpreter should be able to keep their distance from the other participants involved in the triadic therapeutic process. Failure to do so can easily lead to compromising adequate MHI and MHC provision, in other words, it can result in conflict. To this extent, the research claim that narratives in MHI in Ireland are consensually co-constructed is at least possibly untrue. Furthermore, following

the discussion between therapeutic versus logistical and specialised versus mainstream services discussed in Chapters 4 and 5, it is interesting to note that among the respondents who have made the connection between boundaries and the client's psychological safety (MHN1, OT1, PSY1, PSY2, THER1, THER3) only one works in a logistical rather than a therapeutic environment, and two thirds are in specialised rather than in mainstream services.

6.3.6. Safety issues in response to "Additional Information" and "Mental Health Interpreting"

I have opted to treat these two headings together because in a number of interviews they were interrelated. For example, respondents would share their views on MHI while I was collecting demographic information. Or vice versa, they provided additional information when replying to my original question on MHI issues. Similarly to emerging safety issues in reply to my question concerning familiarity discussed in the previous section, the safety of the interpreter was mentioned with the highest frequency.

6.3.6.1. The interpreter's safety

The concern for the interpreter's physical safety was reiterated on a number of occasions (#00:14:24-3#). One of these instances was in reply to my original question on MHI (in bold), as can be seen from the following extract.

> **KZ And, ehm... do you think it's very different to interpret... if they come, for instance, to this ward rather than... the diabetes ward down [the...] #00:13:58-5#**
>
> MHN5 Well, you're dealing with, with a psychiatric illness, you know. #00:14:10-0#
>
> KZ Uhm. #00:14:10-3#
>
> [silence] #00:14:12-6#
>
> KZ [Eh...] #00:14:12-8#
>
> MHN5 Where, where they could, you know, you don't know, they could be #00:14:15-9#
>
> [silence] #00:14:17-9#
>
> Th' patient could get quite annoyed... get upset, maybe. Get violent. Threatening, all that sort of stuff, you know. #00:14:24-3#
>
> KZ Ehm... #00:14:26-1#

The fact that the interpreter's physical safety has to be considered, and that safety issues are paramount, was also confirmed by MHN1. Interpreters cannot be left on their own with the patient, because patients may feel incarcerated and become frustrated. So interpreters are only left alone with them if it is safe, and even if they are left with the patient for a while to build up the patient's trust, there is always a staff member nearby. Although it is not explicitly stated in guidelines for mental health professionals working with interpreters, it is implied that best practice is not to leave the interpreter alone with the client at all, or that the interpreter should be made aware of boundaries (The British Psychological Society n.d.; Health Services Executive 2007; Miletic et al. 2006; Tribe & Thompson 2007).

The most significant findings in relation to safety emerged from the respondents' views on the interpreter's psychological safety while replying to my original question on the special characteristics of MHI. Generally, the respondents agreed that interpreting in MHC is emotionally more taxing than interpreting in other settings (INT9, INT11) and that interpreters need to be physically, mentally and psychologically prepared for such assignments (INT9, INT11, INT12). Certain aspects of the job pose difficulties, such as making personal connections to the client's narrative or to the client's circumstances. For example, these may include instances if the interpreter is working with an underage client and has children themselves (INT10), or if the interpreter's parents work in the same profession as the client (INT8). Some INTs found that self-harm, self-cutting, or the client tearing bits of their hair out during the session is especially difficult to deal with and are also particular to the MHC environment (INT3, INT9). In addition, one interpreter recalled extreme body language as a special characteristic of MHI (#00:38:49-7#).

> INT9 [Like] you... you've got people... #00:38:41-3#
>
> [silence] #00:38:42-4#
>
> who... who're sitting on a chair. And suddenly they run away. Or they sit on the floor. Or they hide under the table. #00:38:49-7#
>
> KZ Uhm. #00:38:50-0#

INT9 So that is... quite unusual. It, it might... #00:38:54-3#

[silence] #00:38:56-3#

not sound so special what... as I mentioned it to you in this situation, but... it really is... if suddenly, in the middle of a session, somebody hides under the table and stuff. #00:39:05-9#

KZ Yeah. #00:39:06-9#

As a consequence, some INTs (INT3, INT7, INT8, INT9, INT10, INT11) mentioned that even if not vicariously traumatised, they are emotionally drained after MHI sessions. Sources in CI and MHI literature (Bot and Wadensjö 2004; Fox 2001; Fox and Gander 2004; Pollard 1998) also warn against vicarious traumatisation. However, it is significant, that other INTs (INT5, INT6, INT12) consider the idea of vicarious traumatisation exaggerated (#00:17:32-4#), as can be seen in the following extract.

INT12 We, when, when both are talking to you and it's your job to hear both and relay both... you, you're see, you see it from both, you're seeing it from #00:17:04-6#

KZ [Yeah.] #00:17:05-0#

INT12 [both] points of view. You know, you're tryin' to, you have to try. An' especially if you want to speak in the first person. Now don't get me wrong. You know, I'm not... I think you can over-dramatise these things. When people used to talk about... #00:17:15-0#

[silence] #00:17:16-0#

ehm... Oh, you need to be debriefed, you nee' to be... you'll [???], it's not my trauma. #00:17:19-6#

[silence] #00:17:20-5#

Not my trauma... So, I mean, I think it's a crazy thing to... #00:17:23-2#

[silence] #00:17:24-1#

conflate the experience of the interpreter with the experience of the person who's telling the story. It may be distressing to hear it, distressing to watch... but, like, don't overdo it, you know. #00:17:32-4#

[silence] #00:17:33-0#

[???] flippin'... repeat these words, you know. It didn't happen to you, so... You know, I think you can overdo that one as well, but... I still would try and see from this woman's point what she's saying. Tryin' to... #00:17:41-8#

KZ Mmm. #00:17:42-2#

INT12 Tryin' to communicate what she's tryin' to say...

Some INTs also confided that they are able to switch off after the assignment.

INT6 No. Because, the once I've worked... away... once I've finished the interview... the appointment, I don't think I got the case. Ok. [whistles] I switch, I switch off my brain. And I don't think, you know, about their stories, their complaints. #00:01:19-3#

These respondents probably share the view expressed by a legal advisor on court interpreting. Coulter (Vancouver Community College / Open Learning Agency 2000) suggests that in special cases when the interpreter feels that s/he cannot cope with the distress due to personal conflict of interest, it is acceptable, and desirable, for the interpreter to let this be known to the court. However, Coulter continues, emotional distress cannot be used too often. If "you can't cope with it, don't work as an interpreter" (mins40-43).

In contrast to these INTs, some MHPs, especially those working in therapeutic rather than logistical and / or specialised rather than mainstream services, took the issue of secondary or vicarious traumatisation very seriously and repeatedly brought it to my attention during the interviews. Consequently, some of the MHP respondents make sure that the interpreter is familiar with the environment before the session begins and that they are not carrying the trauma with them following the assignment (PSY2). Perhaps the clearest indication of the respondents' contribution to the current research is the interview where one of the respondents (PSY1) brought up the subject of the interpreter's psychological safety on more than one occasion (#00:14:05-6#) as can be seen (in bold) in the following extracts.

PSY1 [So] we would've had... other people, who're... you know, ehm... asylum seekers themselves, #00:13:39-0#

KZ [Uhm.] #00:13:39-3#

PSY1 [and...] Ehm... which isn't fair to... to the client, but certainly isn't fair to the interpreter, either. That they would be in a situation where they #00:13:47-5#

KZ [Yeah.] #00:13:47-9#

PSY1 [hear some] very traumatic stories... And they could have a similar background themselves, and... #00:13:53-5#

KZ [Yeah.] #00:13:54-0#

PSY1 Yeah. #00:13:54-1#

KZ [Yeah]. Yeah, yeah. #00:13:55-3#

PSY1 And that just brings me to... #00:13:57-2#

KZ [Uhm.] #00:13:57-3#

PSY1 [I don't know] if this... you may come to this later, but it's another issue that I want to #00:14:00-9#

KZ [Yeah. yeah, yeah.] #00:14:01-9#

PSY1 [raise] when it comes to interpreters, and that is a... secondary traumatisation. #00:14:05-6#

KZ Yeah. #00:14:05-9#

PSY1 Oh, you were going to come to that. #00:14:07-5#

KZ No, please, go, talk about it. #00:14:08-7#

PSY1 [Yeah, yeah.] #00:14:09-4#

KZ If you're... you know, I'm her', I'm trying to listen to what you're saying [???] #00:14:13-0#

The MHP then continued with their concern over the interpreter's vicarious traumatisation (#00:14:22-4#).

PSY1 [Ok. Yeah. Yeah.] Ehm... you know, I think we need to, to be aware that, that the interpreter is very much part of, of the story that's being told, #00:14:22-4#

KZ [Uhm.] #00:14:23-0#

PSY1 [and] is absorbing the... the trauma that's, that's been #00:14:26-7#

KZ [Yeah.] #00:14:27-2#

PSY1 [...] been spoken about. So... We need to... as... as professionals, to speak to the interpreter afterwards, and to m', to build time into our sessions to do that. [To] #00:14:40-4#

KZ [So] would... would you provide the debriefing? With another counsellor? Or with the same counsellor? Or... #00:14:46-1#

PSY1 Usually we would do it individually. We', if, if I was working with an interpreter, I would spend some time #00:14:51-4#

KZ [Ok.] #00:14:52-6#

PSY1 with the interpreter afterwards. #00:14:52-8#

KZ And... is that common practice at the moment? Or... #00:14:58-1#

PSY1 In our service it is. [Yeah.] #00:15:00-0#

KZ [Yeah.] #00:15:00-0#

PSY1 Now, we're a very small service. #00:15:01-6#

KZ Yeah. Yeah. #00:15:03-0#

PSY1 [...] And it's something that we're very aware of, I think. You know #00:15:08-

1#

KZ [Yeah.] #00:15:08-2#

PSY1 in the, the... broader... services, I don't know. #00:15:11-2#

And later on, once again, the same MHP returned to the subject, also on their own initiative

PSY1 And they'd be issues that we've mentioned: confidentiality, eh... ehm... #00:17:34-0#

[silence] #00:17:35-6#

boundaries, say, say, working within the service. That, that, ehm... respect for the... the difference... #00:17:41-6#

KZ [Uhm.] #00:17:42-6#

PSY1 Ehm... #00:17:42-8#

[silence] #00:17:46-3#

So they're, I think they're the really, the issues that need to be addressed, ehm, in training. And also an awareness for the interpreter of the issues of vicarious traumatisation. #00:17:55-4#

This contribution was almost entirely replicated by another MHP respondent (PSY2) and was reiterated by others (THER1, THER3, THER4). Once again, it is worth observing that most of these MHPs work in therapeutic rather than logistical and / or specialised rather than mainstream services, which corroborates findings on these differences presented in Chapters 4 and 5.

6.4. Interpreter Support in Mental Health Interpreting

The following section examines the research claim that narratives in MHI in Ireland are consensually co-constructed with regard to interpreter support at the metanarrative level of service provision. The respondents' concern for the physical and psychological safety of all the participants in interpreter-mediated encounters in MHC settings often generated discussions about suggestions on how to improve safety in general. As the focus of the current study is the interpreting situation and the interpreter's position, these discussions concentrated on how to minimise potential risk for the interpreter. Consequently, a number of aspects were considered by the respondents in relation to how the interpreters could be supported in carrying out their work. Some of these topics are pertinent to MHI and arise from the especially emotionally taxing nature of assignments in such settings. As can be seen

in Figure 6.2., the references made to support services or processes were coded under the following nodes: briefing, counselling, debriefing, interpreter meetings, peer support, post session discussion, preparation, self help, and supervision. In line with the general coding process and as described in Chapter 3, they were coded in node-pairs of brought up by the participant (e.g. "counselling") and prompted by KZ (e.g. "counselling KZ").
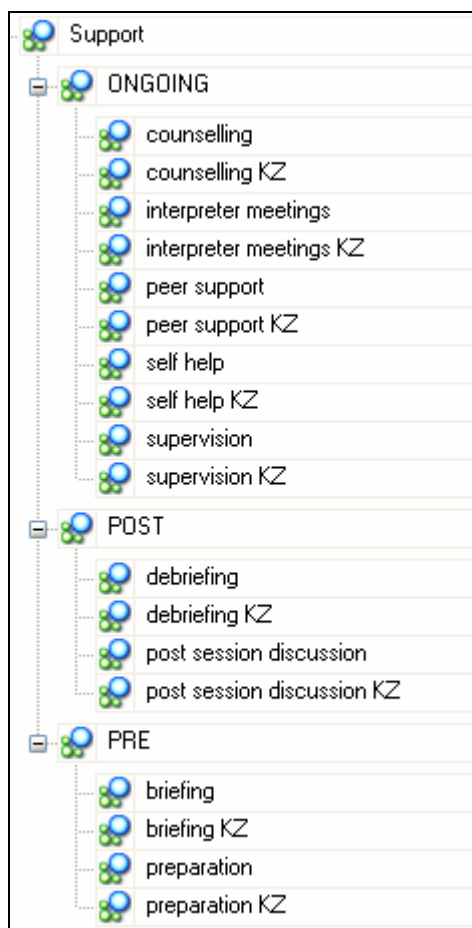
Figure 6.2. Node structure on "the support of interpreters"

These references were further classified into three main categories depending on when they occur in relation to the actual interpreter-mediated therapeutic encounter. Thus, the category of "pre-encounter" support includes the nodes "briefing" (the mental health professional or service provider passes on information to the interpreter concerning the client and the session) and "preparation" (the interpreter prepares for the assignment by compiling a glossary or by getting mentally and psychologically ready for the MHI / CI session). "Post-encounter" support services comprise "debriefing" (the mental health professional or a colleague ensures that the interpreter has not been negatively affected by the session, or provides psychological

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support) and "post-session discussion" (the interpreter and the mental health professional clarify cultural or linguistic issues that have arisen during the encounter). Lastly, the parent node "ongoing services" incorporates the nodes "counselling" (ongoing psychological support for interpreters by a mental health professional), "interpreter meetings" (semi-formal discussion groups for interpreters to discuss issues regarding MHI sessions), "peer support" (which can take the form of telephone help lines, informal meetings or a support group for interpreters suffering from secondary traumatisation), "self help" (such as relaxation exercises) and "supervision" (or monitoring, which would help continuous professional development).

This categorisation provides the structure for the presentation of findings on issues related to interpreter support. The results are discussed under the three main headings of pre-session support, post-session support, and ongoing services rather than under the main interview themes as in the previous sections of the current chapter. By this variation on the organisational principles I intend to signal that the review here moves on to the examination of practical issues. It also serves to highlight the difference from the previous section on safety in terms of the dialogue between the respondents and the researcher. As presented in Table 6.2., the respondents' unprompted replies constitute just over 83.87% of the overall responses. The corresponding proportion of references to safety-related issues is even higher, 93.1%. In comparison, the number of responses regarding interpreter support services is somewhat lower, 78.45%. This indicates that I had a slightly more significant role in eliciting these answers and the distinctive representation reflects this difference. Nevertheless, I have decided to preserve the unity throughout the chapter by sometimes indicating my original questions in bold to demonstrate the dialogic nature of the interview process.

6.4.1. Pre-session support

6.4.1.1. Preparation

In order to prepare efficiently for an assignment, the interpreter would need as much information on the upcoming job as possible. However, such details are very difficult to obtain from the agencies which contract interpreters in Ireland either because they do not receive enough information themselves, or because they do not

understand the significance of such information for interpreters. Additionally, agencies often quote reasons of privacy, which seems a little incomprehensible, given that the interpreter working on the case will be bound by confidentiality anyway. Therefore, it can happen that the interpreter is not even aware that s/he is going into a mental health session (INT4, INT9, INT11) but is contracted to take on a general medical assignment. INT9, with years of experience, some conference interpreting training and a psychology degree, also explained that receiving information on the case is desirable if the interpreter's psychological safety is to be considered. The INT's argument follows a broad question on my part, "What else do you think would help the interpreters?" (#00:40:49-8#) and is part of a list of suggestions the INT made during the interview. The INT also gave reasons as to why briefing is important. These include dealing with distressed family members present at the interpreting session (#00:43:38-2#) or the interpreter having a bad day (#00:44:07-7#).

