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INTERPRETING IN MENTAL HEALTH: AN EFFECTIVE COMMUNICATION FACILITATION PRACTICE

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Abstract

Immigration is an expanded phenomenon that characterises our present societies. It brings with it new challenges and new needs to be faced by administrations. Those unquestionably affect the healthcare sector, urging for it to be adapted to treat users from different linguistic and cultural backgrounds. Public Service Interpreting guarantees effective communication in multicultural and multilinguistic contexts. It is increasingly necessary in the healthcare sector of the current multicultural societies. The need for Public Service Interpreting is experienced with greater intensity in such services as mental health, where anamnesis constitutes the principal route of diagnosis for a later treatment, in which linguistic and cultural comprehension is essential. However, not all kinds of interpreting services should be accepted. Some quality standards –that are only achieved thanks to an appropriate training– must be required. Healthcare interpreters must be properly trained in

regard to languages, interpreting techniques, etc., but also in multiculturalism. An extensive knowledge of both involved cultures is essential to make healthcare interpreters able to assist healthcare providers by finding out cultural biases in mental health patie4nts' discourse, as those could affect communication in healthcare.

In this paper, I present some of the results of a multiple case study that describes, analyses and compares the healthcare interpreting services provided in the cities of Barcelona and Montreal. The present article outlines, from the interpreter's perspective, the benefits that interpreting brings to communication in healthcare and describes the negative effects that unprofessional interpreting services could entail.

Keywords: Cross-cultural communication; effective communication; intercultural mediation; interpreting; mental health

1. INTRODUCTION

Like many countries inside and outside of Europe, Spain has experimented, in its most recent history, a great increase in immigration rates. Newcomers have all sorts of different profiles: some of them immigrated for working reasons, others moved into the country with the intention of becoming permanent residents, while others are temporary residents staying in Spain for touristic

reasons. They have different economic and legal statuses in the country and bring with them different habits and customs that coexist and interrelate in everyday life. This has set up a new social reality with new needs and new interests, but also with new risks of polarization in society, social exclusion of ethnic minorities, marginalization and conflict. New challenges and new needs are consequently imposed in our societies, which affect directly the healthcare sector, since its users have very diverse linguistic and cultural backgrounds.

Spanish administrations offer many *ad hoc* solutions, among which we find professional and volunteer interpreters. However, in order to achieve better quality guarantees, there is a need to increase the awareness of interpreting as a specialised professional activity. In Catalonia, different professional figures share the task of interpreting between healthcare providers and their patients, which doesn't make the situation any better. Those professionals have different functions that are only slightly defined. As a result, they often assume responsibilities that don't belong to the interpreting professional (Linguamón, 2010). Moreover, Arumí, Bestue, García-Beyaert, Gil-Bardají, Minett, Onos, Ruiz de Infante, Ugarte, & Vargas-Urpí (2011), observed a lack of specific training for Catalan healthcare interpreters, which frequently lead to unprofessional performance. Given their lack of training, these interpreters are considered assistants that help other

professionals perform their duties. For that reason, they are called only in very punctual cases. In fact, in many occasions family members, friends, neighbours or other people accompanying the patient are asked to intervene as spontaneous interpreters instead.

According to Hale (2007), the quality of communication between healthcare providers and patients conditions the trust of the latter in the proposed treatments and, thus, affects the quality of healthcare services. Specially so in mental health services, where trust is the basis for any clinical encounter, as it is the key into the patients' worlds, without which they could never be properly treated. For this reason, professional interpreting services should be required. Neglecting to do so would not only hinder allophone patients' integration into our society, but would also be violating their rights to equal access to healthcare services. Failure to optimise interpreting services would also increase the costs of public health services, since some of the clinical encounters would be banal and unsuccessful due to communication problems. That would, in turn, originate new appointments dedicated to solve problems dealt with in previous encounters. Investing in quality interpreting services could prevent such situations.

