

Good practice issues in working with interpreters in mental health

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If access to appropriate mental health services is not to be limited to people's ability to speak a dominant or host language used by mental health providers, an interpreter or bicultural worker will be required. This article makes suggestions for good practice in working with interpreters either in situations of ongoing-armed conflict or with asylum seekers refugees and internally displaced people who have fled from areas of armed conflict.

Key words: Interpreters, language, culture, mental health, psychological well-being, training, support

Context

More people are migrating across borders or within countries either as displaced people owing to armed conflict or for other reasons. UNHCR (2003) gives a figure of 20.6 million people 'of concern' at the beginning of 2003, compared with 19.8 million in 2002. The 2003 figure roughly equates to one out of every 300 people world-wide. Issues of good cross-cultural communication are thus becoming increasingly important within health services, and language is a central facet of this (Bischoff, Bovier, Isah, Françoise, Ariel & Louis, 2003). Without a common language, people are unable to communicate their requirements and health workers their ser-

vices, with negative consequences for psychological well-being and service provision. A range of studies have noted that language concordance (when health worker and patient speak the same language or have access to qualified interpreters) leads to better access to health care, quality of communication, patient satisfaction, fewer emergency visits and improved compliance with health regimes (Lee, Batal, Masselin & Kutner, 2002; Eyton, Bischoff, Rrustemi, Durieux, Loutan, Gilbert & Bovier 2002; Riddick, 1998; Stolk, Ziguras, Saunders, Garlick, Stuart & Coffey, 1998; Perez-Stable, Napoles-Springer & Miramontes, 1997; Manson, 1988; Morales, Cunningham, Brown, Lin & Hays, 1999). The inability to communicate can have particular resonance in situations of armed conflict, when individuals, families and communities may be displaced or fragmented. The inability to speak the dominant or host language might exacerbate feelings related to displacement and this may be counter to good psychological well-being and health. The resulting problems of access to mental health services and exclusion of individuals or communities may mean that different cultural perspectives are not represented or considered when these services are developed, and that services

offered might be inappropriate or not meaningful to members of target groups. An interpreter often provides an important link between the two parties and their contribution should be respected accordingly. It is also important to remember that most communities contain people who offer 'mental health' services but who might label their work differently, and who may not be identified as such by those using purely western frames of reference.

Working with interpreters in mental health: key issues

The question of whether interpreters should merely translate the spoken word or play a role in interpreting cultural and contextual variables that may be relevant to the mental health issues in question is a complex one, especially when someone has fled to another region or country because of armed conflict or when the mental health worker¹ is from a different cultural background to the person seeking help.

The modern disciplines of Psychology and Psychiatry were generally developed in a 'western' context, in America and Europe. There has been a developing view that some of the knowledge that they embody and its applicability will be limited by this particular context (Fernando, 1991; Young, 1995; Summerfield, 2002; Mezzich, Kirkmayer & Kleinman, 1999; Owusu-Bempah & Howitt, 2000; Richards, 1997). For example, views on the body and the mind as separate or interwoven entities, notions of the self, views of the family structure, treatment options, notions of individualism and collectivism may differ materially in different cultures, and an interpreter/bicultural worker may need to ensure that these differences are communicated to a mental health worker².

The power and politics of language to allow

or block communication should not be underestimated at either the individual or community/national level, and can have particular resonance in a situation of armed conflict. Language has also been used at various times to restrict access to, for example, due legal process. In South Africa under apartheid, legal proceedings were conducted in English or Afrikaans, effectively excluding more than half the population (Sacks, 2000). Alternatively a number of regional communities are working hard to retain their language from a dominant or historically-imposed language and through this protect their cultural identity, for example in Wales and Catalonia. Also, after the break up of the former Federal Republic of Yugoslavia, the various new countries changed the name of the same language associated with their old country from Serbo-Croat to Serbian, Croatian and Bosnian respectively.

Issues of control and accountability between the mental health worker, interpreter and client can be exacerbated when language and culture are not shared (Patel, 2003; Mudarikiri, 2003; Tribe, 2004). In situations of armed conflict and displacement particular consideration is required to ensure that people have access to the best possible service, and feel that they have been heard and respected and not further dis-empowered. The very experience of being in a situation of armed conflict or displacement can itself be very frightening and threatening to individuals and communities. Interpreters can provide an essential voice to those who wish to access mental health services. The people they might normally turn to may be unavailable or displaced themselves.

