The Effect of Work Experience on Interpreting in Mental Health Settings

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Abstract

Interpreters who work in the mental health setting play a critical role in fostering the therapeutic relationship between the mental health professional and the patient. In this study I examined the effect of experience on the efficacy of mental health interpreting. Specifically I examined the decision-making process and strategies of interpreters with general interpreting experience and of interpreters who have experience in mental health settings. Utilizing a pilot case study approach, I analyzed two ASL-English interpreters’ work in a mental health setting. The two interpreters had similar qualities in all facets, except that one interpreter had extensive experience working in a mental health setting, while the other had limited experience. The participants interpreted a segment of a simulated therapy session and then answered a series of questions about their interpreting-related thought process. The results show that the experienced interpreter (a) used more time to interpret the session, (b) asked for more clarifications, (c) paused the therapy session more frequently, and (d) demonstrated a broader range of comparisons than did the non-experienced interpreter. The results of this case study suggest context-specific experience may play a positive role in how interpreters employ interpreting strategies in mental health settings.

Keywords: interpreting skills, mental health, sign language, Deaf/Hard of Hearing, experience
The Effect of Work Experience on Interpreting Mental Health Settings

Communication with individuals who have mental illness can present significant challenges to the psychologist or therapist who is providing treatment. Individuals with mental illness may exhibit symptoms such as being disorganized in their thought processes, using grammatically or phonetically unstructured speech, and experiencing hallucinations and delusions. These symptoms can severely impact the patients’ ability to provide answers to the therapist’s questions during treatment. The challenge is greater when an individual undergoing mental health treatment is Deaf or Hard of Hearing and communication is mediated through an American Sign Language (ASL)-English interpreter (Cornes & Napier, 2005; Sue, Sue & Sue, 2005). The American Psychological Association (1993) states that the responsibility for effective therapeutic treatment lies with the therapist through whom the client receives the needed therapy (Leigh, 1999; Sussman & Brauer, 1999). If the interaction is to be successful the interpreter must be able to manage the challenges and responsibilities of facilitating communication between the therapist and patient.

As with every patient, Deaf patients must trust their therapist enough to openly share their thoughts (DeMatteo, Veltri & Lee, 1986). To guide effective therapy with Deaf patients, the therapist must pay close attention to their patients’ specific medical issues and how they affect the therapy session, must understand the patients’ culture, and must provide necessary accommodations to facilitate the free flow of information (Glickman & Harvey, 2008). While the protocol for appropriate access for effective treatment of Deaf patients is well defined, services in mental health settings are not prevalent in the Deaf community due to the lack of therapists trained to work with this population (Leigh, 1999; Sussman & Brauer, 1999). Currently, there are only two viable options for hearing, non-signing therapists working with Deaf patients who use
American Sign Language (ASL) as their primary language: either (a) become fluent in ASL, or (b) provide therapy via an interpreter (Glickman & Harvey, 2008). Because there are a limited number of therapists who are fluent in ASL, the majority of Deaf patients rely on interpreters to communicate in their therapy sessions with non-signing therapists (Glickman & Harvey, 2008).

When comparing mental health interpreting settings to other settings within the interpreting field, Williams (1993) believes no other interpreting specialization requires the need to possess excellent interpreting competence. Not only must an effective mental health interpreter have superior interpreting ability, but they must also be familiar with the underlying philosophies and therapeutic approaches of mental health (Green, Hawkins, Malcolm & Stewart, 2001). Interpreters who possess characteristics such as the ability to engage in healthy self-analysis and dialogue with the therapist about language-related issues post-therapy session may provide benefits the mental health field.

Ideally, the interpreter works with the therapist to enhance the therapeutic benefit for the Deaf patient (DeMatteo et al., 1986). The responsibilities of the interpreter are to facilitate communication while being mindful of cultural and language barriers. In assuming these responsibilities, the interpreters also become active participants in their interpreting assignment (Nilsson, 2010). Because interpreters serve as active participants in the therapeutic environments with various responsibilities, questions arise regarding the factors that contribute to their decision-making while interpreting in this setting.

