# Working with Interpreters

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Working with interpreters is essential to the practice of cultural consultation. In mental health care, language remains the central vehicle for building an alliance; gathering information; conducting a mental status examination; gaining access to subjective experiences, emotions, and memories; and engaging in therapeutic interventions. Effective work with interpreters in clinical assessment and intervention requires consideration of ethical and pragmatic issues. Collaboration also requires an appreciation of the complex interactions of language, cognition, emotion, and expression. This chapter will provide an orientation to working with mental health interpreters, with a review of relevant research literature and theoretical models followed by guidelines and practical recommendations relevant to cultural consultation. For cultural consultation, knowledge of the sociocultural context of a patient's current and former life is crucial, and interpreters who only know the language in an academic way should be paired with a culture broker who knows the relevant social contexts. This broader role is discussed in Chapter 6.

Mental health interpreting has its own special characteristics which pertain to the need to deal with strong emotion and interpersonal conflict, to convey idiosyncratic features of the patient's style of expression in order to allow assessment of their mental state, and to track subtle shifts in experience that may be important both for maintaining rapport and intervening. This requires rethinking the dominant models of practice for interpreting which evolved in very different settings.

## Medical Interpreting as an Ethical Imperative

Verbal communication is central to the diagnostic and therapeutic tasks of all health professionals. In Canada, the codes of ethics that regulate the conduct of health and social service professions "stress the need for the provider to obtain informed consent, provide explanations, ensure confidentiality, and refrain from practicing the

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profession under conditions that may impair service quality" (Bowen, 2001, p. 20). Language barriers constitute a major impediment to health service delivery, and the failure to address them may constitute malpractice or, when they are institutionalized, an ethical, civil, or human rights violation (Blake, 2003).

According to the 2006 census, about 1.7 % of the population in Canada (i.e., about 520,380 people) knew neither of the two official languages, English and French (Statistics Canada, 2007a). Almost one in five (19.7 % or 6,147,840) of Canada's 31 million people have a mother tongue other than English or French (Statistics Canada, 2007b). For comparison, in 2000 in the United States, as many as 21,320,407 people (8.1 % of the population) spoke English less than "very well" (U.S. Census Bureau, 2000). In Australia in 2006, 561,413 people (3 % of the population) did not speak English well or not at all (Australian Bureau of Statistics, 2006). These statistics illustrate the magnitude of the challenge facing the health services in countries receiving large numbers of immigrants.

The scientific literature is replete with examples of poor-quality services due to the failure to address language differences. In some cases, this arises from barriers to access or biases in referral. For example, studies have found that non-English-speaking patients were less likely to be offered follow-up appointments after a visit to an emergency department in Los Angeles (Sarver & Baker, 2000) and women were less likely to receive preventive services for breast cancer in Ontario, Canada (Woloshin, Schwartz, Katz, & Welch, 1997). Language also influences the uptake of treatment interventions. Non-English-speaking patients visiting an ambulatory clinic in a teaching hospital in the USA have lower rates of adherence to treatment (David & Rhee, 1998). There is an ethical imperative to ensure equal access to health care services and equal quality of services; without successful communication, this cannot be achieved. Providing interpreter services in health institutions is a key means of meeting this ethical obligation. In recognition of this ethical and pragmatic issue, models of medical and community interpreting have been developing rapidly in several countries in recent years (Bancroft, 2005).

## Medical and Community Interpreters and Culture Brokers

In addition to health services, interpreting occurs in many settings, including business, the military, the legal system, community services, and conferences. Most of the research on interpreting has been conducted in legal, community, or conference settings. Conference interpreting became a recognized profession after World War II and the Nuremberg trials, where for the first time simultaneous interpreting was available for a large audience and many languages. Professionalization occurred through the development of university level courses leading to degrees, the creation of national and international associations, and the establishment of codes of ethics.

Community interpreting—that is, "interpreting in institutional settings of a given society in which public service providers and individual clients do not speak the same language" (Pöchhacker, 2003 p. 126)—is fundamentally different from conference interpreting, both because it deals with conversations rather than monologues and especially because the interpreter is an integral part of the interaction, not simply an onlooker.

*Culture brokering* (also called *cross-cultural mediation*) can be defined as mediation between two culturally different realities for the purpose of reducing conflicts and/or producing a change between the two groups (Cohen-Emerique, 2003, 2004a, 2004b; Cohen-Emerique & Fayman, 2005). Culture brokering focuses on negotiating cultural differences and may or may not include linguistic dimensions. As such, community interpreting and culture brokering are distinct but overlapping. An interpreter can play many roles inside and outside the consultation room. Based on ethnographic research on medical interpreting in a paediatric hospital, Leanza (2005b) described four broad roles for interpreters: linguistic agent, system agent, community agent (also called a "life-world agent"), and integration agent. Acting as a linguistic agent, the interpreter attempts to remain impartial and does not add text or comments. In contrast, the three other categories imply that the interpreter enters the interaction as an active partner. As a system agent, the interpreter transmits

the dominant discourse, i.e., biomedical information in health care, and cultural differences tend to be ignored. As a community agent or culture broker, the interpreter can be a mediator for both interlocutors, making additions that explain differences in values, address conflicts, or serve patient advocacy. As integration agents, interpreters may play roles outside the consultation setting, elsewhere in the health care system or in the community, helping the patient to find resources to better adapt to the society (e.g., accompanying a patient to the pharmacy). Research in health care settings indicates that these broader roles are not often employed by professional interpreters. In fact, in interactions when interpreters do add text, they most often act in the roles of system agent, giving biomedical advice (Davidson, 2000; Wadensjö, 1998). Health professionals rarely solicit the community agent roles even if they are aware of them (Leanza, 2005a, 2005b; Rosenberg, Leanza, & Seller, 2007).

Reflecting on the South African psychiatric system, Drennan and Swartz (1999) point out that asking the interpreter to play the role of a cultural informant carries the implicit assumption that culture is monolithic and can be summarized for easy consumption by mental health professionals. The cultural informant tends to be a one-sided role that does not include patient advocacy, which is a key aspect of culture brokering. The role of patient advocate requires great skill and self-confidence on the part of the interpreter who must be both an insider member of the health care team in order to be heard and an outsider, allied with the patient, in order to play the role of advocate. Working as an integral part of the treatment team may undermine this advocacy role which therefore requires explicit institutional recognition and support.

## Neutrality: The Central Issue in Health Care Interpreting

With an environmental scan, Bancroft (2005) found that virtually all codes of ethics and standards of practice for health care interpreters emphasized three basic issues: confidentiality, accuracy or completeness, and impartiality or neutrality. Neutrality remains a controversial issue in mental health contexts. Examples of neutrality as an ethical principle can be found in the injunctions to *give no advice*, *allow no influence of feelings or beliefs on work*, and *insert no opinions even if asked*. This emphasis on neutrality is a direct effect of the ethics of conference interpreting in which interpreters must not add to the "official text" or change it in any way.

In psychiatry and psychotherapy, however, the neutral stance of the interpreter has been challenged by those who view neutrality as more or less impossible and who argue, instead, for the construction of a collaborative relationship between clinician and interpreter. Those who advocate neutrality in psychiatry are usually concerned with the potential for errors by interpreters with the resultant risk of poor quality of care (Demetriou, 1991; Farooq & Fear, 2003; Marcos, 1979). To reduce this risk, they may provide restrictive guidelines (Miletic et al., 2006) or even consider it impossible to offer effective psychological care through an interpreter (Yahyaoui, 1988). In collaborative care models, where a team may develop a more prolonged and complex interaction with patients, interpreters are sometimes integrated as team members (Bot, 2003, 2005; Raval, 2005; Raval & Maltby, 2005). This is usually the case in the Cultural Consultation Service, where a relationship develops with interpreters regularly used by the service.

