The Interpreters' Newsletter 2021 (26), 29-51
DOI: 10.13137/2421-714X/33261 ISSN 1591-4127 (print) ISSN 2421-714X (online)
https://www.openstarts.units.it/dspace/handle/10077/2119

A non-native-speaking patient with and without an interpreter: what is the difference? A case study in mental health

Sofie Van de Geuchte and Leona Van Vaerenbergh
University of Antwerp

Abstract

Communication is vital in psychiatry, but it can be impaired when speakers do not share a language or lack language proficiency. The aim of this study is twofold: firstly, we examine how the interpreter's presence has an impact on communication between psychiatrist and patient in a psychiatric consult; secondly, we explore the possibility to compare two different types of language mediation (in this case, a professional interpreter and Dutch as a foreign language to the patient) through the triangulation of data and analytic methods. In this respect, two psychiatric consultations were video-recorded. Additionally, a retrospective interview was conducted with the psychiatrist. The discursive data were analysed using conversation analysis focusing on turn design, question-answer sequences, and topic development, combined with quantitative elements (e.g. turn count) and the results from a thematic analysis of the interview transcription. The analysis revealed advantages and disadvantages in working with an interpreter and showed some discrepancies between the psychiatrist's perceptions or expectations and what we found in the discursive data. We conclude that the combination of research methods provides valuable insights into psychiatric consultations with and without an interpreter.

Keywords

Interpreted-mental health consultations, language barrier, language mediation, interpreting studies, case study, conversation analysis, retrospective interview, triangulation of data and methods.

Introduction

Communication is of vital importance in psychiatry: it is used during anamnesis, diagnosis, treatment, and building of a therapeutic relationship. Smooth communication is not self-evident and can be impaired by many elements, particularly when doctor and patient do not share the same language or lack language proficiency (e.g. Bauer/Allegria 2010). In this respect, research has mentioned that doctors adapt their interviewing style and pose more closed-ended questions (Drennan/Swartz 2002) and that patients provide shorter replies, speak slower, make more pauses, utter incomplete sentences, stutter more (Marcos *et al.* 1973), and report fewer symptoms (Price/Cuellar 1981).

Interpreters can bridge the language gap. Research on interpreters in mental health care already covers various topics, such as interpreter accuracy (e.g. Vasquez/Javier 1991; Farooq *et al.* 1997), interpreter role (e.g. Bot 2005; Delizée/De Ridder 2016), interpreters' effect on treatment outcome (e.g. Dekker *et al.* 2009), interpreting training (e.g. Cerci/Neale 2018), and patient satisfaction (e.g. Villalobos *et al.* 2016). Research has shown that interpreters have gained attention from various disciplines, such as psychology and sociology. We noticed, however, that studies performed on interpreters in mental health care are less frequently carried out from the angle of linguistics or Interpreting Studies (with some exceptions, e.g. Delizée/Michaux 2019, 2020). The interdisciplinarity is also reflected in the many research methods and ways of collecting data: interviews, focus group discussions, questionnaires, studies based on audio/video recordings using discourse analysis (e.g. Sleptsova *et al.* 2017; Bot 2005), as well as studies that combine multiple research methods, e.g. observations and interviews (Mirza *et al.* 2017), questionnaires and interviews (Hsieh *et al.* 2013), and discourse analysis and interviews (Bot 2005).

Most studies only discuss professional interpreters as the pre-eminent way to bridge language gaps. In contrast, other solutions, such as a *lingua franca* or the use of the doctor's native language, are not mentioned. This paper reports on a unique study in which two types of language mediation are compared (professional interpreter and the use of Dutch as a foreign language to the patient) using conversation analysis, combined with the results of a thematic analysis of an interview with the attending psychiatrist. The aim of the present study is, firstly, to examine how the interpreter's presence impacts communication between psychiatrist and patient in a psychiatric consultation; secondly, to explore the possibility of comparing two different types of language mediation through triangulation of data and analytic methods.

This paper starts with an outline of the data and methodology (section 1), continues with the results and discussion (section 2), and ends with a conclusion (section 3).

1. Data and methodology

This study uses a triangulation of data and analytic methods. We analyse two sets of data: firstly, two video-recorded psychiatric consultations; secondly, a retro-

spective interview was conducted with the attending resident-psychiatrist. Next, different analytic methods were selected: we look at the video-recorded consultations through the lens of (qualitative) conversation analysis, but we combine this method with quantitative elements by, for example, counting the number of turns-at-talk and measuring the pauses; the interview, on the other hand, is analysed using thematic analysis. This triangulation of data and analytic methods is chosen to obtain a more comprehensive understanding of the psychiatric consultation with and without an interpreter. Moreover, this kind of triangulation attempts to improve the validity of the results (e.g. Aguilar-Solano 2020). After briefly introducing the participants and data (1.1), the methodology will be elaborated on (1.2).

1.1. Participants and data

1.1.1. Participants

There are three participants: the resident-psychiatrist, the patient, and the interpreter. The psychiatrist is a male resident-psychiatrist (25-35 years old). The patient is a Hungarian woman (20-30 years old) who has been living in Belgium for several years and has an intermediate understanding and knowledge of the Dutch language. She comes to the psychiatric hospital for a regular follow-up after a psychotic episode about a year ago. This disorder is in remission.

The interpreter is a male, professional public service interpreter (40-50 years old) who comes under the *Agentschap Integratie en Inburgering* (Agency for Integration), a Flemish government service. These interpreters are bound by a code of ethics for public service interpreting. One of the implications is that the interpreter has to give a complete and faithful rendition of everything said, without additions, omissions, or alterations (Agentschap Integratie en Inburgering 2017: 2).

1.1.2. Data

The first data set contains two psychiatric consultations: one that is held in Dutch (foreign language to the patient but not to the doctor) (= C1), and one in which an interpreter is present (Dutch-Hungarian) (= C2). These are two subsequent consultations with an interval of approximately five weeks that were both video-recorded using a Sony HDR-AS200V device with a remote control the doctor handled. The recordings last respectively 28 minutes (C1) and 45 minutes (C2).