This study addresses the issue of whether and how skilled interpreters highly experienced with working in the mental health setting differ from skilled interpreters with limited experience in the mental health context. There are at least three dimensions to consider when researching the interpreting profession generally: the process (i.e., the activity of interpreting), the product (i.e.,
the result of the interpreting activity), and the producer (i.e., the interpreter) (Nilsson, 2010). This study focused primarily on the second and third dimension— the producer based on their product. The literature on interpreting in mental health settings indicates that an untrained bilingual cannot provide adequate interpreting services in this setting (Bot, 2005). Rather, therapy requires professional interpreters who have a high degree of linguistic fluency in their two working languages. In this study, I ask, “How does experience, irrespective of linguistic capabilities, affect the decision-making process of the interpreter in mental health settings?”

Learning more about the strategies and decisions utilized by experienced interpreters in mental health settings will provide useful information for interpreting practitioners, mental health professionals, and members of the Deaf community. In what follows I will describe the method of acquiring the data necessary to examine this issue, present the findings, and discuss the implications of context-specific experience for interpreting in the mental health setting.

**Method**

In order to examine differences between skilled interpreters with much or little experience in mental health settings, two ASL-English interpreters were videotaped as they provided interpretation in a (mock) mental health therapy session. Due to the need for privacy in mental health treatment, actual therapy sessions with Deaf patients were not used in this research study. Ko and Goebert (2011) recommend establishing a substantial relationship with patients before requesting to videotape their sessions. Even then, the patient’s mental state also must be considered. In any case, contemporary videotaped therapy sessions with Deaf patients were not readily available and thus were not incorporated into this research project. Instead, mock scenes were created based on a commercially produced video recording of a therapy session. The video was analyzed for differences in how each interpreter utilized interpreting strategies, such as
requests for clarification or use of simultaneous (i.e., *continual*) versus consecutive (i.e., *turn-taking*) interpretation.

**Participants**

Two actors, one hearing and one Deaf, simulated the 15-minute segment of a therapy session between a hearing therapist and Deaf client. Two individuals were enlisted by the Department of Psychology at Gallaudet University for the roles of “therapist” and “patient.” The hearing individual served as the therapist, and the Deaf individual served as the patient. Both the therapist and the patient were female graduate students at Gallaudet University and were between the ages of 20 to 25 years old. The purpose of recording the dialogue between the therapist and patient during the mock therapy session was to create identical source material for the interpreters.

Two ASL-English interpreters were the participants in this study. Interpreter A, who was designated as the *more experienced* interpreter, worked in the mental health setting 11 years, while Interpreter B, who was designated as the *less experienced* interpreter, worked in the mental health setting sporadically over a period of three years. Both interpreters were certified by the Registry of Interpreters for the Deaf (RID), and were compensated for their involvement in the study. The interpreters’ credentials were intended to be similar except for the number of years they had interpreted within the mental health setting. This difference was the independent variable manipulated for the study. Experience in mental health interpreting notwithstanding, both interpreters were credible professionals who were recommended for this research project on the basis of their commensurate education, training, and overall interpreting experience, which made them well suited for the goals of this study.

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1 From here forward, references to the therapist and patient will refer to the mock therapist/patient.
2 See Table 1, page 21.
Materials and Procedure

Mock therapy session recording. The DVD series used to create the therapy session was entitled, “Diagnosis According to the DSM-IV: A Newbridge Professional Program” (Wohl, 1994). This series contains 15-minute segments of actual therapeutic sessions between patients diagnosed with a variety of psychological disorders and their therapists. I selected a 15-minute segment of the video to simulate a therapy session involving a Deaf patient and a hearing, non-signing therapist. The taping of the mock therapy session took place in the Counseling Center at Gallaudet University in a room arranged to resemble that of the therapy session in the commercially produced DVD. Two video cameras within the room captured the footage of the participants. The actor participants received the script to prepare for taping the mock therapy session and compensation for their participation in creating the video.

