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## Interpreter output in talking therapySummary of thesis

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# Interpreter output in talking therapy Summary of thesis.

Jan Cambridge<sup>1</sup>

## Abstract

This thesis investigated current praxis among professional interpreters working in psychiatric outpatient clinics. Four clinical encounters were filmed and analyzed using thematic analysis, and post hoc satisfaction questionnaires were completed after the interviews. Two clinicians and eight certified and registered interpreters (working between English and either Punjabi or Urdu) were interviewed with part of the interpreters' interview consisting of responses to dilemma vignettes. A Delphi process validated responses to these vignettes. Four clinical encounters at routine appointments in psychiatric outpatient clinics were filmed and analysed using thematic analysis; post hoc satisfaction questionnaires were used after the filmed interviews. The complexity of interpreters' work was revealed in the breakdown of the components forming the impartial interpreting model. Taking the model as the cognitive framework for observation of practice provided depth of insight into the whole communication event. A tension between doctors' and interpreters' understandings of each other's roles and professional needs revealed that each believed themselves to be helping the other, when in fact they were working against each other. The impartial model was seen to be in use, but only in part, and interpreting practitioners were revealed to consider close interpreting and the full impartial model as not appropriate for mental health clinics, but only for courts of law. There were noticeable gaps among the interpreters in their education and training for this work. The clinicians declared a lack of training on working with interpreters, and this was evidenced in the course of their interviews. This thesis highlights the complexity of need that faces the profession of public service interpreting especially in terms of standardizing both training and praxis.

## Findings

The National Health Service employs predominantly minimally trained (or untrained) interpreters, who are nonetheless expected to handle very complex message exchanges. In the interactions observed, all interpreters were the fundamental gatekeepers. Untrained or minimally trained interpreters do not use any model of delivery, even partially, nor are they aware of the interpreters' professional code of conduct. They are not affiliated to any professional bodies of interpreters. These interpreters are willing, keen to be helpful, but ignorant of the healthcare system, doctors' procedures and goals, or of their own interlocutor role.

The key theoretical concept in the thesis is that a performance model is necessary to give coherence and discipline to the communicative work of the interpreter. The impartial model is clearly laid out in the code of conduct laid down by the The National Register of Public Service Interpreters (NRPSI) and its accompanying guide to good practice (NRPSI, 2011)

The impartial model represents and explains the ethics and working practices of the professional interpreter to trainee interpreters, and to the clients and professionals that interpreters work with. The thesis also stresses the need for professional training.

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The study employed a Delphi panel to discuss what was observed in the recorded interactions. The five panelists on the panel consisted of conference and public service interpreters (n=4) and one very experienced member of the Chartered Institute of Linguists who had contributed to the interpreting profession by leading the development of codes of conduct, setting examinations, amongst others. Four out of the five panelists did not believe that cultural briefing (adding contextual social and cultural information without reference to the patient) was an appropriate thing for interpreters to engage in.

On the whole both the interviewed and observed interpreters displayed a lack of professional education as set out in the idealized models and academic and professional literature. They showed very little awareness of interpreting theory nor of the interpreting model. They only implemented this model in part, and the parts they chose to implement were not consistent across the sample. Interpreting in any medical field requires a broad and deep knowledge of the vocabulary of peoples' lived lives in both languages. Most of the interpreters observed would benefit from formal language training to bring both their languages up to a professional level. More importantly however, there appeared to be no understanding among the interpreters observed as to why mental health clinicians phrase questions in a specific way, and why it is important to respect both form and wording of the question. It was also clear that the interpreters had a great need for formal, systematic training in interpreting techniques: clear diction, competent note taking, and training in the consecutive mode, whispered simultaneous mode and sight translation.

For interpreters who have had appropriate professional training, applied linguistics is the bedrock of what they do: it is the anatomy and physiology of communication. The thesis revealed a double helix, taking both clinician and interpreter down the pathway from good intentions to suboptimal performance. This included interpreters just wanting to help Limited English proficient clients; a lack of sufficient theoretical underpinning to promote good practice by clinician and interpreter; lack of mutual insight into professional goals and needs; lack of a requirement for interpreters to undertake mandatory continuing professional development; and lack of revalidation of interpreters' fitness to practice at set intervals.

The interviewed interpreters distinguished between the manner in which they would need to interpret before the courts, and a looser, freer, simpler use of language in mental health care to express an overall message. However, the psychiatrists who were interviewed said they wanted a more forensic style of close interpreting as required by the courts. In my view, it is not tenable to suggest that the community members for whom they interpret in court would deserve a lower standard of service when they suffer from (mental) illness.

## The influence of institution and state

There are other influences impacting on service delivery across language and culture. At micro level, training and mutual understanding within the multidisciplinary team have a negative impact on interpreter output. At macro level the unregulated market makes training as a public service interpreter unattractive. An unregulated market means there can be no real accountability of interpreters because of the low level of expectation among clinicians. By definition, interpreters' services cannot be reliably evaluated by those employing them or using their services, because each speaks only one of the languages concerned and no bilingual record is made of the conversation. Any interpreter must thus be taken on trust, potentially putting patient, clinician and institution at risk. It would therefore seem appropriate to only use the services of interpreters who are listed on the National Register of Public Service Interpreters (NRPSI), as this means they have satisfied nationally agreed registration criteria for qualifications, signed a code of conduct, have passed security checks and are subject to a disciplinary code.

In medical settings, interpreters are gatekeepers to intricate and vital message details, resulting in a position of great influence. In view of the vulnerabilities outlined in this thesis, I believe what Stanley Baldwin described in 1931<sup>1</sup> as "power without responsibility" to be an unidentified risk in all medical settings. Interpreters lacking any affiliation to a nationally recognized professional body and not listed on the NRPSI are not bound by any known ethical or disciplinary code.

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### Reference

Cambridge, J. (2012). *Interpreter output in talking therapy. Towards a methodology for good practice* (Doctoral Thesis, University of Warwick).

NRPSI (2011) National Register of Public Service Interpreters Code of Conduct.

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<sup>i</sup> *Stanley Baldwin served three terms as the Prime Minister of Britain between 1923 and 1937. He used this phrase in a speech attacking the press.*