The second data set contains a retrospective semi-structured interview with the resident-psychiatrist. The interview took place approximately two months after C2, and the psychiatrist was asked how he experienced the difference between the consultation with and without an interpreter. The interview was audio-recorded using a Sony ICD-PX820 digital voice recorder.

1.2. Conversation analysis

Since we are interested in how the doctor and patient communicate and how this changes when an interpreter is present, we adopt a conversation analytic approach to analyse how the interaction unfolds and is co-constructed.

Conversation analysis (CA) is a frequently used research method in public service interpreting (Zanettin 2019: 108), with the pioneering work of Wadensjö (1998), who studies interpreting as interaction. Since that study, CA has been successfully applied to various settings, such as police interviews (e.g. Nakana 2011), healthcare encounters (e.g. Raymond 2014), and mental health care encounters (e.g. Bot 2005; Vranjes/Bot 2021). However, mental health remains a challenging setting to gather video-recorded data necessary for a detailed turn-by-turn analysis of the interaction (Zanettin 2019: 109).

This study relies on some basic principles found in CA: firstly, turn-at-talk and turn-design or how the participants construct their turn to carry out actions (Drew 2013: 131); secondly, sequence organisation or the way turns are ordered and combined (Schegloff 2007), more specifically question-answer sequences; thirdly, social actions or what the participants do with their turns (Levinson 2013); finally, we analyse topic development which is less typical for CA (except e.g. Levinson 1983; Drew/Holt 1998). This section provides an overview of these foci, but we will first introduce the transcription method.

1.2.1. Transcription

The consultations were transcribed using the Jefferson transcription system, which is a system that is often used in CA studies because it allows a detailed analysis of not only what is said but also how it is said by including paralinguistic features, such as pauses, gestures, and intonation (see Jefferson 2004: 24-31). A list of the transcription conventions used in this study is presented at the end of the paper. We anonymised the following data: all personal names, all geographic references, names of employers, schools, institutions, and medication.

The Hungarian segments were transcribed and translated by a professional translator with mother tongue Hungarian, and excellent knowledge of English and Dutch. The transcriber/translator made a transcription of the Hungarian segments and translated them into English and Dutch. After receiving the translation, we went through the entire document with the transcriber/translator and asked questions.

1.2.2. Turns and turn-design

Doctor and patient take turns in speaking in a psychiatric consultation. These turns are a fundamental element in CA (e.g. Drew 2013): in a turn-at-talk, we have to keep the previous turn in mind, decide what we want to achieve with our turn, and anticipate what will come next. This makes turns-at-talk and the turn-design

crucial interactional building blocks that contain ample information, such as how turns are constructed and how the consultations are structured. It becomes more complicated to manage the turns-at-talk when an interpreter is present because the consultation no longer is dyadic but changes to a triad.

We qualitatively analysed the interaction and added a quantitative element by counting the number of turns and measuring the turn duration and pauses[1] (with the audio editor Audacity). Since we compare a consultation with and without an interpreter, this quantitative information gives more insight into the differences in the communicative behaviour of the speakers.

1.2.3. Question-answer sequences

Turns are combined into clusters or sequences. In psychiatric consultations, question-answer sequences are omnipresent, which is why this is a significant focus in this research. Questions are the primary mechanism by which doctors control the conversation, achieve their aims (e.g. history taking, making a diagnosis), and form a therapeutic alliance (Thompson *et al.* 2016). We analyse question-answer sequences to find out if the doctor poses different or fewer/more questions in a consultation with or without an interpreter, if the questions indicate interactional problems, and if the interpreter's rendition has an impact on the communication flow (e.g. does the rendition alter the meaning of what was said?).

We investigated the question types, the questions' social action in the psychiatric consultation, the patient's answers, and the possible impact of translation shifts in the question-answer sequences. The question types were classified into two categories: closed-ended questions and open-ended questions. A further sub-classification of those two categories is based on Thompson *et al.* (2016). The category of closed-ended questions includes yes/no questions, declarative questions, tag questions, lexical tag questions[2], alternative questions that give the patient alternatives to choose from, and check questions. The category of open-ended questions includes 'wh'-questions (i.e. content questions), incomplete questions, and repair questions (for more detailed information on the different types, see Thompson *et al.* 2016: 41-42).

Since questions are asked to obtain answers, we also analysed the response to the questions. Following Englert (2010: 2680-2681), we coded all the reactions with the following categories: answer, no response, and non-answer. A reaction was coded as 'answer' if it fitted the form and topic of the question. It was coded as 'no response' if there was no reaction, as if the question was being ignored. Finally, a 'non-answer' means that an answer is provided but does not fit the question. As far as the category 'answers' was concerned, we also counted

1 Pauses between turns were counted from 0.5 seconds onwards because a short pause between two turns is common.

2 In the case of a tag question, a verb and pronoun are added to a declarative question (e.g. you are sleeping well, aren't you?). The tags of lexical tag questions are shorter: a question tag is added (e.g. you are sleeping well, right?).

the number of one-word answers because it showed that not all answers were equally workable for the doctor, such as concise answers, in particular 'yes', 'no', 'hm', 'okay'. The fact that non-answers did not meet the doctor's expectations can have several explanations that we coded as well[3]: the answer can be vague, unclear, off-topic, non-type-conforming (e.g. a content question answered with yes or no), or the patient can answer with a remark about the question or a supplementary question.

1.2.4. Social actions

Turns-at-talk are ordered to perform (social) actions: we are 'doing' things when we speak, such as greeting, apologising, asking questions (Levinson 2013). Asking questions in a consultation serves different actions. Englert (2010: 2676-2679) identifies five different actions: "information request" (to gather more information on a topic); "repair initiation" (to repair communication by asking for clarification or by reformulating the question to make the patient understand; to make sure doctor and patient are on the same level of understanding to continue the consultation); "request for confirmation" (to have a statement confirmed by the patient); "assessment" (to make an assessment or to paraphrase what the patient said); and "suggesting, offering and requesting" (to make a suggestion, an offer or request to do something, e.g. may I take your ID?).

