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Working through interpreters

Saeed Farooq & Chris Fear

Abstract Language is the essential psychiatric tool for eliciting both history and mental state. Both diagnosis and treatment are handicapped if there is no common language between doctor and patient and understanding is facilitated through a third party, who usually has no psychiatric training. Many factors can affect this process resulting in a convoluted interview and greater potential for misunderstandings and diagnostic errors. Linguistics and the use of interpreters are rarely mentioned in standard psychiatric texts. The different processes of translation and interpretation and their use in psychiatry are explored here. The variety of errors and pitfalls described in the literature are considered. The authors offer advice on the use of trained and untrained interpreters in order to minimise errors and make the most of the information available.

Language is the principal investigative and therapeutic tool in psychiatry. Interference with communication impairs our ability to assess a patient comprehensively. Nowhere is this more apparent than in the situation where patient and professional are separated by a language barrier, creating a state of dependency on an interpreter, who holds the key to mutual understanding. In today's multi-racial society, particularly in larger cities, it is not uncommon to encounter such a situation, where particular skills are required of both interpreter and doctor. Nevertheless, the study of linguistics in relation to psychiatry is rarely mentioned in psychiatric texts, where disorders of communication are often seen as a consequence of disordered attention and the important influences of social cognition and context are ignored (Thomas & Fraser, 1994).

In the early 1990s, it was estimated that there were 20–30 million refugees and displaced persons in the world, together with many more-temporary non-native residents in the form of students and tourists (Jablensky, 1994). Migrant populations exhibit a higher incidence of mental illness compared with native populations (Westermeyer, 1989). Moreover, in some countries there are diverse native populations between whom communication is problematic. For example, four entirely different languages are spoken in Pakistan's North-West Province, which has a population of only 10 million or so. Tourists introduce further languages and cultures to the mix. People with different forms of disability may also have specific language difficulties. For example, several different forms of sign language are used around the world by those who have impaired hearing.

The few studies that have addressed this issue in British hospitals have concluded that the quality of communication tends to be poor. In the samples used for two surveys of British Asians in hospital, more than half had experienced difficulties in communication and reported dissatisfaction with existing interpretation services (Stevens & Fletcher, 1989; Madhok *et al*, 1992). Similarly, in a survey of 1000 professionals working in different psychiatric services in Australia, more than one-third reported having contact, at least on a weekly basis, with patients with whom effective communication was either limited or impossible because of language barriers (Minas *et al*, 1994).

Language and symptom recognition

Foster (1992) defined bilingual people for whom English is their second language as those 'who function with varying levels of proficiency in the English-speaking work-a-day world, but who may dream, express surprise, count their change, make love or soothe a child in their mother tongue'. Psychoanalytic work with bilingual people through their second language appears to be less effective than through their first language (Greenson, 1950), possibly because using the former does not allow access to important areas of the intrapsychic world.

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Language has been found also to have a significant influence on presenting symptoms. Work with bilingual Spanish patients found more-obvious evidence of psychosis in subjects when they were interviewed in their mother tongue than when they were interviewed in English, their second language (Del Castillo, 1970). In a further study, of bilingual Spanish patients with schizophrenia, interviews that used a single set of questions but asked them in both Spanish and English, were rated by experienced English- or Spanish-speaking psychiatrists as showing more psychopathology in the part of the interview conducted in Spanish (Marcos *et al*, 1973). More-frequent misunderstandings, briefer answers and higher occurrences of speech disturbance were rated in the English section of the interview. From this it has been inferred that bilingual people are more likely to experience psychotic symptoms in their own native language, possibly because this allows a freer association of ideas. These studies suggest that, even when the use of the patient's native language is not apparently strictly necessary to ensure understanding, the information gathered from an interview in the native tongue is likely to be more meaningful and to give a clearer representation of the patient's psychopathology.

Interpretation and translation

Many hospitals and local authorities maintain lists of interpreters. Working through an interpreter provides an opportunity for patients to present symptoms in their own language, but it also adds other dimensions to the interview process. It must be remembered that interpretation is a very much more complex process than is word-for-word translation. Rather than the simple substitution of one language for another, it calls for the deciphering of two linguistic codes, each with its own geographical, cultural, historical and linguistic traditions. Furthermore, possible complications introduced by adding two more relationships to the interview (interpreter–patient and interpreter–interviewer) should not be underestimated.