> INT9 There's, also it would be good if interpreters had an introduction. #00:43:10-3#
>
> KZ Uhm. #00:43:10-9#
>
> [silence] #00:43:12-9#
>
> INT9 A briefing about the case. For example, sometimes, especially... in hospitals. I would arrive at the hospital, and I wouldn't know what kind of case it is. #00:43:22-2#
>
> KZ [Uhm.] #00:43:22-6#
>
> INT9 So it might be something as minor as occu', occupation [sic] therapy, and some extra therapy... for your thumb, or whatever. Or something SP, you know this, SPD [?], or if somebody has, has just died. #00:43:33-5#
>
> KZ Uhm. #00:43:34-2#
>
> INT9 And the whole family was there in tears. And you just wouldn't know. #00:43:38-2#
>
> KZ Mmm. #00:43:38-8#
>
> INT9 And there's, and there's something... really tragic, really, really sad, and... #00:43:43-6#
>
> [silence] #00:43:45-3#
>
> It's very hard to deal with. #00:43:46-5#
>
> KZ Mmm. #00:43:47-0#
>
> INT9 So... #00:43:47-9#

[silence] #00:43:49-3#

You should be prepared to that [sic]. #00:43:50-9#

[silence] #00:43:52-2#

You really should, I think. You should know what kind of case you're dealing with. #00:43:55-1#

[silence] #00:43:57-4#

Because it's, also you should have ehm... #00:43:59-2#

[silence] #00:44:01-6#

you should be able to decide whether you take on this case or not. But sometimes you might have a very bad day yourself.   #00:44:07-7#

KZ Uhm. #00:44:08-2#

[silence] #00:44:10-3#

INT9 Be it for personal reasons... #00:44:11-8#

[silence] #00:44:13-6#

It might be problems... #00:44:14-6#

[silence] #00:44:16-4#

with your own mental health, or with your own physical health. #00:44:18-8#

KZ Uhm. #00:44:19-4#

INT9 If you, like you might just have the flu, or you might... just be coming to terms with a bereavement. And... if you just feel very bad yourself, and you have to deal with a case where youngsters have died and the family just heard about it, #00:44:31-4#

KZ Uhm. #00:44:31-9#

INT9 and you're there... to interpret... that the doctors announce... This person is dead. His brain died. We have to switch off the life machine. That's, that's very harsh. #00:44:43-5#

[silence] #00:44:44-6#

And... it's, it's a lot of pressure. So, if I was given the choice, I wouldn't take on cases like that if I had a bad day. And I'm only a person. I have bad days, too, you know, like. #00:44:53-4#

KZ Mmm. #00:44:54-5#

INT9 I... I have my own... #00:44:56-0#

[silence] #00:44:57-4#

problems, like everybody does. And if I don't feel very strong on a day, I would not to', take on cases such as rape and death and so on, 'cause they're extremely hard

to deal with. If I know this is a... a day I'm feeling weak myself... even mentally or physically. #00:45:12-6#

It transpired from the interviews that some interpreters are proactive in trying to determine the nature of the assignment, which is illustrated by the following interview excerpt. As INT10 explained, the interpreter needs to be properly informed to provide appropriate services (#00:14:24-8#). This is not only in the interest of the client, but it is the only way to ensure consensual co-construction of the discourse in therapy. The passage also illustrates how even if an answer was prompted by me as the researcher (in bold), it could elicit valuable information beyond the remit of the question originally posed.

KZ And would you know in advance what the case is about? Or... #00:14:05-7#

INT10 Ehm... No. But sometimes I will ask. If I'm, if I'm lost... Because you need to highlight, you need to have to hi', highlight. #00:14:14-1#

KZ Yeah. #00:14:14-7#

INT10 You know what I mean? So... I... I don't feel shy about asking. #00:14:18-3#

KZ [Ok.] #00:14:18-8#

INT10 I ask straight and say, Listen... I can't do my job without being knowin'... eh... you know the background of this story. #00:14:24-8#

KZ Yeah. #00:14:25-3#

INT10 So... sometimes they will, you know, they will fill me up [sic], you know. #00:14:28-4#

KZ [Uhm.] #00:14:28-9#

INT10 [I don't] need a lot of details. I just need the... highlights. #00:14:31-6#

KZ Yeah. #00:14:32-0#

INT10 So I could help them. You know what I mean? #00:14:34-1#

KZ Yeah. Ok. #00:14:35-3#

INT10 If you don't ask it's like going in the dark, you know. #00:14:37-6#

KZ Uhm. Yeah. #00:14:38-3#

INT10 Wouldn't be able to do your work at all. #00:14:40-4#

Probably the most common way of preparing for an assignment for interpreters is compiling a glossary of the specialised terms that are anticipated during the interpreter-mediated encounter. Apart from the lack of information on assignments, the difficulty for community interpreters in Ireland is that very few are able to

specialise in a particular area. Therefore, most interpreters need to have a number of glossaries, which take time to prepare and the effort invested may not yield sufficient results. Nevertheless, some interpreters engage in such practices, as disclosed by INT3 (#00:13:48-1#), an interpreter with CI qualifications, in reply to my original question on the mode of interpreting. The two cases INT3 refers to (#00:13:33-3#) are the ones conducted in MHC setting among the many the INT has engaged in across a great variety of settings.

> **KZ And, ehm... when you interpret, is it then different from other... settings? In terms of modes of interpreting, so chouchotage, or, or, or... simultaneous or consecutive. [Or do you use] #00:13:29-8#**
>
> INT3 [But... both,] both cases were... both were consecutive interpreting. #00:13:33-3#
>
> KZ [Uhm.] #00:13:33-7#
>
> INT3 Ehm... I s'pose, most, most of the time... that's what I do. Consecutive interpreting. [???] for me... that particular case... it was the same. The only thing, I s'pose, is that... I always like to have all the glossaries prepared... #00:13:48-1#
>
> KZ [Uhm.] #00:13:48-6#
>
> INT3 for any kind o'... I know, for example... even if it's an emergency. I always get... call, an' I say, go to the, to the... hospital, I have my glossary. And for this particular case I did not... had specifically prepared... the type of glossary. But I normally do... in advance. But... I s'pose... they perhaps there was not that, probably they didn't know... #00:14:10-3#
>
> KZ [Uhm.] #00:14:11-0#
>
> INT3 the details. So... #00:14:12-2#

Others, however, have more spiritual ways of preparing themselves for the sessions, especially in the area of MHI, which requires particular mental and psychological preparation. Chanting in order "to be in as the highest possible life state" (INT12 #00:11:42-4#), is one way of coping with emotional involvement. Others include techniques also used in post-session counselling, as discussed in sections 6.4.2.2. on debriefing and 6.4.3.2. on self-help below.

6.4.1.2. Briefing

Briefing, or information exchange directly preceding the interpreter-mediated session, is crucial for interpreters. As a last-minute preparation tool, it allows them to concentrate on the task ahead. This is confirmed by a number of INT respondents (INT3, INT4, INT5, INT9, INT10, INT11). The significance of briefing was

acknowledged by some of the MHPs as well, although perhaps my question (in bold) was a cue to agree, as can be seen in the extract below.

> **KZ So do you have a chance to talk to interpreters? #00:17:46-4#**
>
> MHN4 [Yeah] you would. #00:17:46-7#
>
> KZ [Ok.] #00:17:47-2#
>
> MHN4 Absolutely. Yes. #00:17:47-9#
>
> KZ Ok. #00:17:48-4#
>
> MHN4 [Ehm...] You would make it your point. Ehm... There aren', there aren't that many situations where... an interpreter here would, say, would just be thrown into the mess. #00:17:56-9#
>
> KZ [Uhm.] #00:17:57-6#

However, MHPs evidently have a different viewpoint in evaluating the significance of briefing. While some MHPs (MHN5, PSY2, THER3, THER4) mentioned providing information which the INTs identified as the most important aspect of briefing sessions, they listed different priorities with regard to such meetings. For example, from the MHPs' point of view, it is necessary and desirable to ensure that the interpreter is aware of confidentiality issues (MHN2, PSY1, PSY2). According to the quote below, some MHPs regard this as the single most issue to cover during briefing.

> KZ Do you talk to the interpreters before or after the... #00:20:26-1#
>
> MHN2 Just kind of before, when they in, it's just kind of explained. #00:20:29-0#
>
> KZ. Uhm. #00:20:29-4#
>
> MHN2 But, but most of them know all about confidentiality agreements. #00:20:32-9#
>
> KZ Ok. #00:20:33-4#

Other MHPs mentioned further reasons for allowing time for pre-session briefing, such as defining the "ground rules" (MHN4) or "boundaries" (PSY2); asking the interpreter to empathise with the client (PSY1); or giving safety cautions to the interpreter, in case there is a chance that the client can turn violent (MHN5). In reply to my question on debriefing (in bold), PSY2 described the process in terms of preparing the interpreter for possible emotional difficulties (PSY2).

KZ D'you use, you mentioned debriefing. Do you brief interpreters before you... #00:26:53-0#

PSY2 When not yet. When I, when I... meet them for first time... #00:26:58-1#

KZ Uhm. #00:26:58-6#

PSY2 I talk to them... few minutes before I see the client, like. #00:27:02-8#

KZ [Uhm.] #00:27:02-9#

PSY2 You know... We just meet, met, eh... I haven't rea', met you before... Have you interpreted in mental health before? Or psychology? Do you know how it works? #00:27:12-2#

KZ Uhm. #00:27:12-8#

PSY2 Some of them, No this is my first time... ever. So it's like, Ok, you might hear difficult stories, ta-ra-ra. So we check again at the end to see #00:27:22-7#

KZ [Uhm.] #00:27:23-3#

PSY2 [how] you feel an... And then at the end again... #00:27:25-4#

Another MHP gave similar reasons for briefing practices, with a lesser emphasis on the interpreter's safety and focusing more on the idea that an interpreter-mediated encounter in MHC is co-constructed by all the participants present.

THER4 And that... you can't just kind of... go into a room... or you shouldn't go into the room without having some sense of a... the broad context into which you're... you're just one... #00:12:30-8#

KZ [element] #00:12:32-2#

THER4 you know, agent or element. #00:12:33-3#

KZ [Yeah.] #00:12:32-9#

The following extract from an interview with an INT illustrates how briefing can serve as a mutual information exchange. In this case the mental health professional provides the interpreter with details of the particular case (#00:14:15-5#). At the same time, the interpreter offers some cultural background notes which can help the mental health professional frame the upcoming encounter (#00:14:48-0#). Such practices can move towards consensual co-construction of communicative events (#00:14:59-8#). My own questions (in bold) in the passage below highlight how repeated enquiries on the same subject can elicit a more detailed reply during the course of a narrative interview.

KZ So you actually didn't [???] Did you have debriefing, or di, or briefing before, prior to... #00:13:59-0#

INT5 Yeah. #00:13:59-2#

KZ Yeah. Ok. With... #00:14:00-4#

INT5 Yeah. #00:14:00-9#

KZ With the therapist. Or... [mental health prof'...] #00:14:02-6#

INT5 [???] the psychologist. #00:14:04-1#

KZ And what would the briefing involve? Would you say something to them, or would you, they say something to you? Or... #00:14:09-6#

INT5 Ehm... Well, basically... the... the therapist would give me the background of the... #00:14:15-5#

KZ [Uhm.] #00:14:15-8#

INT5 [case]. And what previous work had been done with the family. And eh... then I would maybe... you know, recognise certain... eh, ah, characteristics about, I mean, I would... maybe see if the family is Roma, I would suggest [a few] #00:14:34-7#

KZ [Uhm.] #00:14:34-6#

INT5 ... ways of... you know, for approaching them, or... If the family... I don't know... had more children, I, I would try to put it in a context. And I would try to... #00:14:48-0#

KZ [Uhm.] #00:14:47-9#

INT5 give my, you know... ideas... in the beginning of the interview. We would work out... a strategy together an'... You know. That would... make things easier. #00:14:59-8#

INT4 recounted experience of a similar nature in response to my query on briefing practices (in bold).

KZ Ok. Eh, so did you have a discussion with the psychologist before or after the interpreting? Or... #00:16:16-6#

INT4 Well, I, yes there was some, some brief, ehm... briefing, you know. #00:16:20-6#

KZ Uhm. #00:16:20-8#

INT4 I just, re, eh, re[???]. If you only start, 'cause my, eh... my [???], she only said that there was a couple of people for {language}. Who's probably ethnically gypsies, #00:16:33-8#

KZ Uhm. #00:16:33-9#

INT4 and, ehm... she needs to assess them, eh, 'cause they, they, they say that, eh... one of them said, I really don't remember that #00:16:40-9#

KZ Uhm. #00:16:41-4#

INT4 that they need, eh, this kind of help. #00:16:43-3#

Following the research dialogue outside the realm of the narrative interviews, I would have one comment to make on not only receiving details from the mental health professional but also offering cultural background of the client. These two INTs have both received very little, if any, training. INT5 had some training in psychology, which probably explains the collegial identification with the mental health professional and the suggestion to "work out a strategy together" (#00:14:59-8#). Therefore, perhaps a word of caution is necessary when encouraging the practice of mutual information exchange. I believe that while it is desirable to have a good, or consensual, working relationship between the mental health professional and the interpreter, it is also important that the interpreter does not confuse his or her role as a cultural mediator or a co-counsellor. The distinction between these roles and their application can be clarified and acquired through appropriate training, as also suggested by, for example, Hale (2007). However, at present the research claim has once again been found untrue, as co-construction of narratives with regard to pre-session support is not consensual across the board.

6.4.2. Post-session support

According to the respondents, post-session meetings have two main functions: firstly, to discuss issues that may have arisen during the interpreter-mediated encounter proper and may be necessary for further therapy (which facilitates consensual co-construction of the therapeutic process); secondly, as a therapeutic tool for the interpreters to recover from possible emotional involvement, also called debriefing. On the whole, INTs showed more awareness of these issues than the MHP respondents. Additionally, debriefing is more widely recognised by MHPs working in therapeutic and / or specialised services than their colleagues working in logistical and / or mainstream services, which confirm the findings presented in Chapters 4 and 5.

6.4.2.1. Post-session discussions

The MHPs' viewpoint differs considerably from that of the INTs with regard to post-session discussion. In this instance MHPs are more eager to allocate time for the purpose. In contrast with the INTs' expressed need for psychological support after the session, the MHP respondents mostly focused on practical issues for after-session meetings, such as clarifying certain issues which have arisen during the session (MHN4, THER2, THER3.); or elaborating on what the client said during the session, especially if the client is hyper-aroused (THER3), or psychotic (MHN5).

One untrained INT also recalled such an incident, when replying to my question if there had been any problems trying to interpret for a client who was incoherent due to his condition.

INT4 Well, you know... I tried to interpret him as much as I could, you know. But then, you know, just, eh... I remember, though, back then, I, I, I, I [???] the interviewer that in my humble view this man simply doesn't know what he's saying. Or... #00:26:13-3#

KZ Uhm. #00:26:13-6#

INT4 Half doesn't know what he's saying, half doesn't remember what he did. #00:26:16-2#

KZ Uhm. Ok. #00:26:17-4#

[silence] #00:26:18-8#

KZ Was that during the interview or after? #00:26:20-9#

INT4 After, after. #00:26:21-7#

Another untrained INT had a similar story to tell.

INT2 Yeah. For example, if they... if they say something which I couldn't understand. Or if they... they answer, they gave a different answer or wrong faulty answer to the questions, I usually tell... tell the doctors afterwards. #00:44:51-6#

KZ Uhm. #00:44:52-2#

INT2 I said, you know, I, I, I can't, I can't say this person is very clear and... #00:44:57-0#

KZ [Uhm.] #00:44:57-3#

INT2 mentally. You know. He's not very... well #00:45:01-8#

KZ Do you say that during the session? When you're interpreting [or afterwards]? #00:45:05-0#

INT2 No, I don't. Afterwards. #00:45:05-6#

KZ Ok. #00:45:06-5#

INT2 But during the session, no. #00:45:07-6#

Such practices were criticised by most INTs, who view any analysis on their part as a breach of their role definitions. An example of such an opinion is the remark quoted below. It follows a short exchange on what happens if the mental health professional suspects that the client is not telling the truth and believes that the interpreter would have the cultural background knowledge to determine whether this is the case.

INT6 Yeah. I would have the, the insight. And that's why the, sometimes the doctor ask me for my opinion. [???] And I say, I'm not expertise [sic]. I can't give you an opinion. #00:18:05-8#

KZ Uhm. #00:18:06-2#

INT6 Maybe I am, but I don't [???] you. It's not my #00:18:08-1#

KZ Yeah. #00:18:08-7#

INT6 It's not my job. Pay me, I said, pay me [???] #00:18:11-5#

KZ Yeah. #00:18:12-4#

INT6 [laughs] #00:18:13-1#

I don't give you my opinion. [laughs] [???] #00:18:17-2#

There were MHPs as well who acknowledged that a post-session discussion does not entitle either the mental health professional or the interpreter to encourage the breaching of role boundaries. In the following extract the respondent replied to a cue on my part.

KZ Ehm... So, d'you speak to the interpreters afterwards? To clarify anything? Or [to debrief them? Or...] #00:18:17-9#

MHN4 [Some...] Sometimes, it would, it would, ehm... sometimes the work would go on... when the patient isn't around. #00:18:25-1#

KZ [Uhm.] #00:18:25-7#

MHN4 Or the client isn't around. And that you would be... lookin' to clarify maybe some issues. Ehm... so you might go back over, and say, Look, [???] what did they mean by that? Eh, eh, you know? Is there anything that I... I picked up wrong? It's this... that kind of thing. You would do a little bit of a debrief, and... you would, although, you wouldn't be asking, ehm... opinion about professional issues, because that would be beyond the scope of an intrpreter and beyond fair to ask for them to do so. #00:18:58-3#

The fact that INTs look for debriefing while MHPs seek clarification of issues raised during the interpreter-mediated session does not necessarily mean that the exchange between the mental health professional and the interpreter following the actual assignment is necessarily conflictual. Thus, in terms of the post-session information exchange, there is no conclusive evidence provided in the data regarding the research claim.