1.2.5. Topic development

The analysis of topic development is not a typical focus in CA, except for a few studies, such as Levinson (1983) and Drew and Holt (1998). The main reason for the lack of conversation analytic studies is the problematic concept of 'topic' (Yang 2019). Therefore, CA does not focus on a definition of topics but instead sees topical coherence as an action to be performed in the conversation:

> Topical coherence is something constructed across turns by the collaboration of participants. What needs then to be studied is how potential topics are introduced and collaboratively ratified, how they are marked as 'new', 'touched off', how they are avoided or competed over and how they are collaboratively closed down (Levinson 1983: 315).

This study includes the analysis of topic development since it gives information on the consultations' structure and how speakers shift from one topic to another with and without an interpreter.

To categorise the topics, we needed categories to code the sequences. Therefore, we used the *Roter Interaction Analysis System* (RIAS) (Roter 2013), a coding system widely used to code doctor-patient communication. However, we did not use the RIAS software but only took over their categories to label the topics in our

3 Englert (2010) only coded remarks like "I don't know" as non-answers.

discursive data[4]. From now on, we call them RIAS-topics (see Table 1). The RIAS manual explains what these topics mean by giving examples of what they entail (Roter 2013); we use those examples as subtopics.

RIAS-topics	Subtopics
1. Medical condition	condition, symptoms, diagnosis, prognosis, past tests, test results, medical background, personal and medical histories, practices and allergies
2. Therapeutic regimen	treatment plan*: medication*, therapy*, new appointment*, recommendation*
3. Lifestyle information	smoking, diet, alcohol, exercise habits, family situation*, home situation*, work or employment, health habits, self-care issues and activities*
4. Psychosocial information	stress, feelings, emotions, general state of mind, philosophical outlook, values, beliefs, *behaviour
5. Other information	clinic paperwork, exam or study procedures
* Opening	
* Closing	

**These (sub)topics were adapted or added according to what appeared in the data; the other ones are taken from the RIAS-manual*
Table 1: RIAS-topics and subtopics

We added two topics that cannot be found in RIAS: opening and closing. The opening topic contains all turns that precede the doctor's opening question (e.g. how are you doing?). The closing topic contains turns in which doctors indicate that they are closing the consultation. This can be saying goodbye, but if the doctor asks if there are any questions and the patient answers no, this was also coded as closing. If, on the other hand, the patient answers with a specific question or statement, the turns were coded according to the content of that question/statement.

It is insufficient to merely analyse the topics to understand how a consultation is structured and how it unfolds; it is also essential to examine the shifts from one topic to another. Every time we encountered a topic shift, we analysed how long the topic lasted (pauses in and between turns included), how many turns that topic took, who initiated the new topic and how the shift took place (with a question or a statement). CA literature teaches us that there is a preference for continuity in talk (Sacks 1987). That is why we looked at who initiated the transition and if the introduced topic was linked to the previous one. Many CA studies focus on topic management, and various terms are used for the different kinds of shifts. We decided to adopt the following three terms: "fitted" (e.g. Yang 2019) means that there is a continuum with the prior turn; "disjunctive with a transition marker" (e.g. Yang 2019) means that the topic is closed down

4 RIAS support for the software ended at the beginning of 2019.

by a marker, such as 'okay' followed by a pause, after which the new topic is introduced; and "disjunctive abrupt" (Garcia/Joanette 1997) means that there is no transition marker and the shift is abrupt. Finally, we added one category ourselves: 'semi-fitted' topic shifts which are shifts that do not fit the last turn but refer, for instance, to a topic earlier in the consultation, often because the doctor wants to elaborate on something that was said before.

1.3. Thematic analysis

The resident-psychiatrist was interviewed asking for his thoughts about the different consultations, and he was asked to comment on some video fragments from the consultation. The interview took the form of a semi-structured retrospective interview that was qualitatively analysed using thematic analysis (e.g. Paillé/Mucchielli 2012; Vaismoradi/Turunen 2013). The interview was transcribed, and the most important themes that emerged in the interview were coded: mainly disadvantages that the doctor encountered when holding the consultation with an interpreter, a *lingua franca*, or in a language that is not the patient's native language (e.g. feeling restricted by the interpreter's presence, feeling uncomfortable in a French consultation, feeling frustrated when he was unable to elaborate on topics because of language problems).

Table 2 gives an overview of the psychiatrist's main statements in the interview about the consultations without and with an interpreter.

	Consultation in Dutch (C1)	**Consultation with interpreter (C2)**
1.	It is shorter, lasts hardly half an hour.	Lasts longer, 45 minutes.
2.	The patient speaks in a fragmentary way. She is not sufficiently able to express her thoughts and feelings.	The patient continues talking for a longer time, is talking more freely, more about her feelings.
3.	He (=psychiatrist) is not sure the patient understands him. Therefore: more repetitions, checks.	He (=psychiatrist) is more sure that the patient understands him.
4.	The conversation is more like going through a list, is more directed by yes-no questions.	The conversation is in-depth, explores, can deepen. More detailed questions can be asked.
5.	It does not go beyond facts. Therapy is purely medicinal.	More therapeutic, more empathic, better for rapport building.
6.	He (=psychiatrist) inserts silences to allow the patient to add more.	The interpreter fills up silences.
7.	There is direct contact.	There is no direct contact. The conversation is mediated by the interpreter.

Table 2: Summary of the interview

In the following section, the doctor's perceptions, listed in the above Table, are compared to the qualitative and quantitative analysis of the discursive data.

2. Results and discussion

2.1. Turns and turn design

As expected, the consultation with the interpreter (C2) lasts longer than the consultation without the interpreter (C1) (C1: 28', C2: 45') since the doctor's turns have to be translated into Hungarian, and the patient's turns have to be translated from Hungarian into Dutch. This also applies to the total turn duration, i.e. the duration of the consultation minus the pauses between the turns (see Table 3). However, Table 3 also shows that when we deduct the interpreter's turn duration from the total turn duration (38'34.0" – 18'41.4"), the consultation without an interpreter lasts longer than the consultation with an interpreter. In particular, the doctor's turns last longer in C1 (C1: 14'23.9", C2: 12'52.5").