Context for interpreting assignment. The interpreters received the following information prior to interpreting the simulated therapy session:

Patient A has a long history of bipolar disorder, or possibly schizoaffective disorder, bipolar type. Reasons for this psychiatric appointment will be to discuss recent events, which led to this particular session, and to assess the current severity of the patient’s mental state.

Mock therapy sessions. I asked each interpreter to allot two hours in order to complete paperwork, check logistics, and complete the mock therapy session and follow-up interview. At no time were the participants informed of the focus of the research project. The observation room featured one camera focused solely on the interpreter and a second camera focused on the interpreter and the TV monitor displaying the mock therapy session on DVD. The interpreters were seated in front of the TV monitor, which enabled them to have a clear view of both the
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patient and the therapist. The TV monitor was connected to a laptop, which enabled me to see what the interpreters were observing while interpreting the session. In addition, the observation room contained a one-way window, which allowed me to observe the interpreters without being in the room.

I provided an explanation to the interpreters of how to do the mock therapy session. They could pause the videotaped sessions as many times as needed in order to render their interpreted. Furthermore, they could review portions of the session if they needed clarification of the message. I left the room once the interpreters were ready, and they then interpreted the mock therapy session. Due to the nature of the pausing and starting of the video, the interpreters mentioned periodic “jumping” of this DVD.

**Follow-up interviews with participants.** Using the following protocol, I interviewed each interpreter individually after she had completed the mock therapy session:

- Is this typical of your work?
- Were there any segments that you found particularly challenging? If so, how did you manage the task of interpreting those segments?
- Is there anything you already know you would interpret differently the next time?
- Is there anything you would change if you could redo the interpretation?

These questions were asked to gather insights regarding their decision-making and thought processes while interpreting the session. The questions were asked in the same order for both participants. Follow up questions were employed for purposes of clarity; otherwise I simply listened and took notes. Each interpreter answered the questions; they then reviewed their mock therapy session interpretation with me and described the thought process and rationale behind their decisions.
The videos of both interpreters were converted into QuickTime files and uploaded into the Eudico² Linguistic Annotator (ELAN), a language archiving technology program, which allowed for effective navigation through the interpreted sessions and labeling of specific portions of the videos. Taping these interviews ensured multiple opportunities to review and analyze the data accurately. In addition to analyzing thought process, I also carefully analyzed the video data in its entirety multiple times, documenting differences in the interpretations of both interpreters.

Results

The differences were noted in: (a) time to complete session, (b) requests for clarification, (c) frequency of pauses, (d) number of comparisons, and (e) semantics of signs used. These differences in performance and sign variation are presented in Table 2. The findings may be summarized as follows:

- The more experienced interpreter took six minutes and 42 seconds longer than the less experienced interpreter;
- The less experienced interpreter requested clarification five times fewer than did the more experienced interpreter (with the exception of some technological issues on requests for clarification);
- The more experienced interpreter paused the mock therapy session in order to render her interpretation 50 times more than the less experienced interpreter did; and
- The more experienced interpreter included four more comparisons than the less experienced interpreter did.³

³ See Table 2.