Languages are not interchangeable. Words in one language might not exist in another (Hoffman, 1998) or may reflect a culture or

societal context (Stroll, 2002). Time frames and the pattern and placing of tenses do not correspond across some languages (Tribe, 2004). Translating between languages can in effect mean translating between two separate world views. Various languages do not always distinguish between present, perfect and pluperfect tenses and grammatical constructions can differ in a number of ways. Language is multi-faceted, dynamic, and constantly changing to incorporate new words or societal changes. The exact relationship between language and meaning is contested. Many theorists argue that language not only transmits meaning but also constructs and shapes it at the individual and societal level (Anderson & Goolishian, 1992; Burr, 1995). Generally then, language bears a close relation to particular ways of construing meaning that may not be shared across cultures (Mudarikiri, 2003), and may both reflect and shape how the world is interpreted.

Models of Interpretation

Four basic models of interpreting are presented below, although other writers offer slightly different accounts.

1. The linguistic mode, where the interpreter tries to interpret (as far as is possible) word-for-word and adopts a neutral and distanced position (Cushing, 2003; Tribe, 1999).
2. The psychotherapeutic or constructionist mode, where the meaning/feeling of the words is most important, and the interpreter is primarily concerned with the meaning to be conveyed rather than word-for-word interpretation. (Tribe, 1998b, 1999; Raval, 2003).
3. The advocate or community interpreter, where the interpreter takes the role of advocate for the client, either at the individual or wider group or com-

munity level, and represents their interests beyond interpreting language for them (Drennan & Swartz, 1999; Baylav, 2003; Razban, 2003).

4. Cultural broker/bicultural worker, where the interpreter interprets not only the spoken word but also relevant cultural and contextual variables (Tribe 1998a; Drennan & Swartz, 1999).

Each of the above models of interpreting has their place and will be appropriate in particular circumstances. For example the linguistic or word for word approach will be most appropriate in a medico-legal setting when purely factual information is required and any psychological meaning or emotional resonance is seen as marginal or largely irrelevant. This model assumes that to some degree languages are inter-changeable codes, which relate to a universal set of meanings, it minimises the differences between languages and the ways they construct meanings³.

The psychotherapeutic or constructionist mode is most useful when working within a context of psychotherapy or counselling where the meaning/feeling of the emotions and words is paramount and the interpreter is primarily concerned with ensuring that the meaning of the client's words and emotions are conveyed rather than purely concentrating on the linguistic forms⁴. This model gives the interpreter more flexibility to manoeuvre in ensuring that the client's meaning is accurately conveyed but also requires a higher level of responsibility, expertise, training, and trust between the client, mental health professional and the interpreter. If it is to be used, all three members of the interpreting triad must feel prepared and comfortable with it. The interpreter is likely to require additional clarity and guidance on working in this way. It will be most suitable if there is to be a series

of meetings rather than a one off assessment.

The advocate or community interpreter is important in ensuring that a community or faith group with specific health or cultural views and needs are understood and met. The role is broader than those explained previously and might include empowering the client to negotiate or challenge the health care offered at the individual level as well as challenging at the service provision level. In Britain health advocates or link workers are employed by and throughout many parts of the National Health Service to try and ensure that there is some equity of health provision and appropriate service provision regardless of the patient's language skills.

Finally a bicultural worker or cultural broker is concerned with interpreting cultural and contextual variables as well as the words.

This model is based on the view that to understand the client's emotional world it is important to understand their context and cultural worldview. The latter will be extremely useful when working within mental health and psychological well-being; but it requires trust, open communication and shared responsibility between the client, interpreter and mental health practitioner. This model of working is recommended when there is time to develop these characteristics; when the interpreter is experienced and the mental health worker has developed experience and expertise with working with interpreters and feels comfortable working in a more collaborative manner.

Regardless of which model of interpreting is employed it is vital that the mental health worker and interpreter are clear about how they are going to work together and that this is agreed in advance, if not the session is unlikely to work well.