	C1 **WITHOUT interpreter**	**C2** **WITH interpreter**
Doctor	**14' 23.9"**	**12' 52.5"**
Patient	**7' 19.2"**	**7' 0.2"**
Interpreter (Hungarian)	-	11' 7.6"
Interpreter (Dutch)	-	7' 33.8"
Interpreter (total)	**-**	**18' 41.4"**
TOTAL	21' 43.1"	38' 34.0"

Table 3: Overview of total turn duration

The interview showed that the doctor believes there is a significant difference between the duration of a consultation with and without an interpreter: he cannot elaborate on topics, because of language problems in the consultation without interpreter. The fact that C2's total turn duration is shorter than C1, when we deduct the interpreter's turn duration, does not mean that less information is given in the consultation with an interpreter. Therefore, we have to consider the content of the turns, since in C1 much time is spent on repetition and making sure everything is understood.

However, Table 4 shows that the patient in C2 makes fewer pauses (C1: 1'34.2", C2: 0'32.2"), which indicates that she has fewer difficulties expressing herself in the consultation with the interpreter. Additionally, the patient's turn duration without pauses (DwP) is longer in C2 (C1:5'45.0", C2: 6'28.0"), which corresponds to the doctor's perception that the patient in C1 speaks in a fragmentary way and is not able to express her thoughts and feelings correctly.

In contrast, in C2, the doctor felt that the patient had longer turns because she could speak more freely in her native language and gave more information about

her feelings. However, the doctor also stated that he likes leaving pauses to allow the patient to add something, but he feels that this was difficult with the interpreter present since the interpreter urged him to fill the pauses. The analysis of pauses does not confirm this: the doctor's pauses in C1 and C2 are approximately the same (C1: 3'36.5", C2: 3'38.9").

	C1 WITHOUT interpreter		C2 WITH interpreter	
	PT	**DwP**	**PT**	**DwP**
Doctor	**3' 36.5"**	**10' 47.4"**	**3' 38.9"**	**9' 13.6"**
Patient	**1' 34.2"**	**5' 45.0"**	**0' 32.2"**	**6' 28.0"**
Interpreter (Hungarian)	-	-	0' 7.6"	11' 0.0"
Interpreter (Dutch)	-	-	0' 17.5"	7' 16.3"
Interpreter (total)	**-**	**-**	**0' 25.1"**	**18' 16.3"**

Table 4: Pauses within turns (PT) and duration without pauses (DwP)

The above findings are confirmed in Table 5, showing the average turn duration, which in C2 is longer, both for the doctor and the patient.

	C1 WITHOUT interpreter		C2 WITH interpreter	
	PI	**PE**	**PI**	**PE**
Doctor	**4.8"**	**3.6"**	**6.6"**	**4.7"**
Patient	**2.4"**	**1.9"**	**3.4"**	**3.2"**
Interpreter (Hungarian)	-	-	6.0"	5.9"
Interpreter (Dutch)	-	-	4.1"	3.9"

Table 5: Average turn duration with the pauses included (PI) and pauses excluded (PE)

Table 5 also confirms that the patient makes fewer pauses in C2 since there is hardly any difference between PI (3.4") and PE (3.2"). This indicates that the patient speaks more in the consultation with the interpreter, with fewer obstacles or problems (pauses), confirming the doctor's perception.

2.2. Question-answer sequences

2.2.1. Questions

Questions constitute a significant part of the psychiatrist's speech: 74,6% in C1 and 74.4% in C2. This is self-evident since an essential task of the psychiatrist is to gather information and explore the patient's problems.

The question types, as well as the intended social action in both consultations, will be compared. Table 6 shows that the ratio between closed-ended and open-ended questions is approximately the same in C1 and C2. However, the doctor stated that he believes the consultation without the interpreter is more like going through a list and more directed by yes-no questions because of language problems, which would be in line with the findings of Drennan/Swartz (2002).

	C1 WITHOUT interpreter		**C2 WITH interpreter**	
	#	**%**	**#**	**%**
Closed-ended questions				
Total	**99**	**73,3**	**64**	**73,6**
Open-ended questions				
Content	12	8,9	15	17,2
Incomplete	13	9,6	2	2,3
Repair	4	3,0	0	0
Total	**29**	**21,5**	**17**	**19,5**
Other – double	7	5,2	6	6,9
TOTAL	**135**	**100**	**87**	**100**

Table 6: Doctor's questions

At the same time, Table 6 shows a significant shift within the category of the open-ended questions. The number of content questions is nearly double in C2 (C1: 8,9%, C2: 17,2%), whereas the number of incomplete questions the doctor uses to engage the patient in the consultation is strongly reduced (C1: 9,6%, C2: 2,3%). Finally, there are zero repair questions in C2. These elements indicate that there are remarkably fewer language problems in the consultation with the interpreter. In this respect, the psychiatrist mentioned in the interview that he could elaborate on specific topics more when the interpreter was present, which is confirmed by the higher number of content questions and the fewer repair and incomplete questions.

Table 7 also shows a significant shift of the questions' intended action from C1 to C2: the doctor poses more questions with the action 'information request' (C1: 40,7%, C2: 63,6%), makes more assessments (C1: 11%, C2: 17%) and fewer questions with the action 'repair' (C1: 17,8%, C2: 4,6%) and 'request for confirmation' (C1: 23,7%, C2: 10,2%).

	C1 WITHOUT interpreter	C2 WITH interpreter
	%	%
Information request	40.7	63.6
Repair	17.8	4.6
Request for confirmation	23.7	10.2
Assessments	11.1	17.0
Suggesting, offering, requesting	6.7	4.6
TOTAL	**100**	**100**

Table 7: Questions' intended action

This again confirms that there are fewer language problems in the consultation with the interpreter: the doctor has more time to ask questions aimed at obtaining information, and making assessments, because he has to ask fewer questions to repair communication (repair questions, requests for confirmation). This confirms the doctor's perception that, in C1, he constantly has to check whether the patient understood what was said (and therefore uses more repetitions and checks).