By examining the distinct interpreting services offered in Barcelona and Montreal, we could state how each one of them improved communication between allophone

patients and healthcare providers. As reported by Angelelli (2004), interpreting services are strongly influenced by the social and cultural contexts in which they are offered. This was taken into account when doing this study. The comparison allowed outlining similarities and differences between healthcare interpreting settings serving a vast population of allophone immigrants in each city, even though at a different level of professionalization; healthcare interpreting services being at their early stages in Barcelona, and already settled and with a wider tradition in Montreal. This comparison allowed us to list the benefits that such services bring to healthcare communication, as well as to describe the negative effects of unprofessional interpreting.

2. IMMIGRATION, MENTAL HEALTH AND EFFECTIVE COMMUNICATION

Migratory processes modify many aspects of a person's life. They distance the person from their loved ones, as well as from different aspects that define them, as their language, their customs, their land, or their culture. All these changes can negatively affect the health of immigrants. Based on that, it can be stated that the increase of the migratory flows that a country receives, changes the profile of its healthcare services' users.

Conforming to Carballo (2006), immigrants in need for healthcare services are often in a situation of alienation and chronic sadness. In addition, they are generally far away from their families and live in a constant state of economic or even legal insecurity (as many of them have not reached a stable immigration status in the host country). They also find difficulties with both the language and the culture of their host country. All this adds up to the fact that they often experience a social and political-legal rejection, which complicates the task of communication with their host society's public service providers. This adds to the intrinsic difficulties of living in a new place, such as ignorance or lack of command of the local language(s) and the main culture (including the healthcare culture). Still, according to Valero-Garcés (2014), these people always modify, acquire and adopt changes of behaviour (to some extent) when they migrate into another country.

Based on Martincano (2003), Valero-Garcés (2014) states that the most important concerns regarding the access of immigrants to national health systems in the 21st century are active abandonment, lack of knowledge, bureaucratic complexity, obstacles imposed by local authorities, and difficulties with the language, as well as cultural and religious issues, and social and working difficulties. The author also points out that the professional's social interference can affect the quality of the healthcare services provided. She adds that, when

working with patients of immigrant origin, healthcare providers can reveal emotions (ethnocentrism, xenophobia, racism, segregation, prejudices, stereotypes, discrimination, rejection, aggression, exclusion, etc.), especially when working with patients that inspire feelings of oppression and prejudice. Likewise, the author insists that a vast majority of immigrants tend to suffer the so-called Ulysses syndrome, defined by Martincano (2003) as a disease related to chronic stress that involves loneliness, the struggle for survival, frustration, and the feeling of failure that many immigrants feel.

In this sense, Qureshi Burckhardt et al. (2009) explain that the migratory process itself, or the simple fact of belonging to a minority ethnic group, are sources of stress that can affect the individual's mental health. All of this proves that immigration and culture have a huge impact on people's health and healthcare. The authors add that the expression of possible psychiatric disorders, the interpretations and given explanations, or the way of searching for relief are strongly linked to culture and therefore biased by it.

It is therefore important to remember that equal access to public services is a fundamental human right, which implies, to begin with, understanding and being understood to eliminate communicative obstacles that may interfere in the proper provision of such services. In

this sense, García-Beyaert (2008) defends the "right to effective communication", defining it as the right of every individual to understand and to be understood when in contact with public institutions, so that communication barriers do not impede the respect of allophone speakers' fundamental rights covered by these institutions.

When in a vulnerable situation, it is especially difficult (as well as important) to clearly communicate accurate information. Reaching effective communication is even more complicated when cultural differences are not properly taken into account and handled by a professional able to promote an effective understanding. Along these lines, Gumperz (1971) explains:

> *Effective communication requires that speakers and audiences agree both on the meaning of words and on the social import or values attached to choice of expression… We will use the term 'social significance' or 'social meaning' to refer to the social values implied when an utterance is used in a certain context.*

In this sense, Ayonrinde (2003) declares that when the same way of interpreting the world is not shared, participants can have different expectations regarding the nature and form of the healthcare provider-patient relationship. This is where the mediation of a competent

interpreter becomes especially important. Without such a mediation, as Qureshi Burckhardt et al. (2009) insist, even though an understandable exchange of words can occur, there will be no effective communication, as the context and meanings are different for each person. To add up to this there is the fact that every language and every culture have their own way of expressing and decoding emotions, which may not be shared by both of the conversational partners in cross-cultural consultations.