Pioneering ethnographic research on medical interpreting by Kaufert and Koolage (1984) and later by Wadensjö (1998) made it clear that interpreters do not simply transmit information. Even when interpreters try to be neutral, research underscores the difficulty of attaining neutrality (Davidson, 2000; Hsieh, 2006a, 2007, 2009; Kaufert & Koolage, 1984; Leanza, 2005a, 2008; Pöchhacker, 2004; Rosenberg et al., 2007; Rosenberg, Seller, & Leanza, 2008). Indeed, from a pragmatic linguistic point of view, interpreters cannot avoid inserting some of their own knowledge and perspective into the clinical interaction both verbally and nonverbally (through the expression on their face, tone of voice, gestures, and timing). Interpreters are not invisible scribes but present as team members in the therapeutic setting, with their personal identities and social

positions influencing the interaction. Moreover, interpreters' active involvement can be seen as an asset when both the interpreter and the health care professional share a patient-centered approach. What is essential for mental health consultation is the practitioner's ability to be sensitive to the interpreter's complex impact on the clinical interaction to ensure the process proceeds in a constructive way.

**Case Vignette 5-1**

The CCS saw a patient from an African country who was referred from the regional refugee clinic. He was seeking political asylum after having been tortured by police in his own country. He was very anxious with significant posttraumatic symptoms including flashbacks, sleep disorder, and depressed mood despite receiving high doses of medication from his primary care physician. The interpreter accompanying him identified with the patient's experience and began to intrude in the consultation with comments about his own police trauma and difficulties finding political asylum prior to his successful migration. He offered unsolicited advice on the legal options during the consultations despite the consultant's attempts to maintain boundaries and guide the process. A decision was made not to use this interpreter again for CCS consultations because his level of identification with patients was impairing his ability to function in this role.

As this case illustrates, although the interpreter's identity, personal experience, and perspective will inevitably have effects on the interaction, a basic level of professional neutrality is essential to be able to focus on the patient's needs and provide appropriate clinical service.

## The Interpreter's Identity

Although interpreters are usually chosen on the basis of their linguistic skills, other characteristics including age, gender, socioeconomic status, education, ethnicity, and religion can be important issues in interpreted interactions. For example, in a study in a Swiss hospital, Sleptsova (2007) found that interpreters' socioeconomic status tended to be closer to that of health care professionals than patients. As a result, interpreters tended to align themselves with the physicians and nurses, and interpretation was biased in favor of the biomedical practitioner's perspective.

Interpreting in general has been a profession characterized by a larger proportion of women than men (Pöchhacker, 2003; Zeller, 1984). To our knowledge, only one study has directly addressed gender issues in interpreted medical consultations. Bischoff, Hudelson, and Bovier (2008) looked at patient–physician gender concordance and patient satisfaction about communication in professionally interpreted consultations compared to non-interpreted consultations. They found that the presence of a professional interpreter tended to reduce gender-related communication barriers in consultations. They suggest that professional interpreters who have training in cultural mediation are better able to manage complexities involving gender and facilitate the communication process within an ethical framework.

Language, geographic origin, ethnicity, religion, social class, education, and political orientation are all variables that can influence the interpreters position vis-à-vis the patient. Regional dialects, accents, and styles of speaking can convey a lot of information about social status and may facilitate rapport or create barriers. Discussing potential conflicts with the interpreter and being alert to them in the interaction can allow the clinician to optimize the match of interpreter and patient.

**Case Vignette 5-2**
A Rwanda Tutsi mother sought help for her 8-year-old son. The father was killed during the war, and the consultant felt that a Rwanda Hutu interpreter might be inappropriate. After inquiring, the mother disclosed that the boy's father was Hutu. They had a mixed marriage and that she believed that a Hutu interpreter would be more helpful than a Tutsi interpreter.

Despite efforts to identify an appropriate match, patients and interpreters may have unanticipated reactions to each other that must be negotiated in the clinical setting. This negotiation may be particularly complex in the case of small communities where interpreter and patient are likely to know each other or where they have other reasons to be especially concerned about potential breaches in confidentiality.

**Case Vignette 5-3**
An Eastern European immigrant family was interviewed by the CCS consultant with an interpreter whom they had previously seen at community gatherings. They were ambivalent about the mental health consultation because psychiatric services in their country of origin were associated with political persecution, stigma, and incarceration in asylums. When the consultant asked the interpreter to probe into issues related to criminal activity by a family member, the interpreter became very distressed and insisted that the consultation had to stop and a new interpreter found. He felt that his neutrality was compromized as the community was very small and he was known to the family. He shared the family's concerns about political abuses by psychiatrists in their native country and worried that the consultation might lead to problems for the family.

As these vignettes illustrate, the interpreter's identity may be an immediate issue, based on fears or projections, or become problematic as the interview unfolds. Flexibility in identifying and responding issues is essential to maintain trust and effective communication.

Trust is fundamental in any clinical encounter. Clinician, interpreter, and patient must all have a modicum of trust in each other. In an analysis of a set of health care practitioner and interpreter narratives on interpreted interventions, Robb and Greenhalgh (2006) drew on Greener's (2003) typology which distinguishes three forms of trust: *voluntary* ("based either on kinship-like bonds and continuity of the interpersonal relationship over time, or on confidence in the institution and professional role that the individual represents," p. 434), *coercive* ("where one person effectively has no choice but to trust the other," p. 434), and *hegemonic* ("where a person's propensity to trust, and awareness of alternatives, is shaped and constrained by the system so that people trust without knowing there is an alternative," p. 434). Only voluntary trust was associated with an openness to the patient's lifeworld and collaboration with the interpreter by the clinician. To enhance trust in the system, the patient may play a role in choosing an interpreter.

## Organizational Issues in Working with Community Interpreters in Mental Health

Working effectively with community interpreters goes beyond the lists of technical tips focused on the interpreter–practitioner relationship commonly found in the literature (Bjorn, 2005; Hays, 2008; Jackson, Zatzick, Harris, & Gardiner, 2008; Prendes-Lintel & Peterson, 2008; Richie, 1964). Effective work requires changes at level of policy, health systems, institutions, and service organizations (Leanza, 2008). At present, community interpreters lack social recognition for their work. Attempts to make interpreters part of a routine health care practice are likely to fail without such recognition, which can only be

**Table 5.1** Institutional guidelines for use of community interpreters

- Evaluate linguistic needs of institution, patient population and catchment area
- Establish language policies
- Develop working relationship with regional bank of professional interpreters
- Allocate resources to fulfil the linguistic needs
  - Adequate budget specifically earmarked for interpreters
  - Supervision time
  - Room for interpreters
  - Training for gatekeepers, health care practitioners and interpreters
- Insure adequate time in clinical services for work with interpreters
- Develop overall organizational cultural competence

achieved through policies, ethical guidelines, and legislation that support patients' right to have access to health care in a mastered and meaningful language. Policies must also address training and accreditation of interpreters, health care professionals, and gatekeepers.

Table 5.1 lists some of the resources needed at an institutional level to implement community mental health interpreters. Community interpreters are professionals, and as such, they require the resources and compensation associated with a profession: a decent salary, a formal place in the health care team, an office in the institution, continuing education, and supervision.

A major obstacle to the implementation of interpreting services in health care systems is financial expense. Hospital administrators tend to view interpreted interventions as only adding costs to health care without any clear clinical or economic benefits. However, a review of the literature by Bowen and Kaufert (2003) and subsequent studies (Hampers & McNulty, 2002; Jacobs, Shepard, Suaya, & Stone, 2004) demonstrated that the use of interpreting services may actually reduce costs and improve quality of care. Patients who are inadequately assessed and treated because of poor communication may go on to use additional health services in an effort to get appropriate care. Bowen and Kaufert insist that when assessing the cost-effectiveness of interpreting services, the benefits must be considered not just for a single institution but in terms of its impact on the entire health care system and society as a whole.

Interpreters need specific training in mental health issues as well as in the interaction of culture and psychopathology. Interpreters may find mental health interpreting particularly demanding or distressing and need specific training and support around affective issues. Interpreters who work with children and families need additional training in order to be able to address the child in an age-appropriate way and accurately convey information about the language and nonverbal communication skills of the child.