The accuracy of meaning is lost where an unskilled interpreter simply translates. This is well illustrated in the cases of two suicides by Spanish-speaking patients who had been managed by English-speaking psychiatrists working through interpreters. It was concluded that the patients' emotional suffering and despair were underestimated in the interpretation process (Sabin, 1975). The few studies (reviewed below) which have attempted to examine the role of interpreters in psychiatric interviewing have been based largely on analyses of audiotapes of interviews. Although a range of difficulties has been identified, there have been many methodological problems, including a lack of control groups, use of unqualified interpreters and unstructured interviews. Furthermore, the studies failed to relate errors in interpretation to outcome of the interview. These issues were addressed in a study by Farooq *et al* (1997), which recognised the following categories of error (examples of which are given in Table 1).

Omission

In omission, the message is completely or partially deleted by the interpreter. This is more likely to occur in questions about sensitive personal issues such as sex and finances, especially when the interpreter is a family member or has a personal conflict of interest. Even minor omissions may be of considerable importance. In the example in Table 1, parts of the message, and the patient's ambivalent response, were not transmitted.

Addition

This is where the interpreter includes in the answer information not expressed by the patient.

Condensation

In condensation, a complicated or lengthy response is simplified and explained, possibly with the use of paraphrase. This is a particular problem when assessing patients whose thoughts are disordered and whose response is incoherent to the interpreter, who is usually a layperson.

Substitution

Substitution refers to the interpreter's replacement of one concept by another. In many such cases, the original question might have been better worded or the interpreter might have sought clarification.

Role exchange

In role exchange, the interpreter takes over the interview, replacing the interviewer's questions with his or her own.

Closed / open questioning

The way in which the psychiatrist asks the question (making it open or closed) is altered by the interpreter, which may lead to a different answer from the patient. Alternatively, the interpreter may explore the response to the psychiatrist's open question with further closed questions, delivering the results of his or her own investigation rather than obtaining an accurate response to the original question.

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Table 1 Examples form the literature of interpretor error

Error category (reference)	*Examples of error*
Omission (Marcos, 1979)	Clinician: 'Do you feel sad or blue; do you feel life is not worth living sometimes?' Interpreter: 'The doctor wants to know if you feel sad or if you like your life.' Patient: 'No. Yes. I know that my children need me. I cannot give up, I prefer not to think about.' Interpreter: 'She says that she loves her children and that her children need her.'
Addition (Launer, 1978)	Patient: 'When I go to the toilet, I pass stools with difficulty.' Interpreter: 'He has severe pain when passing stools.'
Condensation (Farooq et al, 1997)	Patient: 'When I was born I have left land, land of India, Handsworth and Bengal. Prime Ministers sign, nations kept fighting, Rajah came to me …' Interpreter reported this as reflecting grandiose delusions of involvement with the Prime Minister of India to prevent war.
Substitution (Putch, 1985)	In the following example, the interpreter could not translate the word 'allergy' as there is no equivalent in the Navajo language. Physician: 'M., would you ask her if she is allergic to any medication?' Interpreter: 'Does white man's medicine make you vomit?'
Role exchange (Putch, 1985)	In this example, the psychiatrist was preparing to prescribe medication for a Vietnamese patient with a generalised anxiety disorder. Psychiatrist: 'Ask her how long she thinks she will need to take medication.' Interpreter: 'He says you should take this medication for two weeks and then come back and see him.'
Closed / open questioning (Farooq *et al*, 1997)	Psychiatrist: 'Do you feel happy or sad in your spirits?' Interpreter conveys this accurately. Patient: 'If I am not unhappy or sad … [pause] … then I am happy.' Interpreter (without relaying the response): 'Do you feel sad now?' Patient: 'Yes.' Interpreter: 'She is unhappy.'
Normalisation (Marcos, 1979)	Psychiatrist (through interpreter): 'Is there anything that bothers you?' Patient: 'I know, I know that God is with me, I am not afraid, they can't get me …I am wearing these new pants and I feel protected. I feel good, I don't get headaches any more.' Interpreter: 'He says that he is not afraid, he feels good; he does not have headaches any more.'

Normalisation

This is peculiar to interpreter-mediated psychiatric interviews. The interpreter attempts to make sense of the patient's phenomenology, missing the point of the psychiatric interview.

Problems peculiar to psychiatry

There are also more-subtle ways in which interpretation may affect the quality of a psychiatric interview. Many questions asked by psychiatrists could be considered to be presumptuous, at best, if presented without the benefit of empathic expression, and this may damage the quality of the rapport or, worse still, provoke a hostile response. In dealing with a lengthy response, background information may be excluded, distorting the context and making the answer appear illogical or tangential, and this can lead the interviewer to consider the possibility that the patient has thought disorder.

Cultural issues are of huge importance in these situations – both those of the patient and of the interpreter. Both Putch (1985) and Westermeyer (1990) give examples of situations in which interpreters actively dissuaded patients from disclosing vital information which was seen as stigmatising their culture or religion. In other situations, patients' views concerning traditional practices and therapy may be withheld in the interests of 'protecting' the patient from medical authorities.