Even though the need of a professional interpreter that is able to transmit messages from one language into another and handle with care cultural differences is obvious for all specialties of the medical field, it is even more important in mental health, where patients' realities can be distorted, and such distortions will often affect their discourse.

As stated by Halliday (1970), "we use language to represent our experience of the processes, persons, objects, abstractions, qualities, states and relations of the world around us and inside us". That is why effective communication is essential in mental health and professionalised interpreters are needed to guarantee an adequate treatment of allophone immigrant users.

Leanza, Miklavcic, Boivin & Rosenberg (2014) maintain that ethnocultural identities and social position shape

patients' choices on the language used to express their own experience. The authors state that languages have different nuances of meaning linked to social predicaments, developmental experiences, and the structures of family and community life. These determine the language of subjective experience and emotion, which is essential for mental health assessment and intervention. For that reason, interpreting in mental health requires the understanding of emotional meanings that are culturally biased and the ability to transfer them into the other culture without neglecting the patient's language choices. In fact, as stated by Leanza, Miklavcic, Boivin & Rosenberg (2014), patients' decisions to use or avoid specific languages can provide important clinical information. To convey these nuances of language use, clinicians and interpreters must understand psychological dynamics, respect patients' modes of self-presentation, and attend to nonverbal communication.

3. THE STUDY

3.1. Method

This article is a contribution derived from the research carried out for the doctoral thesis *La interpretación en los servicios públicos en el ámbito sanitario. Estudio comparativo de las ciudades de Barcelona y Montreal [Public Service Interpreting in Healthcare Settings. A*

Comparative Study Between the Cities of Barcelona and Montreal] (Burdeus-Domingo, 2015). This research's main objective was to analyse healthcare interpreting settings from a threefold perspective: that one of the interpreters, that one of the Administration (conformed by the perspectives of healthcare professionals and those of interpreting service managers), and that one of the users.

The present article aims to describe the benefits that healthcare interpreting brings to communication in the medical context, as well as the negative consequences of using non-professional interpreters. This is done by examining the information reported by interpreters working in Barcelona's and Montreal's healthcare sectors. The exposed information was obtained through the above-mentioned multiple case study, which followed a replication-based methodology. In other words, it reproduced the same research process in Barcelona and Montreal, with the subsequent comparison of the data obtained, which allowed reaching significant conclusions.

3.2. Data collection instruments and procedures

Questionnaires were distributed in different languages (Spanish, English, French, Romanian, Russian, Arabic and Chinese) to allophone users of the healthcare

interpreting services of both cities. Moreover, interviews were conducted in the local languages (Spanish and Catalan in Barcelona, and English and French in Montreal) to the rest of the subjects involved.

The first phase of data collection took place between September 2011 and June 2012. It collected all possible data to outline a general image of the healthcare interpreting services offered in Barcelona. The second phase of data collection, corresponding to the city of Montreal, took place between September 2012 and May 2013. In this phase, information was collected to describe the services offered in the Canadian city.

For the design of the questionnaires, we relied on the model employed by the research group MIRAS (Arumí *et al*., 2012) in their project entitled *Traducción e Inmigración: la formación de traductores e intérpretes para los servicios públicos, nuevas soluciones para nuevas realidades [Translation and Immigration: Translators' and Interpreters' Training for Public Services, New Solutions for New Realities]* which, in turn, was elaborated based on the models already contrasted and used by Valero-Garcés & Lázaro-Gutiérrez (2008). They included closed questions (yes/no, multiple choice) and open-ended questions where informers could extend their responses.

On the other hand, different semi-structured interviews were designed, based on a model designed for a previous study (Burdeus-Domingo, 2010). An interview script was designed for each informant profile. These scripts were flexibly used in interviews, depending on the information flow shared on each interview.