Mental health professionals also need specific training in how to work with interpreters. Health care training curricula need to include courses that sensitize students and future practitioners to issues of clinician–patient miscommunication and teach them how to work with an interpreter in different situations, as this is a specific competence. Working with an interpreter requires a shift from thinking in terms of a dyadic to a triadic interaction (Rosenberg et al., 2007). Training requires an investment of time and the opportunity to practice and apply skills under supervision. Research in continuing medical education shows that "one shot" formal didactic sessions do not improve practice and outcome; there is a need for an interactive training process or practice-based interventions (Davis et al., 1999; Davis, Thomson, Oxman, & Haynes, 1995). Hence, models and skills for working with interpreters should be included as basic curriculum in the undergraduate training of future practitioners as well as being included in the programs of post-graduate specialty training and maintenance of professional certification (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003). Language is only one aspect of culture, and working with interpreters should be integrated into broader models of cultural competence. This requires an approach that goes beyond viewing interpreting as simply a communication strategy to consider the wider social meaning of language and the social positioning of practitioners, interpreters, and patients. Positive outcomes depend on viewing the clinical encounter as a process of communication and negotiation in social context. This

attention to social context will also enhance the professional recognition of the work of community interpreters and culture brokers.

## Institutional Policies and Practices

The first step in establishing interpreter services is to evaluate the clinic's needs in terms of languages, frequency of use, specialized skills, and budget. This will determine the mix of in-house, on-call, and telephone interpreters best suited to meet local needs. Having a dedicated budget provides a structural incentive for health care practitioners to collaborate with interpreters. Interpreters must be adequately compensated to insure their stability and quality. Use of interpreters also requires organizational changes to allow the additional time and flexibility in scheduling and workload. A study conducted in Montreal by Battaglini et al. (2007) found that up to 40 % more time is required for medical consultations for immigrants who had been in Canada less than 10 years.

In Montreal, the regional health authority maintains a central bank of interpreters who are trained and available on call to visit clinics and hospitals. Unless there is an in-house interpreting service with its own office, however, on-call interpreters have no place to stay between interventions. In our own research in a comprehensive community health clinic Montreal, we found that interpreters in usually sat in the waiting room with patients (Rosenberg et al., 2008). Providing a physical space for interpreters is part of the institutional recognition of their activity and their integration in the health care team. This integration should also take the form of including interpreters in key clinical team meetings, such as case conferences. Providing supervision for interpreters, either alone or along with other health care practitioners, is essential for high-quality care.

Continuing education for both practitioners and interpreters should include all institutional staff who may function as gatekeepers, particularly receptionists and administrators. Learning to work together should be a priority in such institutional continuing education programs. The first barrier to employing interpreters is the inability of staff who act as gatekeepers to identify patients who need language services before they arrive at the hospital (Hasnain-Wynia, Yonek, Pierce, Kang, & Greising, 2006). Failure to provide access to interpreters has important legal implications in the areas of confidentiality, informed consent, and even the ability to carry out essential clinical tasks (e.g., the ability to assess suicidal risk).

## Gatekeepers and Initial Assessment of the Need for an Interpreter

Gatekeepers may play a crucial role in inquiring about a patient's language, particularly in those clinical settings that do not have on-site interpreting services and therefore need to arrange these services in advance. A potential language barrier can be detected at the gatekeeper stage by asking questions such as: "Are you new in Canada?" "Would you like to have an interpreter?" Interpreters can be provided and longer appointments can be scheduled to provide time for translation, clarification, and explanation. Staff and administrators in primary care and other clinical settings should be sensitized as to how to interact with patients who have not mastered English or French or who are not familiar with the Canadian health care system. Reception staff should be prepared to provide help with the completion of any required forms and explain to patients the rationale for the questions asked.

At the CCS, it is the role of the clinical coordinator to inquire whether a patient needs an interpreter and clarify that family members should not assume the role of a professional interpreter. Sometimes the need for an interpreter can be ascertained by talking to the referring clinician, but often it requires discussion with the patient or family when setting up the consultation appointment. In some instances, the need for an interpreter does not become apparent until the initial consultation and a second interview must be arranged.

## Selecting the Right Interpreter

In the choice of interpreter, awareness of social, cultural, and political issues is essential to gain

and maintain patients' trust. Geography and identity, as well as past and present conflicts, must be considered when choosing an interpreter so that someone of the appropriate ethnicity, religion, political views, dialect, and gender is obtained. Patients' requests may sometimes seem arbitrary but, in our experience, are often well founded.

**Vignette 5-4**
A middle-aged Kurdish man from Turkey expressly demanded that his interpreter not be Turkish, suggesting as alternatives an Armenian or a Greek who spoke Turkish. Before the consultation began, he checked the ethnicity of the interpreter, and after he was reassured, he explained that he had been a victim of psychological and physical abuse by the Turkish military.

**Vignette 5-5**
A middle-aged couple from Bangladesh was referred to the CCS, for the assessment of the wife's chronic depression, which appeared to be exacerbated by tensions with her husband. A Bengali-speaking interpreter translated the questions the psychiatrist asked the couple, to which the husband responded exclusively. After a little while, the interpreter, who had noticed that the man did not speak Bengali fluently and had an accent, inquired from which part of the country they came, only to discover that the couple came from the same region as himself, where Chittagonian was spoken. The interpreter shifted languages, allowing the woman to understand and express herself, thus interacting directly. She exclaimed positively: "For 15 years I could not speak, finally I can!"

The following two examples show the complexity in selecting an appropriate interpreter and the unforeseen consequences of a mismatch.

This case illustrates both the difficulty of knowing precisely which language the patient is most comfortable speaking and the benefit of finding a good match. Many countries have far more linguistic diversity than North America or Europe. An atlas of languages can be helpful at times (Asher & Moseley, 2007), but for many smaller groups, a precise match will not possible. Instead, a local common language (e.g., Arabic, Bahasa Indonesia, Swahili, Tagalog) may be the best that can be achieved. When family members differ in their skill with a language, assessment and interaction will have unavoidable biases that must be considered. Moreover, despite the appearance of using a common language, local variations may introduce important differences in meaning.

**Vignette 5-6**
An elderly Russian woman was referred to clarify her diagnosis. She was deaf and a sign language interpreter translated the interview. The patient provided information on her medical history, focusing on her cancer surgery, which had taken place many years earlier. For more than an hour, the interpreter kept repeating that the patient felt that cancer was coming out of her legs when suddenly she realized that it was not cancer but worms. The reason for the misunderstanding stemmed from the fact that the interpreter was trained in American Sign Language while the patient used Russian Sign Language and the two systems differed in important respects. The shift from worries about cancer to delusions about infestation with worms led to a change in diagnosis from hypochondriasis to psychosis.

If patients have concerns about confidentiality vis-à-vis other members of their linguistic community, they may perceive the presence of an interpreter/translator as threatening. Moreover, in small communities, there is a high likelihood that patients will know the interpreter. Each case, therefore, requires a specific assessment of the patient's needs and requirements for communication in their mother tongue or language in which they are most fluent.

Lack of confidentiality may also be an issue for the interpreter, who may feel burdened or exposed. On the other hand, an interpreter who has the requisite language skills but is obviously not part of the local community may be well situated to facilitate therapeutic exchange. For example, a Tamil man from Sri Lanka reacted positively to the presence of a culture broker who spoke Tamil but was not part of the Tamil community in Canada. Her status as both insider and outsider favored a therapeutic alliance by creating a space of trust.

Gender is another important variable in the construction of the triadic alliance required for clinical interpreting. Women from certain regions of the world may feel uncomfortable in the presence of a male interpreter. When feasible, it is helpful to ask patients if they have a preference for the gender of the interpreter. This is particularly important in cases of rape and violence. In these cases, female interpreters may be chosen by default as they are more likely to be acceptable to patients of either gender.