Establishing a working agreement with interpreters: good practice issues

Research repeatedly shows that family members do not make good interpreters and good practice would of course preclude the use of children. Reasons cited are lack of training in interpretation skills, a thorough understanding of two cultures, as well as inability to act as cultural mediators (Lee et al, 2002; Launer, 1978; David & Rhee, 1998; Ebden, Bhatt, Carey & Harrison, 1988). Ideally, agencies should use trained interpreters, have written guidelines and a written contract for their interpreters. Trained and qualified interpreters are language and/or cultural experts, and should be treated with professional respect. Unfortunately, interpreters report that frequently this does not happen, (Baylav, 2003; Tribe with Sanders, 2003; Razban, 2003).

The importance of contracting within mental health work has a long history (Sills, 1997). A contract is an agreement between two or more people that contains, supports, gives structure and provides clarity and definition to the process and the contractual arrangements. Establishing a working agreement from the onset is a good way to ensure that the work undertaken commences as smoothly as possible. The exact nature of the contract between an interpreter and an agency will depend on the context but are likely to include such areas as confidentiality, roles, responsibilities, ethics, professional issues and boundaries (Sills, 1997). For example, it is important that the client retains self-determination in the same way as any other client and that this is not compromised by the presence of an interpreter. Interpreters who have not undergone training or have no contract might believe that they are being helpful by

meeting the client outside the session, while mental health workers may view this prejudicial to the therapeutic process. A contract will also make clear what an interpreter can expect from the employing organisation. All these issues can be addressed in a contract, which will also be influenced by the organisation's wider mission, the organisational culture and the way they view interpreters and the role of language. Interpreters may be full-time members of the team, employed on an ad hoc basis, representatives of a community organisation, hired from an interpreting agency or simply be people known to speak a relevant language and are 'brought into help' without any contractual relationship with the agency. The latter is more likely in situations of armed conflict or when resources are very tight. It is far from ideal, and should only be considered when no other alternative is available. Most organisations working with interpreters will have examples of the contracts they use and these can be tailored to meet specific requirements.

Additional issues

This section is not definitive or comprehensive but may help you develop specific guidelines for the particular context, cultural location and requirements of your own work⁵. It can also be useful to consult codes of practice for interpreters and guidelines for working with interpreters used by other agencies. Local interpreting services and national organisations, where they exist, should also be able to assist. Circumstances of armed conflict or displacement may mean that it may be difficult to always follow best practice guidelines but these should be used as a benchmark for good practice, and ensure that the best possible service is offered to people requiring interpreters.

- Find out the client's first language and try and book an interpreter who speaks this language, ideally from the same country, and when necessary the same dialect.
- Do not assume that someone who speaks a language can speak and understand all its dialects. Especially in a mental health context, the patient's [client's] exact meaning and intent will be extremely important (Patel, 2003; Marshall, Koenig, Grifhorst & Van Ewijk, 1988; Tribe with Sanders, 2003).
- It is often helpful to match an interpreter and client for gender, age and religion, particularly if this is relevant to the meeting or consultation, for example where it concerns a sexual assault or domestic violence (Patel, 2003; Nijad 2003).
- If you are planning to see the client a number of times, try to use the same interpreter throughout, to facilitate the process for all the participants. Ideally, chose an interpreter with experience of working within the arena of mental health and who feels comfortable about doing so.
- It is important to create a good environment where each of you feels able to ask for clarification if the issues are not understood.
- Try and avoid using technical or specialist terminology whenever possible. If this is unavoidable, try to ensure beforehand that the interpreter is familiar with the terminology, as this can minimise the potential for misunderstandings.
- Time spent with the interpreter reviewing any specialist words to ensure clarity of meaning between the two of you is often well spent.
- Whenever possible, meet the interpreter for 10-15 minutes before the actual meeting to explain the purpose of the meeting

and allow both of you to clarify any outstanding issues. It can also be an opportunity to clarify any technical concepts, vocabulary or jargon, which is likely to be used, as well as to check whether there are any cultural issues likely to bear on the situation.

