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INTERPRETING FOR VULNERABLE PEOPLE– COOPERATION BETWEEN PROFESSIONALS

Hanneke Bot

BOT – Bilingual Communication & Training

Abstract

In this paper, I examine the prerequisites for communication across the language barrier in the treatment of people who suffer from psychological and / or psychiatric disorders – in short: (psycho)therapeutic[1] talk. Communication across the language barrier is always more complicated than between people sharing the same language – an interpreter is needed. In therapeutic talk, where language is so important as it is both the means of expression of symptoms and the most important means of treatment, interpreting becomes extra challenging. So, how to go best about it?

[1] I will use the words 'therapy' and 'therapist' as generic terms to refer to mental health talk in general and the people professionally engaged in this communication (nurses, psychologists, psychotherapists, social workers, psychiatrists and the like)

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1. WHAT MAKES THERAPEUTIC TALK DIFFERENT?

Several factors define the specific nature of therapeutic talk, some belonging to the type of talk in general, some to the patient and some to the therapist.

First of all, there is the specific nature of the topic at hand. Therapeutic talk is most often about difficult, shameful and emotional events, memories and feelings. Often, topics one would not dare speak about with someone else. In the therapeutic encounter, the patient has to talk about it – hence no basis for treatment. This asks for a specific environment in which the patient feels safe to express him or herself.

In psychiatry an extra difficulty lies in the fact that patients may be confused and express themselves in words that do not exist, may speak ramblingly and disjointed.

Also, patients' behaviour does not always fit with 'normal' social behaviour and the social rules of ordinary day-to-day talk. They may produce overlapping talk, may not stop talking for long episodes; they could behave in a way that is seen as rude or aggressive; may cling to either the therapist or the interpreter; may easily become angry or feel insulted et cetera. This poses a

strong challenge to the social and communicative skills of both the therapist and the interpreter.

The emotional nature of the talk can be difficult for several reasons. The words may sometimes be difficult to interpret, but it can also be difficult for the interpreter to endure stories about atrocities, abuse and aggression and the concomitant strong feelings of sadness and despair expressed by the patient. Interpreters may have a history of forced migration and trauma themselves, which memories may be awakened by stories of the patient. Also, interpreters often find it difficult to find a way to deal with feelings expressed by the patient towards themselves, especially when these feelings are of a negative nature: aggression, insults and the like. But also (exaggerated) praise may be difficult to receive properly. Dealing with such feelings is the core business of therapists – a lot of their training is about just that. Interpreters do not have this training but do have to deal with it.

The therapist listens carefully to the patient – of course to the content of the talk but sometimes even more so to the way in which the patient phrases his turns. Does he use an active form of the verb to describe his actions, or does he always use a passive tense – as if he is not an acting person but things 'are happening' to him? In which register does he speak? Does he know to express himself subtly, or does he only have a limited vocabulary to talk about emotions? Does he use specific words very often?

Therapists phrase their interventions carefully, based on theoretical considerations and their evaluation of the talk at hand. They very often pose their interventions as questions ('is it possible that…?'; 'maybe is …. the case?') in order to encourage the patient to think about himself, his feelings and his reactions. They may sometimes use language difficult to understand when they try to differentiate between emotions or try to dig deeper to find underlying feelings and may phrase interventions that the interpreter may find difficult to understand because the purpose of the intervention escapes him or her.

In general, all this asks for controlled deviations from codes of conduct of interpreters, as these do not cater for situations in which the neutrality and the partisanship of the interpreter is challenged and the interpreter will need all his skills to steer away from too much involvement while at the same time making sure not to be too 'offstandish', business-like or cool in order to keep the working relationship safe for all participants.

In the following section, I will relate some characteristics of therapeutic communication (working relationship; careful listening, careful formulation of interventions) with some characteristics of codes of conduct for interpreters (faithful interpretation, 'just translate'; neutral stance; no interventions), how these tally and which deviations might be necessary and appropriate. Then, I will define which training is needed

for both interpreters and therapists to cooperate well together in this type of talk.

2. THERAPEUTIC COMMUNICATION AND INTERPRETING

2. 1. The working relationship

Research (see for example Wampold & Imel 2015) has made clear that an important aspect of successful therapy, maybe even the most important one, lies in the working relationship (or therapeutic relation; or working alliance) between therapist and patient. Complete books have been written about this working relationship and the concomitant attitude of the therapist (e.g. Hafkenscheid 2014); it is an important aspect of therapists training. So it is understandable that interpreters may experience problems when trying to adapt to the therapeutic way of relating to patients as they have generally no knowledge about it. I here try to summarise the most important aspects of this working relationship in less than a page – needless to say that these are just the headlines.

