Bare necessities

Training, supervision and support should not be luxuries in mental heath interpreting. Beverley Costa explains

Beverley Costa was born in London and raised in a bicultural and bilingual family. After training as a group and individual psychotherapist and psychodramatist, she set up Mothertongue, a culturally and linguistically sensitive therapeutic support service for people from black and minority ethnic communities, in 2000. Mothertongue also runs a Mental Health Interpreting Service.

Clearly there are specific language requirements for mental health interpreters (MHIs) with respect to terminology and the need to understand mental health structures. But there are further demands on the MHI in terms of understanding and working with the complexities of the relationships between professionals and clients in a therapeutic context.

Doherty et al (2010) analysed the responses from a selection of MHIs to a questionnaire about the impact on them personally from interpreting in a mental health context. They found that interpreting in a mental health context was perceived to be significantly more demanding and emotionally intense than when interpreting in other contexts. The stressors they listed included:

- Working with distressed clients.
- The emotional impact due to the interpreters' resonance with the client's story.
- Containing their own emotional responses.
- Not having an outlet for their own emotional distress.
- Maintaining boundaries.
- Possible violent clients or Child Protection cases.
- Feeling uncomfortable with silence.

Interpreting as a core role

This situation is made more complex by the nebulous nature of clinical work and the perception by the public of the way in which therapeutic interventions can work.

A solicitor, an immigration worker or a housing officer, for example, all have information, which the interpreter does not have and which the client needs. As far as the client is concerned, therefore, there is logic to the presence of the other professional. The interpreter is there solely to help them to understand the exchange of information.

A clinician, a therapist or a counsellor may well appear to have nothing to offer the client, especially if they cannot prescribe medication. It might seem that a clinician is only offering warmth, empathy and a few common sense strategies and exercises. Indeed, it could appear to the client that an interpreter, who is warm and empathetic, would be better to talk to. The communication, after all, would be direct.

And so, from the beginning, the clinical professional's role is often perceived as superfluous. He or she does not speak the client's language and may therefore seem to have nothing to offer that the interpreter cannot provide.

One of the interpreters who answered questions in an informal questionnaire and interviews I conducted with MHIs from a range of agencies saw her role as crucial in helping to facilitate the therapeutic alliance and trust between the clinician and the client.

The importance of clinical authority

However, it is perhaps understandable that this situation can produce all kinds of insecurity, deskilling or a sense of disempowerment on the part of a clinician who is not trained to work with an interpreter. In other, non-clinical contexts, it may be acceptable and even perceived as helpful for an interpreter to take some control and intervene in a session, as it will not jeopardise the authority of the service provider. However, a clinician needs to establish authority from the outset, because they hold the clinical responsibility for the work. In this way both the client and the interpreter can feel safe and contained.

Clinicians who are not trained to work with interpreters may defer all responsibility to the interpreters or try to undermine them by, for example:

- Enquiring interpreters to break bad news to clients.
- Expecting interpreters to manage the consequences of misjudged interventions.
- Wresting control from interpreters by discounting them or excluding them from the process.
- Refusing to be available for the pre- and post-briefing meetings.
- Ignoring the needs of interpreters.

These are very delicate situations for interpreters, where they will need to be assertive and remind professionals of the limits and responsibilities of both their roles. At the same time they need to be sensitive to the clinician's authority in the session. If the clinical professional allows the interpreter to take control of the session, then the clinician is abdicating the clinical responsibility, which is clearly unacceptable practice.

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Interpreters working with clinicians who are untrained in working with interpreters will have to train the clinicians as they go along. Interpreters are not themselves trained to do this. Nevertheless, they will need to call on their skills of subtle negotiation, assertiveness and communication. MHIs report that they welcome the support they gain from supervision in this area. An interpreter, in one of the interviews, mentioned the importance of support to bolster her knowledge that she in fact has the authority to ask for the necessary structures.

The team at Mothertongue

Supervision

The purpose of supervision for MHIs is to help them perform their role in a way that best meets the client's needs. Doherty et al (2010), from their research into the needs of MHIs, recommend that 'in order to safeguard interpreter health and wellbeing and to ensure a high quality of interpreting when working in a mental health context, formal supervision and support (should) be provided.'

Above all the supervision must provide a 'shame-free' space where supervisees feel they can talk freely about their uncertainties and any mistakes they may have made, so that they can learn and improve. Although Doherty et al (2010) are not specific about the form this supervision should take, I would recommend that it covers all of the following functions although not necessarily in every supervision session:

1 Managerial supervision. The process of this will vary according to the needs of each service and is beyond the remit of this article.

