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Working with interpreters across language and culture in mental health

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Abstract
Background: Mental health professionals need to be able to work effectively with interpreters to promote good clinical practice and ensure equality of access and service delivery as well as meet the requirements of European law. The process offers practitioners an opportunity to enrich their understanding of the diverse idioms of distress, cultural constructions and explanatory health beliefs.
Aims: This paper draws upon the literature and clinical accounts to provide a set of positive practice guidelines on working with interpreters in mental health.
Method: Key indicator words for the literature review were "interpreters and mental health" and "language and mental health". Papers that related purely to linguistic theory, cultural theory, or sign language interpreting were not included. To assist with triangulation of the data the authors also drew upon accounts of support and supervision groups for interpreters and bicultural workers, expert panels on the topic, training programmes and published guidelines for interpreters and clinicians.
Results and Conclusions: Mental health services around the world need to be accessible, inclusive, appropriate and accord with best practice and national legislation. The paper reviews opportunities and challenges in working with interpreters in mental health services and offers some positive practice guidelines for clinicians based on the available literature.
Declaration of interest: None.

Keywords: *Interpreters, bicultural, mental health, positive practice*

Why do we need interpreters?

As people increasingly move across national borders to live and work (www.statistics.gov.uk) there will be an increasing need for interpreters if access to mental health services is not to be limited to those fluent in the dominant language of the host country. At least three million people living in the United Kingdom were born in countries where English is not the national language (National Centre for Languages, 2006). This pattern is likely to be similar in many countries around the world. It is therefore important to ensure that health providers have access to interpreters and employ staff who are trained in working effectively and productively in partnership with interpreters.

This paper will not discuss in detail the use of British Sign Language (BSL) interpreters for Deaf people, as it has its own specialist literature, but merely note with concern the National Institute for Mental Health (NIMH, 2004) findings that the level and organization of mental health services for Deaf people were far from adequate. The NIMH report also comments on the need for more BSL interpreters to be trained as well as the need for

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clinicians to work alongside them and undertake relevant training. More recently, the UK government has recognized BSL as a language in its own right.

It has been suggested that the use of qualified interpreters in early mental health interventions is not only better clinical practice but may be cost effective as the costs of inadequate diagnosis and referral might be higher than employing qualified interpreters (Bischoff, Bovier, Isah, Francoise, Ariel & Louis, 2003). This requires further research. A number of studies have noted that language matching (when health worker and patient speak the same language or have access to qualified interpreters) leads to better health status assessments (Perez-Stable, Napoles-Springer, & Miramontes, 1997). It can also improve access and quality of care (Bloom et al., 2005; Ziguras et al., 2003), and that this can increase client trust and rapport with the provider, and improve the ability of the client to understand and follow the proposed treatment regiment (Ramirez, 2003). Farooq and Fear (2003) claim that the use of qualified and experienced interpreters will minimize qualitative distortions in psychiatric interviews.

While Gerrish et al. (2004) note that inadequate training of both nurses and interpreters adversely affected the quality of interaction where interpreters were used. Stolk et al. (1998) found that training health professionals in working with interpreters increased their willingness to work alongside interpreters. Difficulties seem to arise as a result of inadequate training for both parties. Further discussion of the challenges and pitfalls of working with an interpreter can be located in Elderkin-Thompson et al. (1982), Kravitz et al. (2000) and Vasquez & Javier (1991). Although, the economic costs of interpretation on consultation time is under researched, a study in the USA indicated physician time for consultations was increased from between 20 and 38 minutes when an interpreter was used (Kravitz et al., 2000).

Training for clinicians and interpreters

The Register of Public Service Interpreters (www.nrpsi.co.uk) or the Institute of Linguists (www.iol.org.uk) would be the organizations to contact when trying to locate a suitably qualified interpreter. The lack of a clear training structure in the past which provided interpreters with a comprehensive career structure and related professional recognition frequently militated against some people choosing this as a profession. Interpreters should be viewed as colleagues in the same way as another professional within a multi-disciplinary team would be. Issues of racism and power dynamics may require vigilance and discussion in supervision or other appropriate forums. Interpreters can not only enhance clinical work and understanding but are the ones that actually make it possible for mental health practitioners to communicate with their clients and vice versa.

The provision of good practice guidelines and appropriate training for clinicians and interpreters will benefit the service offered to patients as well as enhancing the confidence and skills of all the participants (Tribe, 1998; Williams, 2005). (Suggestions about training within a mental health context and a possible curriculum for such training can be located in Tribe & Raval, 2003, pp. 54–69).