Finally, the indirect nature of an interpreter-mediated interview is an interruption of the process of psychiatric assessment, which combines form and content of speech, facial expressions and bodily movements to reach an impression of mental state. In these circumstances, the process of using an interpreter has been likened to first watching television without sound, then receiving the sound without the pictures, and later trying to combine the two (Kline *et al*, 1980).

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Other sources of error

So far, we have concentrated on sources of error arising from the actions of the interpreter. However, it should be remembered that the clinician's competence and familiarity with the use of interpreters are also extremely important. In the first meeting with a new patient, there is an understandable desire to obtain as much information as possible as quickly as possible to allow an early assessment of mental state. This may lead to the recruitment of the patient's friends, or even other patients, to help out. It is a widespread misconception that being bilingual automatically qualifies a person to be an interpreter. Apart from confidentiality issues, any deficient linguistic or translating skills of the individual, his or her lack of understanding of the clinical situation, and of mental health in particular, and his or her relationship with the patient are likely to magnify any of the errors of interpretation already discussed. Further complications arise from role conflicts (e.g. for a patient's friends or family) or an inadequate understanding of cultural values, as distinct from language.

The process will be further complicated if a clinician speaks quickly, uses long sentences or fails to use 'laymen's' language. Talking to the interpreter about the patient using the third person invites a conversation about them rather than with them, and raises the interpreter from the position of facilitator to participant, distorting the process still further. A clinician conducting an interview involving two or more people with an alien language and culture may feel threatened by the situation and easily become overwhelmed. In such circumstances, the interpreter may lose sight of his or her role and the situation of 'role exchange' becomes more likely, with the interpreter taking over the interview.

Interviewing through an interpreter is difficult enough in simple history-taking exercises, but the problems experienced in conducting a mental state examination are formidable. Using a methodology which employed both qualitative and quantitative measures, Farooq *et al* (1997) recorded many errors in translation that muddied the meaning of the verbal responses. Interviews were conducted both in English, through an interpreter, and in the patient's own language by a psychiatrist fluent in that language. Errors were also found in the rating of symptoms and these could be minimised by the use of an experienced interpreter.

It has been suggested that unfamiliarity with psychiatric work makes even the most sophisticated medical interpreter an emergency translator (Westermeyer, 1990). Moreover, in states of anxiety, delusion, depression or thought disorder, patients frequently lose their ability to communicate freely in an acquired language, making an interview with a bilingual patient in their second language unreliable (Marcos *et al*, 1973). Significant factors affecting this reliability include the age at which the second language was acquired, its day-to-day use at home and work, the patient's attitude to primary and secondary languages and the clinical picture.

Similar considerations should be applied to health professionals who are bilingual, particularly if their second language was acquired in the classroom, as they are likely to use too learned a 'register', the linguistic term defining the social/intellectual level at which a language is pitched. This can result in discomfort, causing a patient to see their own speech as unpolished or rustic and may interfere with effective communication.

The interpreter in psychiatric practice

For clinician and interpreter to work together effectively, each requires a knowledge of the other's style of work and of what can reasonably be expected (Box 1). This improves with practice, so that the doctor learns to ask translatable questions and the interpreter to render 'nonsensical' responses verbatim. It is important that interviewer and interpreter meet before the interview, to clarify the goals of the psychiatric assessment, the main areas to be assessed and any sensitive issues that are to be explored (e.g. relationships or suicide). It may be necessary to discuss the importance of confidentiality, the need for translation of documents and the problems that can arise if the interpreter tries to 'make sense' of a patient's verbalisations. It should be remembered that an interpreter-mediated interview will take up

Box 1 Tips for working with an interpreter

- Meet with the interpreter before the interview to explain its purpose and goal
- Speak slowly and clearly
- Use simple, 'layman's' terms where possible
- Speak to the patient, not the interpreter
- Clarify confusing responses
- Ask for a verbatim translation if the response is still unclear
- Avoid taking notes: concentrate on non-verbal behaviour
- Meet with the interpreter afterwards for feedback
- Remember to ask the interpreter for his or her impression of the normality of conversation
- Practice

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to twice as long as a standard clinical interview and will require considerable skill and patience from clinician and interpreter alike.

