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Interpreters in Transcultural Psychiatry

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HIGHLIGHTS

- Effective use of interpreters can be improved by the training of clinicians.
- When using the assistance of an interpreter, the clinician should use qualified interpreters and be aware of the possibility for misunderstandings.
- Empowerment of patients could be an important factor in improving the quality of care for patients with limited language proficiency.

In recent years, globalization and humanitarian crises have exponentially increased the population of migrants worldwide and, thereby, the number of individuals with limited language proficiency (LLP) in the new host countries. In psychiatric care, verbal communication

between clinicians and patients is essential and remains the primary method to ensure an accurate diagnosis and provide effective treatment. A qualified interpreter should assist encounters between clinicians and patients with LLP. A qualified interpreter is one whose language skills have been assessed; who has received formal training in interpretation techniques; who has knowledge about ethical standards, psychiatric terminology, and cultural nuances about mental health; and who has demonstrated the necessary skills to effectively interpret communications in a health care setting (1). It is a legal right for patients with LLP to be assisted with a qualified interpreter in most countries, including Denmark (1, 2).

A systematic review of studies about the effects of LLP and the use of interpreters on the quality of psychiatric care found that the use of professional interpreters can improve provider–patient communication and patient satisfaction. The same review found that miscommunication between clinicians and patients with LLP can lead to the inappropriate discontinuation of pharmacological treatment and unnecessary hospitalizations (3). Furthermore, studies have found a high risk of misdiagnosis among patients who are immigrants and refugees, who are likely to have LLP (4). Inaccurate interpretation of verbal and nonverbal

communication can lead to a misunderstanding of patients' symptoms. Hence, the quality of interpretation in psychiatric settings is essential to ensure accurate diagnosis and appropriate treatment. Effective interpretation requires adequate understanding of idioms of psychiatric distress, cultural views about mental health, meaning of body language, and other nonverbal communication in the context of psychiatric assessment and treatment.

It is essential that clinicians become aware of the complexities involved in interpretation; identify the skills and experience required of interpreters; and develop awareness about best practices before, during, and after an encounter to increase the chance of adequate communication (5).

This column discusses challenges encountered in the use of interpreters in transcultural psychiatry through a clinical case example and describes key areas of working effectively with interpreters in psychiatric settings.

Case Example

The following case example shows how patients in a minority group are particularly vulnerable to

misunderstanding and, therefore, misdiagnosis, which can result in inadequate treatment due to language and cultural barriers. The patient described has given oral and written consent.

After living in a violent marriage, a 53-year-old woman of Turkish origin was referred to the Competence Centre for Transcultural Psychiatry (CTP) in Denmark for assessment and treatment of suspected posttraumatic stress disorder. The patient's primary care physician (the first author [SS]) at CTP was an ethnic Dane. The patient spoke only a little Danish, so it was suggested that they work with an interpreter. The interpreter was a woman born to Turkish parents in Denmark; Turkish was her second language.

The patient grew up in Istanbul with her family and had been in Denmark since 1999. In the initial assessment, the patient described racing thoughts and anxiety, especially in relation to bacteria, and the doctor noted several psychiatric symptoms (e.g., sparse eye contact, the presence of thought disturbances, and probable auditory hallucinations). On the basis of these observations, it was suspected that the patient was psychotic. There were barriers in communication, and the interpreter had trouble translating what the patient

was saying. In the debriefing between the interpreter and the doctor, it became clear that the interpreter was skilled and highly professional but still could not make sense of the patient's statements and that, because of the language problems, an accurate psychopathological examination was not possible. Therefore, it was decided that the patient should be seen by a doctor at CTP who grew up in Turkey (the second author [NS]) to resolve any culture- or language-related misunderstandings or errors.

NS spoke to the patient without an interpreter and carried out parts of the Present State Examination. NS noticed that the patient used many metaphors, which is common in Turkey. For example, when the patient was asked how we could help her, she replied, "My problems have become like algae; it does not matter how much of it you remove, after a while, it will stick to me again." NS explained that an interpreter who was not born and raised in Turkey could have difficulties understanding these metaphors. A flow of speech with many metaphors could, therefore, be perceived as incoherent.

NS had speculations as to why there was poor eye contact, and with her knowledge of the Turkish culture and customs, one explanation could be that the patient

was divorced. In Turkey, divorced women of this patient's generation would typically not make eye contact with men. After many years of this practice, it is likely to become a habit and a more general behavior when encountering both men and women. NS further mentioned that the poor eye contact also could reflect the patient's skepticism about the Danish health care system. Of course, the lack of eye contact could also be due to other reasons, such as shyness. NS did not find the patient to be psychotic.

NS could not continue the treatment, given that she was about to finish her employment at CTP. On the basis of NS's examination and considerations, the decision was made to switch to a Turkish-born interpreter. The Turkish-born interpreter had no trouble understanding the patient, and he did not perceive the patient's speech as incoherent, which was reflected in the interpretation, so that the conversation between the patient and the doctor was now fluid. After the change of interpreter, the patient was also no longer assessed as psychotic and, accordingly, antipsychotic treatment was not initiated.

Factors Influencing Interpreter-Mediated Encounters

The case example presented earlier illustrates important aspects of interpreter-mediated encounters that can affect treatment outcomes. In this section, we discuss strategies to address factors pertaining to clinicians, interpreters, patients, and systems.

Clinician-Related Factors.