To foster a working alliance and continuity of care, it is good practice to work with the same interpreter for a given case whenever possible. Continuity is important to enhance the teamwork between clinicians and interpreters. For patients, changes in the therapeutic team can be stressful and disorienting. Patients develop alliances and attachments to the interpreter, and an abrupt switch can undermine trust and confidence.

In some cases, patients may become close to the interpreter, who may be seen as playing the role of a mother or older sister, mirroring the systemic transferences of family life and recreating safe relationships or networks within the clinical setting. For example, in several cases seen by the CCS, South Asian women who had recently married and migrated to Canada found the interpreter a person with whom they could identify but who represented a path of acculturation, providing an example of independence that was dissonant with their traditional role in the family but closer to their expectations of Canadian life (see Chapter 8).

## The Use of Informal or Ad Hoc Interpreters

In many clinical settings, professional interpreters are not available or are not used because they are costly and difficult to arrange, or staff and administrators are not fully aware of their vital importance. Instead, family members, friends, or other clinical or support staff are recruited to serve as ad hoc interpreters. This practice, though widespread because of its low cost and convenience, is strongly discouraged because it has potentially serious negative clinical consequences. For example, a qualitative study of family medicine consultations (Leanza, Boivin, & Rosenberg, 2010) identified risks associated with having family members as interpreters. Family members often become the main interlocutors in the consultation, answering for the patient. They could decide not to convey patients' statements that they judged went beyond the expectations of a medical agenda and did not convey some of the physicians' statements in order to control patients' decisions.

When it is necessary to use "ad hoc" interpreters because of the lack of available professionals, it is important to recognize that their presence raises specific clinical issues (Hsieh, 2006a, 2006b). If the interpreter is a family member, there can be a range of different situations. Although such persons can play important, even vital roles in the diagnostic and treatment processes, they should not be the people responsible for ensuring the flow of information between the patient and the practitioner (Rosenberg et al., 2007).

In the case of a child interpreting for an adult (parent, grandparent, uncle, etc.), the clinician must avoid sensitive issues that would negatively affect the child or child–adult relationship. The child may also have limited capacity to translate complex issues. It is best to roughly evaluate what the problem is through the child and inform the patient of the need to find another interpreter in order to assure quality of translation and to

avoid the child becoming further entangled in a difficult situation. Similar issues arise in the case of an adolescent interpreting for an adult. While the adolescent may have more capacity to understand complex issues, it remains important to be aware of sensitive issues that may be difficult to translate and to hear. If difficult issues such as sexuality, the diagnosis of a malignant disease, or war trauma are involved, the patient should be informed of the importance of including a professional interpreter to complete the consultation.

A growing body of literature looks at the role that children and adolescents may have as culture brokers and interpreters for their immigrant families (Jones & Trickett, 2005). Two opposing perspectives are found in the literature. The first perspective frame this interaction as a form of "parentification" or "role reversal" which undermines traditional power relations within the family and may expose children to major stressors (Trickett & Jones, 2007). In the medical literature, two studies suggest that involving children in the communication of sensitive issues (e.g., death, complex or life-threatening disease) can have traumatic effects on the child (Haffner, 1992; Jacobs, Kroll, Green, & David, 1995). An alternative view sees this role of the child as a common task and responsibility in migrant families that need not alter or disrupt family relations (Trickett & Jones, 2007). Indeed, Morales and Hanson (2005) review some research which suggests that children who function as language brokers "acquire higher cognitive and decision-making abilities due to their brokering experience" (p. 492). In some circumstances, the young interpreter may play a protective role as a family advocate, preventing physicians, employers, or others from embarrassing their relatives, and this successful advocacy may enhance self-esteem and self-efficacy (Free, Green, Bhavnani, & Newman, 2003; Green, Free, Bhavnani, & Newman, 2005).

In the case of adults (e.g., a husband interpreting for his wife (or vice versa) or an adult child interpreting for a parent), it may be tempting for the clinician to rely on this ad hoc interpreter. Although family members are often long-term caregivers and can be of invaluable help to understand the patients' reality, this is distinct from the task of working as an interpreter. In order to avoid misunderstandings on a long-term basis and also to have an outside perspective on the patient, it is important to employ a professional interpreter. In cases of possible maltreatment or domestic violence, it is crucial to avoid using family members as interpreters, as this may prevent the patient from disclosing issues of an interpersonal nature, including abuse.

The case of a parent interpreting for a child or adolescent is less common in migrant families, because children are among the first in the family to acquire facility in the new language, but this situation can occur, particularly with young children. It poses the dilemma that the child's perceptions are all filtered through the adult family member, and so areas of conflict or disagreement and nuances of emotional tone and meaning may be lost. Again, interpreting by a professional, even with the parent present for comfort, may improve the accuracy and completeness of the communication.

Bilingual health care staff may be able to interpret but require training for the task. It is important to first make certain the staff person is willing to perform this extra task, as not every bilingual person is comfortable interpreting. In any case, all of the rules previously discussed apply, namely, checking for concordance of gender, ethnicity, etc.; asking if both interpreter and patient agree to be matched; and reminding the interpreter of the importance of confidentiality. When professional interpreters are not available, it may be possible to train a pool of bilingual staff to act as interpreters and arrange institutional procedures that allow them to be on call when necessary.

## Working with Interpreters in Cultural Consultation

The following suggestions (see Table 5.2) for working with interpreters are drawn from our work with the CCS, published guides for medical interviews with an interpreter (Bischoff & Loutan, 2008), and advice from Montreal's Inter-regional Interpreters Bank.[1] These suggestions are offered not as a prescriptive list of dos and don'ts but as

[1] The document can be downloaded at http://www.sante-montreal.qc.ca/

**Table 5.2** Guidelines for working with interpreters in clinical settings

| |
|---|
| *Prior to the interview* |
| • Contact the interpreter before the consultation. Provide some general information regarding the patient and ask if he/she would be comfortable interpreting for the patient |
| • If the interpreter is not a trained or professional interpreter, determine his relation to the patient and remind him of the basic rules of interpreting |
| • Remind the interpreter that everything that is said in the consultation room must be kept confidential |
| • Ask the interpreter to translate everything that is said and to tell you when accurate translation is not possible |
| • Ask the interpreter to describe her impressions of the patient's feelings and emotions, making clear that you recognize the difficulty of this task |
| • Ask the interpreter to tell you when he/she is unsure of the meaning of the patient's verbal and/or nonverbal communication |
| • Arrange the interview setting so that patient and practitioner can see the interpreter and each other; placing three chairs in triangle is usually the best way to achieve this |
| *During the interview* |
| • Present yourself and the interpreter |
| • Ask the patient if he agrees to being interpreted by this interpreter |
| • Inform the patient that the interpreter will translate everything you and the patient say |
| • Inform the patient that the interpreter will respect confidentiality |
| • Look mainly at the patient and use first-person singular speech |
| • Use simple and short sentences |
| • Be aware of how your communicative style may be direct or indirect (e.g., the way you frame questions, you make comments, and the ways you interpret what the patient says) |
| • Summarize your understanding frequently, asking the patient to confirm or to correct you |
| • If the patient and interpreter have engaged in several exchanges without translation, interrupt them and ask the interpreter to translate |
| *After the interview* |
| • Ask the interpreter if she has something to add about the patient or the consultation process |
| • Check the interpreter's personal feelings about the content of the interview and offer sources of support for any distress uncovered |
| • Record the name of the interpreter and contact information in the patient's file for future reference |

general principles to be applied flexibly, taking into account the particularities of the context, including the specific health issue, interpreter, time, and the type of consultation. These suggestions apply to interpretation for all kinds of health care. Those who interpret for mental health practitioners must have some additional training concerning mental illness and its treatment.