3.3. Population, sampling and corpus

A random sample was drawn, in which participants were randomly chosen among those who claimed to be available at the different participating health institutions.

The corpus of this study was formed from the set of recordings and questionnaires obtained in the observation phase. 81 recorded interviews and 110 questionnaires were compiled and analysed. Specifically, in Barcelona, between September 2011 and June 2012, 9 service managers, 15 interpreters and 26 healthcare professionals from a total of 10 healthcare centres were interviewed, of which 4 were primary care centres (CAP Sagrada Familia, Cap Collblanc, Cap Drassanes, Cap Trinitat Vella y CAP Fondo) and 6, hospitals (Hospital Vall d'Hebrón, Hospital Sant Pau, Hospital Can Ruti, Hospital del Mar, Hospital General de l'Hospitalet, Hospital Dos de Maig). Among the participants in Barcelona there were 11 physicians, 8 nurses, 4 social workers and 3 administrative assistants. On the other hand, in Montreal, between September 2012 and May

2013, two managers of translation and medical interpreting services were interviewed (the one of the Montreal Interregional Interpreters Bank and the one of the Montreal Children's Hospital's Sociocultural Consultation and Interpretation Services), 16 interpreters, and 13 healthcare professionals belonging to different healthcare institutions in 2 healthcare and social services centres (CSSS de la Montagne and CSSS Jeanne-Mance) and a hospital (Montreal Children Hospital): 2 physicians, 1 unit coordinator, 3 nurses, 5 social workers, 1 nutritionist and 1 administrative assistant. The following table synthetises the instruments applied and the corpus obtained:

Instrument	Subject profile	Barcelona	Montreal
Interviews	Healthcare interpreters	15	16
	Healthcare professionals	26	13
	Service managers	9	2
Questionnaires	Users	101	9

Table 1. Instruments and corpus.

3.4. Data analysis

For the analysis of the data obtained through questionnaires, a quantitative analysis was applied. When analysing the data obtained through closed questions, the actual percentages were calculated (i.e., including blank answers), although in some cases we also presented the absolute frequency to facilitate data interpretation. The open answers were translated into Spanish and analysed using content analysis techniques, as was done with interviews.

The data obtained through interviews was analysed following qualitative content analysis techniques, systematically describing the meaning of qualitative material by classifying it according to a series of categories that formed our coding framework (Schreier, 2012). This method allowed us to handle a huge amount of material, leaving for future investigations all the information that could not be grouped within the coding framework previously established in a thematic mesh (created when designing the data collection instruments).

Finally, to validate the obtained results, a triangulation of the information obtained was made. Triangulation allowed drawing concrete and truthful conclusions from the results, decreasing the potential risk of subjectivity by comparing data of diverse origin. A multiple triangulation was performed, combining data and

methods triangulation. Trough data triangulation we compared the results obtained from each participant profile, whereas through methods triangulation we compared the data obtained with the application of the two instruments (interviews and questionnaires). A first triangulation of the data obtained in each city allowed us to draw a general image of each city's healthcare interpreting services, taking into account as many details as possible. Also, the triangulation of the representative data of each city was triangulated in order to extract the final conclusions of the study, which included topics such as the ones dealt with in this article: the benefits provided by the examined healthcare interpreting services or the negative effects of unprofessional interpreting in healthcare.

3.5. Limitations

We are aware of the limitations of this research, since we were forced to restrict ourselves to a relatively small sample in some cases. Despite the effort made to achieve a comparable volume of data in both cities, this was only achieved for some profiles. This was due to the characteristics of the services, on the one hand (since Montreal's healthcare interpreting services are much more centralised than Barcelona's and, therefore, the number of service managers is reduced to two) and to the restrictions imposed by research ethics in the healthcare field, on the other hand. In fact, research ethics

restrictions complicated considerably the task of getting questionnaires filled in by users of Montreal's services of healthcare interpreting. Nevertheless, this research presents a first inclusive approximation (which takes into account the opinion of all the subjects related to cross-cultural communication through an interpreter in healthcare) to the benefits of professional healthcare interpreting.