6.4.2.2. Debriefing

As far as debriefing is concerned, a number of respondents mentioned or complained about the fact that although this is common practice among colleagues working in MHC (INT9, PSY1, PSY2), such emotional or therapeutic support is unavailable to them (INT9, INT11, INT12). INT9 covers both of these aspects in the following extract (#00:13:34-5# and #00:13:21-2# respectively), which also illustrates how the narrative interview evolved through meta-communicative exchanges (in bold) on the formulation of responses.

KZ And when you interpret, do you have any debriefing sessions, after the... eh... we're talking about mental health interpreting #00:12:47-1#

INT9 [Uhm.] #00:12:47-0#

KZ [now]. So would you be debriefed by a... therapist a, or... #00:12:51-6#

INT9 No. Never. And... #00:12:54-0#

[silence] #00:12:55-6#

Eh, just especially, 'cause [overlapping] #00:12:56-9#

KZ [overlapping] #00:12:57-2#

INT9 So do you, eh.. shall I just answer... the questions as precise as possible? #00:13:02-6#

KZ [You can keep talking] #00:13:03-6#

INT9 [Or start commenting something as well.] #00:13:04-5#

KZ No, no. Go ahead. #00:13:05-0#

INT9 No, I've never had a debriefing session, and #00:13:06-6#

KZ [Aha] #00:13:07-0#

INT9 [I] know very well what debriefing sessions are. I actually had training in debriefing #00:13:11-2#

KZ [Uhm.] #00:13:11-5#

INT9 [sessions] when studying psychology, #00:13:12-8#

KZ Yeah. #00:13:13-1#

INT9 and I really feel that the lack of debriefing sessions. And... I feel it's a... huge problem. #00:13:19-3#

KZ [Uhm.] #00:13:19-9#

INT9 [For] many interpreters. #00:13:21-2#

KZ Do you personally have a problem? #00:13:24-1#

INT9 [Oh, yes. Oh, yes.] #00:13:24-7#

KZ [Because...] #00:13:24-5#

INT9 Like I think people dying, I witnessed people dying. Sorry? #00:13:28-7#

KZ Even though you have training? In psychology. #00:13:31-7#

INT9 Oh, yeah. But you know, even psychologists #00:13:33-3#

KZ [Yeah.] #00:13:33-0#

INT9 have debriefing. #00:13:34-5#

KZ Yeah. #00:13:34-9#

INT9 Even psychiatrists have debriefing. Like in the States. #00:13:39-0#

KZ Yeah. #00:13:39-7#

INT9 It's, it's really a natural thing. And not only in the States. #00:13:42-3#

KZ Yeah. #00:13:43-0#

INT9 So, just because I had the training, it does not mean #00:13:46-1#

KZ Uhm. #00:13:46-6#

INT9 that ehm... #00:13:47-6#

[silence] #00:13:48-7#

totally... resistant to any emotions and seeing people dying, or... speaking to rape victims doesn't affect me, you know, so. #00:13:57-7#

KZ Ok. #00:13:59-1#

INT9 Just because I had the training, ehm... is actually, tha', that is actually why I understand the need of it even more. #00:14:05-5#

As THER1 explains in reference to a particular case, debriefing is sometimes necessary in order to protect the interpreter's psychological safety.

THER1 You know, so that was kind of necessary. Ahhm, in other ways, there was one interpreter I think I spoke to about a client, ahhm [...] and [...] just to kind of, I I

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wasn't sure if the interpreter realised how serious the situation was. #00:17:44-1#

KZ Hmm. #00:17:44-4#

THER1 and how they were feeling afterwards. Ahhm, so I was checking in with them. You know, because there was a lot of raw stuff. Ahhm, and now [???] #00:17:57-5#

KZ Hmm. #00:17:58-0#

THER1 Because they do get a debriefing. #00:18:00-1#

KZ With you or with somebody else? #00:18:02-3#

THER1 Somebody else. #00:18:02-9#

PSY1 remarked on the psychological difficulties interpreters face in narrative terms, which is particularly pertinent to the current study.

PSY1 [Ok. Yeah. Yeah.] Ehm... you know, I think we need to, to be aware that, that the interpreter is very much part of, of the story that's being told, #00:14:22-4#

KZ [Uhm.] #00:14:23-0#

PSY1 [and] is absorbing the... the trauma that's, that's been #00:14:26-7#

KZ [Yeah.] #00:14:27-2#

PSY1 [...] been spoken about. So... We need to... as... as professionals, to speak to the interpreter afterwards, and to m', to build time into our sessions to do that. [To] #00:14:40-4#

However, if debriefing is not available, the interpreter can take this secondary trauma with them and vent it elsewhere, as one of the INTs humorously commented.

INT7 Eh... You go home and then you... #00:25:05-5#

[silence] #00:25:07-5#

you take it out on... whoever is there. #00:25:09-7#

[both laugh] #00:25:11-3#

In addition, some INTs also mentioned that debriefing services are limited to particular (mostly specialised) services (INT1, INT3, INT8). In reply to a general closing question (in bold), INT3 highlighted the need for debriefing and mentioned a particular specialised service where such support is available.

KZ Is there anything else that you can remember about your... assignments? Or anything maybe that... you wanna say about mental health interpreting? #00:30:27-6#

INT3 No, I would say that... you mentioned at the beginning that ehm... ehm... I believe that, ehm.... whether it's an interpreting agency, or it's... [???] a hospital,

there should be... debriefing provided.. Ehm... Where there is opportunity to... for in that particular case for the... for the... interpreter after the assignment to... to [???] debrief [???] you need to be [???] a professional and... need to discuss issues, ehm... I suppose... situations like... people... [???] in mental health. That should be, eh... the, the [???] to be provided and to be considered as... #00:31:13-2#

KZ [Yeah.] #00:31:14-0#

INT3 somethin' which is... very important. And I know that eh... Spirasi, eh... they do provide eh... debriefing #00:31:23-5#

KZ [Uhm.] #00:31:24-0#

INT3 [for] interpreters. #00:31:24-7#

Thus, it appears that in specialised services there is recognition of the need for debriefing. Consequently, in specialised and / or therapeutic services, there is a tendency to incorporate some time for the interpreter's debriefing (PSY1, PSY2, THER1, THER3, THER4). Such services are not provided by mainstream and / or logistical services or contracting agencies.

One of the MHP respondents was surprised to learn that agencies did not provide support services to interpreters (#00:20:13-1#). The following extract clearly shows how the narrative interviews allowed for a real dialogue to develop, where respondents also had an opportunity to ask questions (in bold).

MHN4 There has been, eh... I haven't, haven't come across that yet. And I'm, I'm, I'm not too sure... ehm... whether say... I can imagine that if I was... forget it's who it's we use... But an interpreting service, I think, should provide that for their own staff in many ways, you know. #00:19:24-6#

KZ [An'...] #00:19:25-1#

MHN4 I think that's fund', that should, eh... interpreter should be able to go back and say, Jeys, girls, that was tough. And then if there's further need to debrief, talk... depends, whatever... I think that's legitimately a part of the service... or, or of the business that they're running. And they should provide it for their own staff. #00:19:43-2#

KZ Uhm. They're not staff members that's the prob'. Or we're not staff members. #00:19:47-4#

MHN4 Right, right. So you're, your, your agency. #00:19:50-4#

KZ [we're left in limb', yeah.] #00:19:51-0#

MHN4 Yeah. #00:19:51-7#

KZ So you're left in limbo and #00:19:53-2#

MHN4 [Right, right.] #00:19:53-5#

KZ unfortunately. [laughs] #00:19:55-3#

**MHN4 If you were to ask for such a service, do you think they would...
#00:19:58-0#**

KZ No. No. No b'cause #00:19:59-2#

MHN4 [No. No.] It's very separate. #00:20:00-9#

KZ Yes. #00:20:01-0#

MHN4 And you're on your own. #00:20:01-5#

KZ They actually don't take responsibility for y'. 'Cause they... eh, just, ehm... outsource you basically. #00:20:07-4#

**MHN4 Right, right, right. And so therefore, they accept no liability, either.
#00:20:10-3#**

KZ [whispering] [No. No.] #00:20:10-6#

MHN4 That's the idea. #00:20:11-1#

KZ No. No, no. #00:20:12-4#

MHN4 That's interesting. #00:20:13-1#

KZ Just for you to know. [laughs] #00:20:15-0#

It would be unfair to MHPs working in mainstream and / or logistical services to say that they are unaware of the benefits debriefing can have for an interpreter. While some MHPs are cognisant that the interpreter might find it difficult to deal with the fallout of a session, they are simply unable to provide debriefing, especially in mainstream organisations. The biggest constraint is time, as already discussed in section 4.2.2.2. on the situational significance of narratives. Other MHPs believe that this should be the responsibility of the interpreter's employer, that is, the agency (MHN4). This suggestion stems from a misunderstanding that agencies actually employ interpreters, which is in fact incorrect, as they only outsource the work on an occasional basis, a problem not specific to Ireland (Ozolins 2007). Therefore, the research claim that narratives in MHI in Ireland are consensually co-constructed has been found untrue with regard to post-session debriefing services.

6.4.3. Ongoing support

Forms of ongoing support include counselling (which is in some sense akin to debriefing), self-help, supervision as well as interpreter meetings and peer support. The difference between these categories is in the person of the support provider. While in the case of self-help it is obviously the interpreter him or herself, in the case

of counselling the support is provided by a trained professional and / or other interpreters with similar experiences. Interpreter meetings and peer support involves, perhaps senior or more experienced, interpreters helping their colleagues, as is the case with supervision. Since the latter has been mentioned in relation to training issues in section 4.4.2., it will not be covered again in the following sections.

6.4.3.1. Counselling

Generally, the issues mentioned under ongoing counselling are similar to those brought up in relation to occasional debriefing sessions. There appears to be no clear trend among the INTs interviewed as to their need for ongoing or occasional counselling when working in a MHC environment. Some INTs would like to see some form of psychological support either by other interpreters (#00:13:55-6#) or mental health professionals (#00:14:01-9#), as seen below.

> KZ And... what do you think would help you? To throw away... #00:13:41-0#
>
> INT11 Counselling. Counselling. #00:13:42-9#
>
> [silence] #00:13:45-1#
>
> KZ By interpreters? By counsellors? By... #00:13:47-9#
>
> INT11 Both. #00:13:48-4#
>
> KZ Ok. #00:13:49-3#
>
> [silence] #00:13:52-2#
>
> Ehm... #00:13:52-8#
>
> INT11 By interpre', interpreters because they might have similar experience. #00:13:55-6#
>
> KZ Uhm. #00:13:55-8#
>
> INT11 So they might just know how to... how to help. #00:13:58-7#
>
> KZ Uhm. #00:13:59-5#
>
> INT11 Eh... But counsellors... #00:14:01-9#
>
> KZ Uhm. #00:14:02-7#

However, other INTs feel that they do not need counselling and find other ways to look after themselves (INT6).

In addition, some INTs believe that counselling (like vicarious traumatisation and debriefing) is overrated (INT5, INT12). INT5, for example, considered the question of ongoing interpreter support in terms of societal practices and expectations in reply to my query on the need for counselling in the case of secondary traumatisation.

INT5 I think... we as a society in general, not Irish society, you know, universal, are relying too much on this... you know... help and... #00:01:56-1#

KZ Mmm. #00:01:56-4#

INT5 You know. The counselling is a big thing now and I think it would be a backlash. #00:02:01-6#

KZ [Ok.] #00:02:02-2#

INT5 [???] soon. #00:02:03-2#

KZ So it is overrated [in your opinion?] #00:02:05-4#

INT5 [I think it is] [overrated] #00:02:06-9#

KZ [???] #00:02:07-0#

INT5 Yeah. Not totally, but... [Yeah.] #00:02:09-7#

KZ [Yeah.] [Yeah.] #00:02:10-5#

INT5 Generally, yeah. #00:02:11-5#

As far as MHPs' views on the subject are concerned, once again, there appears to be a division between mainstream and specialised as well as between therapeutic and logistical services. Although the number of references is too low to present conclusive evidence, it appears that specialised and / or therapeutic services seem to pay more attention to interpreters' counselling needs.

6.4.3.2. Self-help

Some INTs find individual ways of helping themselves through times they may perceive difficult, for example either by listening to music (INT10), or by chanting (IN12). Other forms of self-help include talking to friends about the workday (INT8), taking some time off (INT10), or simply switching off after an assignment (INT6). These are strategies that are used in everyday life and are not restricted to CI or MHI, as seen in the brief passage below.

INT8 Then... you can help yourself. After the session you can just take it easy. Take it easier than usually. 00:48:36-8

KZ [Yeah. Uhm.] 00:48:37-8

INT8 [And just] try to... I don't know... go for a walk, or... you know, treat yourself in... a certain way that makes you... get rid of that stress, basically, you know. 00:48:47-2

6.4.3.3. Interpreter meetings and peer support

Some INTs commented that meeting other interpreters and sharing experience with them may also help keep their spirits up. These meetings may take the form of so-called supervision meetings organised by a service (INT6, INT8, INT10), as well as meetings or continuous professional development sessions organised by the Irish Translators' and Interpreters' Association (INT8, INT9). A further suggestion was setting up a telephone helpline for interpreters, although this may have inherent difficulties in a community of such small numbers (#00:49:15-7#), as disclosed by INT8, who also offered an alternative suggestion (#00:49:41-2#) in the following section.

KZ Yeah, I, well I, I kinda still think it would be good... if... we could... you know, man a phone line. #00:48:53-9#

INT8 Yeah. #00:48:54-8#

KZ And... just have a rota... system of who... could be go', you know, or who could be called when, or whatever. But eh... #00:49:04-0#

INT8 Yeah, but in a way, as well... you will have... interpreters in [sic] the phone line, probably. #00:49:10-7#

KZ Yeah. #00:49:11-3#

INT8 You don't... we all know each other. Do you really tell someone...? #00:49:15-7#

KZ Ok. #00:49:16-6#

INT8 You know what I mean? #00:49:17-6#

KZ Uhm. #00:49:18-1#

INT8 [Like] I could tell you, and I don't mind, and... [you know] #00:49:20-7#

KZ [Uhm.] #00:49:20-7#

INT8 But... I wouldn't call a number I know... someone who knows me is gonna be in [sic] the other end. #00:49:26-0#

KZ [Uhm.] #00:49:26-9#

INT8 And I may not even trust that person. #00:49:28-6#

KZ Yeah. #00:49:29-1#

INT8 You know, I don't even li', maybe I don't even like that person, [you know]. #00:49:32-5#

KZ [Uhm.] #00:49:32-6#

INT8 I don't know who's gonna come up in the phone. #00:49:34-4#

KZ Yeah, that's [true]. #00:49:35-4#

INT8 [D'you] know what I mean? #00:49:36-3#

I think the peer-to-peer, it's ok. Like if you choose a person, #00:49:41-2#

KZ [Uhm.] #00:49:41-5#

INT8 [you] work with that person. #00:49:42-4#

KZ [Yeah.] #00:49:42-8#

INT8 [You know] in pairs, that's fine. #00:49:44-4#

KZ Yeah. Pairs, or threes, or [whatever.] #00:49:46-7#

INT8 [Or] threes. Or, yeah. Like a team. #00:49:48-4#

KZ [Yeah.] #00:49:49-1#

INT8 [You] know. And then... you choose your own team, and... you kind of... #00:49:54-1#

KZ Yeah. #00:49:54-8#

Successful supervision meetings, where interpreters can share their experiences with each other as well as avail of professional support, were mentioned on a number of occasions. Such meetings are organised by Spirasi, a specialised organisation, as transpires from the following extract (#00:02:40-9#). This is a particular point which is highlighted by INT10 in reply to my original broad question on any support services (in bold).

KZ When you interpret, do you get any support? So... after... your mental health interpreting, m' #00:02:32-8#

INT10 We... at the beginning when we started we had nothing. #00:02:35-9#

KZ Uhm. #00:02:36-2#

INT10 We had no support whatsoever. But, eh, the Spirasi people, they started, you know, #00:02:40-9#

KZ [Uhm.] #00:02:40-9#

INT10 recently, about three years ago. #00:02:42-3#

KZ Yeah. #00:02:42-7#

INT10 And we find it great. #00:02:44-1#

KZ Ok. #00:02:44-7#

INT10 It's the only thing, it's, it's, it's eh on a kind of eh... #00:02:48-7#

KZ It's a Wednesday evening? #00:02:50-1#

INT10 It, it was u', Wednesday evening, but kind of a... it's a course, eh, you know, like a workshop. #00:02:56-3#

KZ Uhm. #00:02:56-9#

The usefulness of such meetings was confirmed by another INT when answering my question on debriefing (in bold).

KZ Uhm. Ok. And afterwards, did you go to another therapist if you had a problem? Or it was too much. Or... #00:26:58-5#

INT1 Ehm... Well, I didn't have that problem. #00:27:00-5#

KZ [Ok.] #00:27:01-0#

INT1 'Cause as I was saying, the supervision meetings and of course, ehm... were quite enough. And, I, I didn't feel like I wanted to do it anyway. #00:27:08-4#

KZ Ok. Ok. #00:27:10-6#

Fair enough. Ehm... #00:27:14-5#

Unfortunately, there were also reports that the meetings had diminished in regularity, as can be seen in the next passage.