A widely used definition of the therapeutic working relationship, supposedly theory-neutral, i.e. unrelated to a specific therapeutic school, stems from Bordin (Bordin 1979) and consists of three aspects. First of all there should be agreement about the goals of the treatment, secondly there should be agreement about the tasks (which will be different depending on the schools of

therapy) that need to be carried out, thirdly the working relationship is dependent on the quality of the (developing) relationship between therapist and patient. In this relationship the attitude of the therapist is very important. In general it is seen as comprised of three aspects: empathic, accepting and authentic.

Agreement about goals and tasks will be found by talking about it in the beginning of treatment while adjustments may be made on the basis of brief evaluations during the course of the therapy (either with a brief questionnaire or by asking questions like 'how do you feel things are going'). For interpreters this should not pose specific problems. However, as far as the attitude is concerned, there might be problems.

'Empathy' is the ability to understand and share the feelings of someone else. It implies 'feeling with' the patient. The therapist tries to feel and understand what the patient is feeling and shares this in words ('this must be very difficult for you'; 'you must have been very sad') and in attitude, facial expression, demeanour. The latter includes a smile, a laugh, sometime even a minor tear. The therapist 'lives with' the patient but should never be overwhelmed with emotions, as the patient might be. The patient has to notice that the therapist understands his misery but is also strong enough to bear his stories. The patient should not have to feel worried about the wellbeing of the therapist, which might cause him to hold back ugly things that have been happening to him. The therapist does not copy the feelings of the

patient but makes sure he understands them and feels them, albeit to a lesser extent.

'Accepting' means that the therapist accepts his patient as he is. This does not mean that the therapist accepts all patients behaviour – but he does not reject the patient because of it.

'Authenticity' means being 'real'; the empathy and acceptance has to feel 'real' to the patient and not 'faked' as a 'therapeutic technique'. This even includes that a therapist might feel and express (mild) irritation or anger about specific behaviour the patient expresses towards the therapist – this should be talked about, the behaviour and therapists' reaction should be examined and understood after which negative feelings usually diminish and disappear. This can work as a valuable experience of how to deal with negative feelings towards a person – the breach in empathy that had occurred, is healed again. Authenticity does not only come in words, but in tone of voice, subtle facial expression et cetera. A slight movement of the eyebrow may spoil the impression and make clear that expressed feelings are untrue / faked.

How can interpreters fit in into this working relationship? How should they behave – in the widest sense of the word – in order to support this relationship? There is no simple solution to this – there is little research we can rely on in this field.

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I would like to mention the important research that has been done by Iglesias-Fernández (forthcoming) about empathy and if interpreters retain this in their way of interpreting. She investigated to which extent the prosodic- phonetic characteristics of empathy (such as slower articulation rate, lengthening of vowels) are retained by telephone interpreters in Spain. She found that the interpreters retain the empathy towards the health provider but not towards the patient. She explains this by referring to the protocol interpreters are bound to in which there is a strong emphasis on neutrality and non-partisanship and no room for the expression of empathy. We see here that codes of conduct that strongly emphasize neutrality, can have a negative impact on therapeutic work.

But her work can be used to teach interpreters to retain expressions of empathy, if they are aware of its characteristics and feel free to use them also towards the patients.

As far as acceptance is concerned, I know of interpreters who find it hard to interpret for patients, especially when they are compatriots, who 'are not doing well' for example, do not work, are aggressive, have an addiction, lie about their history and reasons to have fled their country, do not behave as exemplary citizens. They feel ashamed about them and feel they give their people, or migrants in general, a bad name. Although these feelings may be understandable, they are not therapeutical. Therapy is about change, changing behaviour, changing

feelings. It is easier to change when you feel the freedom to do so: not because you are judged negatively and feel forced to. As it is difficult to hide such negative emotions (as I mentioned earlier, a slight movement of the brow can betray underlying feelings) it is important that also interpreters understand this principle and teach themselves to live up to it.

Authenticity is the most difficult element of the three. Maybe the following is an example easy to understand. During a session, a patient suddenly becomes very angry, starts shouting and jumps from his chair. Here, one does not have to feign acceptance or neutrality, one can show fright or even fear, a true feeling at that moment. It does mean, that the feeling of accepting the patient, with all his faults and difficulties, should be real. Of course, when the emotion has faded, the incident needs to be talked about.