- Some medical and legal agencies find it useful to have a specialised medical or dictionary of psychological words available for interpreters to consult (Tribe & Morrissey, 2003).
- Your interpreter is not only proficient in two languages but is also likely to be a valuable source of relevant cultural information if you allow them to be.
- It could be appropriate to include any interpreters in induction courses or relevant meetings held by your agency. As well as having an integrating function and acknowledging their contribution, this can provide a learning opportunity for mental health workers. It can also provide useful insights into the organisational culture and aims of the organisation (Tribe with Sanders, 2003).
- You should consider in advance how to arrange a three-way consultation, perhaps re-arranging the furniture before the patient arrives. Some people believe a triangular shaped arrangement works best, where everyone can see everyone else; others believe that the interpreter should sit behind the patient and act merely as the patient's voice, using the first person singular.
- If you are working in a refugee camp or a situation of armed conflict you might have to conduct a meeting in a semi-private or communal area, and may need to consider in advance how issues of best practice and confidentiality are maintained.
- You should consider the pace at which

you speak when you work with an interpreter. The interpreter has to remember what has been said, translate it, and then convey it to the other person. If you speak for too long, the interpreter may struggle to remember the first part of what you said. Conversely, if you speak too slowly, you may find that your speech becomes fragmented and you lose the thread of what you are saying. You will find that with open communication and trust, a comfortable rhythm becomes established, with which everyone feels comfortable (Razban, 2003).

- Try to avoid using proverbs and sayings, as these tend to be culturally embedded or located. If something does not make literal sense, it is best avoided. For example, in English the expression that someone is 'flying a kite' can mean just that, but is more likely to refer to someone saying something to see how people will react. Also, the English language uses a lot of metaphors and expressions, which relate to sport. To take a cricketing metaphor, people say, 'you are on a sticky wicket' to mean that someone is in a difficult situation. Or 'it just isn't cricket' which means that someone has broken the agreed rules in a situation, and that their behaviour is seen as highly unacceptable. An interpreter cannot be expected to know what all such expressions mean, particularly when they occur in a conversation about mental health.
- Try to spend a few minutes with your interpreter after each session reviewing how you worked together and discuss any other pertinent aspects.
- You have a responsibility to help the interpreter to de-brief after the session and to ensure that any support they need is available.

- Make the interpreter comfortable enough to give his or her impression of the meeting and your work together.
- If the interpreter and client are from a different cultural background to your own, you should also use the time to ask the interpreter to clarify any relevant cultural issues arising from the session.
- It is bad practice to ask interpreters to wait with the person/family without you as they are often put under immense pressure to take on tasks beyond their remit unless they are specifically employed as an advocate. Training may have assisted interpreters in negotiating the appropriate boundaries surrounding their work and role.
- It is also important not to discuss anything with the interpreter in front of the client that does not need to be said to the client, as this can make the client uneasy. If such issues require discussion, get the interpreter to explain this to the client or discuss them with the interpreter before or after the meeting (Razban, 2003; Baylav, 2003).
- Welcome criticism of yourself, even if you do not agree with the interpreter.

Training issues

Lack of a professional identity and regulated training for interpreters is an issue in a number of countries (Tribe with Sanders, 2003, Hwa-Froelich & Westby, 2003). Working as an interpreter frequently requires skills, knowledge and training beyond an ability to speak two languages fluently. Training and qualifications for interpreters vary across countries, as do the legal and professional requirements, although this need is increasingly recognised, with a range of qualifications currently being offered in a number of countries. For example, in the UK a range of

diplomas, certificates and Masters level qualifications are available. The Institute of Linguists and the Languages National Training Organisation are attempting to formalise interpreting as a profession through mechanisms such as the National Vocational Qualifications framework, the National Language Standards and the Register of Public Service. It is hoped that this will go some way to recognise the contribution made by interpreters and enhance their role and status. Interestingly, although training for interpreters is often seen as necessary, there is not always the same enthusiasm for training by mental health workers themselves. There appears to be an assumption that they will somehow know 'how to do it', but in general this is not the case. A study by Elderkin-Thompson, Cohen Silver & Waitzkin (2001) noted that errors in interpretation occur frequently when bilingual nurses (untrained in interpretation skills) acted as medical interpreters. They stressed the need for skills training in interpretation.