KZ And d'you get any support when you're doing mental health interpreting? Like debriefing or interpreter meetings, or... 00:06:58-2

INT8 Ehm... we're meant to have them, but they never happen. Well, they don't happen as regularly as 00:07:04-8

KZ As they... [used to] 00:07:05-3

INT8 as they... used to or... they would like. 00:07:07-5

KZ I haven't heard of one for month. 00:07:09-7

INT8 No. And since I work there, it's been like that. We've had maybe one... every three-four month. If so, you know. 00:07:17-6

KZ Really? 00:07:18-3

INT8 So it's not really... 00:07:19-9

KZ ['Cause] 00:07:20-2

INT8 It's not, it's not what they want to make it. Basically. 00:07:22-9

KZ Yeah. 00:07:22-9

INT8 Yeah. 00:07:23-3

KZ Because I think they used to have, or from what I... ga', gather 00:07:27-0

INT8 Uhm. 00:07:27-5

KZ they used to have it quite often. 00:07:29-4

INT8 [Uhm] 00:07:29-1

In terms of the research claim which posits that narratives in MHI in Ireland are consensually co-constructed, such uneven provision of ongoing support points to the refutation of the claim.

6.5. Conclusion

The current chapter has tested the research claim at the metanarrative level of service provision and examined if narratives in MHI in Ireland are indeed consensually co-constructed. It centred on issues around safety, a subject which was brought to the researcher's attention by the respondents, and on interpreter support, a topic which was more often elicited by the researcher. In keeping with the narrative framework of the project, a dialogic analysis of the respondents' views has shown how their contribution was facilitated during the interview process. In order to highlight the significance of the issue, the findings have been presented in relation to the original interview themes or to my actual interview questions to demonstrate that the topic is not restricted to any one particular aspect of the research.

With regard to safety, the respondents expressed their concerns over both the psychological and the physical safety of each participant in interpreter-mediated encounters. In other words, the respondents voiced their concern regarding the physical but more importantly the psychological safety of the client not only during the interpreter-mediated but also outside the MHI session. Some MHP respondents also remarked upon the physical safety of the mental health professional as well as that of the interpreter. While the psychological safety of the mental health professional was commented on, it mostly featured in comparison with the psychological safety of the interpreter, which attracted the most attention. Some INT respondents in particular emphasised that while mental health professionals received training to cope with the emotional and psychological fallout from their occupation,

interpreters receive no such induction even when working in highly charged environments, such as MHI.

It transpired that the respondents referred to safety in relation to the preidentified interview theme regarding special attributes of MHI with relative high frequency. This suggests that safety, particularly the interpreter's psychological safety which attracted the most attention, is a prominent characteristic of MHI. However, there are two interesting points to make. Firstly, while a great proportion of the interviewed INTs stated that MHI is more emotionally draining than other interpreting environments and may lead to some degree of secondary traumatisation of the interpreter, other INTs clearly maintained that the subject is over-inflated. It is, therefore, evident, that there is no consensus on the degree and nature of secondary traumatisation among the INT participants. Thus, in this respect the research claim has been found untrue, as not only the actual service provision but also the perceived need for certain aspects of service provision have shown an uneven conflicting approach on the INTs' part.

Secondly, there appears to be a distinction between MHPs working in therapeutic as opposed to logistical and specialised as opposed to mainstream services. It is significant that MHPs in therapeutic and / or specialised services are not only more aware of safety issues than their colleagues in logistical and / or mainstream services, but they also expressed more concerns about the subject. This result is in line with the findings of the other analysis Chapters 4 on Perceptions of Narratives and Accuracy and 5 on the Control of Communication, and once again shows that narratives in MHI in Ireland are not always consensually co-constructed.

With regard to support services for interpreters working in MHC settings in Ireland, the respondents stated that these are currently insufficient and there is much room for improvement. This applies to services prior to or following the interpreter-mediated event as well as ongoing support, whether the support is pragmatic, such as information exchange, or psychological in nature, such as counselling for interpreters who have suffered secondary traumatisation. As regards pre-session support, INTs highlighted the need to receive information on the case. While the onus to prepare for particular assignments is on the interpreter, INT respondents expressed that the necessary mental and psychological preparation is almost impossible due to the lack of basic information, such as that the session is actually a MHI assignment.

Somewhat contrary to the INTs claims, MHPs stated that they try to provide such information in general.

As far as post-session support is concerned, there is a clear difference between the INTs' and the MHPs' needs. While the former would require more psychological support, the latter see information exchange as essential for the successful therapy. Furthermore, psychological support directly following a difficult session was identified by some, but not all INTs. MHPs working in therapeutic rather than logistical and / or specialised rather than mainstream services also highlighted the importance of the interpreter's psychological wellbeing. MHPs in therapeutic and / or specialised settings expressed great concerns that interpreters may not receive such help, and are ill-equipped to deal with secondary traumatisation. MHPs in general also maintained that post-session clarification of cultural and linguistic issues is essential for follow-on therapy. In relation to the subject INTs were more than willing to provide such aid, but some of them emphasised that they refrain from getting involved in psychological or medical assessment of the clients.

As far as ongoing support is concerned, INTs expressed more concerns than MHPs. However, there is no agreement across INT respondents as to the need for such support. Some would like to see ongoing counselling for their psychological needs, others would prefer pragmatic solutions, such as interpreter meetings and peer support, perhaps by setting up a telephone helpline. Opponents of post-session psychological support reiterated that such services are superfluous, and that they favour self-help, which may take various form, including listening to music or chanting.

On the whole, the current chapter intended to investigate the research claim that narratives in MHI in Ireland are consensually co-constructed. Taking the metanarrative level of service provision, the findings have confirmed the results presented in the other analysis chapters. Thus, it is evident that such consensual co-construction does not apply across every type of MHI setting and every assignment. While it is true that certain characteristics, such as the interpreter's vicarious traumatisation, can be clearly associated with this particular interpreting environment, the complexities of MHI have once again been found to be more subtle and the research claim to be untrue.

CHAPTER 7 – CONCLUSION

This chapter provides a brief summary of the evolution of the research process, presents the findings of the current study, and considers areas for further exploration. The current project is located in the discourse of mental health interpreting (MHI) practice and research with particular reference to the Irish context. It set out to test the research claim that narratives in MHI in Ireland are consensually co-constructed. The formulation of this claim was based on the premise that the field of community interpreting (CI) is normally divided into two broad areas, interpreting taking place in legal-type and medical-type settings respectively. According to this distinction, the former comprise court, police, asylum proceedings or any other settings involving representatives of the law, while the latter includes hospitals or MHI. Furthermore, it was argued that interpreting in legal settings is often considered more conflictual, and the primary participants of the interpreter-mediated encounter do not necessarily share the same goal with regard to the encounter. Medical interpreting, on the other hand, is regarded more consensual where both the primary participants and the interpreter are working together to achieve a favourable outcome for the service user. Following this line of argument, it seemed that interpreter-mediated encounters in MHI would fall under the consensual category. This has been also proposed by scholars (Mikkelson 2008) and also by research participants in an earlier study carried out by the author (Zimányi 2005).

In order to test the research claim, three principal characteristics of the narrative paradigm were identified, which include the story / plot, dialogism / discourse and the co-constructed nature of social realities. Based on these three concepts, subsequently three organisational levels were established to aid the examination of the MHI landscape in Ireland. These narrative organisational levels defined as (1) the story level of actual narratives which evolve and which are interpreted during interpreter-mediated encounters; (2) the discourse level of the interpreter-mediated encounter as a socially constructed event; and (3) the metanarrative level of service provision and MHI as a profession. This taxonomy has facilitated a tripartite organisation of the data analysis based on information collected and prepared during a narrative research process.

A similar number of mental health professionals (MHP) who have worked with interpreters and interpreters (INT) who have experience in MHC settings were

interviewed. A sufficient number of respondents from a satisfyingly diverse range of backgrounds agreed to take part. In order to gain comparable data between the two professional groups, all respondents were asked questions on the same set of predefined themes. These topics were chosen to shed light on issues related to the proposed consensual co-construction of narratives in MHI, and included (1) the perception of mental health among the cultural groups the respondents have had experience with; (2) the cultural and situational significance of narratives; (3) the interpreter's familiarity with the evolving narrative and with the participants in the interpreter-mediated encounter; (4) modes of interpreting; (5) interpreting narratives in MHC; and (6) general issues on MHI.

The recorded and transcribed interviews then underwent a rigorous coding process, which also continued in the narrative paradigm. Consequently, two approaches were applied to the data set. On the one hand, the researcher's position was acknowledged by using a simple auto-coding device in the qualitative data analysis software NVivo, which imposed a top-down coding. This identified the sections of the transcribed interview texts which were replies to the original interview themes. On the other hand, the entire data set of all the transcribed interviews was coded in a grounded theory fashion, whereby topics mentioned by the respondents received a code name under a node in the same software. In addition, and to follow up on the narrative approach, these bottom-up nodes each had a twin pair, identifying the originator of the comment, whether it was brought up by a respondent or rather prompted by the researcher.

Subsequent statistical analysis of the number of references revealed that the intention to facilitate respondents in voicing their opinion had been successful. 83.87% of the coded references belonged to the former category, that is over four fifths of interview material had been authored by the respondents rather than the researcher. The bottom-up nodes were then grouped into thematic clusters, following which I identified three main areas of interest for analysis. These included "accuracy" with special reference to the interpreting of "narratives," "control of communication" and "safety." Furthermore, it became apparent that due to the respondents' interest in practical issues around service provision in and the professionalisation of MHI in Ireland, these should also be included in the presentation of findings.

With the data prepared, further analytical decisions had to be made, and it was decided that the most appropriate method of analysis was to use various narrative analytical tools proposed by Riessman (2008). As a result, a full tripartite structure for the presentation of the data analysis was developed, and the analysis chapters followed a similar structure. They each addressed an issue of emerging interest at a previously identified narrative level in the form of an ongoing research dialogue. Accordingly, Chapter 4 examined perceptions around narratives and accuracy as well as training issues at the story level in the form of a dialogue between the respondent MHPs and INTs. Chapter 5 explored the topic of the control of communication at the discourse level of interpreter-mediated encounters along with employment issues. The findings were presented on the basis of the respondents' views in dialogue with the only available monograph on MHI (Bot 2005a) and the wider CI literature. Finally, Chapter 6 investigated the subject of safety as well as interpreter support at the metanarrative level of service provision and MHI. In addition, it performed a dialogic analysis of the respondents' communication with the researcher throughout the interviews.

The three analysis chapters have yielded similar results and shown that the consensual element of co-construction does not necessarily apply across the board in MHI in Ireland. The findings of Chapter 4 demonstrated that there is a difference between INTs and MHPs with regard to their views on the significance of narratives. As the story level of narrative was the focus of the investigation here, this difference is noteworthy from a pragmatic viewpoint. INTs, on the one hand, showed some awareness of the potential cultural differences in narrative construction. However, they displayed little knowledge of the significance of narratives in terms of the interpreting environment, that is, mental health care. Apart from those INTs who have a background in psychology or psychiatry, none of them showed an understanding of the conflict that may arise from the transmission of such differences across languages and cultures.

MHPs, on the other hand, displayed awareness of issues around narrative and consider narrative construction significant to some degree – depending on the school of psychiatry or psychology to which they subscribe. In addition, based on the MHPs' responses, there appeared a clear division between professionals along the lines of therapeutic sessions and sessions which are concerned more with the logistics of mental health service provision, where there seems to be less time to

allow for narratives to develop. Similarly, there seems to be a difference between specialised and mainstream services in Ireland, as encounters in the latter environment do not necessarily allow for the time necessary for the facilitation of therapeutic narratives.

The other main concern of the chapter was the concept of accuracy. The fact that under the umbrella of "accuracy" "verbatim" is the category mentioned most often by the respondents, especially by MHPs, seems to indicate that they define accuracy along the lines of word-for-word interpreting. This shows very little understanding of pragmatic equivalences sought to be carried out in interpreting. The INTs' concept of accuracy appears mostly to be comprised of "no omission or addition," and few of them consider levels of organisation higher than words or expressions. Many of them did not see register an integral aspect of equivalence, either. When probed further, they agreed that benevolent misrepresentations of register, aimed at facilitating communication, may lead to the primary parties' misperception of each other's communicative competences. Judging by the ease of this realisation on the INTs' part, it appears that raising awareness of the issue of register through interpreter training is essential. Similar information dissemination among MHPs, who displayed a lower degree of awareness of accuracy issues in general, would also remedy their lack of understanding of the issue which can have far-reaching consequences. The respondents, mostly INTs, demonstrated an understanding of the necessity of such training. They highlighted training of interpreters as well as interpreter users as a priority for the improvement of interpreting services in MHI.

With regard to the practical solutions to the current situation, these results imply that both interpreters and interpreter users could benefit from training. For the latter, this could entail the definition of interpreting and translation and raising awareness of the process of interpreting – with a brief introduction into concepts of pragmatic equivalence and "verbatim" translation. Such a training program is currently being compiled at Spirasi for professionals of various medical fields including an audio CD and a booklet with a view to training sessions to be organised. Furthermore, the Health Services Executive has now made available not only guidelines for medical professionals on how to work with interpreters but also user-friendly packages of determining what language the patient speaks and what their basic complaints are, which can be used in some selected hospital wards.

Interpreters on the other hand, or rather those working as interpreters, should undergo training which includes a thorough discussion and understanding of pragmatic equivalence. Naturally, the problem of tailoring training for such a range of languages currently required in Ireland remains to be solved. This is to be overcome by a tiered educational system, albeit at postgraduate or fourth level. At the time of completion, the Graduate Certificate in Community Interpreting at Dublin City University is being restructured to provide a graduate certificate, a graduate diploma and a masters option. The first will include a general introduction to CI and ethics as well as non-language specific basic training in anatomy and the Irish legal system with the cooperation of the School or Nursing and the School of Law and Government at the university. In addition to these modules, the graduate diploma will also comprise language-specific interpreting practice and hopefully shadowing or observation sessions in a CI setting, for example, schools. Finally, candidates who wish to further their education can complete a masters degree on submission of a dissertation within a related area.

The discourse level of the interpreter-mediated encounters and the relationship of the participants became the focus of Chapter 5 on the Control of Communication. Respondents in the current study, supported by CI scholars in general, are of the opinion that at encounter-level discourse there is a delicate balance between the lack of familiarity and excessive acquaintance with the client. Thus, familiarity is necessary to develop trust between the participants. At the same time, over-familiarity, especially between the client and the interpreter, is perceived to threaten professional boundaries. In addition to familiarity issues, the question of control distribution among the participants was examined in the chapter by looking at each of the participants in interpreter-mediated encounters. As indicated in Bot's research (2005a) and the current project, the client rarely, if ever, takes total control of the flow of communication in interpreter-mediated sessions. As long as "the therapist allows" (Bot 2005a p142), the client may take temporary control. It is clear that the client's story cannot always flow and that it is restricted, therefore, co-constructed by both the mental health professional and the interpreter. It is also clear that it is not always consensually done so, as the principal story-teller cannot take full responsibility for the narrative.

Additionally, it was confirmed by the respondents that the mental health professional in interpreter-mediated encounters has considerable control over the flow of communication. While some respondent MHPs in the current research try to maintain full control and would prefer clear role boundaries for the interpreter, most realise that this is close to impossible due to fact that they have no access to most of the linguistic and some of the cultural communication taking place during these encounters. Bot's evaluation (2005a) and the findings of the current study agree that there appears to be a sharing of control over the communication flow in interpreter-mediated encounters, where the interpreter manages the cultural-linguistic information transfer, but the ultimate responsibility for the session management rests with the mental health professional. In sum, there is a constant tension between the mental health professional maintaining ultimate control over the communication and the interpreter constantly challenging this control when contributing to the multilingual encounter as a participant. While the participants' control evidently contributes to co-construction, their struggle for control suggests that such co-construction is not necessarily consensual.

This power re-distribution is what the control of interpreter-mediated encounters hinges on. MHPs commented that interpreters whom they consider professionals can distinguish between various forms of control. According to the MHPs, these professional and trained interpreters do not overstep boundaries but manage the communication flow and facilitate the achievement of the session's primary objective, which is the client's improved wellbeing. Most respondents commented that the difference between professional and unprofessional interpreters is very palpable. However, INTs also remarked that trained and professional interpreters are not recognised for their worth on an employment scene where only market forces dictate the contracting of interpreters. INTs shared their views on the drawbacks of the current system where there is no regulation, standardisation or quality control. In terms of professionalisation, there is no consensual co-construction of narratives either at the level of discourse or that of metanarrative.

In terms of future recommendations, these difficulties are not easily overcome, due to the fact that market forces are beyond the control of policy advisors and professionals. However, members of the Irish Translators' and Interpreters' Association in general and of the national association's executive committee and CI subcommittee in particular have been working in the background to reach policy

makers who restrict or free market conditions. A significant step would be if the Courts Service, An Garda Síochána (the Irish police force), the Health Services Executives or individual hospitals would consider prioritising trained interpreters when issuing a tender or selecting service providing agencies who contract interpreters. While these authorities are not directly related to MHI, the focus of the current project, such tendencies would have an influence on general practices in the wider area of CI.