In general, it all boils down to the observation that professionalism goes well together with having feelings towards the people one is interpreting for and that these may show, although they should always be in accordance with the therapeutic objective at hand at that moment and be usually somewhat restricted in their expression. For interpreters, it is a good rule, to be very watchful of the way the therapist is dealing with the situation, and to follow him in the expression of emotion. It is the therapist who sets the mood, not the interpreter. This means, the interpreter has to stall his expression.

> *For example, the patient says something the interpreter feels it is to laugh about. But the therapist may not agree with this evaluation of the words of the patient. Only, the therapist has not had the rendition by the interpreter, so he cannot react yet. It is best when the interpreter waits for the therapists' reaction and then expresses the same emotion.*

I even think that the interpreter should follow the emotions of the therapist in a modest way so as not to attract attention.

2.2 Careful listening

As mentioned above, therapists do not only listen to the content of their patients' words, but also to the way they express themselves. The use of an active or a passive tense may say something about the way the patient sees himself and the world around him; the register they use, specific words, repetition of words, it is all part of how the patient expresses his identity and could even be a clue to some underlying emotion, feeling or motivation. This requires careful listening by the interpreter and careful and faithful interpreting. An example of how this can go wrong, stems from my own research (Bot, 2005).

> *The patient is a man in his fifties from Afghanistan who has suffered several war-traumas and has lost a leg. He does not want*

> *other people to feel pity for him, he finds it difficult to show others his pain. In therapy, though, he can speak about his problems. In the sessions I recorded, he uses 'theologisms', expressions with a religious connation, such as 'god forbid', 'thanks to god', 'god knows', 22 times. The interpreter chose to render these in secular terms. For example 'god forbid' is rendered as 'his fear is' (note also the 3rd person in the rendition). The interpreter told me later that he sees these 'theologisms' as idiom and not as expressions of religiosity. He felt that if he had rendered them literally, it would have made the therapist think this person was overly religious. In the sessions though, it led to confusion and irritation when the therapist, unaware of the religious undertone of patients' talk, asks the patient whether he has started to doubt god. This clearly offended the patient.*

This example, which stretches over two consecutive sessions, shows how subtle changes in renditions, especially when they are repetitive, can lead to misunderstanding. It can be said that the interpreter made the patient more secular than he had expressed himself – and that led to an unintentional affront by the therapist. For the patient this must have been a confusing experience. In this treatment, the working relationship seemed well established. The patient says several times how grateful he is and he emphasizes that the sessions are helpful and that he likes the therapist listening to

him. The therapist has told me that he likes the patient and his coping style. Despite this, there is this affront that may have left the patient baffled (Bot 2005). The example shows how difficult it can be and how careful one has to be with interpreting words as idiomatic.

On top of all that, psychotic patients pose an extra problem to interpreters. Psychosis in general, is a psychiatric state of mind in which the person has lost the normal contact with reality. It includes observing (hearing, seeing, smelling, feeling, tasting) without the concomitant sensory input or having thoughts that do not tally with reality (often about being persecuted; about people who have 'a plan' with the patient; thinking that for example the news anchor-person is directing himself to the patient personally et cetera). Often psychotic patients may speak in a way that is difficult to interpret. Their words may be difficult to understand because of their delusional nature, there is often no logical story that the interpreter can easily store and render. On top of that, they may speak very fast, do not keep the rules of grammar, may use words that do not exist in any vocabulary or may produce a random string of words, may change subject several times in even one sentence, may repeat themselves time after time et cetera. So it becomes impossible for interpreters to interpret: they can not understand properly what the patient tries to convey, they cannot translate specific words he uses, they cannot keep up with the pace of talking et cetera.

In these situations, there is no other solution for the interpreter, than to stop interpreting and to start meta-communicating with the therapist. The interpreter has to explain to the therapist why he cannot interpret; he has to describe the way the patient talks; which words come up often; maybe there is a theme in his speech which he can convey to the therapist; he should tell if the patient is using 'new' words that he has invented himself; et cetera. An observant therapist usually has already noticed, from the behaviour of the patient, that something is amiss and is happy to follow the interpreter in his meta-communication. And if this is not the case, than the interpreter has to explain to the therapist, that there is no other way for him to convey the message. It may be clear that this goes against the rules formulated in most codes of conduct. Here just 'rendering a faithful translation' does not suffice.