2.2.2. Answers

It is impossible to assess the interaction by analysing the questions without taking the answers into account. The percentages of the different response types (answer, no response, non-answer) are very similar in C1 and C2 (see Table 8).

	C1 WITHOUT interpreter		C2 WITH interpreter	
	#	%	#	%
Answer	113	**83.7**	71	**82.6**
No response	0	**0.0**	0	**0.0**
Non-answer	22	**16.3**	15	**17.4**
TOTAL	135	**100**	86	**100**

Table 8: Answer types

However, within the category of 'answers' we notice that in C2, the number of 1-word answers considerably decreases: in C1, 35,7% of the 'answers' are 1-word answers, whereas in C2, it is only 11,3%. This confirms the doctor's perception that the patient's Dutch turns are rather fragmentary.

Within the category of 'non-answers' (Table 9), we notice in C1 that there are more vague/unclear answers, and questions as response, indicating communication problems.

	C1 WITHOUT interpreter	C2 WITH interpreter
	#	#
a. Off-topic	-	1
b. Vague, unclear	8	4
c. Non-type conforming	-	-
d. Question	10	4
e. Remark	2	4
f. Incomplete answer	2	-
g. Interpreter initiates	-	2
TOTAL	**22**	**15**

Table 9: Non-answer types

In the consultation with the interpreter, both the doctor and patient need fewer clarifications, and the patient expresses herself more clearly.

2.2.3. Translation shifts

Many elements discussed above indicate that the interpreter facilitates communication in C2. It is however essential to look at the interpreter's renditions because they can have a significant impact on communication. It is evident that interpreting gives rise to shifts such as additions, omissions, and substitutions and that these translation shifts may have an impact on the communication flow. Two examples were selected to illustrate this: Excerpt 1 concerns the rendition of a doctor's question; Excerpt 2 concerns the rendition of a patient's answer.

In this first excerpt, the patient just mentioned that she suffers from concentration and learning problems, but that this was already the case before her psychosis.

533	**D**	En je vindt nie dat het verergerd is in vergelijking met vroeger *and you don't think that it deteriorated compared to before*
534		das wat hetzelfde gebleven? *that kind of remained the same?*
535	**I**	De euh úgy látja, hogy ez tulajdonképpen nem súlyosbodott? Az előzőekkel összehasonlítva? *But euh you haven't noticed that this actually would have aggravated? When compared to the before?*
536	**P**	Nem *No*

Excerpt 1: Omission of the doctor's second question

The doctor asks two declarative questions in lines 533-534: the first question is negatively formulated ("you don't think"), the second is positively formulated ("remained the same"). Consequently, the doctor expects a positive answer ('yes') to his second question. However, the interpreter only translates the first question that the patient answers with "No" (line 536). Because the interpreter has omitted the second question, the patient's answer is ambiguous, and the doctor is not sure how to understand the answer. Therefore, he repeats the second question: "Hetzelfde dan?" ("The same then?"). Finally, the communication was restored, but it took several turns and some interactional effort.

In the lines preceding Excerpt 2, the psychiatrist assessed by explaining what he believes the patient wanted to say: that she is happy at the moment and is relieved that she found a steady job as a house cleaner. He concludes by assuming that the patient's father is also happy with this situation (the father is an important topic in the consultation). Excerpt 2 shows the patient's reaction and the interpreter's rendition:

144	**P**	Hát én >elégedett< vagyok, >de az< édesapám kevésbé, mert hogy takarítok és >ennek olyannyira nem örül< *Well, I'm >happy<, >but my< father is less, because I am cleaning and > he's not so happy with that<*
145	**I**	#Mmmmm hij# is minder gelukkig minder tevreden over want het is maar kuisen en euh (.) euh en hij (.) hij wil iets meer *#mmmmm he# is less happy less pleased about it because it is only cleaning and euh (.) euh and he (.) wants something more*

Excerpt 2: Rendition of patient's answer with addition and omission

In Excerpt 2, the patient answers that she is happy, but her father is less happy. The interpreter omits the first part of the answer, although the fact that the patient confirms that she is happy contains essential information for the psychiatrist. Additionally, the interpreter adds the word "only" and the sentence "he wants something more". This indicates that the interpreter assumes that the father thinks of her cleaning job as inferior, which the patient did not say. Finally, the interpreter's rendition brings the conversation to the subtopic 'father'.

Even though we already found several elements that indicate that there are fewer communicative problems in the consultation with the interpreter (turns and turn-design, actions, question-answer sequences), the analysis of the interpreter's renditions of the question-answer sequences shows that translation shifts can have a significant impact on the type and function of the questions, but also upon the topic development (see section 2.3) and, therefore, the consultation itself. This demonstrates the importance of proper interpreter training in the specific setting of psychiatry.

2.3. Topic development

Topic development encompasses the topics discussed as well as the shifts from one topic to another. In both areas, we notice differences between C1 and C2.

2.3.1. Topics

Table 10 shows that the topics 'psychosocial information' (C1: 1x, C2: 6x) and 'lifestyle information' (C1: 5x, C2: 9x) occur more frequently in C2 than in C1. These are two crucial topics in a psychiatric consultation.

(RIAS) topics	Number of occurrences		Number of Turns		Topic duration	
	C1 without I	C2 with I	C1 without I	C2 with I	C1 without I	C2 with I
Medical information	4	3	23	18	1'41.0"	1'6.1"
Therapeutic regimen	3	4	99	46	7'31.3"	3'11.9"
Lifestyle information	5	9	217	151	10'49.0"	10'21.4"
Psychosocial information	1	6	21	41	1'13.9"	3'40.8"
Other information	0	0	0	0	0'0.0"	0'0"
Opening	2	1	9	4	0'19.5"	0'6.9"
Closing	1	2	9	9	0'11.1"	0'18.0"
Total			378	269	21'45.8"	37'22.7"

Table 10: Summary of topics in C1 and C2

Additionally, in C2, a higher number of turns is devoted to the topic 'psychosocial information' (C1: 21 turns, C2: 41 turns), and the total duration increases from 1'13.9" in C1 to 3'40.8" in C2. The topic 'lifestyle information' has fewer turns in C2 than in C1 (C1: 217 turns, C2: 151 turns), but the total duration is approximately the same (C1: 10'49.0", C2: 10'21.4"). This means that, in the consultation with the interpreter, they speak longer about lifestyle without shifting the topic. This confirms that the patient speaks longer when she can speak her native language (Table 5).

