



## **Working Through Interpreters**

### **Dr Chris Fear and Professor Saeed Farooq**

Language is the principle investigative tool in psychiatry. Without a commonly understood language, we cannot assess a patient effectively. Where language barriers separate patient and clinician, skilled interpretation holds the key to mutual understanding.

Language barriers can lead to the misinterpretation of a patient's condition, even in cases where the patient is fluent in the language being used.

#### **Bilingual patients**

Studies of bilingual patients suggest that even though interviews can be carried out perfectly well in either language, the information gathered through the medium of the mother tongue is more meaningful and gives a clearer representation of the patient's psychopathology.

It can be difficult to decide when to bring in an interpreter, as patients who appear fluent in everyday conversation may struggle with the language and concepts of a clinical interview. Patient choice is a prime consideration. Bilingual patients often feel stigmatised and that their linguistic skills are being denigrated when an interpreter is brought in. It is important to approach the topic carefully, recognising the patient's language skills while explaining that even those with excellent English might find they can concentrate more on the interview if they have skilled assistance.

Clinicians should:

- check the level of communication and comprehension in English;
- be aware that in stressful situations, for example during relapse, the patient's command of the language will commonly reduce;
- check that the person has understood what you have said
- remember that some affective experiences may only be accessible in the patient's first language as emotional experiences may be difficult to express in a second language.

#### **Errors in the rating of symptoms**

Errors in the rating of symptoms are minimised by the use of clinicians experienced in interpreter-mediated interviewing and interpreters experienced in psychiatric settings.

During an interpretation of a clinical interview, possible sources of error might include:

- the clinician's competence and experience;
- the interpreter's unfamiliarity with the psychiatric setting;
- engagement of a poorly-qualified or inexperienced interpreter or a bilingual person with no qualifications;
- the patient speaking too quickly, using complex sentences, humorous or sarcastic comments;
- role conflicts;
- mental state examination.

The clinician should also be aware of a range of errors that might be made by the interpreter:

- **addition** – the interpreter includes information not expressed by the patient
- **closed questions changed to open questions** and *vice versa*
- **condensation** – a complicated or lengthy response is shortened, altering its meaning
- **normalisation** – the interpreter attempts to make sense of, or sanitise, a bizarre response
- **omission** – the message is completely or partially deleted by the interpreter
- **role exchange** – the interpreter takes over the interview, asking their own questions
- **substitution** – one concept is replaced by another
- **similar phonetic sounds** - words borrowed from another language are mistaken for words in the native language that sound similar
- **conceptual errors** – subtleties of psychopathology are misunderstood and lost.

The wish to obtain information rapidly may lead to the recruitment of a friend or relative of the patient or another patient/lay person (staff, visitor etc.) as interpreter, but being bilingual does not automatically qualify someone as an interpreter.

The following should be considered:

- confidentiality;
- linguistic or translation skill deficiencies;
- unfamiliarity with the aims of the clinical situation (especially in mental health);
- personal relationships/role conflicts that may distort the interview and affect the information discussed;

- inadequate understanding of cultural context;
- greater likelihood of errors that may have adverse clinical consequences.

The interpreter may also have priorities that conflict with those of patients, which might inhibit discussions regarding sensitive issues (domestic violence, substance abuse, psychiatric illness, sexually transmitted diseases etc.).

It is especially risky to have children interpret, as they are unlikely to have a full command of two languages or of medical terminology; they are more likely to make errors of clinical consequence and they are particularly likely to avoid (and probably should not be exposed to) sensitive issues.

It is important to give adequate consideration to the setting of the interview and what you want to achieve. Clinicians should:

- position the protagonists to best advantage in the room;
- meet with the interpreter to set the ground rules and goals for the interview.

Unless the interpreter is very experienced, you should assume they have no specialist knowledge of mental health.

Where possible, your questions should have been planned in advance and discussed with the interpreter before the interview. This will allow you to make best use of the time available. It is also important to hold a debriefing meeting in order to discuss things with the interpreter and give/receive feedback.