In discussing the signs used by the interpreters, ASL gloss was used. ASL gloss involves the usage of the English text to signify sign language and is typically displayed in small capital
letters (Vicars, 2012). In the simulation, the patient complained of “hearing voices.” When rendering the interpretation of the English phrase “hearing voices,” three interpreted variations occurred: (a) producing the sign MESSAGE (in capital letters to indicate the sign in ASL), (b) incorporating the patient’s sign, such as depicting verb (dv): talking above and around head, or 3) a combination of 1) and 2). Table 3 provides a summary of interpretations for the term “hearing voices.” Of the nine times the more experienced interpreter interpreted “hearing voices,” she signed MESSAGE two times, dv: talking above and around head a total of four times, and a combination of the patient’s sign choice and MESSAGE three times. For the interpreter less experienced in mental health settings, out of the 10 instances she interpreted “hearing voices,” one time she signed MESSAGE, seven times she used the patient’s sign of dv: talking about and around head and two times she used both the sign MESSAGE and the patient’s sign choice.4

Post Hoc Commentary

The more experienced and less experienced interpreters were individually interviewed immediately following their interpretation of the mock therapy session. I asked each interpreter to discuss her thought processes and interpreting decisions while watching the video of her interpretation.

Time to complete session. The more experienced interpreter stated, “…I’m thinking I want to make sure that I get everything; I don’t want to forget anything, so let me pause it and say just that much.” This statement suggests the more experienced interpreter may have placed emphasis on making sure she interpreted the message and overall content clearly and fully, resulting in a longer period of time to complete the mock therapy session in comparison to the less experienced interpreter. The goal of professional interpreters is to interpret the content

4 See Table 3.
clearly and fully. In this context, it could be considered significant that the more experienced interpreter would stress taking her time, which may indicate a greater sensitivity to the possibility of missing important information given the mental health complication.

During the interview, the less experienced interpreter expressed regret about moving quickly through the mock therapy session instead of using the mouse to pause the video when needed. She stated, “I felt myself signing very quickly, [thinking] ‘Okay moving on; now what was next?’ So maybe [next time] taking a moment to say, ‘Okay, what was this therapist asking and what would be the most effective way to sign that?’” It may be the less experienced interpreter was inherently less intuitive about the ramifications of mental health as the experienced interpreter. With additional experience she may develop those skills. Conducting a study with more participants would help elucidate the role of experience.

**Requests for clarification.** When asked about the frequency of clarifications, the more experienced interpreter said:

I’ll judge that decision of interrupting the patient based on how upset they are at the moment. If they’re describing something very terrifying, or something very emotional, and I don’t have it exactly right at that point, I might not interrupt at that moment because I feel that it might be more important for the therapist to see this episode rather than get the exact details.

The more experienced interpreter also said that if she thought the details would be important, such as in relaying an actual experience, she might interrupt to be certain of details, but if the patient were really caught up in telling the story, then she would be less inclined to interrupt. The experienced interpreter was making the decision that the behavior of the patient was as important to the therapist as what was being said. This was not only an interpreting
decision, but perhaps a therapeutic decision as well. She explained that, in the mental health setting, interruptions can be detrimental to the therapeutic process, meaning interruptions need to be strategic and need to take into consideration the patient’s welfare.

In regard to an interpreter’s need to review portions of the mock therapy session for clarification, the less experienced interpreter commented on how she handled missed information:

If I have a sense that the [information] is something that I should not [gloss over],
then I won’t drop it. [However,] in a real life setting, I would be a little more assertive in saying, “I didn’t understand that,” or “I’m going to have to get that again,” because every word can be so important.

This perspective was supported by four instances of this less experienced interpreter’s requesting clarification throughout the mock therapy session, compared to the more experienced interpreter’s nine instances. Overall, there might be the implication that concern for clarity and detail is critical to the therapeutic process is present in the greater number of requests for clarification and the pauses to review in the experienced interpreter’s performance compared to the less experienced one.

**Frequency of video pauses.** The more experienced interpreter tended to treat the mock therapy session as a consecutive interpretation by pausing after every question posed by the therapist. She also thought she paused too much during some of the patient’s dialogues, explaining, “Some of these were little stories embedded in the whole [dialogue], and now I think I should have just watched the whole story, paused it, and then told the story.” The less experienced interpreter seemed to treat the mock therapy session more like a simultaneous
interpretation, only pausing for larger chunks of information. The less experienced interpreter stated:

I have such a hard time with the whole consecutive [versus] simultaneous [interpreting methods]. Should I do a whole question-answer pair, [or just] the whole question…there are real differences about what [an interpreter’s training] has included, and my training did not include consecutive interpreting at all, so I’m not comfortable with it, so I thought, “I’ll let [the DVD] go.”