2 Professional support and mentoring to handle issues pertaining to the role and the context (as illustrated in the examples above and below). This is the '7th eye' in Hawkins's and Shohet's (2000) model of supervision, called the '7–eyed model of supervision'. Interpreters interviewed commented on the impact on them of sometimes being treated as a 'tool' by clinicians, with very little attention given to the impact of the work on them. They were often in the role of a 'bystander', witnessing and communicating intense and distressing material, but unable to take any action to provide relief. This role, while crucial, needs to be supported on a personal level. Interpreters may also witness practice by clinicians which gives them cause for concern. This can be a source of stress for the interpreters. All the interpreters interviewed for this article commented upon the stress this can generate. Contextual supervision plays a vital function if there is going to be a systemic change. If there is no mechanism or process for feedback to go back to the clinicians, their managers and commissioners, then it can leave interpreters feeling disempowered and unsupported. They are left to continue managing situations without optimism for a possibility of change. Interviewed interpreters noted the importance of being able to give feedback to a person who had the authority to challenge the service providers so that the work could be improved.

'Many MHIs work in the NHS. It is hoped that it will become mandatory for mental health departments who use interpreters to provide supervision for them as well'

3 Case management to deal with ethical issues, to ensure that guidelines are followed, and to identify gaps in skills and training and development needs.

4 Clinical supervision to explore issues of the client work (individually with the interpreter or in joint supervision with the clinician), including issues of risk, transference, countertransference and alliances (Tribe and Thompson, 2009) and to help them to process distressing and traumatic material they might hear which may affect them emotionally and personally (Costa ITI 2010). Interpreters who had experienced this aspect of supervision regarded it as important, with one such explaining: 'All interpreters should be encouraged to use this. Without it there can be a huge impact on one's work or one's personal life.'

CASE STUDY

An interpreter was booked to conduct a routine mental health assessment with a client — an unaccompanied young asylum seeker. The assessment was conducted by a Community Psychiatric Nurse (CPN). One of the questions from the assessment of the young man was: 'Do you have any family?' At this point the client started to hit his head on the table and to shout: 'What does she think I am? A stone?' He continued to hit his head and started to bleed. The CPN was shocked and confused and started to exclaim: 'What have I done? What have I done?' She seemed unable to do anything and left the room. It was left to the interpreter to calm the boy down and to clean him up. He told her that he was angry that the CPN had asked him if he had any family. Even though they were all dead, he had come from people, he said. — he was not 'a stone'.

5 Personal/pastoral support to discuss how outside factors may be affecting work; helping the supervisee to stay fit for work by, for example, managing stress or taking care of himself before it becomes critical.

MHIs may be offered one or, if lucky, two of the above functions. Frequently they are offered no supervision at all. Muriel and Claire Smith (*The Linguist* April/May 2009, p8) comment that even when support is offered to interpreters: '…this doesn't mirror the years of support, training and supervision that enable therapists to address the challenges of mental health practice.'

It is proposed that all of the above functions of supervision are important if we wish for the effective and consistent provision of Mental Health Interpreting. This can be offered in groups, individually or, where possible, jointly to the clinician and interpreter as a team.

The mental health interpreters interviewed all felt that supervision and support would be welcomed by other MHIs. They all mentioned the difficulty in discussing anything with friends and family because of a fear of confidentiality. To paraphrase one interpreter: if you demand a level of confidentiality from the interpreter, you need to be prepared to put in the corresponding level of support. Of the interpreters interviewed, none had had training in interpreting in a mental health context, except for those working for Mothertongue.

The following are examples of the ways in which interpreters have made use of supervision. They illustrate each of the functions of supervision (items 2 to 5) as described above.

Professional support and mentoring

The interpreter describes a situation where the clinician leaves the room and leaves the interpreter on her own with the client.

In supervision the interpreter is encouraged and coached to be assertive and to remind/teach the clinician that she should not be left alone with the client. This is because the client may well divulge material to the interpreter which she (the client) does not want the clinician to know, thus putting the interpreter in a difficult position, especially if there are risk elements to the disclosure. A clinician is trained to judge situations of risk. An interpreter is not and should not be left in a position where she is exposed to this.

'(Interpreters) were often in the role of a "bystander", witnessing and communicating intense and distressing material, but unable to take any action to provide relief'

Case management

The clinician invites a family member into the room and then allows her to interpret informally from time to time.

Through supervision the interpreter is encouraged to explore the dilemma about her role — either she is there to interpret or she should not be hearing this information. She does not know whether to remind the clinician about her role or whether she is interfering with the clinician's clinical judgement and his relationship formation with the client and family. Her intervention might be what is needed, but likewise it might cut across the work that the clinician is trying to do.