In addition, while accreditation is nearly impossible at the moment, as competent examiners for the variety of languages presently spoken in Ireland are hard to come by, ideally, a central register of interpreters could be established. ITIA membership is a good starting point for authorities who are looking for an interpreter. However, it is clear that until trained and experienced interpreters are given priority and financially advantaged over their untrained fellow workers, there will be little incentive for training and signing up to the code of ethics.

Furthermore, it is interesting to note that in other areas of T/IS, for example, subtitling, there is great interest in fantitles and non-professional translators from an academic viewpoint. Researchers often approve of and encourage such practices and study them from a descriptive, often Bourdieusian perspective. However, producing fantitles differs substantially from interpreting on at least two significant counts. Firstly, fantitles are often a product of a number of people who mutually "censor" each other's suggestions to arrive at the most desirable solution. In this consensually co-constructed activity responsibility for the quality of the product is shared between the producers. This does not apply to CI situations where the interpreter is mostly on his / her own and has no support or supervision. Secondly, and as a consequence, the ethical implications differ greatly, and the potential negative corollaries are more serious and higher in number in the case of CI compared to fantitles. Nevertheless, this area will provide a wealth of interest for researchers, and would attract a lot of attention in Ireland, once access to actual interpreter-mediated encounters in the form of observation or recordings has been granted.

The findings of Chapter 6 investigating the respondents' views related to safety issues corroborated the results of Chapters 4 and 5, insofar as consensual cooperation is not evidently omnipresent. Safety emerged as a topic for analysis in a truly narrative vein, whereby the respondents' preoccupation with the subject prompted the researcher to pay special attention to their views. The most noteworthy result of

the research dialogue is that safety, with special reference to the interpreter's psychological safety and the risk of vicarious traumatisation, is an attribute which distinguishes MHI from other areas of CI. It is also interesting to note, though, that not all the respondents agreed on the significance of such risks. While some INTs confirmed that they had experienced emotional fallout following MHI sessions, others expressed the view that such reaction was overrated, and that the interpreter's suffering could not be compared to that of the client.

The other important qualification of these findings is that, once again, there appears to be a division among the respondent MHPs with regard to their attitude to and awareness of safety issues. In this sense, findings presented here substantiate those reported in the other two analysis chapters. Thus, MHPs working in specialised rather than mainstream and / or therapeutic rather than logistical services seem to be more cognisant of and concerned about the interpreter's psychological safety. Furthermore, the diversity of the responses confirmed that narratives are not consensually co-constructed. Thus, in light of the sometimes contradictory views of the respondents, the metanarrative level of service provision in MHI cannot be considered a consensual activity.

As regards the practical implications of the research, this implies that safety of all participants in interpreter-mediated encounters is paramount. In particular, the physical and psychological safety of the interpreter should be reflected upon. Prior to the session, such considerations include the provision of information about the nature of the assignment, and as much data about the case, the setting, as the interpreter-user service can pass on to the interpreter, whether through an agency or not. After the session, debriefing by the same interpreter-user mental health professional or a colleague should be made available if the interpreter needs to access such help.

As for the ongoing support of interpreters, the onus is our own collegial networks. The possibilities range from the already existing CI subcommittee of the ITIA, which is a semi-official forum for some interpreters to promote interpreter rights and best practice, through a suggested phone helpline to interpreter meetings. The latter gained impetus a few years ago, however, attempts to put interpreters on a social security footing equal to nurses who are sometimes also contracted through agencies have failed so far, and without a clearly identified position on the employment market, it is difficult to get organised.

Although the main focus of the research is MHI, there are some developments in teh wider area of MHC in Ireland as well. The Health Research Board (HRB), a government-funded research body, has been collecting information on those admitted to psychiatric facilities (Kartalova 2 April 2008). However, this information only provides details on the country of residence (with a simple distinction between the UK, Northern Ireland and Ireland) and offers no further information on county or at least provincial classification within Ireland or on the country of origin elsewhere. The HRB is running a pilot project, WISDOM in Co. Donegal, the most north-western county in the Republic of Ireland, which contains information on patients who have been admitted to psychiatric services. The details include place of birth, ethnicity, citizenship, religion and need for translation and interpreting services. Should the latter arise, the language requested by the client is indicated. A full nationwide service enquiring about the national and linguistic background of MHC clients is due to be introduced in 2010 (Kartalova 2 April 2008). Unfortunately, the future of this project is now uncertain due to the financial difficulties experienced in Ireland at the time of completion.

In sum, the findings of the research at all three narrative levels have shown that co-construction of narratives in MHI in Ireland is not at all consensual across the board. This implies that the research claim has been found untrue. In addition, a clear pattern of division between mainstream versus specialised as well as logistical versus therapeutic services has emerged as the most significant result. These findings have consequences within the framework of this study both in theoretical and practical terms. With regard to theory, the division between the legal-type and medical-type interpreting has been found too general. By extension, it can be suggested that an alternative taxonomy of CI can be considered along the lines of consensual / conflictual construction in relation to the actual encounters or even parts of encounters. This can have a bearing on the interpreter's role and the strategies interpreters apply in interpreter-mediated encounters. On a practical level, this means that they can consciously prepare for consensual or potentially conflictual situations to arise. The distinction between the mainstream / specialised and the logistical / therapeutic settings can be an indicator of such variations.

On a theoretical level, the findings call for further research and a reconsideration of taxonomy in CI in general. While subfields of CI such as MHI had previously been considered homogenous, it is perhaps time that we included a more fluent and

inclusive classification. That is, the consensual or conflictual nature of an interpreted event does not solely depend on the environment in which it takes place, but also on the nature and type of the event within that environment. This realisation may prove useful in interpreter training as well as in the conceptualisation of CI, if we put even more emphasis on a narrative / discursive and pragmatic understanding of interpreted events.

The limitations of the current study arose in terms of the restricted availability of recorded interaction, a phenomenon which hinders all CI research in Ireland at present. As a result, the investigation could not fully map the evolution of narratives at the story level, the topic which originally attracted the researcher's interest. Nevertheless, the research interviews provided rich material on the organisation of narratives, especially in the form of a particular story, which recurred on a number of occasions within the same interview. While the secondary evidence clearly cannot serve as proof of the evolution of interpreted narratives or the interpreter's influence on such developments, it points to the need for further research. It is possible that due to the unfortunate restrictions with regard to recording and the consequent unfeasibility of primary data collection, such studies on the evolution of interpreter-mediated narratives will have to be at least partly completed outside the jurisdiction of Ireland in the near future.

Furthermore, the research method which comprised the analysis of material collected through interviews with respondent INTs and MHPs has been mostly successful in obtaining information on the discourse level of interpreter-mediated encounters. Further evidence on the development of the social organisation of such sessions will also need to avail of recordings or at least observation of such encounters. It is to be seen whether approval and access will be granted in Ireland or if research will be complemented by data collected outside Ireland.

With regard to the metanarrative level of service provision, the research project has succeeded in the examination of MHI services in the Irish context and provided evidence of interpreting in settings which had not been considered before. Thus, within the limitations posed by the current state or service provision as well as the lack of established research practices in the country, the project has succeeded in paving the way for already running or future studies in CI in Ireland.

EPILOGUE

A lot has changed since the story of this research project began. One the one hand, migration patterns and interpreting needs have been transformed and interpreting for speakers with limited English proficiency in mental healthcare (MHC) situations may not seem a priority for many in the economic downturn prevailing at the time of completion of this research. However, the significance of the need for such services has not diminished with the turn in Ireland's economic development. On the contrary, the provision of quality services in the area of mental health interpreting (MHI) has perhaps become even more important.

As for my own interests, they have not subsided in the evolution of narratives in interpreter-mediated encounters. Recent years have only shown more avenues where the practices of CI can be researched and hopefully improved. While this story may have ended, the discourse of CI research I was hoping to join, seamlessly continues…

Appendix A – Informed Consent Form

DUBLIN CITY UNIVERSITY
SCHOOL OF APPLIED LANGUAGE AND INTERCULTURAL STUDIES
CENTRE FOR TRANSLATION AND TEXTUAL STUDIES

The current research, titled "Re-constructing Identities through Narratives with an Interpreter: A Case Study in Community Interpreting in Mental Health Care in Ireland," is conducted by Ms. Krisztina Zimányi. She is supervised by Prof. Jenny Williams, head of the Interpreting Research Team within the Centre for Translation and Textual Studies associated with the School of Applied Language and Intercultural Studies, at Dublin City University. The research, which is planned to be finished by December 2008, has received funding from the Research Advisory Panel at DCU for the first year of the researcher's doctoral studies. The researcher has received funding under the post-graduate scholarship for the academic year 2006/7 and has been renewed for the year 2007/8 by the Irish Research Council for the Humanities and Social Sciences.

The research study investigates to what extent and how interpreting influences communication between a mental health professional and a patient. In order to identify whose voice is really heard during mental health interviews, the researcher will interview mental health professionals who have worked with interpreters and interpreters who have worked in mental health care. These interviews will help highlight specific characteristics of mental health interpreting and will provide a picture of the state of mental health interpreting in Ireland. The interviews will be audio-recorded, transcribed and analysed.

Participation in the research is entirely anonymous. Throughout the research, the participants will remain anonymous and every effort will be made to conceal their identity. Therefore, the researcher will change the names of participants and institutions, geographical names or any other particulars which can be traced back to any of the participants. In order to maintain confidentiality, all audio recordings and transcripts will be stored on the researcher's password-protected computer based at

DCU. All material related to the research will be destroyed by the researcher five years following the publication of the doctoral thesis. It is very important that all participants understand that their participation is entirely voluntary. They can withdraw from the research any time up to the publication of the information. There will be no penalty for withdrawing at any stage. By signing the informed consent form, all participants indicate that they understand what the research is about and their participation in the research.

<u>Participant – please complete the following (Circle Yes or No for each question)</u>

Have you read the Plain Language Statement?

  Yes/No

Do you understand the information provided?

  Yes/No

Have you had an opportunity to ask questions and discuss this study?

  Yes/No

Have you received satisfactory answers to all your questions?

  Yes/No

Do you consent to your interview will be audiotaped?

  Yes/No

I also understand that all participants may withdraw from the research at any point. There will be no penalty for withdrawing before all stages of the research have been completed.

I have read and understood the information in this form. My questions and concerns have been answered by the researchers, and I have a copy of this consent form. Therefore, I consent to take part in this research project.

  Participants Signature: _____

  Name in Block Capitals: _____

  Witness: _____

  Date: _____

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If participants have concerns about this study and wish to contact an independent person, please contact:

The Secretary

Dublin City University Research Ethics Committee

c/o Office of the Vice-President for Research

Dublin City University

Dublin 9.

Tel 01-7008000

Appendix C – Demographic Data Sheet for INT respondents

Date of interview:
Time:
Venue:
Where did you hear about the research?

Interpreters:
Code name of interpreter:

Age (optional):   Gender:

Nationality:

Length of residency in Ireland:

Longer stay in countries other than home and Ireland:

Languages spoken:

Languages interpreted:

Educational background: secondary, tertiary, fourth level, diploma.

Details of qualifications:

Country of education:

Translation or interpreting training (country/level/type/specialisation/mode)

Experience in interpreting – outside and in Ireland
Settings interpreted in (underline all that apply): court, medical, garda stations, schools, medical, refugees, medico-legal, Safepass or other construction, driving tests, business, conference, prison services, other (specify)

Length of interpreting experience and frequency of assignments (amount of experience):

Mental health interpreting training:
specialised mental health interpreting training (e.g. DPSI)

Mental health interpreting support:
- debriefing sessions,
- interpreter meetings,
- pre-session consultation,
- other (please specify)

Mental health interpreting experience (number of assignments)

- Mental health interpreting venues where you have worked (underline all that applies): Spirasi,
- St Brendan's,
- St Vincent's (Clontarf /Fairview), r
- Refugee settings (e.g. Tús Nua),
- St. Ida's,
- Jonathan Swift,
- GPs
- other (specify)

Appendix D – Demographic Data Sheet for MHP Respondents

Therapists:

Date of interview
Time
Venue
Where did you hear about the research?

Code name of therapist

Service type:
- general mental health service with occasional non-English-speaking patients,
- mental health service for immigrants,
- mental health service for refugees,
- specialised services (e.g. torture care)

<u>Experience with non-Irish mental health patients</u>:
Number:

Frequency:

Average length of therapy:

Types of mental health problems:

Nationalities worked with:

Languages worked with:

Appendix E – A Fully Transcribed Interview

The following section is a full transcript of an interview, where all identifiable details which refer to those mentioned during the interview have been removed.

KZ Yeah. And then, if... you have any questions, let me know. #00:00:03-4#

OT1 Uhm. #00:00:04-1#

KZ Or... if you won't mind. #00:00:06-6#

OT1 [Yeah.] [???] #00:00:07-3#

KZ [Well, we can go] through it later on. #00:00:07-8#

OT1 [Yeah.] No I can... #00:00:08-4#

KZ Ehm... #00:00:09-9#

OT1 [???] that's fine. #00:00:12-8#

I had to do this other people myself doing [my masters] #00:00:17-2#

KZ [Oh, god...] [laughs] #00:00:17-8#

OT1 degree. So... #00:00:18-3#

[silence] #00:00:19-9#

Yeah, that's fine. #00:00:21-0#

[signing consent form] #00:00:32-4#

KZ Thanks. Thank you. #00:00:32-8#

OT1 Ok. #00:00:33-6#

[setting up equipment] #00:00:38-9#

OT1 That's a neat little recorder. #00:00:39-6#

KZ It's nice. It's actually an MP3 player. #00:00:42-3#

OT1 Hmm. #00:00:42-7#

KZ And eh... it's... [whisper???] #00:00:45-1#

OT1 Hmm. #00:00:46-8#

KZ Not bad, but some of the interviews have been in cafes and stuff and it's very noisy. #00:00:51-0#

OT1 Oh, yeah. #00:00:51-4#

KZ But it's still... holding it's best. #00:00:53-6#

OT1 [Uhm.] #00:00:53-5#

KZ [It's good. ?] Ehm... I'm just wondering... before... #00:00:56-9#

OT1 [Uhm.] #00:00:57-3#

KZ I ask anything else. What exactly does an occupational therapist [do] [laughing]? #00:01:00-8#

OT1 [That's] ok. Ehm... I s'pose occupational... therapy... #00:01:06-0#

[silence] #00:01:08-0#

is really based on the principle that what people do... #00:01:10-5#

KZ [Uhm.] #00:01:11-0#

OT1 every day keeps them healthy. So... your work, your play, your... relationships, your homelife. All of that kinda thing. Having a balanced an'... productive life like that keeps you healthy. Ehm... But if somebody breaks a leg, or if they have a stroke, or they have schizophrenia, then they can't do these things any more. #00:01:31-2#

KZ Uhm. #00:01:31-6#

OT1 So it's an occupational therapist's job to... help them back to ativities they want to be able to do? #00:01:37-8#

KZ Uhm. #00:01:38-2#

OT1 Or maybe find new ways for them to do it? #00:01:40-9#

KZ Ok. #00:01:41-4#

OT1 [Maybe] adapt things. Yeah. Kinda it's a very rehabilitative type of... #00:01:45-5#

KZ [Uhm.] #00:01:45-5#

OT1 job. #00:01:46-9#

KZ So how much... of it is practical and how much is it, is it, eh, verbal? Or oral? Or... #00:01:53-6#

OT1 Ehm... In mental health? #00:01:56-8#

KZ Uhm. #00:01:57-5#

OT1 Ehm... a great deal of it is, is, is, is oral, I suppose. #00:02:01-7#

KZ Ok. #00:02:02-3#

OT1 Ehm... And you'd be, you'd be trying to get people back to... to normal life. Through a lot of kind of encouraging, motivating, #00:02:11-3#

KZ [Uhm.] #00:02:11-8#

OT1 setting goals. Tryin' to improve their self-esteem. So it's a lot more verbal. #00:02:16-3#

KZ [Mmm.] OK. #00:02:17-2#

OT1 [Ehm...] But sometimes, I mean, things like craft, cooking... learning relaxation, maybe just goin' to the shops, or a trip to the cinema #00:02:26-1#

KZ [Uhm.] #00:02:26-8#

OT1 [or some]thing like that. Like a practical activity has very... therapeutic benefit. And we, we would use that quite a lot as well. #00:02:33-8#

KZ And... th', you're based in the psychiatry... department of psychiatry [here]. #00:02:38-2#

OT1 [I'm th'] but all of the people that I particularly see #00:02:40-7#

KZ [Alright.] #00:02:41-3#

OT1 are outpatients. #00:02:41-7#

KZ Ok. #00:02:42-6#

OT1 So they're living at home. #00:02:43-7#

KZ Yeah, yeah. #00:02:44-6#

OT1 But there are... two or three other girls here that work just with the... patients who're on the ward there. #00:02:50-0#

KZ Uhm. And would your patients be... then... psychiatry patients? [???] #00:02:55-#

OT1 [Yeah.] Yeah. Yeah. #00:02:56-6#

KZ [Ok.] #00:02:56-5#

OT1 It'd be people with things like... depression, or anxiety, or... schizophrenia, or... panic, or... yo', anger management. And problems like that [?]. #00:03:06-2#

KZ Ok. So... [Ti-di-di-di] it's a specialised service [in reference to the data sheet]. #00:03:12-0#