The subtopics of 'lifestyle information' in C2 differ from those in C1 (see Table 11 and 12).

(RIAS) subtopics	Number of topic units	Number of turns	Duration
Activities – travel	2	50	2'12.7"
Activities – general	1	15	0'30.8"
Diet	1	8	0'10.1"
Employment – study	1	12	0'32.5"
Family situation – relation	1	45	2'49.2"
Health habits – sleep	1	15	0'34.0"
Self-care issues – cannabis	1	13	0'37.2"
Work	2	59	3'22.5"
Total	10	217	10'49.0"

Table 11: Subtopics 'lifestyle information' in C1

(RIAS) subtopics	Number of topic units	Number of turns	Duration
Activities	1	1	0'12.9"
Activities – travel	2	19	0'55.6"
Family situation – mother	1	5	0'25.5"
Family situation – relation	2	12	0'42.4"
Health habits	1	5	0'13.5"
Health habits – sleep	1	30	1'31.9"
Home situation – father	3	42	4'9.3"
Work/employment	2	37	2'10.3"
Total	13	151	10'21.4"

Table 12: Subtopics 'lifestyle information' in C2

In addition to the patient's relationship with her boyfriend, both her mother's character and the relationship with her father are discussed in C2. It is, in particular, the topic about the father that has an essential position in the conversation with 3 topic units, 42 turns, and a total duration of 4'9.3". This is why the doctor mentioned in the interview that he believes the consultation with an interpreter is more therapeutic and more empathic, since he and the patient understand each other and because feelings about essential topics in the patient's life can be discussed.

Next, Table 13 shows that only one subtopic of 'psychosocial information' occurs in C1, i.e. feelings of anxiety, whereas in C2, feelings of insecurity, feelings in general, and mood are also discussed.

(RIAS) subtopics	Number of topic units		Number of turns		Duration	
	C1	C2	C1	C2	C1	C2
Mood	0	3	0	12	0'0.0"	1'12.3"
Feelings – insecurity	0	2	0	16	0'0.0"	1'47.8"
Feelings – anxiety	1	1	21	9	1'13.9"	0'35.4"
Feelings – general	0	1	0	4	0'0.0"	0'5.3"
Total	1	7	21	41	1'13.9"	3'40.8"

Table 13: Subtopics 'psychosocial information' in C1 and C2

We can conclude that more time is spent on discussing the patient's feelings when the interpreter is present, which is essential information in a psychiatric consultation. This confirms the doctor's perception that they could elaborate on the topic of feelings more than in the consultation without the interpreter because language problems no longer hinder them.

Even though the patient can speak in her native language and talk about feelings more, we noticed a striking difference in the patient's non-verbal behaviour: in C2, she nearly constantly looks down while speaking, there is almost no eye contact, and no gesturing. This is entirely different in the consultation without the interpreter (C1). This was a striking element in the analysis of the video recordings, but the psychiatrist mentions in the interview that he overlooked this aspect of the non-verbal behaviour during the consultation. This highlights the importance of a multimodal analysis in which non-verbal elements, such as facial expression, and gaze and gesture are taken into account. They contain crucial information on for example, turn management, interactional problems and emotions (e.g. Miletich 2015; Davitti 2018).

2.3.2. Topic shifts

Neither C1 nor C2 shows a fixed structure or a returning topic order. In both consultations, it is common that one topic recurs several times. Nevertheless, there are differences here between the two consultations.

Firstly, in C1, almost all of the topic shifts are initiated by the doctor (23 of 26), whereas in C2, 8 of 30 topic shifts are initiated by the patient and 1 topic shift by the interpreter (see Table 14).

Topic shifts	C1 without interpreter	C2 with interpreter
initiated by doctor	23	21
initiated by patient	3	8
initiated by interpreter	0	1
Total	26	30

Table 14: Initiation of topic shifts in C1 and C2

This indicates that the patient takes more initiative to participate in the consultation when the interpreter is present.

Secondly, Table 15 shows differences concerning the transition types.

	C1 without interpreter		C2 with interpreter	
	#	%	#	%
Fitted shifts	**4**	**15,38**	**12**	**40**
Semi-fitted shifts	**4**	**15,38**	**5**	**16,66**
Disjunctive shifts	**18**	**69,23**	**13**	**43,33**
Transition marker	13	72,22	4	30,76
Abrupt	5	27,77	9	69,23

Table 15: Transition types in C1 and C2

C2 has a higher percentage of fitted shifts (C1: 15,38%, C2: 40%) and a lower percentage of disjunctive shifts (C1: 69,23%, C2: 43,33%). Nevertheless, within the category of disjunctive shifts, the percentage of abrupt shifts is higher in C2 (C1: 27,77%, C2: 69,23%). The high number of fitted shifts in the consultation with the interpreter indicates smoother communication (one topic goes over into another). On the other hand, the high number of disjunctive shifts in the consultation without the interpreter indicates communicative problems and can be seen as a reflection of the doctor's frustration: he was unable to elaborate on topics because of language problems.

3. Conclusion

The aim of this study was twofold: firstly, we wanted to examine how the interpreter's presence has an impact on communication between psychiatrist and patient in a psychiatric consultation; secondly, we aimed to explore the possibility of comparing two different types of language mediation (professional interpreter and Dutch as a foreign language to the patient) through the triangulation of data and analytic methods. Two data sets were used: two video-recorded psychiatric consultations and a retrospective interview with the psychiatrist. These

data were analysed through the analytic lens of CA, combined with quantitative elements, while the interview was analysed using thematic analysis.