4. OVERCOMING COMMUNICATION BARRIERS IN HEALTHCARE

Both cities have different ways of facing communication barriers when allophone users demand healthcare services. At best, interpreting services will be provided to guarantee communication between allophone patients and healthcare providers. However, it must be stated that other methods of communication are also used. These include consultations without intermediary or the use of voluntary interpreters (only in Montreal), as well as the use of gestures, drawings, multilingual linguistic material or multilingual software, or even the intervention of friends or family members (sometimes underage) as accidental interpreters, bilingual health professionals, or phone interpreting services.

4.1. Description of the examined healthcare interpreting services

Having a greater tradition, Montreal's interpreting services have a more solid structure and a greater professional recognition, within the limits of an emerging profession.

In Barcelona, healthcare centres that have interpreting services have few people performing those tasks. Working only in the healthcare sector, they are destined to healthcare centres but contracted by external entities. In Montreal, however, the Interregional Interpreting Bank provides interpreting services to different institutions in the healthcare sector, but also in social services and education. Although these services are available, the Montreal Children Hospital has its own transcultural service (the Sociocultural Consultation and Interpretation Services) where healthcare interpreting services are offered, in addition to multicultural training and counselling.

It is worth noting the greater difference between both cities' healthcare interpreting services, which resides in the chosen professional profile. Barcelona has two different professional profiles in in-person interpreting services in the healthcare sector (intercultural mediators and community health agents), which reveals a lack of consensus in this respect. However, Montreal established the professional profile of the cultural interpreter. To compare the three profiles mentioned, all we need is to

examine their main functions. The following table synthesises the main differences between the three:

Professional profile	Main functions
Intercultural mediator	To facilitate communication between healthcare professionals and users, interpreting the different cultural codes.
Community health agent	To facilitate communication between the parts of the triadic conversation in the healthcare sector. To develop health promotion activities. To provide healthcare advice.
Cultural interpreter	To facilitate communication between professionals and users, interpreting both verbal and non-verbal language, as well as the different cultural signs, without interfering in the conversation.

Table 2. Barcelona's and Montreal's healthcare interpreting professional profiles and their functions.

Differences in the training programs add up to the ahead-mentioned ones. While training requirements for this type of professionals in Barcelona are limited to an intercultural mediation course, in Montreal specific

training in public service interpreting is required. Although this specific public service interpreting training remains quite limited and differs from what could be considered an ideal training for this practice (Burdeus-Domingo, 2015), it is observed that Montreal's professionalism levels are more advanced.

4.2. Benefits of interpreting services in healthcare

Even though the healthcare interpreting services provided in Barcelona and Montreal have different levels of professionalization and face different budgetary problems, there are no doubts that they all have shown to provide huge benefits to the healthcare sector, both at a healthcare institution level and for their professionals, their users and the relationship between them, as well as for society as a whole, although it can be supposed that those benefits are experienced at different levels in each city.

Observing the information collected in the interviews to interpreters of both cities, healthcare interpreting services have provided many benefits to the relationship between healthcare providers and patients. They tend to highlight the following:

1. Better understanding of the conversational exchange.

2. Increased trust between patients and healthcare providers.
3. Increased comfort of patients and healthcare providers in cross-cultural consultations.
4. Increased cultural awareness.
5. Promotion of rapprochement between the parties.
6. Increment of healthcare professionals' safety at work.
7. Improvement of healthcare quality.
8. Improvement of the implementation of treatments and, therefore, of the result of the provided care.
9. Decrease of misunderstandings.
10. Increased appreciation of healthcare services by allophone users.
11. Increased feeling among allophone users of belonging to a healthcare centre.

With regard to the benefits brought by their services to the healthcare centres that require them to treat allophone users, interpreters highlighted that healthcare centres get:

1. To respect the right of allophones to access public health services.
2. To reduce the number of needed consultations.
3. To save time and money.
4. To attend a wider population, making possible a decrease in the risk of exclusion.
5. To improve access to healthcare services.