Working in partnership with interpreters

Working with interpreters can feel initially challenging, some mental health practitioners report feeling anxious about working alongside interpreters in the consulting room (Raval, 1996). Others report feeling ambivalent about having a third person in the consulting room (Tribe & Morrissey, 2004). While some clinicians have reported that working with

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interpreters has led to feelings of being scrutinized or distanced from their clients (Kline et al., 1980; Roe & Roe, 1991).

Working in partnership with an interpreter may require the acquisition of new skills but can benefit all aspects of our clinical practice in a number of ways. At the micro level these may include encouraging reflection (Raval, 1996) and ensuring clarity of speech and thoughtfulness about our use of language (Tribe & Morrissey, 2004). At the macro level working trans-culturally can enrich practice. It may do this through requiring clinicians to question previously held assumptions and to widen their field of focus to appreciate other cultural constructions of behaviour, idioms of distress, contextual meanings and explanatory health beliefs. (Most mental health practitioners trained in Britain have undergone a training which is steeped in western values and views; this is frequently not recognized or acknowledged).

MacLachlan (2006) claims that it is through language that people establish ways of constructing reality. How this is subsequently negotiated is an issue of concern for people working clinically across cultures and has implications when working with interpreters. Thus, clinicians need to be curious and open in ensuring that they respect and understand other cultural constructions and explanatory health beliefs if they are to offer an appropriate and equitable service.

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Different roles for interpreters

It has often been assumed that an interpreter merely interprets the spoken word, whilst this is the primary task, an interpreter can also provide important cultural and contextual information which may have a significant bearing on the psychological issue being discussed. Raval (2003) has suggested that interpreting needs to advance meaning in the fullest linguistic and cultural sense. The role of bicultural worker requires experience on the part of the interpreter and the clinician to ensure that this information is contained and negotiated appropriately particularly within a mental health setting and does not merely reflect an over construction of the bicultural worker's own personal themes, premises and assumptions. Having said that, an understanding of the cultural, social and contextual variables of a patient's difficulties and life circumstances can provide vital information to the clinician and can ameliorate issues of racism or lack of acknowledgement of different cultural constructions and world views (Patel, 2003).

Theoretical underpinnings for the positive practice guidelines

In compiling the positive practice guidelines, Internet searches (2000 – 2006) were conducted using the words of interpreters and mental health and language and mental health. The following data bases were used and the number of references found: PubMed (12 references), Psycinfo (1 reference), CINAHL (interpreters and mental health (8 references), language and mental health (226 references), Ethnomed (126 references), OMINI (4 references plus additional links) and Education Resources Information Centre databases (2 references), as well as manual searches of references lists and associated books published in English (1986 – 2006). When only abstracts were available, the individual papers were located and references that were identified on other research papers were followed up. Many of the papers related to the use of the English language rather than to language interpretation and therefore were not relevant to this study. To assist with triangulation of the data the authors also drew upon accounts of support and supervision groups for interpreters and bicultural workers, expert panels on the topic, training

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programmes and other published guidelines for interpreters and clinicians. This is an emerging field and as Tribe and Raval (2003, p. 25) have noted "The literature in this area of work is restricted and largely limited to descriptive reports about difficulties that arise in the clinical work when done with the help of an interpreter". Wallin and Ahlstrom (2006) also noted in a systematic literature review of cross-cultural interview studies using interpreters that the role of the interpreter in health settings is usually only sparsely described in the literature. There is a need for further empirical data in this area.

Positive practice when working with interpreters

The following sections contain positive practice guidelines to support practitioners in structuring their own practice and move towards improving clinical service provision and the service offered to non English speaking clients. Supporting references have been inserted into the text for further reference.

The following suggestions relate to both health practitioners and service providers

- An agency (or service provider) may need to consider conducting a formal needs assessment relating to interpreting services, this might include obtaining base line data on the language needs of the communities they serve and a review of the languages spoken by staff.
- Lipton et al. (2002) alert us to the possible psychosocial consequences experienced by interpreters in relation to working with torture and traumatized clients. An interpreter is entitled to support in the same way as any other professional. Remember that a duty of care and employment responsibilities covers all employees (Management of Health and Safety at Work Regulations, 1999).
- Therefore, provide on-going support and supervision, interpreters have rarely had a comprehensive mental health training which would cover such topics as boundaries, self-care and are as susceptible to vicarious traumatization as anyone else (Tribe & Morrissey, 2004). Interpreters frequently hear very difficult information in sessions; for example that a client is to be detained in a psychiatric hospital, has been given a particular diagnosis or prognosis, descriptions of abuse or other events which may have life-changing or serious implications for the client.
- To protect the patient's confidentiality, the use of family and friends as interpreters is contra indicated (Juckett, 2005).
- Ensure that interpreters are viewed as part of the relevant team, respected appropriately and attend relevant meetings when deemed appropriate this will not only allow them to contribute to service provision and delivery but also help them understand the health trust and the work undertaken (Raval, 2005; Raval & Smith, 2003; Tribe & Morrissey, 2003).
- Ensure you provide appropriate induction and training for your interpreters, and clinicians even if you use an agency to provide interpreters, running appropriate training and information sessions may ensure that the interpreters are conversant with the organization's aims, objectives and culture (Kiramayer et al., 2003; Tribe & Morrissey, 2003; Williams, 2005).