OT1 [Uhm.] #00:03:12-6#

KZ [an' it's part of] a hospital. Ehm... how many... just talkin' about non-Irish #00:03:17-6#

OT1 [Uhm.] #00:03:18-2#

KZ or non-English speakers, rather than #00:03:19-2#

OT1 [Uhm.] #00:03:19-4#

KZ non-Irish #00:03:19-8#

OT1 [Uhm.] #00:03:20-0#

KZ 'cause you might have English #00:03:20-6#

OT1 [Uhm.] #00:03:21-1#

KZ American. I don't know. Ehm... how many patients would you have... at the moment, maybe? #00:03:26-1#

OT1 Ehm... I s'pose on my case load... I s'pose... there would be maybe half a dozen. #00:03:32-0#

KZ Uhm. #00:03:32-9#

OT1 Of which, ehm... of which I use an interpreter for two. #00:03:38-9#

KZ Uhm. #00:03:39-6#

OT1 Eh... One... a {nationality} man, and the other is a... sign language interpreter. So while it's not English #00:03:47-7#

KZ [Ooh.] #00:03:48-0#

OT1 it's also, it's, it's a different language, a completely different language and culture as well. So... you know. #00:03:53-0#

KZ Eh... And are they using Irish sign language? #00:03:55-6#

OT1 They are, yeah. #00:03:56-0#

KZ Ok. So Irish sign... Because English sign language is different. #00:03:58-5#

OT1 Yeah. There's... It's, it's so many different kinda, different types, you know. #00:04:02-4#

KZ Yeah. Yeah. [I] know. That's gr', that's amazing. #00:04:05-2#

OT1 Uhm. #00:04:05-7#

KZ Ehm... And how often would you meet these p', meet the patients? #00:04:09-3#

OT1 Probably... at the moment, it's probably about every two weeks. #00:04:12-4#

KZ Uhm. #00:04:13-1#

OT1 It's every two weeks. #00:04:14-5#

KZ And how long would the therapy go on? #00:04:17-4#

OT1 Ehm... It really varies. Eh, d', I actually just finished with the lady with sign language today. #00:04:23-1#

KZ [Uhm.] #00:04:23-4#

OT1 Ehm... And that, I probably have seen her for maybe eight sessions? #00:04:27-7#

KZ Uhm. #00:04:28-3#

OT1 Ehm... But the {nationality} guy that I'm working with... gosh, that's been since October twice a week, so... that's... #00:04:37-0#

KZ [Uhm.] #00:04:37-1#

OT1 God, we're probably up to twelve sessions an'... #00:04:40-0#

KZ [Yeah.] #00:04:40-1#

OT1 [you] can probably see that he would be... I'd be, he'll be on the case load for a long time. #00:04:44-1#

KZ Uhm. #00:04:44-0#

OT1 It depends on need, it depends on... #00:04:46-5#

KZ [Yeah.] #00:04:46-7#

OT1 you know, the progress towards their goals, or whatever. #00:04:50-1#

KZ And do you assess them? Or... is there a psychia' #00:04:54-1#

OT1 [Uhm.] #00:04:54-3#

KZ [does] the psychiatrist assess them? #00:04:55-4#

OT1 Well, the psychiatrist would, I s'pose, diagnose an' #00:04:58-4#

KZ [Uhm.] #00:04:58-6#

OT1 [say...] Look, eh, this person, ehm... is... socially isolated, and they're not going out, and they have... you know, nothing to do all day. And they'r every anxious, or they're maybe... agoraphobic or something #00:05:11-2#

KZ [Uhm.] #00:05:11-4#

OT1 like that. Can you help? And I'll go in and see what I can do to help. [So...] #00:05:14-8#

KZ [Ok.] And d'you determine how long the... sessions go on for? #00:05:18-0#

OT1 It's usually hard to determine that at the beginning. #00:05:20-2#

KZ [Yeah, yeah.] #00:05:21-4#

OT1 [Some]times you have an idea, but... with the nature of mental health and its ups and downs #00:05:25-3#

KZ [Yeah. It's difficult.] #00:05:26-5#

OT1 [you'll, sometimes] you'll think... it's worked and it's finished, an... #00:05:30-7#

KZ [there'll be a relapse] #00:05:31-3#

OT1 [it won't be.] There'll be a down, yeah, there'll be a relapse and a downturn. So... #00:05:34-2#

KZ Ehm... So you said you're working with depre', or you, well, depression, anxiety... #00:05:40-3#

OT1 [Yeah.] #00:05:40-7#

KZ ehm... panic attacks. #00:05:42-8#

OT1 Yeah. Schizophrenia. Things like that. #00:05:45-4#

KZ Schizophrenia... Ehm... And what nationalities have you worked with? #00:05:49-7#

OT1 Just the {nationality}. [At the] #00:05:52-0#

KZ [Ok.] #00:05:52-1#

OT1 moment. T'... for now. Yeah. #00:05:53-4#

KZ And... #00:05:54-3#

OT1 [Uhm.] #00:05:54-3#

KZ [have you] worked with... anybody else before? Non-English speaker, or... #00:05:58-2#

OT1 Ehm... #00:05:59-0#

[silence] #00:06:01-6#

I'm trying to think now. #00:06:02-4#

[silence] #00:06:06-8#

Not thr', probably not through #00:06:08-0#

KZ [Uhm.] #00:06:08-5#

OT1 an interpreter. #00:06:08-6#

KZ Ok. #00:06:09-4#

OT1 Yeah. #00:06:10-1#

[silence] #00:06:12-0#

KZ Fair enough. Ok. Ehm... Have you worked with anyone else who's English-speaking but no', not Irish? #00:06:19-3#

OT1 Uhm. #00:06:19-9#

KZ Ok. #00:06:20-6#

OT1 [There] #00:06:20-6#

KZ [Ok.] #00:06:21-0#

OT1 would be several other people on the case #00:06:23-5#

KZ [Ok.] #00:06:23-8#

OT1 [load that would be...] English wouldn't be the first language. #00:06:25-2#

KZ Uhm. #00:06:25-8#

OT1 But they would have enough to... communicate, you know. #00:06:28-2#

KZ Ok. [muttering to herself???] Ok. Ehm... Because what I'm trying to see is, do you think eh... if there's any difference between, ehm... kinda perception of mental illness between various cultures? #00:06:43-2#

[silence] #00:06:45-1#

OT1 [I d'] #00:06:45-6#

KZ [In your] experience, obviously. #00:06:46-5#

OT1 [I think] yeah, I think there, there is. I mean, ehm... I think things like... schizophrenia... especially in something like the African culture #00:06:57-0#

KZ [Uhm.] #00:06:57-6#

OT1 can be perceived very differently. Ehm... I did work with one {nationality} lady, and she lived down the country, in a... when I was working down there. And... I know that a lot of... her... let's say, delusions, or her ha', hallucinations were quite ehm... related to things like voodoo, and, and sort of black magic and being possessed #00:07:18-8#

KZ [Uhm.] #00:07:19-5#

OT1 [or] being bewitched. That kind of magical thinking? #00:07:21-9#

KZ Uhm. #00:07:22-5#

OT1 That... we wouldn't really have... here. #00:07:25-5#

KZ [Ok.] #00:07:25-6#

OT1 Well, we possibly, you know, we'd, we would used to, but... And then, there'd be, would be quite uniquely Irish delusions as well. Things like bein'... pursued by the IRA, or... #00:07:35-7#

KZ [Oh.] #00:07:36-4#

OT1 believing' that you... you know, maybe you can see the Virgin Mary, or that kind of thing. #00:07:39-8#

KZ [Uhm.] #00:07:40-5#

OT1 That are quite uniquely Ir', that are... you can see where they'd come out of Irish culture, [you know.] #00:07:44-4#

KZ [Yeah.] #00:07:44-5#

OT1 Ehm... But, eh, eh, I s'pose you're asking whether it's perceived differently as regards a disability or not. And ehm... #00:07:52-3#

KZ Yeah. #00:07:52-5#

OT1 I think, I think i', I think it is. I think... I had one lady, a {nationality} lady saying to me th', the other day that... among her cultures it's just the kinda... way is to, kinda to get on with it. [And] #00:08:06-9#

KZ [Uhm.] #00:08:06-9#

OT1 to kinda hide. Especially for women in that culture, to kinda hide what's goin' on.

#00:08:10-8#

KZ [Uhm.] #00:08:10-7#

OT1 That the home an' family is sorta to be kept together at all costs, and that. You know, despite how much discomfort or depression that could cause, ehm... I s'pose for the wife or the mum. Ehm... Whereas I s'pose in Irish society we might be saying, Look, take a break from it. Get your husband to help out. That kinda thing. Whereas that mightn't be realistic in that culture. Ehm...So you have to bear that in mind, too. #00:08:35-3#

KZ Ok. And, eh, b, I've asked you already #00:08:38-8#

OT1 [Uhm.] #00:08:39-0#

KZ [if] oral... eh, communication was important, or... verbal communication. #00:08:45-1#

[paper noise in the background] #00:08:45-3#

OT1 [Vital.] Vital, absolutely. In this job, anyway. #00:08:48-1#

KZ Yeah. And, ehm.. How important are stories in your area? So not necessarily psychiatry or [not for] #00:08:54-8#

OT1 [Uhm.] #00:08:54-9#

KZ a psychiatrist. But for you as an occupational therapist. Do they mean anything? Or... #00:08:59-5#

OT1 You mean somebody's, somebody's own narrative? [Or] #00:09:01-8#

KZ [Yeah.] #00:09:01-8#

OT1 personal story? #00:09:02-6#

KZ [Yeah, yeah, yeah.] #00:09:03-1#

OT1 Sorta, they're pretty vitally important. I mean... a huge part of... occupational therapy literature... is all about narratives. #00:09:10-5#

KZ Uhm. #00:09:11-2#

OT1 Ehm... And actually quite a lot of the OT [sic] literature is... not done in kinda the empirical... #00:09:18-4#

KZ [Uhm.] #00:09:19-3#

OT1 [sta]tistically quantifiable stuff. But it's done more in kinda maybe a narrative case study type #00:09:23-4#

KZ [Uhm.] #00:09:23-5#

OT1 research. Ehm... 'Cause people's occupational lives change over their life, their life span, and... Yo'r', I s'pose what you're tryin' to do is get someone's story back on track, [really.] #00:09:35-3#

KZ [Uhm.] #00:09:35-5#

OT1 Ehm... An' I think, it's, it's, it's vitally important. Especially if you're working with somebody of a different culture. To hear some of their story. #00:09:43-8#

KZ [Uhm.] #00:09:44-3#

OT1 Ehm... Like, ho', you know, how did you come to this country? What happened before you, #00:09:48-1#

KZ [Uhm.] #00:09:48-5#

OT1 [you] came here. Because that's... gonna have it, the impact on mental health. Especially if there's been war, percecution or anything like that. #00:09:55-5#

KZ [Uhm.] #00:09:55-5#

OT1 That you have to factor in, you know. #00:09:57-9#

[silence] #00:09:59-2#

KZ And... have you come across any of the stories? With interpreters? Or... #00:10:03-5#

OT1 Yeah, I mean... there would be... it's not something I have explored. #00:10:09-8#

KZ [Uhm.] #00:10:10-4#

OT1 And that's possible... kinda due to... maybe hesitancy on my part to open up those wounds. #00:10:17-7#

KZ [Uhm.] #00:10:18-4#

OT1 [Ehm...] Bearin' in mind that I... I wouldn't be a counsellor. That I, I would be afraid of leavin' the person quite raw. Ehm... But... Yeah, I mean stories of people havin' been, you know, hurt, or... you know, assaulted, or... ehm... you know maybe attacked, or their house... damaged, or [or that] #00:10:36-7#

KZ [Uhm.] #00:10:37-1#

OT1 kind of thing. And having to, sort of... really come with nothing to another country. An', and... so just tryin' to factor in, in your own head, how that would impact on somebody's mental, mental illness. Ehm... Like say, for example, if somebody, somebody's schizophrenic and they have sort of, they're afraid that somebody's... coming to kill them. #00:10:54-7#

KZ Uhm. #00:10:55-2#

OT1 It's very difficult to say to that person, Oh, that's a delusion. When there may have been somebody tryin' to kill them. #00:11:01-2#

KZ [Uhm.] #00:11:01-8#

OT1 [Very] realistically in, in the recent past. #00:11:03-6#

KZ [Yeah.] #00:11:04-2#

OT1 Ehm... that's, you know, yo', you kinda don't know how far to push that, you know, really. #00:11:10-5#

[silence] #00:11:11-9#

I think it's somethin' we just don't know.... enough about yet. I think #00:11:15-2#

KZ [Uhm.] #00:11:15-7#

OT1 especially not the... #00:11:16-8#

KZ And, ehm... particularly when you talk about delusion or schizophrenia [or...] #00:11:21-6#

OT1 [Uhm.] #00:11:21-5#

KZ paranoia, #00:11:22-4#

OT1 [Uhm.] #00:11:23-1#

KZ [obvi]ously... the , the stories people tell wouldn't necessarily have the same sequence... that we would find easy to understand. #00:11:31-4#

OT1 Uhm. #00:11:31-9#

KZ Ehm... have you seen any... differences or strange things with non... Irish, so, with the cultures you don't know? #00:11:39-2#

OT1 Ehm... D'you mean that somebody would tell a story in a completely [different way] #00:11:44-4#

KZ [Different way, yeah.] #00:11:45-0#

OT1 [to an] Irish? Ehm... #00:11:46-4#

[silence] #00:11:51-3#

I... let me see... #00:11:52-5#

I guess so. Yes. I mean... er, er, for example, ehm... #00:11:58-4#

[silence] #00:12:01-3#

Somebody might be very much more concerned with... with somatic symptoms of their illness, which is kinda how they physically feel. Ehm... And they might talk about that in a really, sort of, bizarr way that, you know, about th'... feeling shooting up and down their spine, an... that kind of thing. Whereas... maybe... somebody else might describe it in terms of their feelings. #00:12:25-3#

KZ [Uhm.] #00:12:26-1#

OT1 [An' I] feel this, an' I think this way... Ehm... Often I think... well, li', my experience's been with... especially with the {nationality} kinda... family is that...there's usually somebody else... in the room as well. #00:12:39-9#

KZ [Uhm.] #00:12:40-5#

OT1 [Usu]ally a family member. And so stories can come out... in dribs and drabs. #00:12:44-1#

KZ [Mmm.] #00:12:44-7#

OT1 [Kinda...] people cuttin' in an... ehm... almost... compet', tellin' you competin' stories, or... conflictin' stories, an' that kinda thing. That could be... I find it sometimes difficult. But I wouldn't... necessarily say that that was a cultural thing [laughing], [you know]. #00:13:00-8#

KZ [Yeah.] #00:13:00-8#

OT1 It could've happened in an Irish family, too. #00:13:02-6#

KZ And how can... how can you cope with that through the interpreter? Because, obviously, you don't understand, so the interpreter has to... #00:13:10-0#

OT1 It's, it's, I have to say it, it... it can be a little... hard to get your head around #00:13:16-2#

KZ [Uhm.] #00:13:16-8#

OT1 [because] I mean, if you have... the interpreter there, and you have... the person you're working with, your client, and maybe a family member, now that's four people. And the com', the com', the communication's goin' from... you know, from the interpreter to the client, and the client's sayin' somethin', the family member's tellin' another thing, to you, and the c, the c', the interpreter's tryin' to keep up and, [and] #00:13:36-8#

KZ [Mmm.] #00:13:36-6#

OT1 you're tryin' to keep up, and that can get very... all over the place. And... you know, your own questions, or your own... goals can sometimes, kinda, get lost. An'... I know, I wanna ask... a question here, so just I have to cut in, you know. #00:13:52-0#

KZ So you do cut in then? #00:13:53-4#

OT1 Well, I... I will if it's... if it's going... off down a different path. Ehm... But I do, I would do that with... with an Irish person as well. #00:14:04-3#

KZ [Uhm.] #00:14:04-1#

OT1 If something is, is going off completely down a different tangent that... ehm... An' yo', it's not that you don't want to hear that particular tangent, but... you are there for a purpose. You have an hour and a half, or something like that. #00:14:15-3#

KZ [Uhm.] #00:14:15-1#

OT1 An', an' you want to talk about this person's anxiety and how to help. #00:14:18-3#

KZ [Uhm.] #00:14:19-0#

OT1 [An'] so talking about... let's say, maybe a football match or somethin' like that probably isn't that relevant in th', in... you know... or what's on television, or... that kinda thing. You need to kinda... pull it back from those sorts of topics. An' that can be difficult, because you have to go through... Somebody has to... [laughing] #00:14:34-4#

KZ [laughs] #00:14:34-6#

OT1 to reach its source. #00:14:35-9#

KZ Ehm... And would the interpreter cut in as well? #00:14:39-1#

OT1 Ehm... I've seen them do i'. I mean... say, for example, if I asked a question... ehm... which goes through the interpreter. And the client will start to answer. And it's obvious that the client has not understood the question [or] #00:14:54-7#

KZ [Mmm.] #00:14:54-7#

OT1 he's answering something completely different. An' I've seen the interpreter go, You know, I, I s'pose... my understanding of what they're saying is kinda, No, hang on... you know, that's, that's not what I meant, #00:15:046#