## Preparing for the Consultation

When possible, the consultant should contact the interpreter before the consultation to provide some general information regarding the client and determine if he/she will be comfortable interpreting for the client. This initial contact can help uncover potential conflicts of interest, dual relationships, or errors in matching. If the interpreter is not a trained or professional interpreter, it is important to clarify his relation to the patient and to convey the basic rules of medical interpreting (i.e., the need for confidentiality, accuracy of translation, and the possibility of adding comments when necessary while clearly distinguishing these comments from the patient's actual statements).

The consultant should also briefly explain the patient's situation and the purpose of the consultation as well as the basic parameters, including the time available for the interview (which must be longer than usual as everything must be said twice). The consultant can also specify what the kind of translation needed; in general, this is the most complete and accurate possible, but if the interpreter can function as a cultural informant or culture broker, they may be able to supply additional cultural background information to the clinician and patient to improve the quality of communication (see Chapter 6 on culture brokers). Mental health interpreting requires close attention to feelings and emotions which may need to be described, in addition to translating the client's verbalizations. If the consultant has not worked with the interpreter before, it is worth clarifying how much experience the interpreter has had in mental health settings, and, if necessary,

explaining the rationale for the specific interview methods including the formal mental status examination or any therapeutic interventions. It is important to record the name of the interpreter and context information in the patient's file for future reference.

Room layout also plays an important role in facilitating interpreting and the position of participants has both pragmatic and symbolic implications (Moss, 2008). The seating should be arranged so that patient and practitioner can both see the interpreter and each other; placing the three chairs in triangle is usually the best way to achieve this. When the interview is with a single patient, the interpreter usually sits near the patient. In situations where the consultation involves interviews with a group of people (e.g., family or members of the patient's social network), the interpreter may sit close to the practitioners with the group arranged in a circle or horseshoe configuration (Miletic et al., 2006). This arrangement is also used in French ethnopsychiatry consultations (Chapter 4).

All interpreted consultations are fundamentally cross-cultural encounters. As such, the most important issue is the practitioners' overall attitude to the encounter with the patient. The cross-cultural encounter may threaten the health care practitioner's personal and professional identity (Cohen-Emerique & Hohl, 2002; 2004). In order to avoid defensive reactions that can jeopardize communication or even abruptly end the encounter, Cohen-Emerique and Hohl suggest that practitioners go through a training process that includes the "discovery of self." Only when one is clear about the implicit rules and values in one's own cultural system can one understand the other and find ways, through negotiation and mediation, to offer culturally sensitive care.

## During the Consultation

The first step in the actual consultation involves introducing the participants. The consultant should introduce the members of the team including the interpreter. If it has not already been determined, the patient should be asked if he or she agrees to have the interpreter and others present. During the interview, the consultant should look mainly at the patient and use first-person singular speech (i.e., "Did you feel sad?"); this direct speech will help keep the statement simple, avoid confusion as to who is speaking, and reinforce the relationship between the practitioner and the patient (Roat, Putsch, & Lucero, 1997). Interpretation takes time and requires close attention. The consultant can observe facial expression and paralanguage while waiting for the interpreter to complete the translation.

The quality of the communication process can be assessed during the interview by asking the interpreter for feedback at each step to be sure there is mutual understanding. It is useful to ask for brief summaries to ensure that all three parties have a mutual understanding of what has been discussed; this strategy is also called "back interpretation" (Hsieh, 2006b).

It is important to make efforts to insure that the patient feels comfortable. Most basically, this is achieved by one's attitude: showing an interest in the individual, valuing his/her background, and using a clear, nonspecialized vocabulary, free of jargon, that can be understood by both the patient and the interpreter (neither of whom are likely to have mastery over medical terminology).

Communication between immigrant and refugee patients and practitioners is often difficult because of linguistic barriers combined with misunderstandings that arise from different expectations of roles and outcomes and from different personal and cultural styles of communication or self-presentation (Gumperz & Roberts, 1991; Smith, DeVellis, Kalet, Roberts, & DeVellis, 2005). Humor, irony, and sarcasm can be sophisticated expressions of complex emotions, including mixtures of fear, anger, and criticism, and can easily be misunderstood in intercultural health care settings (Hartog, 2006).

One key issue during the consultation is control of the communication process. While some authors insist that the practitioner must stay in control of the process (Bischoff & Loutan, 2008), in practice it is rarely possible to maintain tight control at every moment as the interpreter may

need to ask for clarification or respond spontaneously to maintain their human presence. Some loss of control is a normal part of a cross-cultural and cross-linguistic consultation. Control can be maintained over the overall structure of the interaction, while allowing some flexibility. Nevertheless, the clinician should have a clear sense of the ongoing process and content of communication and, if this is lost, should pause and ask the interpreter for clarification and re-establish the agenda and goals of the interview.

## After the Consultation

After each interview, it is essential to have a "debriefing" conversation with the interpreter, to review the process of the interview and see if the interpreter has any observations to add about the patient or the consultation itself. It is also important to assess the interpreter's own feelings about the interview, which may have aroused emotions based on the content of the illness or various levels of identification with the patient and predicament (Loutan, Farinelli, & Pampallona, 1999; Valero-Garcés, 2005). In some cases, the interpreter may need follow-up to address emotional reactions or concerns. If exposed to traumatic stories, interpreters need to receive support similar to that available to therapists. A German study on the use of interpreters for refugees found a significant prevalence of PTSD among interpreters, most of whom were not trained and were refugees themselves or had experiences of child abuse and depression (Teegen & Gonnenwein, 2002).

A study conducted by Baistow (1999) in the UK examined the emotional and psychological effects experienced by community interpreters in public services. The majority (80 %) of interpreters surveyed reported feeling very positive about their work and found it fulfilling and rewarding. However, more than two-thirds reported feeling distressed sometimes by the material they had to interpret, and half reported that interpreting sometimes made them feel worried and anxious and experience mood or behavior changes. Baistow proposed several strategies to address the emotional challenges of interpreting: (1) increased liaison between employers, service providers, and interpreter organizations (2) pre- and in-service training which addresses the emotional challenges of community interpreting work; (3) regular supervision for new or inexperienced interpreters; and (4) a referral service for one-on-one counselling of interpreters.

## Working with Interpreters in Psychiatric Assessment

Psychiatric assessment has several goals: (1) identifying the patient's clinical complaints and concerns; (2) recognizing symptoms, behaviors and experiences that may indicate specific forms of psychopathology and make a clinical diagnosis; (3) gathering information about a patient's personal history and social context in order to understand their illness in the context of their biography and life circumstances; (4) identifying sources of strength and resilience that can be mobilized for helping interventions; and, most fundamentally, (5) developing and sustaining clinical empathy, rapport, and a working alliance. The central role of language in psychiatric assessment raises specific issues for mental health interpreting (Table 5.3).

**Table 5.3** Key issues in mental health assessment with an interpreter

- Clinicians need to attend to both denotative and connotative meanings of language, styles of emotion expression, and linguistic idioms
- Interpreters need to be alert to regional accents, dialects, and implications of language for social status (both their own and that of the patient)
- Interpreters need to possess observational skills as well as knowledge of psychopathology so that they can help the clinician recognize specific symptoms (e.g., thought disorder)
- Switching language can convey important information about emotional meaning of specific memories and experiences as well as patient's efforts to position themselves in the clinical interaction
- Interpreters can provide information on cultural norms of expression that can assist in determining whether specific behaviors or experience are unusual

One key component of psychiatric assessment is the mental status examination, which gathers systematic information about symptoms, signs, and experiences needed to identify psychopathology. The formal mental status examination involves open-ended and semi-structured interviewing. In some instances, this may be supplemented by standardized tests, most often to assess cognitive status. In order to assist with this evaluation, the interpreter must understand the goals of the interview as well as the point of specific questions or tasks.

**Case Vignette 5-7**

An elderly Greek woman, who complained of being forgetful, was referred to the CCS for cognitive evaluation. The interview included administration of the Folstein Mini-Mental Status Examination (MMSE; Folstein, Folstein, & McHugh, 1975), a brief measure of cognitive functioning. She was asked to answer a few questions and to follow the instructions which were translated by the interpreter from the English version of the MMSE. As the interpreter presented the items, he was unaware of giving hints to the patient by making gestures and repeating phrases in ways that coached a positive response.