Here the less experienced interpreter states her training did not include consecutive interpretation, which may have been common practice when she earned her degree; thus she did not want to pause the mock therapy session as frequently, which could be a reason her time was shorter the more experienced interpreter’s time. However, she did agree that, in utilizing a time-pressured simultaneous interpreting approach, she ran the risk of being less accurate.

**Number of comparisons.** While the less experienced interpreter did not include any additional comparisons besides the therapist’s explicit comparisons, the more experienced interpreter explained the reasoning behind her decision to set-up comparisons in her interpretation:

Overall I think I do make some decisions in mental health setting to add extra clarity that may involve…setting up questions like, “Is it this or that?” If the therapist says, “Is it this (the experienced interpreter raises/changes the intonation in their voice)?” I know [the intonation] means “or that?” so I will give the Deaf patient both options.

When asked why she felt the need to make such a decision, the more experienced interpreter stated, “…why I do that in [a] mental health setting is because [the patient] can start having
symptoms and ‘checking out’ of their appointment.” Once again, this is a therapeutic decision that could presumably come from the interpreter’s experience with patients in the mental health setting.

**Sign variation.** Although sign variations occurred throughout the interpretation, I chose to focus on the phrase *hearing voices* for this analysis because it is a critical aspect for the therapist to understand the symptoms of the patient. Interpreting the therapist’s phrase *hearing voices* into ASL, the less experienced interpreter followed the patient’s sign choice more closely than the more experienced interpreter. The less experienced interpreter stated that after she saw the sign the patient used she decided to use that same sign throughout the rest of her interpretation.

She used the patient’s sign seven times, only including the gloss sign of MESSAGE in her interpretation a total of three times, compared to the more experienced interpreter’s five times. The more experienced interpreter’s response was substantial:

> So *hearing voices*, this is something mental health interpreters’ talk about a lot. With consumers who are more English-based they will sign HEAR VOICE, [and] will even say, “Yeah I’m adjusting my hearing aid, and it doesn’t help.” They literally think that it is auditory stimulation; they experience it as auditory stimulation, which is fascinating. We commonly use this (signing MESSAGE in front of their forehead), or this (signing TALK in front of their forehead). [During the mock therapy session] it was mentioned first from the therapist, so I thought, “So I’m going to have to do some of these [signs]” and then I picked up on what sign [the patient] was using, and so I said, “Okay that’s fine,” and from then on I would sign MESSAGE and pair it with [the patient’s] sign.
As with clearly explaining via her interpretation the therapist’s implied comparisons, the experienced interpreter chose more often to combine her sign choice with the patient’s own sign.

Overall, the results suggest distinct differences in interpreting strategies used by the more experienced interpreter and the less experienced interpreter in the mental health context. The more experienced interpreter yielded larger numbers in the categories of time, clarification, signs, pausing, and comparisons. The more experienced interpreter made conscious decisions in pausing the therapy session and reviewing sections for the sake of clarity, because, as she explained, “it’s just extra important that I am as clear as I can be if [the patient] is already in a confused mental state.” The more experienced interpreter may have recognized the need for “paying attention to many subtle factors which may have therapeutic significance” (Green, et al., 2001, p.19). The data suggests the more experienced interpreter might have made more specific decisions based in the mental health setting, when compared with the less experienced interpreter. As mentioned previously, it is reasonable to deduce that any professional interpreter would try to provide accurate interpretation in the mental health (or other) context, but it may be that they will pursue that objective in different ways. The more experienced interpreter seemed to focus more on content because she wanted to make sure the therapist’s questions were clear for the patient so that the patient’s responses would reflect their mental state, thereby leading the therapist to an accurate diagnosis. The experienced interpreter approached her interpretation differently (i.e. wanting to pause more to be sure they interpreted each part). In what follows I will discuss these differences in terms of the possible implications for mental health professionals.