KZ [Yeah.] #00:15:05-0#

OT1 [let me] rephrase that. So they're kinda interpre', the', the', they'll stop the client if they see they're... not answering what's actually been asked, you know. #00:15:11-4#

KZ And would they tell you what they're doing? Or you're... #00:15:14-0#

OT1 Ehm... #00:15:14-6#

KZ [Or] is it obvious? #00:15:15-5#

OT1 Sometimes. [If,] #00:15:16-5#

KZ [Uhm.] #00:15:16-8#

OT1 if it's happening very fast, they won't simply have time. #00:15:19-0#

KZ [Uhm.] #00:15:19-5#

OT1 Ehm... But sometimes they will turn to me an' go, They, they, they've just said that blah, And I explained that that's not what you meant. Or somethin' like that. #00:15:27-3#

KZ [Ok.] [Ehm...] #00:15:29-3#

OT1 [Which] I think is good. Because... otherwise you have a couple of over and backs and you're like, Wha', what happened there? [laughs] #00:15:34-5#

[silence] #00:15:37-1#

KZ And... do they... wait for somebody to... finish and then interpret? Or do they start whispering? Or... D', do... have you seen interpreters taking notes? Obviously it's different with sign language. Because you do it simultaneously. #00:15:48-6#

OT1 Yeah. Sign language is often simultaneous, simultaneously. #00:15:52-0#

KZ [Uhm.] #00:15:52-3#

OT1 And, ehm... in some ways that... does... make a difference. Because you, you hear a voice. #00:15:59-0#

KZ [Uhm.] #00:15:59-6#

OT1 [You] know, saying something in almost in real time? Ehm... #00:16:03-2#

[silence] #00:16:05-3#

It has a d', it has its own challenges as regards... havin' to remember that you look, to

you look at the client. #00:16:11-4#

KZ [Uhm.] #00:16:12-0#

OT1 Even though your voice, the voice is coming from... from here. #00:16:14-1#

KZ [Uhm.] #00:16:14-6#

OT1 To look at the client. Ehm... Actually I saw somebody do a terrible job in it today. I was down in FAS [the Training and Employment Authority in Ireland] with... with that particular lady and... #00:16:23-0#

KZ [Uhm.] #00:16:23-4#

OT1 the FAS advisor was, was, was talking to the... to the... interpreter saying, Does she want this, and does she want #00:16:31-2#

KZ [Uhm.] #00:16:31-1#

OT1 a form for that, an'... You know, I, I mean, I was at all cost lookin' at the table. 'Cause I was like, I don't want to draw at', attention to me. I want her to be looking at the... at the client. #00:16:40-4#

KZ [Uhm.] #00:16:40-1#

OT1 An' I just thought, Oh, gosh! #00:16:42-0#

[both sigh] #00:16:43-3#

You know, I felt really bad for the poor gir', lady that was sittin' there and nobody was lookin' at her, [you know.] #00:16:47-5#

KZ [Th', eh, yeah...] And, eh... would you be trained to use interpreters? Or has anybody told you? Yeah. 'Cause you are doing... what... is the best #00:16:55-7#

OT1 [Uhm.] #00:16:55-9#

KZ [for], obviously #00:16:56-7#

OT1 [Uhm. Uhm.] #00:16:57-3#

KZ everyone involved, but... it doesn't come naturally. And a lot of [people] #00:17:00-7#

OT1 [No. No.] #00:17:01-6#

KZ would... #00:17:01-3#

OT1 It doesn't. #00:17:02-2#

KZ [say. Yeah]. Yeah. #00:17:03-4#

OT1 An' especially, things like, ehm... I'm working with this particular man. And a, an' a lot of the therapy is on getting out o' the house. Because that's a big problem for him. As regards anxiety. And... And so... you could end up in a situation, where you're walking down a footpath, or... in a coffee shop, or just... along a narrow road, or... An', an', an' you're tryin' to... juggle where you stand. #00:17:27-1#

KZ [Uhm.] #00:17:27-8#

OT1 [So that] you can get the best... flow of conversation [and sometimes] #00:17:30-8#

KZ Oh, you're actually walking with [them]? #00:17:32-2#

OT1 [Yeah] walkin' along, #00:17:32-8#

KZ [Yeah]. #00:17:33-1#

OT1 [or] walkin' down the street, or... You know. Ehm... Rushin' for the bus, or... #00:17:37-6#

KZ [Uhm.] #00:17:38-1#

OT1 You know. So different things like that. An' that could be difficult. 'Cause it's not exactly sittin' in this... situation. #00:17:43-1#

KZ [Yeah.] #00:17:43-6#

OT1 It's, it's, it's much more organic than that. #00:17:45-5#

KZ Yeah. Ehm... So, obviously the sign language interpreter would be sitting behind you. #00:17:51-0#

OT1 Usually, they'll be sitting opposite the client #00:17:53-9#

KZ [Ok.] #00:17:54-1#

OT1 [an'] I'll be sittin' to the side. Ehm... #00:17:57-4#

KZ And the ehm... spoken language? #00:18:02-6#

OT1 Spoken usually to my side. #00:18:03-7#

KZ [Uhm.] #00:18:04-5#

OT1 [An'] I'll be sittin' opposite the client. #00:18:06-1#

[silence] #00:18:07-8#

KZ And, ehm... So do they take notes? Do you think? Or.. #00:18:11-4#

OT1 No. #00:18:11-4#

KZ No. Ok. #00:18:12-5#

OT1 No. #00:18:12-5#

KZ Obviously, not the... sign language, but the... #00:18:15-8#

OT1 Yeah. #00:18:16-7#

KZ Ok. Ehm... Have you... come across any particularly difficult situation... when working through an interpreter? #00:18:28-4#

OT1 Ehm... #00:18:29-6#

[silence] #00:18:33-1#

Some', I, I s'pose... well, one practical difficulty... #00:18:37-8#

KZ Uhm. #00:18:38-4#

OT1 I found was... I went, I was bringin' this, this same chap... to... on a bus trip. He hadn't been on a bus in a long time and it was practicing that. And ehm... he... I think he saw the bus coming and he just ran out in the middle of the road, out in front of the bus, an' started waiving at the bus an'... Like I was calling his name, but I had no... words to say, Come, you know, Come out of the road! Stop you'll get hurt? Stand o', stand on the footpath! #00:19:04-3#

KZ [Uhm.] #00:19:05-1#

OT1 And mum, his mum ran out in front of the bust as well. An', so I had to, oh, it was like, send the interpreter, 'cause the interpreter was the only person who could help in this #00:19:12-8#

KZ [Uhm.] #00:19:12-9#

OT1 situation. An'... So he had to go an' run, an' kinda, kinda catch them an'... Ehm... It suddenly... just as well brought home to me that I... you've no, you've nothin' you can say. This person has zero English, like. Absolutely nothing. I'm not sure he'd understand No or Yes, or... #00:19:29-2#

KZ [Or] Stop. #00:19:30-2#

OT1 Or Hey, or anything #00:19:31-4#

KZ [Mmm.] #00:19:31-3#

OT1 like that. So... It was just... In an eme', like, not an emergency situation. But in a, in a sit', situation where there's a bit of risk or... #00:19:38-9#

KZ [Uhm.] #00:19:39-4#

OT1 [???] sort of... the interpreter's, is... sort of right arm in that, [you know]. #00:19:44-9#

KZ [Uhm.] #00:19:45-1#

OT1 If it, if they weren't there... Ehm... But then yes, there's other situations where... ehm... #00:19:52-0#

[silence] #00:19:55-0#

difficult situations where... I s'pose in the sign language... eh... especially, I ha' one th', one particular lady, an'... she was very, very, very tearful. And so... it was very, very difficult to comfort somebody... through without any words, without any tone of voice. #00:20:10-3#

KZ [Uhm.] #00:20:10-8#

OT1 Without any... ehm..., anything like that. An' I know that the sign language interpreter can eh, can eh... inflect tone, can let the person know #00:20:19-9#

KZ [Uhm.] #00:20:19-5#

OT1 that I'm saying this in a particular tone. But we couldn't, because thi', the lady would have her head in her hands crying. #00:20:24-7#

KZ [Uhm.] #00:20:26-1#

OT1 An' I mean... if that was a, a speaking person... or a hearing person, you could be talking to them while their had their head in their hands. #00:20:34-2#

KZ [Uhm.] #00:20:34-7#

OT1 [But] when their vision is... blocked, you've... again you've zo, you've zilch, you've absolutely nothing. I s'pose you have touch. You could touch it, [but] #00:20:41-9#

KZ [Uhm.] #00:20:42-1#

OT1 that could give them a fright. #00:20:43-5#

KZ [Yeah.] #00:20:44-3#

OT1 [Because] they wouldn't see you or hear you. Hear you kind of approach. #00:20:46-4#

KZ [Yeah.] #00:20:47-0#

OT1 Ehm... So those were a couple... maybe of things... that were kind of... an, w', just, I s'pose, very last thing was... when things can get... not out of hand, but... somebody is communicating anger through sign lan' [laughing], thro', through an interpreter. Ehm... Or when a conversation just simply goes.. out of your control. Where, say, you've got two people having again, like, maybe a client an' a family member, an' it's happenin' through the interpreter, an' it's, an' it's gone. There's been... five or six interchanges of conversation, #00:21:16-9#

KZ [Uhm.] #00:21:17-2#

OT1 there's obvious high... high emotion, high tension, you know... there's bangin' on the table, that kind of stuff, an' it's like Wha'... wha', what happened there? And you lose... so much of that without the language, you know. #00:21:28-2#

KZ And do you think you lose... [a lot]? #00:21:30-6#

OT1 [I think] so. I think what you probably lose is your authority. #00:21:33-3#

KZ [Uhm.] #00:21:34-3#

OT1 [Ehm...] An' I don't mean that harshly, in a bad way, but...certainly in a situation like that...I would feel... I would, I'd feel difficult to say, Hang on, can we just... stop there. Because... I don't know at what point I'm coming into the conversation. If it was an English... #00:21:48-4#

KZ [Uhm.] #00:21:49-1#

OT1 [conver]sation... I would hear maybe a natural break... in a conversation. A natural pause between subjects. An' I'd come in and go, Ok, you know, I've heard that. It's time to, maybe, can we just bring it back to #00:22:00-6#

KZ [Uhm.] #00:22:00-7#

OT1 what we were talkin' about earlier. Bu' without that... I could be comin' in in the middle of a really traumatic story, that... #00:22:06-6#

KZ [Uhm.] #00:22:07-1#

OT1 I... I don't want them to not... talk about, but... You know, it's kinda difficult to know where to break that stuff... That's just another challenge, I guess. #00:22:17-2#

KZ Ehm... Because... you've been working with this {nationality} man for... #00:22:23-1#

OT1 [Mmm. Mmm.] #00:22:24-0#

KZ three months? [Four months now?] #00:22:25-0#

OT1 [Yeah. Four] months, yeah. #00:22:25-9#

KZ Ehm... Do you that has had an effect on... the interpreting situation. So not necessarily your relationship [with him] #00:22:36-1#

OT1 [Uhm.] #00:22:35-8#

KZ but... the fact that it's interpreted. And... has it, the interpreting changed from the beginning... to now in any way? #00:22:43-6#

OT1 Ehm... #00:22:45-5#

[silence] #00:22:48-3#

I don't think the interpreting is eh... particularly changed. I mean, I think, the interpreter... the same as the therapist, does build up a relationship. With the client. #00:22:57-0#

KZ [Uhm.] #00:22:57-8#

OT1 Ehm... #00:22:58-6#

[silence] #00:23:01-5#

I guess, it might take a little longer for trust to form, or a relationship to form. Without the language. But... ehm... #00:23:10-0#

[silence] #00:23:12-3#

This particular client would be... an extremely challenging client without the language problem. Y, y, you know. So, it's not as if... without the language, it would've been... a straightforward case. And it's, it's certainly wouldn't. #00:23:24-9#

KZ [Uhm.] Uhm. #00:23:26-1#

OT1 D'you know? #00:23:27-1#

[both sigh and laugh/smile] #00:23:30-2#

KZ So you don't eh... in any way feel that the interpreter is becoming more and more part of that? #00:23:34-2#

OT1 Oh, he's an essential part of it. #00:23:36-5#

KZ Ok. #00:23:37-1#

OT1 Absolutely essential part of it. [Ehm...] #00:23:40-5#

KZ [And] you've always worked with the same interpreter? #00:23:42-1#

OT1 [Yeah.] #00:23:42-2#

[silence] #00:23:43-9#

I kinda feel that would be important. #00:23:45-3#

KZ Ok. #00:23:46-2#

OT1 Ehm... #00:23:47-2#

[silence] #00:23:50-5#

I mean it would be... quite difficult. I mean... #00:23:52-8#

[silence/sighs] #00:23:55-1#

I mean the interpreter is very good in, sort of, literally just being a conduit... #00:23:58-3#

KZ [Uhm.] #00:23:59-1#

OT1 [for] what's... the, the conversation. But at the same time, you can't just be, you are, they're... they are a human being [an] #00:24:05-0#

KZ [Uhm.] #00:24:05-6#

OT1 especially, I s'pose the client is male. And having a male... interpreter, sometimes, na', means that I've... In this case, anyway, it seems to be that sometimes the male... relationship... #00:24:16-7#

KZ [Uhm.] #00:24:17-3#

OT1 [yeah] it's a male relationship, is built up more. Ehm... #00:24:20-6#

[silence] #00:24:26-1#

Yeah, I mean. They're, they're really... they're kinda essential bit of it, [like]. #00:24:29-6#

KZ [Uhm.] #00:24:29-8#

OT1 They're as important... there as I am, like. #00:24:32-0#

[silence] #00:24:33-5#

KZ Mmm. How do you... call the interpreter? Or who calls the interpreter? #00:24:38-3#

[silence] #00:24:40-1#

OT1 Ehm... At the moment what we do is... kinda we set... at the end of each session #00:24:44-5#

KZ [Uhm.] #00:24:45-0#

OT1 we'll sit down with... each of our diaries, and set the next session. #00:24:47-2#

KZ [Uhm.] #00:24:47-6#

[silence] #00:24:49-5#

OT1 Ehm... #00:24:50-6#

KZ And... the first instance, would you remember... how... #00:24:53-9#

OT1 [It] was.... #00:24:54-9#

KZ Through an agency? #00:24:56-1#

OT1 Yes, 't was through an agency. #00:24:57-6#

KZ [Ok] #00:24:58-3#

OT1 [Ehm...] Yeah, it was through an agency. Yeah. #00:25:02-1#

KZ [Ok.] #00:25:02-4#

OT1 This particular interpreter is kinda... is well known to the services. Does a lot of... #00:25:06-5#

KZ [Ok.] #00:25:06-8#

OT1 interpreting for the services. So it was... #00:25:09-3#

KZ And what services would that be? #00:25:10-7#

OT1 W', for the mental health services. #00:25:12-4#

KZ Ok. #00:25:12-8#

OT1 Yeah. So they would... attend, kind of... people, appointments with the consultants, [or...] #00:25:18-4#

KZ [Uhm.] #00:25:18-6#

OT1they'll,if there's... somebody, a {nationality} person on the ward... they'll be in almost every second day. Just to make sure that... #00:25:25-0#

KZ [Uhm.] #00:25:25-5#

OT1 communication is open. And things are getting said an', whatever. #00:25:29-2#

KZ Yeah, I've heard that elsewhere as well. In a hospital... obviously, not in dedicated, eh, centres, but in hospitals #00:25:36-0#

OT1 [Uhm.] #00:25:36-4#

KZ [it's] very difficult that...th', your normal communication would be, Oh, how are you today... #00:25:40-2#

OT1 [Yeah.] #00:25:40-5#

KZ The weather's nice... #00:25:41-1#

OT1 [Uhm.] #00:25:41-4#

KZ And that's terribly [lacking] #00:25:42-7#

OT1 [Uhm.] #00:25:42-8#

KZ if there's no interpreter. #00:25:43-9#

OT1 [Yeah.] [Yeah.] #00:25:45-1#

KZ [And] it just means so much to the patient as well. #00:25:46-5#

OT1 [Uhm.] #00:25:47-0#

[silence] #00:25:48-3#

Yeah, yo', you don't even have the basics. #00:25:50-0#

KZ Yeah. [Yeah.] #00:25:51-5#

OT1 [I mean] sometimes, somebody mightn't have English. But they might have... Fine. Ok. You know. Hi. Good morning. Goodbye. #00:25:59-3#

KZ [Uhm.] #00:26:00-1#

OT1 [This] person is... really can't take a, I mean if they don't [know how] to say Goodbye and Hello, it's, it's... d'you know, you're, you're really... You might as well be mute, sometimes, you know [smiling]. #00:26:09-5#

KZ Yeah. And sometimes eye contact is very difficult as well. #00:26:12-6#

OT1 [Uhm.] #00:26:13-2#

KZ With... #00:26:13-7#

OT1 [Uhm] #00:26:14-3#

KZ patients. #00:26:14-4#

OT1 [Uhm.] #00:26:14-6#

KZ [Yeah.] Yeah. Ehm... was there anything else? Sorry... Is there anything else you can think of? #00:26:20-2#