Preparatory work before the consultation meeting

- Try to spend some time considering the implications of working within a triad rather than a dyad (Tribe, 2003). It may be helpful to discuss this with an experienced

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interpreter or with colleagues who have experience of working with interpreters. Working with an interpreter as a conduit makes you dependent on another person and increases the number of communication pathways in operation. This can change the dynamic of the meeting in a number of ways. These may include transferential issues becoming more complicated and two of the three parties not understanding the words of the other at any one time (Sande, 1998). This can initially be disconcerting.

- While Oquendo (1996) notes that cultural nuances may be encoded in language in ways that are not readily conveyed in translation, it may be useful to consider and reflect upon this in advance of the session.
- Establish what is the client's first language and use an interpreter who speaks this language, ideally from the same country, and when necessary the same dialect that the client speaks. Research shows that within a mental health context this will increase the likelihood of a useful encounter and outcome (Bischoff et al., 2003; Farooq & Fear, 2003).
- It is helpful to match for gender, age and religion, particularly if this is relevant to the psychological issue or dilemma in question, for example sexual assault or domestic violence (Nijad, 2003).
- If you are going to see the client for a number of sessions, try to use the same interpreter throughout, this will make the whole process flow better, be more containing for all the participants and is likely to lead to better outcomes (Raval, 1996; Tribe & Raval, 2003).
- The clinician, agency or service provider should check that ideally the interpreter has experience of working within mental health and if not that they feel comfortable working in this arena. If they do not do this the meeting may not be as productive as it might be (Tribe & Morrissey, 2003).
- It is inappropriate to ask family members or other staff to help out merely because they appear to speak the same language as the client (National Institute for Mental Health [NIMH], 2004; Pochacker, 2000).
- You may need to schedule a longer session, as moving between languages takes time and thought and these needs to be planned for. Remember that the work can be extremely tiring for the interpreter (Razban, 2003).
- In addition you should schedule 10 to 15 minutes before and after the session, if the interpreter is being paid on an hourly basis you need to ensure they will be paid for this time (Thompson, 2004). Spending 10 minutes before the session to discuss how you are going to work together, to explain the objectives of the meeting and to share any relevant cultural and contextual information, which are likely to inform the situation. This is time extremely well invested (Tribe, 1998). Clarifying the purpose of the meeting is important and should also take place at this point. This may also be an opportunity to clarify any specialist vocabulary or terminology, which is likely to arise (Thompson, 2004).
- Issues of accountability require consideration, i.e., who does the interpreter and client believe they are working for and accountable to? This requires clarification in the first session (Tribe & Morrissey, 2003). The client can put interpreters under considerable pressure to take on additional tasks and it is important that their role is clearly defined and transparent to all members of the triad (Razban, 2003).
- It is important to make interpreters feel at ease and ensure that they have the best opportunity to use their language skills and cultural understandings in the service of the client/patient (Tribe, 2005). You may wish to consider how you will do this. Green et al. (2002) claimed that failure to tackle communication problems through the routine provision of interpretation and advocacy services could lay the health service open to the charge of institutional racism.