The analysis showed that the interpreter impacts communication in a psychiatric consultation, both positively and negatively, which is in line with previous research (e.g. Bauer/Allegría 2010)[5]. The significant positive impact became apparent in the turns-at-talk and topic development analysis: the interpreter enables the mental health patient to talk about problems and feelings. This is in line with previous findings in the literature that it is difficult to talk about these topics in a foreign language (e.g. Marcos *et al.* 1973). Moreover, the results of the analysis of turn-design, question-answer sequences, and topic developments indicate a more fluent and in-depth conversation with fewer communicative problems, which was also the doctor's perception.

In the interview, the doctor also mentions that the presence of an interpreter involves specific problems, such as pauses between turns and how the interpreter deals with them, which can – as described in the literature – at least partly be solved through clear agreements and good cooperation between doctor and interpreter (Goguikian Ratcliff 2010; Mirza *et al.* 2017: 61; Delizée *et al.* 2021). Therefore, targeted training of interpreters and doctors/therapists is necessary (e.g. Bot 2020: 223). In our case, the doctor can brief the interpreter before the consultation about his practice of inserting pauses and explain why. A second difficulty in having an interpreter present is the interpreter's many translation shifts, of which several had a clear impact on communication. Translation shifts are typical of interpreter-mediated consultations (Napier 2004; Major/Napier 2012) since the interpreter translates into two languages and takes only a few notes. However, interpreters must be made aware of, for example, how psychiatry works and how important the wording of utterances is, but also psychiatrists must learn how to work with interpreters effectively. This confirms the importance of having a briefing session between psychiatrist and interpreter to agree on how to work together.

As far as the methodology is concerned, we can conclude that the triangulation of data and analytic methods provide complementary insights and a more fine-grained picture of what is going on in the psychiatric consultation. Moreover, some discrepancies between the psychiatrist's perception and the results of the qualitative/quantitative analysis of the recorded consultations were revealed. This may give rise to future discussion on how to work with interpreters and it provides incentives for further research. Additionally, the combination of qualitative conversation analysis, quantitative elements, and the retrospective interview was shown to be adequate to compare different types of language mediation.

Acknowledgments

We would like to thank all the participants of the two consultations who agreed to the recording, the members of the Ethical Committee of UZA and UPC KU Leuven, and all the staff members of UPC KU Leuven who helped us with the

5 We will not generalise our findings since our analysis is based on a limited data set.

practical realisation of our research. Finally, we wish to thank Imola Antal for her excellent cooperation concerning the transcription and translation of the Hungarian segments in C2.

Transcription conventions based on Jefferson (2004: 24-31)

=	Equal sign is used to indicate that there is no pause or gap between two utterances.
(.)	A dot in parentheses indicates a really short pause (tenth of a second)
(0.0)	A number in parentheses indicates pauses (seconds and tenths of seconds)
word	Underscoring indicates some kind of stress
WORD	Capitals indicate a raise of voice
::	Colons indicate the prolongation of the prior sound. The longer the colon, the longer the sound was prolonged.
↑↓	Arrows indicate a rising intonation or falling intonation
°WORD°	Degree signs indicate that the words are pronounced softer than the other words
-	A dash indicates a cut-off
[words]	Square brackets are used to indicate overlapping speech.
>words<	Right/left carats indicate that the words are pronounced faster
<words>	Left/Right carats indicate that the words are pronounced slower
.hhh	A dot with 'h's indicates a deep breath
£words£	The pound-sterling indicates that the words are pronounced smiling
#words#	The hashtags indicate that the words are pronounced with a creaky voice
(words)	Parenthesised words are used when information was anonymised, or the transcript is unclear
((words))	Doubled parenthesised words indicate supplementary information (e.g. laughter) or to indicate that something was unintelligible
?[6]	A question mark indicates that the utterance was coded as a question

References

Agentschap Integratie en Inburgering (2017) "Deontologische code van de sociaal tolk" (in English, "Deontological code of the community interpreter"), <http://www.agii.be/sites/default/files/bestanden/deontologische_code_sociaal_tolken.pdf>.

6 Own addition. In Jefferson (2004) the question mark is used to indicate rising intonation.

Aguilar-Solano M. (2020) "Triangulation and trustworthiness - advancing research on public service interpreting through qualitative case study methodologies", *FITISPos International Journal* 7/1, 31-52.
Bauer A. / Alegría M. (2010) "The impact of patient language proficiency and interpreter service use on the quality of psychiatric care: a systematic review", *Psychiatric Services* 61/8, 765-773.
Bot H. (2005) *Dialogue Interpreting in Mental Health*, Amsterdam/New York, Rodopi Publishers.
Bot H. (2020) "Interpreting in mental health, anything special?", in I.E.T. de V. Souza / E. Fragkou (eds) *Handbook of Research on Medical Interpreting*, Hershey, IGI Global, 210-226.
Cerci D. / Neale J. (2018) "Working with interpreters in mental health: are we lost in translation?", *International Journal of Social Psychiatry* 64/5, 509-510.
Davitti E. (2018) "Methodological explorations of interpreter-mediated interaction: novel insights from multimodal analysis", *Qualitative Research* 19/1, 7-29.
Dekker E. / Ginsburg I. / Lantz M. (2009) "Working with interpreters in psychotherapy: a case report using the therapist-interpreter team approach", *Clinical Geriatrics* 17/9, 9-12.
Delizée A. / De Ridder P. (2016) *L'interprète-kaléidoscope ou le questionnement identitaire de l'interprète en santé mentale. Un état de la question*, Mons, Presses de l'Université de Mons.
Delizée A. / De Ridder P. / Bruwier N. (2021) *Santé mentale & interprétation : une collaboration interprofessionnelle riche de sens. Guide pratique à destination du thérapeute et de l'interprète*, Mons, Presses de l'Université de Mons.
Delizée A. / Michaux C. (2019) "The negotiation of meaning in dialogue interpreting. On the effects of the verbalization of interpreters' inferences", in E. Tiselius / M. Albl-Mikasa (eds) *Cognitive Processes in Dialogue Interpreting*, Special issue of *Translation, Cognition & Behavior* 2/2, 263-282.
Delizée A. / Michaux C. (2020) "Les représentations mentales de l'interprète de dialogue : de la pertinence locale à la cohérence discursive globale", in S. Vogeleer / L. Beghin *Déverbaliser - reverbaliser: la traduction comme acte de violence ou comme manipulation du sens ?*, Bruxelles, Presses de l'Université Saint-Louis, 171197.
Drennan G. / Swartz L. (2002) "The paradoxical use of interpreting in psychiatry", *Social Science & Medicine* 54, 1853-1866.
Drew P. (2013) "Turn design", in J. Sidnell / T. Stivers (eds) *The Handbook of Conversation Analysis*, Blackwell Publishing, 131-149.
Drew P. / Holt E. (1998) "Figures of speech: figurative expressions and the management of topic transition in conversation", *Language in Society* 27/4, 495-522.
Englert C. (2010) "Questions and responses in Dutch conversations", *Journal of Pragmatics* 42/10, 2666-2684.
Farooq S. / Fear C. / Oyebode F. (1997) "An investigation of the adequacy of psychiatric interviews conducted through an interpreter", *Psychiatric Bulletin* 21/4, 209-213.