[silence] #00:26:22-9#

OT1 Ehm... #00:26:23-0#

[silence] #00:26:27-9#

I s'pose, one other thing of, of having an interpreter there. I was speaking to the sign language interpreter about it today. Is that sometimes it's very strange to have a witness to you', to your therapy. #00:26:37-1#

KZ [Uhm.] #00:26:37-7#

OT1 Ehm... and that's not... that... y', you see like you're doing anything wrong, or that you wouldn't want them to see what you're doing, or anythin' like that. But... Sometimes in mental health you just don't know what you're doing. And you reach points of... I don't know where to go with this person. I'm gonna really need to go back and maybe talk to my supervisor, or... Re-read the literature, or... come up with a few more ideas. And you kinda get stuck. #00:27:01-3#

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KZ [Uhm.] #00:27:02-2#

OT1 Especially someone who has... incredibly complex needs, like this person has. #00:27:05-3#

[silence] #00:27:07-0#

But... it means that when you reach that point... with the client, you have a witness to it. Like, i', was just the last time I was out of the house with... again there was four... There was family member, client, interpreter and myself, #00:27:18-1#

KZ [Uhm.] #00:27:18-2#

OT1 and I just... I, I had run out of things to say. I just did not know... we'd, kinda, he had relapsed... and... I was just... Oh my god, I, I just really need to go away and rethink... my plan with this person. But you had three pairs of eyes... watching you, waiting for what you were gonna say next. And that was incredibly difficult. #00:27:40-7#

[silence] #00:27:41-8#

You know. #00:27:42-1#

KZ Draining? Or... #00:27:43-5#

OT1 Well, it was very draining. But it was also, you just felt, God, th', th', the weight of people... #00:27:47-2#

#KZ [Uhm.] #00:27:47-8#

OT1 Y', somehow... your words feel like they have more importance when they get... translated through somebody else. #00:27:55-6#

[silence] #00:27:56-7#

So you almost pick them... #00:27:58-1#

[silence] #00:27:59-7#

kind' more carefully than when you would...it you were just talkin' t' a person, English-speaking person to English-speaking person. #00:28:05-3#

[silence] #00:28:05-9#

So when you run out of things to say an' everyone's waiting... kinda hanging on... what you're gonna say next... as the "expert" in inverted commas... it's just horrendously difficult. 'Cause I, ye' an' cu', and different cultural background... y', I mean, the', they'd, they call me the doctor. And I have... done everything I can to s', I'm not a doctor, but... Like... if you're given that weight of... #00:28:28-5#

KZ [Uhm.] #00:28:29-0#

OT1 [of] kind of...the expert, that is gonna fix... me, ehm... [where] #00:28:34-7#

KZ [mutters] #00:28:35-2#

OT1 Yeah... Whereas, I mean, you know, an Irish person would like, ksh... you know, they cancel appointments and they don't bother turning up an'... all that kinda stuff. But that would never ha', actually never really happens with somebody from another

culture. #00:28:46-5#

[silence] #00:28:47-2#

KZ [Mmm.] #00:28:47-9#

OT1 [People] from other cultures, you know, they turn up, they ring, they'll say, Thank you so much for seeing me, you know... [laughing] Like.. Irish people just, you know... you know, whatever, can't bother. #00:28:58-5#

[silence / paper noise] #00:29:01-1#

KZ [???] ask. Ehm... When parents... kinda.... #00:29:06-6#

OT1 Oh, [yeah.] #00:29:07-7#

KZ [interpreter]... many people in the room... #00:29:10-4#

OT1 Yeah, ehm... #00:29:12-4#

[silence] #00:29:16-8#

Ye, ye, ye, yeah... You mean... like, kinda, tryin' to kinda identifying, [or] #00:29:20-5#

KZ [Yeah.] #00:29:21-0#

OT1 bonding with the interpreter #00:29:21-8#

KZ [Yeah.] #00:29:21-8#

OT1 rather... Yeah, that, that really happens. #00:29:23-9#

KZ Especially when you said the male[-to-male] #00:29:26-0#

OT1 [Male-to-]male, oh yeah. Completely. Ehm... You know... you know when... client al', really seems more pleased to see the interpreter than you. #00:29:34-6#

KZ [smiles] #00:29:35-1#

OT1 [That] kinda thing. Ehm... Or, you know, I, I've heard that, will say, with this particular same, same family, has kinda approached the interpreter on their own, #00:29:43-9#

KZ [Uhm.] #00:29:44-5#

OT1 and said, Look, can you come with us to do this, and come with us to that? Or we wan', an' ehm... e..., I suppose, it's a, it's a natural... it must be natural. #00:29:53-1#

KZ It's a survival thing, I think. #00:29:55-6#

OT1 Yeah. #00:29:56-0#

KZ It's a survival instint #00:29:56-5#

OT1 [Mmm.] #00:29:56-8#

KZ to say... you're the anchor. #00:29:58-9#

OT1 Bu'... they are the anchor. #00:30:00-9#

KZ [Yeah.] #00:30:01-2#

OT1 The're, the're, they're the most, I mean not the most important person in the room. But they're the person in that room that it all revolves around. #00:30:05-8#

KZ [Mmm.] #00:30:06-5#

OT1 I mean, it, it should be the client, and I s', I mean it is the client, but... neither the client or [sic] the therapist is anything without the middle... #00:30:14-5#

KZ [Mmm.] #00:30:15-2#

OT1 The middle point. And, ehm... Yeah, I mean, I s'pose, culturally as well, identifying, I mean, you kn', What part of the country 're your from? An' d'you know this person, an' d'you know that person? An' what team from home d'you support? An'... You know, that kind of thing happens a bit as well. An', ehm.. So you have to, I s'pose... beg', be aware of tryin' to get your own hands in there #00:30:40-4#

KZ [smiling] [Yeah.] #00:30:40-5#

OT1 [smiling, [an'] sorta go, Oh, tell me a bit about that. Sounds like a nice place that you're from. Tell me about it. #00:30:45-2#

[both smiling] #00:30:45-3#

You know. [laughs] Tryin' to get in the middle there. But I think that's less of a problem if you've got a good interpreter. If you have an interpreter that understands their role. #00:30:52-6#

KZ [Mmm.] #00:30:53-4#

OT1 An', ehm... an' it happens where [???] the client might ask that, you know, Tell me about where you're from in {name of country}. An' the interpreter might just turn to me and say... they've asked me... to tell them a bit about this. Is that ok if I just, an', an', tha', you know. So it comes back to me an', an' I know what's happening. [Cause] #00:31:08-7#

KZ [Mmm.] #00:31:09-0#

OT1 If they were just ye', chatting away, I'd be like... [laughs] #00:31:12-7#

[both laugh] #00:31:13-8#

KZ Has that happened? #00:31:15-1#

OT1 Ehm... No, no. It, it wouldn't. No, it wouldn't, really happen. #00:31:19-6#

KZ [Uhm. Uhm.] #00:31:20-1#

OT1 I mean the interpreter, I think, is well trained in that, and then... No, they'd usually kind of... or maybe something will happen like... I would ask a question, the person would say a, a long answer in {language} back, and I might just get a short response from the interpreter. #00:31:36-8#

KZ [Uhm.] #00:31:37-4#

OT1 Ehm... But usually, they'll, they'll say something like... they gave a lon'

explanation, they gave loads of people's names. #00:31:43-6#

KZ [Uhm.] #00:31:44-5#

OT1 Ehm... But the, the gist of it, you know, was that. #00:31:47-8#

KZ And would you ask the interpreter, say, Some it up, or Tell me every[thing]? #00:31:52-1#

OT1 No, I mean, I like, I, I prefer when they say it in the first person. Like, if... some is, you know that #00:31:58-3#

KZ [Uhm.] #00:31:58-6#

OT1 that they, they, they use I, an' if they use that. I mean. So then you get... you get a sense of what the person is really saying, you know. #00:32:07-5#

KZ So, you, you're quite aware that you're not getting the full... or, or from what I, what #00:32:13-2#

OT1 Yeah. #00:32:13-7#

KZ [you're saying here] #00:32:14-4#

OT1 No, no. I mean, sometimes, yeah. But, the ve', the on', the, the, ah, the interpreter will always, you know, will always say, they... now I'm tryin' to think of an example, it's a silly example. Ehm... #00:32:28-9#

[silence] #00:32:31-7#

Say, I might ask him about football, and he might say a lot, you know, something lot bit in {language}, and... the interpreter would turn to me and say, He, he says he supports... a particular {name of sports club} team that is doin' well this year. Or something like that. #00:32:45-6#

KZ [Uhm.] #00:32:45-9#

OT1 Rather than sayin' h' supports blah-blah-blah-blah-blah who do, does well. #00:32:48-6#

KZ [Uhm.] #00:32:49-1#

OT1 [in the] blah-blah-blah-blah league, or something like that, which mightn't make any sense to me. But the vast, vast majority of the time... he'll use I and, and translate for that. Which makes it an awful lot easi', you know. It's kinda, it's like... that you're actually hearing the client's voice. Ehm... I mean, in sign language... where, when you never hear the client's voice... #00:33:10-2#

KZ [Uhm.] #00:33:11-1#

OT1 The sign language interpreter's voice is crucial. I mean at least in {language}... I can tell if, if somebody's angry. I can tell if he's said, if he's... using English words, if he, for, you know... place names, or the doctor's name, or... I can get a gist of what he's saying. Ehm... But in sign langauge... it could be absolutely anything, quite often. And, ehm... #00:33:37-0#

KZ [Uhm.] #00:33:37-3#

OT1 So that's... I mean, the, the, the interpreter will sign things like, ehm... er... hmmm, well... There's, you know, she'll say that in my ear, as the cl', you know. So, I

can hea', I can hear... almost... like it's almost as if that's the client's voice coming from this side, even though... so that, it, I mean, that's vital, so I can hear that kind of hesitency, that kind of... maybe a different mood, maybe eh, eh... she'll, she'll, she'll go down... if the person's, is, is down, and she'll, you know, inflect it as a question, ehm... #00:34:09-2#

KZ And do you not get that in... #00:34:12-3#

OT1 Oh, you do, you do. But I s'pose what you hear in {language}, is you hear the inflection. #00:34:17-1#

KZ [Uhm.] #00:34:17-6#

OT1 You hear almost if it's a question, you'll hear if they're angry, you'll hear... you know... I don't know. You'll hear, I mean you can get what mmm, aah, well, mmm... you know is... in {language}. #00:34:29-2#

KZ [Uhm.] #00:34:29-0#

OT1 An' actually you star'... [laughing] you start to pick up the odd word yourself. And I actually I have learned a few more {language} words #00:34:34-3#

KZ [laughs] #00:34:34-8#

OT1 [than he] has English words at this stage. #00:34:35-9#

[silence] #00:34:37-9#

[You know] #00:34:37-9#

KZ [...] #00:34:38-5#

OT1 [You get] #00:34:38-4#

KZ [...] #00:34:38-4#

OT1 You get to know the... actually [laughing] the... the words. Like that, the, the, interpreter says kinda, Do you understand a lot in {language}? That's why [mutters] I don't know what that is [laughing]. #00:34:47-7#

KZ [Yeah.] #00:34:48-0#

OT1 D'you know what I mean? Ehm... #00:34:50-0#

KZ Because, it is a... in... kinda monolingual therapy, it's... a very important part of the communication. #00:34:56-0#

OT1 [Mmm.] #00:34:56-3#

KZ this uhm, ah, thinking... #00:34:57-8#

OT1 Yeah... I don't know, well... #00:35:00-4#

KZ [coughs] #00:35:00-9#

OT1 ouk now,] that kinda stuff, oh, yeah. #00:35:03-5#

KZ Yeah. #00:35:03-8#

OT1 [Or] slang, or... #00:35:04-9#

KZ Yeah. #00:35:05-3#

OT1 shortenin' things, or... [???] sometimes, d'you know what I mean? There has to be, come, that has to come through, otherwise [you wouldn't...] #00:35:13-8#

KZ An' do they come... he', through, in your experience? #00:35:15-3#

OT1 They do, yeah. #00:35:17-0#

KZ [Yeah.] #00:35:17-0#

OT1 I mean, I've had a... I s'pose a... a good experience of it, really. #00:35:20-1#

KZ [Yeah.] #00:35:20-5#

OT1 So far, anyway. I mean my experience that case... the stressors in that case are not... are more to do with... the psycho-social problems #00:35:30-2#

KZ [Mmm.] #00:35:30-7#

OT1 [the] person has. And simply not having a clue [laughing] how to deal with some... rather than the interpreting. #00:35:36-4#

KZ Yeah. Good. #00:35:39-7#

OT1 Hmm? #00:35:40-4#

KZ [mutters] No, that's very interesting. It's very interesting... because you're the first person I... talked to #00:35:46-6#

OT1 [Mmm.] #00:35:47-2#

KZ [who...] has the experience with sign language and... #00:35:49-4#

OT1 [Uhm.] #00:35:49-9#

KZ [and] spoken language. #00:35:50-6#

OT1 [Uhm.] #00:35:51-2#

KZ And it's very, very interesting. #00:35:53-1#

OT1 [Mmm.] Certainly in sign language, I didn't feel like I had bo', built up a relationship really with the person. Ehm... #00:35:59-9#

[silence] #00:36:02-0#

You know, despite trying... And I don't know... #00:36:05-3#

[silence] #00:36:07-1#

Sometimes I felt I'd ask a question, you know, maybe... #00:36:09-9#

[silence] #00:36:11-3#

phh, gosh... #00:36:12-2#

[silence] #00:36:15-9#

Something like, maybe, you know, Is there anything... D'you think there's anything that would help you feel better this week? #00:36:20-3#

KZ Mmm. #00:36:21-0#

OT1 Or something like that. Ehm... An' you can see the person maybe think... and then kinda go... Yeah, I don't know, like. I would've, I find this, [you know...] #00:36:30-6#

KZ [Mmm.] #00:36:30-3#

OT1 And it's almost as if... #00:36:32-3#

[silence] #00:36:34-2#

I don't know, if there was another signing person, or if that was a person speaking English... they would... they'd say something. But, p', an', an', an', an, I'm very aware that I've only, that I, I don't have a general knowledge of people with... sign language. #00:36:47-7#

KZ [Uhm.] #00:36:47-8#

OT1 I only had a knowledge of this one person with depression. Ehm... who has sign language. So... #00:36:53-2#

[silence] #00:36:55-2#

It's kinda, ki', you know, if, if, I was, if you were speaking English to me, would you... say more? #00:37:00-4#

KZ Uhm. #00:37:01-5#

OT1 Ehm... #00:37:03-1#

[silence] #00:37:04-5#

So there was a lot of that. So as I'd a question, which'd be... I, I don't know... I don't know. Sure. Yes. No. #00:37:10-5#

[silence] #00:37:11-3#

KZ Monosyllabic. #00:37:11-9#

OT1 Monosyllabic. Ehm... and just back. Which, an' then you're sitting in complete silence then. #00:37:17-1#

KZ Yeah. #00:37:17-7#

OT1 An' it's like, three of you again. Three pairs of eye', you know, and it's just, you're just like... #00:37:21-7#

[silence] #00:37:23-8#

But now, then again, you can get very... [laughing] you can get monosyllabic answers from an English-speaking person, [laughing] [too.] #00:37:28-1#

KZ [laughing] [Yeah.] #00:37:28-7#

OT1 [And] you often do. Ehm... But somehow you ca', you feel like you can't connect. #00:37:33-7#

KZ [Uhm.] #00:37:34-4#

[silence] #00:37:36-1#

OT1 'Cause you're speaking to the person. #00:37:37-2#

KZ [Yeah.] #00:37:37-8#

OT1 [But] they're watching here. So you're not even gettin' that initial eye-contact. #00:37:42-1#

KZ Ooh. #00:37:42-0#

OT1 Ehm... #00:37:43-3#

[silence] #00:37:45-1#

KZ Yes, because it's simultaneous. #00:37:46-2#

OT1 [Yeah.] #00:37:46-7#

KZ [So] if she would be... #00:37:47-5#

[silence] #00:37:49-2#

OT1 An' that's a big thing. I mean, at least with the {nationality}... I'm eye-to-eye with the person. #00:37:53-7#

KZ [Uhm.] #00:37:54-5#

OT1 Ehm... I can, you know, I can smile, and show them this bit's, you know, [this bit's] #00:37:58-1#

KZ [Mmm.] #00:37:58-2#

OT1 a joke, this bit... ehm... you know... [???] bit serious, or... I'm using my hands to kind of... you know, just listen to me for a minute... while I say this, or... Ehm... But, yeah, in sign language, I don't have any of that. So it's... you're kinda [laughing] #00:38:15-3#

[paper rustling] #00:38:15-8#

attention. You're tryin' to even get eye contact. #00:38:18-0#

KZ [Mmm.] #00:38:18-5#

OT1 So... Yeah, yeah... It's... There are different kind of challanges, but. #00:38:23-1#

KZ Mmm. Thanks a million. #00:38:26-0#

OT1 No problem. #00:38:27-8#

Is there any', if there's anything, I can't think of really anything else, particularly, but... #00:38:31-4#

KZ No, no, that's ample. #00:38:33-4#

OT1 Ok. #00:38:34-0#

KZ [Lovely] #00:38:34-6#

OT1 How many people are you... interviewing? #00:38:36-2#

[off record / end]

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