Difficulties seem to arise as a result of inadequate training for both parties. Stolk et al (1998) found that training health professionals to work with interpreters increased their readiness to work alongside them. Granger & Baker (2003) noted that more experienced interpreters are more likely to see the need for training both for themselves and for the worker they are interpreting for. Further suggestions about training for mental health workers and interpreters can be found in Tribe with Sanders (2003). Minas, Stuart & Klimidi, (1994) undertook a survey of clinical staff in psychiatry in Australia, and argued that the importance of language in all aspects of psychiatry and mental health has been largely ignored, and that this requires urgent change. The role of interpreters is a

sophisticated and difficult one, and within a mental health context this will require a range of skills including knowledge of specialist terminology, ability to reflect on meaning, memory skills and the ability to convey accurately the meaning of the emotions expressed. Other competencies might include an understanding of therapeutic boundaries, issues of confidentiality and therapeutic practice, professional and ethical issues, and dealing with conflict among others. A possible curriculum for in-house training course for interpreters in mental health can be found in Tribe with Sanders (2003).

Using trained rather than ad-hoc interpreters may not only provide a more acceptable option but also enrich the worker's understanding and clinical repertoire. This may happen through offering different understandings and constructions of mental health/psychological well-being and health, with the additional benefit that appropriate and meaningful mental health services are offered. Working with an interpreter may be challenging and require skills acquisition on the part of the MH worker as well as offering opportunities to re-consider preconceived notions of mental health. Undertaking a meeting/consultation with an interpreter can take longer, as twice as many words have to be spoken (Cushing, 2003; Tribe & Morrissey, 2003) and it is important to plan for this.

Process and relationship issues

Working with interpreters can challenge the notion of the traditional mental health dyad. Moving to a three-way or triadic interview can change the dynamics of the meeting, for example issues of transference may require attention. Other process issues might include the client developing a therapeutic or primary alliance with the inter-

preter rather than with the mental health practitioner. If the meeting has a therapeutic focus this may complicate the work and may require attention. As mentioned earlier an interpreter provides an essential service and can ease or mediate the encounter between clients and mental health workers from cultures alien to one another. The presence of a fellow national or member of a familiar community can increase feelings of trust and belonging which the client feels towards the agency and practitioner (Saxtroph and Christiansen, 1991). An interpreter can ease communication and can bridge gaps or differences between the health professional and client. It may also enhance the health professional's understanding of the client's history and culture. Working with an interpreter entails dependence on another person, and this can again change the dynamic of the meeting in a number of ways (Patel, 2003; Mudarikiri, 2003). Issues relating to any preconceived beliefs held by the different members of the triad will also have relevance here. Conversation conducted using interpreters is sometimes referred to as mediated communication, as it is mediated or processed through an interpreter or through a second language (Holder, 2002). Something, which may take a few words to say in one language, may take several sentences in another if the true essence of the communication is to be conveyed. People using interpreters for the first time may find this challenging. How language can change in the process of being interpreted by another individual is still not thoroughly understood and is outside the scope of this article⁶.

A person or family may feel uncomfortable with an interpreter being present. There are several possible reasons. It might be because they are concerned about confidentiality and about information reaching

other members of their family or community, or simply because they are embarrassed. It is important to be cognisant of this, in communities where mental health issues are viewed as having negative connotations and carrying stigma (Razban, 2003) or where armed conflict has compromised a community in some way. Sometimes people are reluctant to admit their need for an interpreter. This may need to be discussed, and ideally the person's decision should be respected with due regard to their particular circumstances. It may help to explain that the interpreter is a professional who has no decision-making powers, and is bound by their contract and the confidentiality policy of the agency (Tribe with Sanders, 2003). The literature shows a range of responses from mental health workers, and all may be worth considering when working in partnership with interpreters. For example, according to Raval (1996) some mental health workers reported that using an interpreter enabled them to be more reflective in their work, while clients said they found it easier to discuss their cultural and religious location, which would seem to be a significant benefit. Raval also reported that practitioners felt that using an interpreter gave them increased respect for trained interpreters and a positive reaction to the use of interpreting services. Kline, Acosta, Austin & Johnson (1980) reported that clients felt better understood. Hillier, Huq, Loshak, Marks & Rahman (1994) reported that clients using an interpreter had a higher return rate following assessment. Other effects noted include mental health workers feel scrutinised or distanced from their clients (Kline et al., 1980; Roe & Roe, 1991). Drennan & Swartz, (1999) have noted the many positive accomplishments of interpreters, and cite several studies, which emphasise interpreter initiative.