Garcia L. J. / Joanette Y. (1997) "Analysis of conversational topic shifts: a multiple case study", *Brain and Language* 58, 92-114.
Goguikian Ratcliff B. (2010) "Du bon usage de l'interprète, entre neutralité et implication émotionnelle", *Cahiers de l'ILSL* 28, 39-56.
Hsieh E. / Pitaloka D. / Johnson A. (2013) "Bilingual health communication: distinctive needs of providers from five specialties", *Health Communication* 28/6, 557-567.
Jefferson G. (2004) "Glossary of transcript symbols with an introduction", in L. G. Lerner (ed.) *Conversation Analysis: Studies from the First Generation*, Amsterdam/Philadelphia, John Benjamins, 13-31.
Levinson S. (1983) *Pragmatics*, Cambridge, Cambridge University Press.
Levinson S.C. (2013) "Action Formation and Ascription", in J. Sidnell / T. Stivers (eds) *The Handbook of Conversation Analysis*, Chichester, Wiley-Blackwell, 103-131.
Major G. / Napier J.M. (2012) "Interpreting and knowledge mediation in the healthcare setting: what do we really mean by 'accuracy'?", *Linguistica Antverpiensia* 11/11, 207-225.
Marcos L. / Urcuyo L. / Kesselman M. / Alpert M. (1973) "The language barrier in evaluating Spanish-American patients", *Archives of General Psychiatry* 29/5, 655-659.
Miletich M. (2015) "Accounting for nonverbal communication in interpreter-mediated events in healthcare settings", *Translation and Translanguaging in Multilingual Contexts* 1/2, 162-181.
Mirza M. / Harrison E. / Chang H.-C. / Salo C. / Birman D. (2017) "Making sense of three-way conversations: a qualitative study of cross-cultural counseling with refugee men", *International Journal of Intercultural Relations* 56, 52-64.
Nakana I. (2011) "The role of silence in interpreted police interviews", *Journal of Pragmatics* 43/9, 2317-2330.
Napier J.M. (2004) "Interpreting omissions: a new perspective", *Interpreting* 6/2, 117-142.
Paillé P. / Mucchielli A. (2012) *L'analyse qualitative en sciences humaines et sociales*, Paris, Armand Colin.
Price C. S. / Cuellar I. (1981) "Effects of language and related variables on the expression of psychopathology in Mexican American psychiatric patients", *Hispanic Journal of Behavioral Sciences* 3/2, 145-160.
Raymond C.W. (2014) "Conveying information in the interpreter-mediated medical visit: the case of epistemic brokering", *Patient Education and Counseling* 97, 38-46.
Roter D. (2013) *The Roter Method of Interaction Process Analysis. Manual*, Baltimore, John Hopkins University.
Sacks H. (1987) "On the preference for agreement and contiguity in sequences in conversation", in G. Button / J. R. Lee (eds) *Talk and Social Organisation*, Clevedon, Multilingual Matters, 54-69.
Schegloff E. A. (2007) *Sequence Organization in Interaction: A Primer in Conversation Analysis*, Cambridge, Cambridge University Press.

Sleptsova M. / Weber I. / Schöpf A. / Nüblin M. / Morina N. / Hofer G. / Langewitz W. (2017) "Using interpreters in medical consultations: what is said and what is translated - A descriptive analysis using RIAS", *Patient Education and Counseling* 100/9, 1667-1671.

Thompson L. / Howes C. / McCabe R. (2016) "Effect of questions used by psychiatrists on therapeutic alliance and adherence", *British Journal of Psychiatry* 209/1, 40-47.

Vaismoradi M. / Turunen H. (2013) "Content analysis and thematic analysis: implications for conducting a qualitative descriptive study", *Nursing and Health Sciences* 15, 398-405.

Vasquez C. / Javier R. (1991) "The problem with interpreters: communicating with Spanish-speaking patients", *Hospital & Community Psychiatry* 42/2, 163-165.

Villalobos B. / Bridges A. / Anastasia E. / Ojeda C. / Rodriguez J. H. / Gomez D. (2016) "Effects of language concordance and interpreter use on therapeutic alliance in Spanish-speaking integrated behavioral health care patients", *Psychological Services* 13/1, 49-59.

Vranjes J. / Bot H. (2021) "A multimodal analysis of turn-taking in interpreter-mediated psychotherapy", *Translation & Interpreting* 13/1, 101-117.

Wadensjö C. (1998) *Interpreting as Interaction*, London, Routledge.

Yang Y. (2019) *The Management of Topics in Ordinary Conversation*, PhD Thesis, University of York.

Zanettin F. (2019) "Conversation analysis", in M. Baker / G. Saldanha (eds) *Routledge Encyclopedia of Translation Studies* (3rd edition), London, Taylor & Francis, 105-109.