2.3 Careful formulation of interventions

Therapists listen carefully, they also formulate their interventions carefully. Therapy is a cooperative effort between therapist and patient. It is usually not the therapist, as an expert, telling the patient what to do. It is the therapist helping the patient to find out what is the matter with him and to help him find out both which help he needs and how to help himself. This leads therapists to ask questions very often, more often than to make statements. Also, they often phrase their interventions tentatively, thus encouraging the patient to reflect on the statement and, importantly, they start an

intervention with a brief phrase that relates themselves with the patient, or that makes a connection with something said earlier. Examples are: 'I just heard you say …,' 'does that mean …'. Or 'yes, I do understand' or 'I'm glad you say this'.

In my own research these short introductory words of interventions went remarkably often unrendered (Bot 2005). One of the interpreters who featured in my research material, mentioned seeing these introductory words as 'fringe' and not the core of the message and unnecessary to render. The same phenomenon was found by Albl-Mikasa (Albl-Mikasa et al 2015) in doctor-patient interaction.

Another problem that arose in my material was that interpreters have the tendency to render tentatively formulated questions as statements. In doing so, they turn the therapist into an expert who knows it all instead of a helper who, together with the patient, searches for understanding and relief. This is thus an important change of the message. Again, interpreters were unaware of the underlying principles of this type of talk which made them miss subtle differences in phrasing. Again, I would like to refer to Albl-Mikasa's work who concludes that lack of knowledge of the structure of doctor-patient interaction makes it difficult for the interpreter to render the words of doctors and patients in such a way that the aim of the consultation is adequately met (Albl-Mikasa & Hohenstein 2017).

It is important for interpreters to realise that therapists do consider this type of introductory words, the use of questions, formulating tentatively, using hedges et cetera, as belonging to the core of their message: their message being about both building a good working relationship and rapport with the patient, talking about a certain subject matter and engaging the patient in understanding his problems and finding solutions for them.

3. HOW DO THERAPISTS AND INTERPRETERS WORK TOGETHER OPTIMALLY?

From my own research (Bot 2005) and my wide experience working with interpreters in clinical mental healthcare, I have come to the conclusion that therapists and interpreters work best together in a style of cooperation that I have called 'interactive' and are both aware of the core values and practices of each other's trade. Such an interactive style combines the importance and necessity of giving faithful renditions and 'leaving the floor' to the primary speakers, while acknowledging that this is neither 100% the case nor is it always expedient.

The interactive style is *firstly* based on the observation that 'not communicating' is impossible: whenever people are in some way interacting, there is communication going on (Watzlawick, 1967). The interpreter as a translation-machine, a non-person not included in the communication between the primary

parties, is a fallacy. It is important that both parties involved are aware of this fact and act according to it. Denying that an interpreter has an influence on the communication can do injustice to the primary parties.

> *For example: when an interpreter renders a therapists' intervention slightly different from the original intention and the patient reacts in accordance to that intervention, the therapist may ascribe the, in his view deviant reaction, to the patient if he does not take into account that there may have been an interpretation problem which should first be investigated and sorted out.*

At the same time, even an interactive interpreter should try its best not to have more influence than necessary and wished for.

This first observation refers to unintentional, omnipresent and difficult to influence factors. It is about the fact that translation and interpreting always involves change compared to the original message and that the interpreter by just being there and being who he is (his appearance, voice, prosody et cetera) communicates something which will have its bearing on the interaction. This counts even when the interpreter works via the telephone: tone of voice, intonation, pace of speaking et cetera have their influence.

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Secondly, as far as the words are concerned, the interactive style includes a dialogic attitude towards words and interpreting them.

> *In 'a dialogical view on language and mind, meanings of words and expressions are understood as being partly established between people in interaction. Meaning cannot be separated from the context in which the words are used and where sense is being made. Words and expressions can simultaneously make sense in various ways to different people as well as to the same individual at various times. Interlocutors understand talk in interaction partly drawing on their knowledge of the conventional use of the current language(s) and partly on their experience of the current specific situation and speech genre. In a dialogical view of language and mind, meanings of words are not glued to lexical items, but are created and re-created by sensemaking subjects' (Bot, H. & C. Wadensjö, 2004 p. 357).*

The concept of dialogism stems from the language philosophy of Bakhtin (1986) and is opposed to monologism.

> *'A monological understanding of language implies emphasizing the importance of everyday, taken-for-granted equivalent meanings of words (as if they were listed in a dictionary); while dialogism*

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> *focuses more on the intersubjective creation of meaning within the specific and changing context of a particular social encounter (Bot, H. & C. Wadensjö, 2004 p. 357).*

Both interpreter and therapist should be aware of the dialogic nature of language and its role in interpreting. The interpreter should be alert to the specific use and meaning of words by both therapist and patient; therapists should be aware of the difficulty for interpreters to render these specific meanings correctly and be helpful and understanding when 'translation problems' arise.