In the interview, addressing the patient directly instead of through the interpreter helps to establish a better rapport and give control of the interview to the clinician. Questions should be planned in advance so as to make the best use of the time available. Long questions, excessive jargon and use of the passive voice will make an interview more difficult. Breaks while the interpreter is speaking to the patient should be used by the clinician to observe the patient's non-verbal behaviours, helping to gain non-verbal clues to the patient's mental state and enabling the next question to be framed more appropriately. Writing notes during these breaks wastes the opportunity to acquire valuable clinical data and should be avoided. A statement that is inconsistent with a patient's non-verbal behaviour should be explored by changing the wording, breaking down the question or asking about a related issue. A post-interview meeting with the interpreter is essential to clarify the interview material and the dynamics of the interaction.

It has been found that these provisions, coupled with the use of a qualified and experienced interpreter, minimise the occurrence of qualitative distortions. The process provides a reliable method for making clinical observations and results in a reliable diagnosis (Farooq *et al*, 1997). However, while this is the standard for which to aim, the reality of clinical practice may require information to be gathered in less than ideal circumstances, greatly magnifying the potential for error.

Occasionally, a situation is encountered that forces the use of a relative or friend of the patient, or even another patient, as an interpreter. Where possible, these situations should be avoided, given the sensitive and confidential information being captured. Interviews using such interpreters should be confined to essential information and arrangements should be made for a second, more appropriate interview to be conducted using a qualified interpreter. It must be remembered that the use of such emergency interpreters will greatly increase the number of errors, particularly those involving role conflict and normalisation. Responses such as 'does not know …' or 'talks irrelevantly …' should be explored further to look for errors or psychopathology: in such situations, a verbatim translation should be requested. The interpreter may have his or her own agenda or insecurities in such settings. During the interview, however, it is important to keep a focus on the patient. Interpreters' questions and insecurities should properly be addressed later.

Where it is not possible to clarify aspects of the patient's mental state, such as where formal thought disorder is suspected and a verbatim translation cannot be given, it is helpful to record the interview on audiotape. This situation may occur however skilled the interpreter is and the recording will allow a more considered view to be taken later, either by the interpreter or by a psychiatrist colleague who is fluent in the language concerned.

Box 2 Errors in interpretation

Addition – the interpreter includes information not expressed by the patient
Closed / open questioning – an open question is translated by the interpreter as closed question and vice versa
Condensation – a complicated or lengthy response is shortened, altering its meaning
Normalisation – the interpreter attempts to make sense of and sanitise a bizarre response
Omission – the message is completely or partly deleted by the interpreter
Role exchange – the interpreter takes over the interview, asking his or her own questions
Substitution – one concept is replaced by another

Conclusions

It has been claimed that transcultural psychiatry is an applied science, converting research-derived concepts into reliable health strategies (Jablensky, 1994). To sustain this position, significant advances are needed in research and in training towards overcoming language barriers in an environment where 80% of psychiatric staff consider that their professional training prepares them 'very little' or 'not at all' for cross-cultural clinical work (Minas *et al*, 1994). Such circumstances demand not only an ability to communicate through an interpreter but also an understanding of an individual's cultural values in a way that has received only limited attention within training programmes for psychiatric staff in multi-cultural settings (Lefley, 1984). It is essential for psychiatrists to recognise the complexity of the task, particularly the power that interpreters have to control the information being relayed back and forth and thus influence the outcome of the interview (Box 2). Interpreters should be selected with care, and supervision by a clinician who is used to working with interpreters is a valuable experience.

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Multiple choice questions

1 When bilingual patients are interviewed in their mother tongue:
a psychoanalytic work is less effective
b patients with schizophrenia are rated as showing more psychopathology
c misunderstandings are fewer
d psychotic symptoms are less obvious
e answers are usually briefer.

2 Interpretation:
a is the same as translation
b allows patients to present symptoms in their own language
c complicates a clinical interview
d involves the substitution of one language for another
e is applicable only to spoken language.

3 The following are most likely to be effective interpreters in a clinical psychiatric setting:
a a bilingual social worker
b a qualified interpreter, experienced in mental health settings
c the patient's brother
d a bilingual general practitioner
e a bilingual consultant psychiatrist.

4 When interviewing through an interpreter:
a careful notes should be taken during the interview
b all questions must be directed to the interpreter for translation to the patient
c interviews of depressed patients are less reliable
d technical terms should be kept to a minimum
e a preliminary meeting with the interpreter is essential.

5 Using a patient's relative or friend as interpreter:
a should be avoided if possible
b does not preclude carrying out a comprehensive interview with the patient
c may lead to the distortion of sensitive information
d requires the addressing of questions to the interpreter during the interview
e makes role exchange more likely.

MCQ answers

1	2	3	4	5
a F	a F	a F	a F	a T
b T	b T	b T	b F	b F
c T	c T	c F	c T	c T
d F	d F	d F	d T	d F
e F	e F	e T	e T	e T

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