Language provides indications of mental status and neuropsychological functioning relevant to the patient's diagnosis (Jackson et al., 2008; Westermeyer & Janca, 1997). The voice may be monotonous or speech slow in cases of depression and disorganized or impoverished in schizophrenia. There are speech tics in Tourette syndrome and speech disorders which may have idiosyncratic presentations that can be mistaken for psychopathology. Deciphering these signs correctly may be crucial to adequately assess, diagnose, and treat mental health problems.

Any assessment or testing is made in reference to norms. In mental health assessment, this norm is often implicit, based on experience with individuals from the dominant cultural groups—most often middle-class, Euro-Americans (Padilla, 2001). The sociocultural background and developmental experiences of patients influence their ways of thinking, expressing suffering, and presenting in clinical situations (Segall, Dasen, Berry, & Poortinga, 1999). All the areas assessed in the mental status examination are influenced by this background and current social and cultural contexts. Knowledge of the associated norms is therefore essential for identifying pathology.

The standard psychiatric mental status examination covers appearance, behavior (including attitude and relationship to the examiner), affect, mood, and cognition (including thought content and process, memory, insight, and judgement). For all of these areas, the interpreter can help the health care professional determine whether the expression is culturally normative or unusual. However, this often requires more cultural background knowledge and exploration with the patient and others in their entourage tasks that fall within the role of the culture broker (see Chapter 6).

Different styles of self-presentation by patients (Goffman, 1959) are a common cause of misunderstanding between physicians and migrants and often go unrecognized (Roberts, Moss, Mass, Sarangi, & Jones, 2005). These differences can include the degree of how personal or impersonal to be in addressing the other, how direct or indirect to be in self-presentation, what to emphasize and what to play down, how to sequence responses, choice of words and idioms, and a range of prosodic features, including intonation and rhythm that may convey irony, sarcasm, and other metalinguistic information (Roberts & Sarangi, 2005).

Nonverbal cues can easily be misinterpreted. Body posture is socioculturally coded, as is interpersonal distance (Hall, 1966). For example, a patient who does not look directly at the physician while talking and keeps her head down might be misinterpreted by the doctor as suffering from depression or domestic abuse. The socially appropriate degree of eye contact varies with gender, age, and authority according to cultural codes. In some cultures, there is a norm of not looking directly to at an elder, a male, and a

person of authority, as a sign of respect and gender-appropriate behavior. There are many societies in which indirectness in communication is important for politeness, respect, and saving face in situations of potential conflict or disagreement. Directness and indirectness are also important clinically as ways to gain patients' adherence to treatment (Smith et al., 2005).

## Structured Interviews and Psychological Testing

Structured interviews and psychological tests are important in research settings and can be useful supplements in clinical evaluation. While it may be tempting to have an interpreter informally translate tests' items "on the fly" during an assessment interview, there is evidence that such informal translation of tests is often neither reliable nor valid. As Vignette 5-2 presented earlier illustrates, it may be particularly difficult for an interpreter to translate specific items that involve unfamiliar or idiomatic expressions.

In addition to the difficulties such impromptu translation, psychological tests have generally been developed through research with specific populations and may not be valid when applied in other cultures or contexts. For a test to work across cultures, it is necessary to establish not only accurate linguistic translation but also meaning equivalence (Greenfield, 1997; Arnold & Matus, 2000).

In cross-cultural research, equivalence in meaning is achieved through a lengthy process involving several steps (Brislin, 1986; Westermeyer & Janca, 1997) (see Table 5.4). This procedure can be improved by insuring that the team of translators vary in age, sex, education, and social class and that the validation of the test is done on samples that also reflect the diversity within the culture (Sartorius & Janca, 1996).

Even if a psychometrically adequate test is available in the patient's language, the results must be viewed with caution. Cognitive testing results are strongly related to educational level (Carlat, 2005). Results are poor for those with less than 8 years of schooling even without any cognitive problems (Ainslie & Murden, 1993).

**Table 5.4** Steps to establish the cross-cultural equivalence of psychological measures

| |
|---|
| *Translation* by a team of bilingual persons who have spent at least several years in each culture–language group |
| *Back translation* into the original language by one or more persons not familiar with ("blind to") the original version of the instrument |
| *Revision* of the translation on the basis of analysis of the three versions (i.e., original, translation, back translation) by a panel with expertise in the two languages, the assessment instrument, and the specific constructs or conditions under study |
| *A pilot study* in the target population to determine basic psychometric properties and identify problematic items or formats. This should include qualitative interviewing of subjects on the ways in which they understood the test and specific items |
| *Revision* of the translation on the basis of the pilot study data |
| *Renorming* the measure by administering it to general population samples |
| *Revalidation of* the measure by establishing its relationship to other "gold standard" measures of the construct |

Cross-cultural research on cognitive development over the past few decades has shown that performance on cognitive tasks is highly dependent on enculturation and socialization (Dasen, 1975; Segall et al., 1999). Cognitive performance is oriented according to what is valued in a society and can be modified by training (Dasen, Lavallée, & Retschiski, 1979). Poor performance in an unfamiliar testing situation may not indicate a lack of competency in other more familiar settings. For example, Nunes, Schliemann, and Carraher (1993) found that street children in Recife (Brazil) performed very well in calculations about the price of the small items (candies, fruits) they sell, but underperformed when asked for the same calculation on a paper–pencil test in a classroom-like setting. It is not only the content of a test that may be confusing but the testing situation itself (Greenfield, 1997).

The interpreter can help the clinician understand the meaning of patients' answers to psychometric tests and give additional diagnostically useful information about how the patient is answering (e.g., with hesitancy or difficulty

finding words). A skilled interpreter may recognize an inappropriate testing situation, i.e., a situation that would embarrass the patient or make him unable to answer. With instructions from the clinician, the interpreter can explain the testing or interview situation to the patient and facilitate the assessment process by providing appropriate clarification and reassurance.

## The Complexity of Language in Mental Health

Ethnocultural identities and social position shape the language used to express experience. Every language has its own nuances of meaning tied to social predicaments, developmental experiences, and the structures of family and community life. These configure the language of subjective experience and emotion, which is a major focus for mental health assessment and intervention. Many people speak multiple languages, associated with different stages of development, education, migratory experiences, and periods in their life. Hybrid identities add additional complexity to the meaning and use of specific languages, which may be associated with specific aspects of identity or represent hybridity itself through creoles or patterns of switching (Harris & Rampton, 2002; Kirmayer, 2006).

Words have both denotative and connotative meanings. Denotation refers to the literal meaning of the word, while connotation involves the conventional associations that the word evokes. Connotations depend on social contexts, and even in the same linguistic or ethnocultural group, a word may have quite different connotations according to social class, educational level, and the context in which it is employed. Connotation can easily be lost if the interpreter translates word for word or does not have sufficient knowledge of the specific cultural contexts of the speaker and listener. A skilled interpreter works to find equivalent meanings, to convey not just the denotation but also some of the crucial connotations of specific words.

Capturing the meaning of words can be especially challenging in the domain of emotions. Cross-cultural research reveals that certain emotions with a precise name in one language do not have close equivalents in other languages (Russell, 1991). Further, emotions that are distinct in one language may be blended or conflated in another. Although cross-cultural research on emotions has suggested the universality of a small set of basic emotions (Mesquita, Frijda, & Scherer, 1997), more complex emotion terms refer to social situations and predicaments that are shaped by culture (Kövecses, 2000). Translating emotional meaning therefore requires not simply finding a roughly equivalent term but explaining the social situations and events that engender the feelings and that call for specific emotional and behavioral responses.