Discussion
There were four primary differences between the more experienced interpreter and the less experienced interpreter in their interpreting product and one difference in the *hearing voices* interpretations. I will present the primary differences between the two interpreters and offer some reasons as to why the differences could exist and, further, how interpreting experience may have impacted those differences.

The first difference occurred in the length of time needed to complete the mock therapy session. The more experienced interpreter took longer than the less experienced interpreter, possibly because the more experienced interpreter directed more attention to how the language should be interpreted in ASL order to achieve the equivalent message stated in English and vice versa. For example, she indicated concern about making choices appropriate to the objectives of the session. In order to make the message culturally appropriate and in the patient’s native language, the more experienced interpreter possibly realized she needed to make sure she took time to set-up her interpretation in a manner most effective, hence requiring more time to contemplate decisions. Also, the more experienced interpreter incorporated signs from previous questions in order to establish context and improve the clarity of her interpretation, resulting in a longer interpreted session.

Next, the more experienced interpreter also requested more clarifications in the message than did the less experienced interpreter. Although it may appear counterintuitive to say so, experience could contribute to this difference as the more experienced interpreter may have wanted to make sure that every aspect and nuance of the therapist’s question was included in the interpretation and that the patient was coherent and taking in the interpretation correctly. Also, she may have been more aware of what the therapist and patient did not know—but needed to know—in order to provide clear messaging for the involved parties. This realization may have
caused the more experienced interpreter to pause the session in order to allow herself the opportunity to render an equivalent interpretation; in other words, she noticed the current mental state of the patient and worked to make sure the interpretation was as true to the patient’s language as possible.

In framing the interpretation the more experienced interpreter used more comparisons than the less experienced interpreter. The more experienced interpreter may have decided this in response to the therapist’s wanting to know if the response was due to one reason or the other. Regardless of whether the presentation of options was stated in an explicit or implicit manner, the more experienced interpreter interpreted the question using a comparison, which made the options explicit. This increased frequency of comparisons again could be based on experience level as the more experienced interpreter knew what kind of response the therapist was seeking. Thus, she presented her ASL interpretation in a manner that yielded a response and enabled the therapist to gather the needed information and make a diagnosis.

The sign choices of the more experienced interpreter displayed appeared to display consistency with the patient’s sign choice. This practice might represent experience as the more experienced interpreter deemed it important to display consistency throughout her interpretation. The different pattern of sign choice of the more experienced interpreter may not mean the less experienced interpreter was inadequate in her work; however, the differences found in this study suggest that the less experienced interpreter might have missed the subtle nuances of communications that occur in the mental health setting, which the more experienced interpreter recognized and rendered in her work. This insight suggests that the more experienced interpreter may have learned from repeated experiences with patients who might be, in her words, “having
symptoms” and “‘checking out.’” She also may have learned from possible conversations with mental health professionals about how to address that contingency.

Further research needs to be conducted in this area in order to validate and build upon these results. Questions may include the following: What are the similarities between a skilled interpreter with experience in mental health settings and a skilled interpreter without experience in mental health settings? What are the preparation strategies of interpreters experienced in mental health settings? How do interpreters handle a therapist’s implicit questions when dealing with patients who display symptoms and behaviors characteristic of psychosis? Future research projects could address the differences in overall experience compared to novice interpreters, and/or survey the mental health interpreting community for what educational components positively affected their mental health interpretation. Experience in most settings will improve proficiency, but the question for future research is whether experience in the mental health context is beneficial enough to require or recommend more education or mentorship for people interested in interpreting in the mental health setting.