Training clinicians in the use of interpreters has received insufficient research attention. Researchers who have worked intensively with interpreters have recommended better equipping clinicians for the demanding task of working with interpreters (6). To our knowledge, there exists only little formalization for training clinicians in using interpreters. Consequently, clinicians' skills vary by level of training and experience. With no formalized training of clinicians, we face a systemic challenge that needs to be addressed on a policy level. Clinicians must be made aware of the ways in which an interpreter's training, experience, and background can affect the clinical encounter (2). Clinicians' attitudes toward interpreters can also affect the care received by patients with LLP. Clinicians could perceive interpreter-mediated sessions as too burdensome and less fruitful because of the need to coordinate with the interpreter and the concern of having less time for actual treatment. The

clinician may also experience the presence of an interpreter as negatively affecting the interaction and alliance with the patient.

Interpreter-Related Factors.

The assistance of an interpreter can lead to a better understanding of the patients' symptoms, but it can also increase the risk of errors in communication; this could occur, for example, if an interpreter abbreviates, adds to, or substitutes the clinician's wordings (3). Interpretation services in mental health settings vary across countries and treatment facilities, and it is difficult to ensure a sufficiently high quality of interpretation across nations. In some countries (e.g., Denmark), interpreters are not required to have any formal certification or training to work as interpreters in the health care system, whereas in others (e.g., the United States), professional interpreters are required to be certified in medical interpretation. Hence, levels of interpreter training, experience, and cultural understanding vary greatly. Internationally accepted standards for the certification of interpreters and guidelines for interpreter-mediated encounters are lacking. Such standards and guidelines would likely have a positive impact on the quality of interpretation and treatment. Mandatory certification

programs for interpreters in more countries are recommended.

Addressing Patient-Related Factors.

All three parties that constitute the triad in an interpreter-mediated clinical encounter play important roles in the outcome. Misinformation or feelings of disempowerment among patients can affect their access to interpreters and their level of engagement during the encounter. Thus, empowerment by providing information about legal rights and guidelines for clinicians working with interpreters can be a cornerstone in achieving equal quality of care for patients with LLP. It is the clinician's responsibility to provide this information to the patients.

There can be several reasons why a patient with LLP would not choose an interpreter; for example, an uncertainty of confidentiality, which the clinician should be aware of and address (7). Future research could aim to better understand patients' experiences with and perspectives about interpreters, given that research in this area is currently insufficient.

Addressing Structural Factors.

Clinicians should also be made aware of how to address

potential structural barriers for achieving good quality of care when working with an interpreter. Barriers include the following: access to interpreters; costs involved in using a qualified interpreter; availability of needed technology to conduct sessions (e.g., video conference equipment and speakerphones); interpreter and clinician training; and a lack of framework comprising the possibility of briefings before the encounter (e.g., to give essential information or instructions to interpreters) and debriefings after the encounter (e.g., to create learning opportunities and to ensure the quality of the service provided to the patient) (8).

Accessibility and cost.

Well-known barriers concerning the accessibility of adequate interpreters are as follows: rare languages and dialects; lack of 24-hour emergency interpreter services; and the logistics of arranging for an interpreter, which can be cumbersome for providers. These barriers may prevent patients from receiving the interpretation that they need. It can also result in an undesirable dual role for bilingual staff or family members. Continuous collaboration between the same clinician and the interpreter throughout a treatment course is often a

preferable situation, but it is not always possible because of accessibility issues. This may affect the alliance between patient and clinician.

Whether interpreter services are free of charge to the patient or funded by public health systems varies greatly across countries. Lack of access to free interpreter services can be a great barrier and can result in the underutilization of health care services among people with LLP.

Frameworks.

It is possible that the misunderstandings in the clinical example given earlier would not have been detected had there not been an opportunity for clinicians and interpreters to debrief after the session and give feedback to each other. Briefings and debriefings give the clinicians and interpreters the opportunity to forestall or rectify misunderstandings, mistrust, and misinterpretation (9). Structured supervision can be valuable to interpreters because they, like clinicians, can have professional and personal challenges because of their demanding job. Supervision can be an important tool for improving the interpretation provided and enforcing the interpreters' professional identity (10).

Ethical Aspects in the Interpreter-Mediated Session

Ethical dilemmas can arise in an interpreter-mediated session. Patients with LLP should give informed consent for treatment, and clinicians must monitor adequate understanding. Ethical acceptance by the patient is important as to whether he or she agrees to have an interpreter, so that the patient's opinions on the quality of the interpretation can be expressed. The issue of patient confidentiality has already been mentioned, but it is important to emphasize the importance of confidentiality and impartial interpretation. Without these elements, the essential trust between patient and clinician in a psychiatric setting may be compromised.

Perspectives and Recommendations

The clinical case described in this column highlights several factors that can affect the quality of interpretation, such as the origin, ethnicity, and gender of the interpreter; the ability of clinicians to identify misunderstandings; and inadequate interpretation that can cause misunderstandings in the diagnostic process. The case also shows how having a qualified interpreter can change the course of diagnosis and treatment.

The risk of misunderstanding in interpreted-mediated sessions is probably inevitable but may be reduced through several strategies. It is important to scientifically elucidate the clinical consequences of errors in interpretation and the possible ways to decrease the risk of errors, such as through training programs. On the basis of the existing knowledge, we highly recommend the development of standardized clinician training on working with interpreters, promoting the use of qualified interpreters in mental health settings, and creating opportunities for patient empowerment. Attention on possible structural barriers, such as accessibility should also be brought forward to secure the best possible conditions for patients with LLP.

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