Patients who come from small or homogenous communities may use compressed, condensed, or elliptical forms of language that reference shared experiences and events (Bernstein, 1966). To an outsider, this style of expression may seem laconic, opaque, or inarticulate. The language of symptom expression and emotion is closely bound to linguistic and cultural idioms. Patients may also use linguistic idioms that only a fluent speaker knows and that serve to convey subtle shades of meaning or attitudes. Such idioms can easily be misunderstood when interpreted concretely (Keesing, 1985). Idioms may vary with education, social class, and ethnicity so that even a fluent interpreter can miss local meanings.

The language that patients use in a health care setting may not be the one they use at home or the language in which they are most able to access memories, emotions, or use meaningful idioms of distress. Social context and efforts to portray oneself as linguistically competent may influence the willingness to use languages even when interpreters are available. Patients' decisions to use or avoid specific languages can provide important clinical information. Some patients may prefer to communicate in a second language because it affords them more distance from distressing feelings. For individuals who have acquired different languages at different developmental stages or life periods, memories may be stratified in terms of language. Switching from one language to another can be done deliberately in search of the

right word or phrase, but it may also occur unconsciously as emotion intensifies or memories are accessed that are associated with a specific language, time, and place (Guttfreund, 1990; Westermeyer, 1989; Westermeyer & Janca, 1997). Language choice may be an adaptive strategy or ego syntonic defence and should not be discarded or ignored without appreciation of the patient's motives or intentions. Code switching may allow patients to move flexibly between social statuses and identifications, avoiding humiliation by agreeing to use the host culture language or denying affiliation with the maternal language to affirm a new identity.

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. The consultant must discuss these issues with the interpreter before the interview and intervene for clarification when interaction around particular emotional states seems dissonant or unclear to avoid misdiagnosis or inappropriate intervention.

## The Role of Interpreters in Treatment Interventions

Interpreters can be used to deliver psychotherapeutic interventions (Bolton, 2002; d'Ardenne, Ruaro, Cestari, Fakhoury, & Priebe, 2007). Various models of collaboration between interpreters and psychotherapists have been described in the literature (Baylav, 2002; Patel, 2002). Older models insist on the linguistic agent role of the interpreter as a neutral "translating machine" (Bradford & Munoz, 1993; Kline, Acosta, Austin, & Johnson, 1980; Price, 1975). Technical advice is given in order to overcome difficulties or risks associated with working with a third person in the consultation (Rack, 1982; Sabin, 1975). Unfortunately, the model of interpreter as a translating machine, or an invisible "nonperson" who does not have any influence on the interaction, ignores systemic interactional processes that may have major influence on the therapeutic process (Bot, 2005). More recent models emphasize that a skilled psychiatric interpreter should form a team with the psychiatrist (Westermeyer, 1989). After working together for a while, they will understand each other and know how to achieve therapeutic objectives together. The interpreter thus becomes a co-therapist, who is recognized as a full member of the team with psychotherapeutic skills (Mudarikiri, 2002; Westermeyer, 1989). At present, there is no clear evidence of the superiority of any one approach to working with interpreters in delivering psychotherapeutic or psychosocial interventions. The choice of a model therefore is dependent on practical and contextual factors, including the availability of interpreter services and other institutional resources, as well as interpreters' and practitioners' training, orientation, and cultural sensitivity.

**Table 5.5** Key principles in providing CBT interventions with an interpreter

- Before beginning, brief interpreters on the logic behind interventions
- Unless interpreter is qualified to work as a co-therapist, encourage short renditions regularly translated to allow tracking process
- Neutrality of the interpreter should be maintained when possible
- Let the interpreter be a cultural informant providing additional background after the session

## Cognitive Behavioral Therapy

Each form of intervention raises specific challenges for the interpreter. For example, d'Ardenne, Farmer, Ruaro, and Priebe (2007) provide a detailed protocol for administering trauma-focused Cognitive Behavioral Therapy (CBT) through an interpreter (Table 5.5). This intervention raises specific issues because trauma-focused involves directing the client to recall and think about traumatic experiences they may have tried to suppress and forget. Interpreters must be briefed on the logic behind this approach in order not to find the intervention overly distressing or interfere with the treatment by attempting to protect clients. The imaginal

exposure technique requires careful timing, with temporal proximity between what the clinician says and the patient exposure. For interpreters, this implies that they must translate short "chunks" and not pause for extended explanations of complex phrases or idioms. Comments on cultural meanings or ambiguities must be made after the consultation (d'Ardenne, Farmer et al., 2007, p. 316).

## Family Therapy

Family therapists have long recognized culture as a crucial consideration in intervention (Falicov, 2003; McGoldrick, Giordano, & Pearce, 1996). The interpreter can play different roles in the therapeutic system that includes the consulting family members and the therapist, but there is agreement that, as part of an interactional system, the interpreter is always more than a translator. The interpreter can provide valuable information on cultural concepts of family and kinship and facilitate exchanges on sensitive topics like gender roles or hierarchy (Hémon, 2001; Macciocchi, 2005; Raval, 1996).

DiNicola (1986) underlines the informational and therapeutic richness of having two languages present in a family therapy setting. He recommends a close working relationship between therapist and interpreter to increase the reliability of the translation. Providing an interpreter can allow members of the family who might otherwise be marginalized to participate more actively in therapy. DiNicola discusses how the process of code switching, i.e., shifting from one language to another, can reveal important information about affective and cognitive states as well as interactional patterns. Because family members may not all share the same language proficiency, language switches can serve as boundary markers between the family members; for example, a family member can switch into the therapist's language in order to reveal something that he does not want to be heard by the rest of the family. But DiNicola warns that attention to language should not divert the therapist from tracking the pattern of interactions that is essential to family assessment and intervention. Code switching is especially important to address intergenerational issues in migration because the emotional language of children and elders may differ and the use of language can highlight generational or dynamic issues crucial to understanding the family's conflicts or dilemmas.

In family therapy, the interpreter can help build common ground from which it is possible to do effective work even if expectations and beliefs are different (Macciocchi, 2005; Raval, 1996). Hémon (2001) describes how trained interpreters, with psychological knowledge, can function as "go-betweens" or culture brokers, adding necessary background information while providing the family with a reassuring presence as a compatriot who knows the health care institution and the therapeutic procedure. The third position is co-therapist. In Hémon's work, at the Centre Minkowska in Paris, the interpreter was usually a colleague or trainee mental health practitioner who speaks the family's language and who could, therefore, take an active role in the therapeutic process.

## Group Therapy

Group therapy practitioners from several theoretical orientations have also produced research and reflections on working with interpreters. While Westermeyer (1989) cautions against group therapy with an interpreter, as it might impede group interaction, recent work suggests that a group led by a therapist who does not speak the same language as the participants working with an experienced interpreter can be therapeutic (Kennard, Elliott, Roberts, & Evans, 2002). A high level of mutual understanding can be reached, but this requires close attention to the dyad of group facilitator and interpreter. According to Kennard, Roberts, and Elliott (2002), the group facilitator should be involved in the selection and training of the interpreter who plays an ongoing role in the group. As in family therapy, patterns of language use and code switching in a group can reveal boundaries, alliances, and areas of affect or conflict (Röder &

Opalič, 1997). The process of interpreting during the session allows time for the therapist to observe verbal and nonverbal behavior in the group: choice of language, timing of language switches, and attitudes of the group toward the therapist (Wolman, 1970).

## Psychodynamic Psychotherapy

Working with an interpreter in psychotherapy involves complex systemic interactions and emotional dynamics. Each of the three participants—patient, interpreter, and practitioner—will respond affectively, consciously or not, to the other two. This interplay of affective links is understood by psychodynamic therapists in terms of the concepts of transference and countertransference. Psychodynamic authors agree that these complex relations need to be clarified and integrated in the understanding of the patient's intrapsychic dynamics and responses in treatment.