As with any research study, various factors can impact the integrity and generalizability of these research findings. First, the quality of the mock therapy session DVD could impact the interpreter’s ability to interpret the message. In fact, the video containing the mock therapy session periodically jumped during both interpreters’ recording sessions, resulting in possible instances where the interpreters may have missed information. In one such instance it is clear that the video jumping did impact the more experienced interpreter’s ability to receive information needed for her to render her interpretation because she noted the issue. Second, the mock therapy session was pre-recorded and viewed from a TV monitor, which was not an
authentic interpreting situation. The interpreters were not able to engage fully with the therapist and patient in the same manner as that which occurs in an actual therapy session.

A third issue is that the mock therapy session was adapted from an actual session for a hearing patient, instead of a Deaf patient, making the video less authentic in the re-enactment of a therapy situation involving a Deaf patient. Next, having only two interpreters as participants limited the generalizability of the results. Lastly, the less experienced interpreter had three years of sporadic encounters of mental-health related interpreting experience. This experience in mental health interpreting could have impacted her interpretation to some extent because she was mildly familiar with what takes place in the mental health setting. Thus, the differences were less stark than they might be between someone with no experience and someone with much experience.

Taking these factors into consideration, I suggest that future research should include a larger sample size, and have the patient and therapist in the room with the interpreter during the data collection phase of the research.

**Conclusion**

Interpreters receive information from a participant of one culture, interpret this information appropriately from one language into another while being mindful of cultural differences, and deliver that information to the awaiting participant of another culture (Kaufert, 1990). In taking on this responsibility the interpreter serves as an active participant in the interpreting assignment. Within the mental health arena in particular, the interpreter works with the therapist to enhance the therapeutic benefit to the Deaf patient during the therapy session (DeMatteo et al., 1986). What impact does experience have on the interpreter’s decisions in terms of incorporating interpreting strategies? In what ways does another skilled interpreter, who
is knowledgeable about mental health issues but lacks experience, differ from an interpreter experienced in mental health settings? This research may have begun to reveal some differences in the categories of length of time to complete the mock therapy session, requests for clarification, frequency of video pausing, and sign variation. This study provides an examination into how experience shapes performance through a case study of two interpreters with comparable interpreting skills but with differential experiential backgrounds in the mental health setting. These findings suggest the importance of experience in interpreters’ ability to render thoughtful and effective interpretations in this critical area of Deaf individuals’ lives.
Table 1

*Participants’ Credentials*

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<tr>
<th></th>
<th>Interpreter A</th>
<th>Interpreter B</th>
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<td>Years of age</td>
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<td>RID Certification</td>
<td>CI, CT</td>
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<td>Years of professional experience</td>
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<tr>
<td>Years interpreting in mental health settings</td>
<td>11</td>
<td>3</td>
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*Interpreter B had experience interpreting in the mental health setting on an irregular basis.*

Table 2

*Comparison of Four Features of Interpreters’ Product for Mock Therapy Session*

<table>
<thead>
<tr>
<th>Features</th>
<th>More Experienced</th>
<th>Less Experienced</th>
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<td>Requests for clarification</td>
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<td>4</td>
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<tr>
<td>Frequency of video pauses</td>
<td>61</td>
<td>11</td>
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<tr>
<td>Number of comparisons</td>
<td>6</td>
<td>2</td>
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*One of the requests for clarification was due to a technical error with the DVD.*

Table 3

*Instances of Interpreting “Hearing Voices”*

<table>
<thead>
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<th>Variations of interpretation</th>
<th>Experienced</th>
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<tr>
<td></td>
<td>More</td>
<td>Less</td>
<td></td>
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<td>Use of gloss</td>
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</tr>
<tr>
<td>Patient’s sign</td>
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<td>7</td>
<td></td>
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<tr>
<td>Combination of gloss and patient’s sign</td>
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<td>(1:7:2)</td>
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References