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- The agency or trust should have written guidelines and a contract that interpreters are asked to adhere to and sign. You may need to ensure that your interpreter signs the contract of the organization or their professional body, which should cover such aspects as confidentiality, roles, responsibilities, ethics and boundaries (Tribe & Morrissey, 2003). For example, it is important that the client or service user maintains self-determination in the same way as any other client and this is not compromised by an interpreter being involved. If working with asylum seekers of refugee clients' issues of trust may be an issue and time may need to be spent addressing this issue (Tribe & Morrissey, 2003). Alexander et al. (2004) have noted that the issue of personal trust was seen as paramount by service users.
- Languages are not a set of interchangeable words or building blocks but construct and shape meaning. The latter has been illustrated by the social constructionists in relation to therapy (McNamee & Gergen, 1992) and in relation to working with interpreters in mental health by Mudakiri (2003). Each language also has its own grammatical structures and traditions. Something, which may take only a few words to say in one language, may take several sentences to be interpreted accurately. If the interpreter appears to be saying a lot more or less than you are, this may merely be a reflection of the different language structures (Tribe & Morrissey, 2003). If you feel concerned about this, ask the interpreter about it.
- Non verbal communication may contain any number of cultural variants so be mindful of this. It is easy to uncritically give NVC undue importance particularly when the interpreter is speaking to the client and you can not understand what is being said (Cushing, 2003).
- The interpreter would normally use the first or third person when interpreting. The authors believe using the first person helps gives a more accurate rendition of the words and emotions being expressed. Immediacy can also be conveyed better (Tribe, 2005).
- Consider the organization of the room and the positioning of chairs before the session starts. A triangle usually works best, although some clinicians prefer the interpreter to sit behind the client and literally become their voice (Cushing, 2003).
- Clinicians need to be extremely cautious in the use and interpretation of psychometric tests, first, they may not have been comprehensively interpreted and back translated. More importantly they may not have been validated for the population which your client is from. This would mean that the meaning of any results would be severely compromised (Holt Barrett, 2005). Rahman et al. (2003) writing about a screening questionnaire for mental health suggests that key informant interviews and focus groups should usefully be undertaken, as questionnaires may incorporate complex conceptual and construct issues.
- It may be appropriate to include any interpreters in induction courses that your agency runs. As well as having an integrating function, this would provide them with useful insights into the organizational culture and aims of the organization (Tribe with Sanders, 2003).

Within/during the clinical consultation/meeting

- It is important that you create an environment where the interpreter feels able to ask for clarification if the issues are not understood (Abdallah-Steinkopff, 1999; Gong-Guy et al., 1991). Your interpreter is not only proficient in two languages but is also likely to be an invaluable source of important cultural information which may be relevant to the psychological issue in question.

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- You may find that your client is initially uncomfortable with an interpreter being present, perhaps because they are concerned about confidentiality and information reaching other members of their community or simply embarrassed about not being proficient in English. It may help to explain that the interpreter is a professional doing their job, has no decision-making powers and is bound by the confidentiality policy of the agency and their professional body (Tribe with Sanders, 2003).
- You may need to adjust the pace of delivery and break your speech into shorter segments, because the interpreter has to remember what you have said and then translate it. Do not make the segments so short that they do not make sense. You should quickly develop a comfortable rhythm (Razban, 2003).
- Try to avoid using complicated technical language. Every discipline has its own abbreviations and language, so remember that the interpreter is unlikely to have received any clinical training in either of the languages they are working in. Some organizations have found it useful to have a specialized psychology or medical dictionary available (Tribe & Morrissey, 2003).
- Try to avoid using proverbs, sayings and colloquial language. If something does not make literal sense, it is best avoided. (For example how would you consider interpreting the following: "I want to pick your brains" or "teach your grandmother to suck eggs"). Unless your interpreter is familiar with these expressions they will experience difficulty interpreting them Tribe (2005).
- Try to avoid discussing with the interpreter any issues that do not require interpretation such as whether they are free to make the next appointment or related issues. This can make the client feel uncomfortable and excluded. If such issues do require discussion, get the interpreter to explain this to the client, or discuss these issues with the interpreter once the client has left (Razban, 2003; Baylav, 2003).
- Remember that words do not always have precise equivalents, and a short sentence in English may take several sentences to explain in another language or vice versa. So do not become impatient if the interpreter takes longer to interpret than you would have expected (Tribe with Sanders, 2003).

After the session

- Schedule 10 minutes with your interpreter after the session reviewing how you worked together and any other issues relevant to the session. You may also want to de brief the interpreter. As detailed earlier, you have a duty of care to your interpreter.
- Remember to complete any documentation that the interpreter needs, for example a time sheet (Thompson, 2004).

Conclusions

These guidelines are intended as a guide to enable clinicians to develop guidelines for the specific requirements of their organization or agency. Working with an interpreter can provide an opportunity to provide more accessible, inclusive and appropriate mental health services in addition to providing opportunities for the clinician to broaden their knowledge and understanding of a range of clinical perspectives, thereby improving their clinical competence and enhancing service delivery. However, there is evidence to suggest that health services do not always meet the communication needs of non-English speaking communities and it remains an area that in need for improvement (Audit Commission, 2001; Robinson, 2002; Turton et al., 2003; Vydelingum, 2000).

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