When the interpreter is part of the therapeutic process, the patient may form two separate transferences, one with the practitioner and another with the interpreter. Due to the facility of communication and identification, the patient may develop a therapeutic alliance with the interpreter first (Westermeyer, 1993; Raval & Smith, 2003; Miller, Martell, Pazdirek, Caruth, & Lopez, 2005). The interpreter may be viewed in two opposing ways simultaneously. On the hand, the interpreter may be seen as an ally and a compatriot who shares a common language and has been through some of the same difficulties, with whom it is possible to identify. When interpreters themselves are migrants, this identification may include the impression that the interpreter occupies an intermediate and apparently successful position between two cultures (Aubert, 2008; Piret, 1991; Valero-Garcés, 2005; Westermeyer, 1989). At the same time, as a member of the same community, the interpreter may also represent a threat. Patients may fear a loss of confidentiality and exposure (Bot & Wadensjö, 2004), with the risk of being stigmatized in the community. Patients may feel ashamed having to disclose mental health problems or conflicts in the presence of a compatriot. Finally, some patients may have migrated in part to get away from their cultures of origin. They may therefore want to free themselves from their mother tongue, which they associate with difficult attachments, oppression, or other conflicts (Aubert, 2008).

Writing about psychodynamic psychotherapy with refugees, Rechtman (1992) advises clinicians to take advantage of the time used by interpreter and patient in the second language to observe the patient–interpreter interaction in order to evaluate its emotional tenor. Sometimes this presence of the interpreter leads to splitting in which the interpreter and practitioner may become polarized as good and bad objects in the patient's representations (Aubert, 2008; Haenel, 1997). For example, the interpreter may be viewed as the bad object, someone who might denounce the patient's political views, and the therapist as the good object, an omnipotent rescuer who will protect the patient (Aubert, 2008; Haenel, 1997; Bot & Wadensjö, 2004).

Of course, interpreters have their own identifications and emotional reactions to the clinician and patient. For example, interpreters who strongly identify with specific patients may overprotect them (Haenel, 1997) or normalize their discourse because of feeling embarrassed by the patient's pathology (Westermeyer, 1993). In some instances, interpreters may feel threatened by the patients for objective reasons like differences in political position or ethnicity or religion that were associated with discrimination, violence, or genocide in their countries of origin. Interpreters' may also present feelings of admiration for the therapist while depreciating patients (Haenel, 1997). If recognized, these relational processes can be helpful in exploring patients' dynamics. If not addressed, however, they may lead to disruptions in communication or a loss of safety that jeopardizes the therapeutic process. Many of these responses are ordinary, expectable emotional reactions that should not be termed transference or countertransference (Spensley & Blacker, 1976). Other feelings may reflect distortions or fantasies based on personal issues. A third level represents the collective

images or fantasies that patients and therapists have of each other in what has been termed ethnocultural transference and countertransference (Comas-Diaz & Jacobsen, 1991). All of these types of emotional reaction need to be explored in regular post-consultation debriefings between the therapist and the interpreter (Rechtman, 1992). The interpreter may need support from the clinician in dealing with patients and situations that evoke intense reactions.

In addition to therapist's potential countertransference toward the patient, a second countertransference can arise toward the interpreter. This may be positive, as when the interpreter is seen as someone with whom to share the difficult life experiences of the patients—holding the patient's emotional world might be easier for two instead of one (Miller et al., 2005). But therapists often have strong feelings of exclusion, powerlessness, and loss of control in interpreted consultations (Raval, 1996; Raval & Smith, 2003; Miller et al., 2005). Such strong reactions can jeopardize the therapeutic process if not detected and worked through (Darling, 2004).

The psychodynamic concept of resistance can also be used to understand aspects of patient–interpreter–therapist dynamics. Patient's resistance may be expressed by attributing a slip of the tongue to the difficulties of translation, talking only to the interpreter to avoid being more fully engaged in the therapeutic process (Piret, 1991), or using code switching to avoid the intensity of affect in the first language. Code switching can also be used intentionally by the therapist according to the effect wished, regulating emotional distance and sense of identification in order to overcome resistance, for example, using the patient's mother tongue to increase identification or decreasing the emotional intensity by using the therapist's language (Oquendo, 1996).

For psychodynamic psychotherapists, language is not only a medium for transmitting representations and affects but is it itself material to interpret in the therapeutic process. A choice of words, dialect, or language can represent both personal and collective issues of desire, regression, power, and history (M'Barga, 1983). A patient's language reflects both pragmatics and emotional dynamics (Rechtman, 1992). The word "interpreter" has a double meaning as someone who can translate from one language to another and someone who can grasp latent meanings within any action or experience (Darling, 2004; Kouassi, 2001; M'Barga, 1983). Some of these latent meanings are sedimented in language through metaphor or forgotten etymologies that may nonetheless influence thought and experience. Translation then can be considered a form of psychoanalytic interpretation to the extent that it brings unconscious meaning to conscious awareness. Translation difficulties can be used as a therapeutic lever, as work by French ethnopsychiatrists has shown (de Pury, 1998; Goguikian Ratcliff & Changkakoti, 2004). In these situations, the interpreter can function as a cultural informant explaining the significance of words in their social contexts to unpack the meaning of pathology, behavior or rituals.

Psychodynamic authors insist on the implication of the interpreter in the therapeutic process. Above all, interpreters must be aware of their own biases and be engaged in the therapeutic work, reflecting on its language (Khelil, 1991). For Kouassi (2001), interpreters should acknowledge their own subjectivity as this can help patients build links between their experience and the social world, as well as between past and present. But this is not an easy task, and interpreters may feel a dissonance between the ideal of neutrality imposed by ethical codes and the emotional involvement asked by the therapist or demanded by the therapeutic situation (Goguikian Ratcliff & Suardi, 2006) (Table 5.6).

**Table 5.6** Key principles for psychodynamic assessment and therapy with an interpreter

- Be aware of and address explicit and implicit transferential and countertransferential issues between the three protagonists
- Pay attention to and address particular forms of resistances that are likely to emerge in interpreted sessions
- Explore the implications of the choice of language
- Consider the interpretative nature of translations
- Use the interpreters' subjectivity as a valuable source of information

## Conclusion: Building an Effective Partnership

The effectiveness of cultural consultation is due in large measure to the systematic employment of professional interpreters. The CCS works closely with professional interpreters, developing a collaboration based on mutual respect, dialogue, and repeated experiences over time with many cases. Interpreters are not only essential for accurate clinical communication in intercultural assessment but can contribute to the delivery of effective interventions (Chen Wu, Leventhal, Ortiz, Gonzalez, & Forsyth, 2006). In psychiatry and psychology, interpreters sometimes have been seen simply as translating "machines" but this view is misleading and potentially harmful for patients. We have shown that there is a wide range of possible roles for interpreters, from "informative translator," who can add some information about contexts and meanings to both patient and practitioner, to full co-therapist, whose subjectivity and insight can play an important part in patients' recovery.

Effective work with interpreters depends not only on interpersonal trust but also on clinical settings that allow the practitioner to make full use of the interpreter's knowledge and skills. This requires transforming institutional understandings of what interpreters do and of their place in the health care system. This transformation involves action at multiple levels of policy and practice: establishing guidelines that will influence training, clinical interventions, institutional practices, and social norms. There is also a need for continued research on mental health interpreting. The principles found in ethical codes for interpreters, which were largely derived from nonmedical contexts, need to be empirically studied and new practices implemented that address the various roles and functions of interpreters and culture brokers in mental health care.

The cultural consultation process requires professional interpreters with specific training in mental health. In addition to training, interpreters need personal qualities that enable them to be sensitive to psychological issues, aware of their own emotional responses and potential biases, and alert to the ways they are likely to be perceived by patients from different backgrounds. Clinicians can play an important role in training interpreters. In the CCS, this has occurred both formally by providing workshops for interpreters and informally by working together repeatedly on cases.

For interpreters to take their proper place as health professionals in the health care system, there must be national, regional, and institutional policies in place and an adequate budget allocated to interpreter services. Training needs to be provided to mental health professionals on how to collaborate with interpreters (Leanza, 2008). Quality assurance standards need to formally require the routine use of interpreters in mental health and to monitor and enforce these standards.

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