Of course, interpreters' main task remains to interpret faithfully – that is their core business and justification of their being there. I am a staunch supporter of a minimal input by interpreters, interpreters should not adjust the register of primary speakers (these best intentions should be left unused), it is not their task to protect primary speakers against their own faults and mistakes et cetera. Primary speakers have to sort out those problems themselves and the interpreter should translate that. But there should be the recognition that renditions are usually not the ideal and utopian 100 % equivalent.

Thirdly, the interactive style is based on the observation that it can be useful and necessary for proper therapeutical communication and understanding, for the interpreter to have intentional and well-reasoned input in the interaction, that goes beyond 'being there and interpreting'. This input consists of meta-

communication, i.e. asking questions for clarification in case the interpreter does not understand what has been said or did not hear it properly and of describing language-use in case this is not instantly translatable. Specifically the last task involves intricate knowledge of both languages at hand, necessary to describe deviations from grammatical rules and structures, neologisms and their possible origins, or deviations from discursive rules.

Fourthly, the interactive style is about having an empathic input. When a therapist is being empathetic and showing that, it could easily been undone by an interpreter whose attitude is too neutral and impartial. This can be difficult for interpreters who are trained for work in the judicial realm in which neutrality and distance from all parties involved is such an important issue. From my work as a member of a complaints committee about the functioning of interpreters mainly in asylum hearings, I know however, that also there, neutrality can be felt as 'too much' and as 'hostile' by the non-professional user. On the other hand, a friendly demeanour as 'intrusive', laughing as 'laughing about' or even 'derisive' (Eindverslag Klachten AdviesCommissie 2009). Shortly, it is not simple to find the correct tone and behaviour to fit in with the talk at hand. In therapeutic talk, it is important to 'join in' (Minuchin & Fischman 1981). For the interpreter, this means, adapting to the atmosphere and to the way therapist and patient behave, in the widest sense, towards one another.

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Therapeutic talk stems from a very different paradigm than the judicial: it is based on cooperation instead of being adversarial. There is room to adapt to what is happening in the session and there is room to correct one's attitude or demeanour, when necessary. Therapists are used to talking about aspects of their working together with the patient. If they do so, it might be helpful for the interpreter not only to translate their words, but also to reflect on their own attitudinal input in what is going on and if necessary, to adapt. Interpreters do have a part in the therapeutic relationship, albeit a modest one, and the interactive model recognises that.

To sum up: in the interactive style the main task of the interpreter is to render the primary parties words faithfully while facilitating the working relationship between the primary parties by modestly joining into the empathic style of the therapist and to meta-communicate when the words are untranslatable.

4. AND HOW DO WE HELP THERAPISTS AND INTEPRETERS TO WORK TOGETHER OPTIMALLY?

Ideally, both therapists and interpreters are trained in interpreter-mediated communication in mental healthcare.
Interpreters working in mental healthcare should have:

- a basic understanding of the organisation of mental healthcare and its system of referral from basic to specialised and clinical care;

- knowledge of the most important and most occurring mental health problems and their symptoms, including the symptoms therapists are looking for in anamnestic and diagnostic consultations;
- an overview of treatment methods for these mental health problems: the various therapeutic schools, their underlying assumptions and ideas about 'what works for whom', the therapeutic aim of the interventions and the style of formulating these interventions and the discursive style of the sessions;
- knowledge of the model of interactive interpreting and training in how to find their best fitting place in a therapeutic session (how 'to join in', how to show empathy and how to follow the therapist in their attitude);
- training in how to render therapeutic interventions, how to preserve therapeutic language use;
- training in how to meta-communicate about language use, focussed on psychiatric language disorders.

Therapists working with interpreters also should have training in how to best cooperate in this setting. This should include:

- basic understanding of the organisation of interpreter services, the education and training of interpreters and their code of conduct;

- knowledge about the model of interactive interpreting and interpreting as a process involving change;
- awareness of their own style of formulating interventions, emphasising that well formulated interventions have a better chance of being well interpreted, the necessity of sometimes explaining – both to the patient and the interpreter - the rationale of the treatment and the interventions;
- training in how to structure an interpreter-mediated session: keeping the chair, addressing the patient directly, keeping long and multiple turns to a minimum, structuring the patient in keeping short turns and helping, if necessary, the interpreter to get his turn.

On top of this, it is wise for interpreters to find training in recognising and preventing 'vicarious traumatisation', i.e. being traumatised by hearing stories about trauma from others. Vicarious traumatisation seriously competes with the ability to empathise with patients and thus needs attention.

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