6. To reduce the number of missed appointments.
7. To bring allophone users closer to healthcare institutions.
8. To promote a reassuring feeling among healthcare professionals.
9. To optimise the exploitation of healthcare resources.
10. To increase success in cross-cultural and multilinguistic communication.
11. To promote the comfort of healthcare professionals within their own work.
12. To increase the accomplishment of treatments.
13. To promote allophone users' communicative independence by not having to rely on their family or friends to ensure communication.
14. To reduce medical errors by increasing the success of medical practices (diagnostics, assessments, etc.).
15. To improve allophone users' trust in the healthcare system.
16. To promote the healthcare centre amongst allophone users, therefore amplifying its number of clients.

When questioned about the benefits bought by healthcare interpreting services to healthcare providers, the interpreters interviewed include in their answers:

1. Saving efforts to initiate communication.
2. Success in communication.
3. Time saving.
4. Increased security and reassuring feelings.

5. Increase of the effectiveness of their work.
6. Avoidance of problems caused by communication failures.
7. Cultural awareness.
8. Reduction in the number of medical errors by increasing the success of medical practices (diagnostics, assessments, etc.).
9. Reduction of confrontations caused by cultural misunderstandings or lack of understanding.

According to the interviewees, society benefits from healthcare interpreting services as long as those:

1. Facilitate access to the healthcare services to allophone users.
2. Make it possible to provide adequate care to foreigners.
3. Promote economic savings in the healthcare system.
4. Facilitate rapprochement.
5. Help to better prevent disease.
6. Eliminate prejudices.
7. Promote cultural awareness.
8. Facilitate allophones' integration.
9. Promote peaceful coexistence: The collected data shows that, in the interpreters' opinions, this is obtained by healthcare interpreting services as they promote the respect of the rules governing each healthcare system, encourage mutual

> understanding, help increasing allophone users' appreciation of healthcare systems, encourage user's integration in society, and make social exclusions decrease.

Finally, the interviewed healthcare interpreters consider that the benefits that their services have provided to their users include:

1. Easier access to healthcare services.
2. Promotion of allophone user's communicative independence, by not having to rely on their relatives or friends to communicate.
3. Reduced risk to see their health worsen due to communication problems.
4. Increased trust on healthcare providers.
5. Possibility to ask questions to healthcare providers.
6. Better understanding of the conversational exchange.
7. Increased reassuring, comfort and safety feelings.
8. Greater success of medical practices (diagnostics, assessments, treatments, etc.).
9. Understanding of the particularities of the local healthcare system.
10. Greater accuracy in the information received.
11. Greater success when communicating in the healthcare sector.
12. Promotion of allophone immigrants' integration.
13. Better knowledge of the services offered by the host society.

4.3. Negative effects of unprofessional interpreting in healthcare

In both studied healthcare contexts, allophone users can be assisted through the intervention of a relative or friend to help them communicate. Barcelona's healthcare professionals often ask them to attend their medical appointments accompanied by a third person able to do so. When they do it, interpreting services are frequently discarded, even if they are available. Instead, in Montreal, family members and friends are only asked to mediate when no professional interpreter is available.

Even though the intervention of family members and friends could eventually work, interviewees from both cities state that, as they have observed when working with patients who have sometimes been treated through the mediation of these intermediaries, they have shown to regularly fail to transmit the healthcare message properly, as they repeatedly commit interpreting mistakes that an interpreter would not make. These mistakes, in our informers' opinion, can, among other things, cause harm to both the user and the healthcare professional. This is because, as they have noticed, although the level of linguistic command family members and friends have is every so often higher than that one of the user who requests their intervention, it is frequently insufficient when it comes to communicating

in specialty areas such as healthcare. Moreover, as specified in the information obtained, the mediation of user's family members and friends violates the user's privacy, as it breaks with the confidentiality principle that governs all healthcare consultations.