Interpreters interviewed for this article commented frequently on the dilemma between intervening, which they would do when interpreting in another context, and being sensitive to the process of the clinical work. They were concerned about the impact that their intervention could have clinically, possibly even undermining the clinical work, albeit unintentionally. For example an interpreter might ask the client, who is pouring out their story, to pause briefly so that the interpreter can translate. The clinician may instead have been keen to allow the client the catharsis, which the unimpeded flow might have permitted.

Clinical supervision

The interpreter suspects the client is lying to the clinician (because of some cultural misunderstanding) and thinks the client realises that this is what the interpreter is thinking.

In supervision the interpreter explores the dilemma about whether to maintain neutrality. If so, how does that affect her relationship with the clinician, who does not know about her doubts? The transference and potentials for alliances across the triad are then considered with the supervisor.

Personal/pastoral support

An interpreter has been interpreting for a woman whose father recently died from cancer. She is very distressed and is suffering from depression. The interpreter is finding it very hard to stop thinking about her after the sessions.

When the interpreter talks about this in supervision she reveals that her father is suffering from the same kind of cancer and she is very scared about his future prognosis. As a result of the supervision she decides that she is able to use coping strategies to manage her own anxieties. However, she also decides that she will probably not want to take on more than one of these types of cases at a time.

In 2008 Mothertongue won the Award for Excellence in the Practice of Counselling and Psychotherapy from the British Association for Counselling and Psychotherapy and, in 2009, The Queen's Award for Volunteering. Email: beverley@mothertongue.org.uk. Website: www.mothertongue.org.uk. Tel: 0118 957 6393.

Attunement

All of these examples illustrate the subtlety of the work of an interpreter in a mental health context and the attunement that is necessary in the situation. A decision to intervene when it is about one's own role is not just a pragmatic decision based on language needs, but one that may affect the relationship and the way the therapy progresses. In therapeutic work with an interpreter the client is not just 'a point of dissemination of words (but) rather… a prolific embedded nexus of ideas and feelings' (Bradford 1993:58).

Ideally, interpreters work with clinicians who have been trained to work with interpreters. In these cases: 'The translator becomes an extension of the therapist… the exercise of their respective roles entails momentary experiences of their sharing a single identity'. (Bradford 1993:58).

Judgement calls

However, this is sadly often not the case, and MHIs need to make judgement calls that can often put them in difficult situations. This is another reason why supervision is valued by MHIs. It is also another reason why it is useful for interpreters and clinicians to be supervised together. One of the interpreters interviewed commented that it was helpful when the clinician spent time offering support after an emotionally difficult session. This can be very useful. However, given that the clinician is also a part of the triad, there is sometimes a danger that the interpreter can begin to feel like another client in the room. For this reason it can help for them to examine the situation with the assistance of an external facilitator.

This inevitably brings us on to practicalities. For what has not been mentioned so far is how much this is all going to cost.

The practicalities: Who is paying for this?

The interpreters who were interviewed felt that this type of supervision was definitely something worth paying for. They also noted that interpreters who had not experienced this type of supervision might not realise its value. However, they added that interpreters are frequently not paid well and that the work is sporadic. Without a regular income it is impossible to budget for this kind of support.

'To paraphrase one interpreter: if you demand a level of confidentiality from the interpreter, you need to be prepared to put in the corresponding level of support'

Some third-sector organisations such as the Medical Foundation, the Refugee Council, Refugee Resource and Mothertongue currently budget for and provide supervision for their interpreters, as they regard this as best practice.

Many MHIs work in the NHS. It is hoped that it will become mandatory for mental health departments who use interpreters to provide supervision for them as well. There have already been improvements made, with training in how to work with an interpreter. This now forms a component of Clinical Psychiatry and Psychology training courses.

Many interpreters are contracted by agencies. There are limited ways of influencing these services. If the organisations that commission these agencies were to insist on the interpreters being both trained to work in a mental health context and supervised appropriately, this would lead to a dramatic improvement in the conditions of MHIs and the quality of the work.

These may seem big aspirations, but the Forum of Bilingual Therapists and Mental Health Interpreters is committed to lobbying the national strategic organisations such as the Department of Health for improvements in Mental Health Interpreter training standards, commissioning contracts and accountability.

Who is able to deliver this type of supervision?

From feedback from the interpreters interviewed, it is clear that they felt they needed a supervisor who had understanding and experience of the clinical and interpreting aspects of the role. There are plenty of training routes available for clinical supervisors at the moment. Perhaps it is time to introduce a new specialism in supervision for mental health interpreters.

As one of the interpreters said: …the main goal of psychotherapy is healing with the help of words. As interpreters, we play an enormous role in facilitating this process.

Interpreting in a mental health context can be hugely rewarding work. We need to make sure that we support the people who are doing this work so that they stay fit and well and able to contribute their vital skills to the process of helping people to heal.

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