Bischoff et al (2003) investigated whether language barriers in screening asylum-seekers in Switzerland affected reporting of health problems and referral to appropriate care. They noted that 'adequate language concordance was associated with higher reporting of past experience of traumatic events and severe psychological symptoms'. The benefits of working with interpreters can be seen in many ways. Faust & Drickey (1986) argue that clients may have an increased sense of professional attention when an interpreter is used to help bridge a language difference. On the other hand, researchers have reported that practitioners have felt hostile when they believed that the interpreter went beyond the remit of their task to interpret (Kaufert & Koolage, 1984). This finding appears to reflect a challenge which Mental Health Practitioners experience when a third person is not only present in the interaction, but also plays a major role and the practitioner may feel that their traditional role and position is in some way threatened. They may also believe that they are being watched or judged in some way. Mental health practitioners frequently report finding this aspect of working with an interpreter difficult, particularly at the beginning. As discussed in earlier sections of this article, issues of control, accountability and power can be brought to the fore. Thus working with interpreters can provide an opportunity to develop new skills and to reflect on ways of working. Prior preparation for the task, including undertaking some training, can produce considerable benefits for all concerned. The more experience obtained in working with interpreters, the easier it should become. It may be helpful to spend time considering all the implications of working with an interpreter by discussing this with an experienced interpreter or, if this is not

possible, with colleagues who have experience of working with interpreters. If the mental health worker is feeling anxious, it does not bode well for the service they may be able to offer to the client. Ideally the interpreter should be not only fluent in two languages, but have some understanding of the two different cultural contexts and have undertaken training in working as an interpreter (Tribe & Raval, 2003; Razban, 2003).

Support and supervision

Apart from the practical issues mentioned already, it is vital to remember the psychological and professional needs of an interpreter, (Patel, Denis, Dosanjh, Mahtani, Miller & Nadirshaw, 2000; Tribe, 1999; Holmgren, Søndergaard, & Elklit, 2003); particularly when working in ongoing or previous armed conflict. Interpreters may be communicating extremely traumatic material, working in areas of immense deprivation, as well as being involved in decisions that may have life-changing implications. They will require support and supervision of their work, and are as vulnerable to vicarious traumatisation and burnout as anyone else. In addition, they may not have received the same training in this regard as many mental health workers. Any organisation using interpreters needs to consider seriously their responsibilities towards these staff members⁷.

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range of practitioners including psychosocial workers, counsellors, local healers, psychotherapists, psychologists and psychiatrists. While recognising there are differences between these professionals, the emphasis here is on mental health practitioners working with interpreters.

² As Summerfield (2002: 248) writes, 'DSM-IV (American Psychiatric Association, 1994) and ICD-10 (World Health Organisation, 1992) are not, as some imagine, a-theoretical and purely descriptive nosologies. They are western cultural documents, carrying particular epistemological ideas about what counts as scientific evidence'. The interested reader is referred to Patel 2003; Mezzich et al, 1999; Young, 1995: Tribe 1999; MacLachalan, 1997.

³ It favours a 'normative' ethic position, which contends that a descriptive system exists that is equally valid for all cultures and languages as opposed to the emic position, which contends that psychological processes and language systems are often culturally constituted meaning systems.

⁴ This model is located more within an emic position.

⁵ General guidelines can be found in Tribe with Sanders, 2003; for guidelines relating to working with interpreters in legal and forensic settings, see Tribe, 2004

⁶ The interested reader is referred to Haenal, 1997; Marshall et al 1998; Van der Veer, 1998.

⁷ The interested reader is referred to Tribe (1998a, 1999), who has documented a support and supervision group for interpreters working with refugees conducted over five years, and reviews some of the issues, which may arise, and how we dealt with them.

¹ This article uses the generic term mental health worker (MH worker) to refer to a

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