The interviewed interpreters claim that some users refuse to address some issues in front of their relatives and friends. They add that, although this can also happen when having the services of an interpreter, it occurs to a lesser extent in the second case, since when they get to know the interpreting services, they are aware that interpreters' code of ethics asks them to safeguard professional secrecy.

Interpreters also considered worth highlighting that, in both cities, there have been cases in which those family members intervening as *ad hoc* interpreters have been minors that attend school in the host country, and, for that reason, they have a certain command of the majority language. According to our informers, this practice is totally discouraged, especially in Montreal's healthcare field, for several reasons, which include the protection of children's interests, who should not neglect their responsibilities (such as going to school, etc.) in order to intervene as *ad hoc* interpreters in other people's consultations, or the stigma that can cause within a family that a young child interprets for their parents, by altering the power relations within it, given the greater

linguistic knowledge of the minor. Also, the interviewees insist that, when a minor user intervenes interpreting in their own case for their parents, they may be able to hide relevant information for their own interest, altering the outcome of the consultation.

5. CONCLUSIONS

When health care providers do not use the existing interpreting services, either because they are not available or because they prefer not to do so, there are many and varied ways in which they establish (or try to establish) communication with allophone users, being the mediation of the patient's relatives or friends the most commonly used.

As we have seen, in Barcelona many healthcare providers tend to ask their patients to bring someone with them to facilitate communication in their consultations (even if there are interpreters available). On the other hand, in the healthcare area of Montreal, the mediation of patient's relatives or friends is only practiced in case of unavailability of interpreting services, in order to avoid information filters caused by non-professional interpreters. This proves that Montreal healthcare professionals have a greater understanding of interpreting, which is with no doubts due to the longer tradition of Montreal's interpreting services. Their experience in the use of these already consolidated and

well-organised interpreting services has allowed them to experience the many benefits that interpreting brings to cross-cultural consultation.

This article corroborates the terrible consequences of using non-professionals as interpreters observed in previous studies, including, as seen in the previous section, aspects such as the loss of relevant information or the disadvantage within the public health system of users from linguistic minorities (Vásquez & Javier, 1991; Cambridge, 1999, etc.). Also, after exposing the benefits of healthcare interpreting services and the negative consequences of the mediation of patients' relatives or friends, we ratify the findings of previous investigations such as that one of Munoz & Kapoor-Kohli (2007), who explain the advantages and disadvantages of this kind of practices. As we have seen, among the advantages of using informal interpreters are the immediate availability and the absence of costs for healthcare centres, while their disadvantages include, as the results of our research have indicated, the breach of confidentiality, interpreting mistakes, lack of neutrality, self-censorship, investment of roles in the family and even truancy (in case of minors).

With regard to professional interpreters, the advantages noted include respect for confidentiality and quality interpretation. However, our results imply the importance of having interpreters formed in healthcare

interpreting (which remains, to some extent, a pending task).

The results of our research have also shown that often, despite the fact that patient's relatives and friends might have a greater linguistic competence in the local language, their mediation hardly ever leads to effective communication. This is because during medical consultations, specialised terminology is used which, although they could be part of the current vocabulary of any native speaker, they are not always part of non-specialist allophones' vocabulary. This idea had been previously exposed by Valero-Garcés (2014) and has been backed up by the present research.

As we have seen, cross-cultural consultations have special peculiarities that only a professional interpreter with a specific training in healthcare interpreting will be able to face, ensuring effective communication. That is why, to conclude, we insist that, while existing healthcare interpreting services provide undeniable benefits, the idiosyncrasy of the healthcare sector and the possible negative consequences of a poor interpreting practice require a greater professionalization of these services, which will adapt this practice to real needs. This professionalization begins with adapting interpreter training to real needs. For interpreters to take their proper place in healthcare settings, they should be properly trained not only in the particularities of clinical

exchange, multiculturality and the healthcare sector, but also in the idiosyncrasy of a specialty so particular and frequent amongst immigrant patients as mental health. This would eventually end up adding to the benefits brought by healthcare interpreting services and reducing the bad consequences brought by poor interpreting practices.

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