Mind your language: working with interpreters in healthcare settings and therapeutic encounters

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Abstract

The National Health Service and specialist agencies within the UK are striving to ensure that they offer services that are inclusive, accessible and appropriate to all users seeking their services. As such, language interpreters will be required to work alongside health professionals to ensure that service users who are not fluent in the English language can gain full access to health and therapeutic provisions. In addition to reasons of governance, equity of service provision and national legislation there are also sound clinical practice reasons with respect to facilitating work with interpreters. Language is not merely a neutral, descriptive medium but has an active role in shaping and constructing how people view and experience the world. The range of meaning-making possibilities that lay or professional language opens up is always already greatly indebted to the speaker's local culture and has particular relevance in the therapeutic encounter. Working with an interpreter can be a challenging but enriching experience. The benefits of working in close partnership with an interpreter are discussed both at generic level when working as a therapist/clinician in any adult mental health setting and, more specifically, when working with sex and relationships problems using clinical material as illustrations.

Keywords: access; interpreter; mental health; best practice; sex and couple therapy

Introduction

People are increasingly moving across national borders and becoming resident in countries where they may not be fluent in the national language. There is, therefore, a range of related issues to be considered to ensure that health and therapeutic agencies and practitioners embrace diversity, different explanatory health beliefs and cultural constructions and remain mindful of excluding these directly or indirectly. In this paper we begin to consider the issues involved when working with an interpreter. We will focus on working with spoken language interpreters, if working with deaf clients, the reader is referred to the specialist literature.[1]

Relevant legislation

There is extensive international and national legislation campaigning for equality of access to health, social and legal services, although the use of interpreters is not always explicitly articulated. Within the UK, legal frameworks that advocate for equality of access to health services include the Race Relations Act (1976) and the Race Relations (Amended) Act (2000); the Human Rights Act (1998); and the Macpherson Report (Macpherson, 1999). There are also a number of specific British policy documents emanating from the Department of Health. These include the National Service Framework for Mental Health (Department of Health, 1999) and the Delivering Race Equality in Mental Health Care – an Action Plan for Reform Inside and Outside Services (Department of Health, 2005).

How interpreters can facilitate access to services and improve service provision?

The use of interpreters has been shown to improve access to and quality of care (Zigarus, Klimidis, Lewis, & Stuart, 2003). Working with interpreters has been shown to increase clients' understanding of their situation and care options offered, trust in the process and the all-important rapport with the health provider, in addition to delivering better treatment compliance (Manson, 1988; Ramirez, 2003). Other studies investigating the relationship between access to healthcare and quality of communication facilitated by interpreters also reported improved appointment keeping, fewer emergency visits, greater patient satisfaction and improved

compliance with health regimes (Eyton et al., 2002; Lee, Batal, Masselin, & Kutner, 2002; Morales, Cunningham, Brown, Lin & Hays, 1999; Riddick, 1998).

In a survey of clinical staff employed in psychiatry in Australia, Minas, Stuart and Klimidi (1994) reported that the crucial role language plays in all aspects of mental health provision had been largely ignored and argue that this requires urgent recognition and change. A similar recent finding was noted by Farooq and Fear (2003) in the UK context. Bischoff, Perneger, Bovier, Louton and Stalder's (2003) work has shown that the quality of communication as perceived by service users who do not speak the local language can be improved with specific training for primary care physicians. If access to services is not to be restricted or limited to those people who are fluent in English or the language of the country of residence, service providers and individual clinicians need be encouraged to access appropriate interpreting services and be supported to provide training for health professionals in working with them. The studies reviewed above were all published in peer reviewed journals and were conducted in a range of countries, the extent to which the issues raised are generalisable across national borders is not straightforward. What is clearly emerging from these findings, however, is the paramount importance of ensuring that those individuals in need of clinical services but who are unable to optimally articulate their needs are not prevented from doing so.

The need for training and professional body requirements

A range of qualifications for interpreters are becoming available including Diploma in Public Services Interpreting, as well as degree and masters level qualifications. In Britain, interpreting as a profession in its own right is slowly becoming established. The Institute of Translation and Interpreting, the National Register of Public Service Interpreting, the National Community Interpreting Project and the Institute of Linguists can all provide relevant information on training and can offer registration opportunities for interpreters. There is currently no accepted national framework to help public sector workers choose an interpreter who is safe to practice, although *some* progress is being made in this direction (Schellekens, 2004). Developments with reference to the Royal College of Psychiatrists, British Psychological Society and British Association of Social Workers are discussed later in this paper.

A number of studies have noted the importance of using qualified interpreters as opposed to *ad hoc* or untrained interpreters[2] (Bischoff et al., 2003; Eyton et al., 2002; Farooq & Fear, 2003; Tribe & Raval, 2003). The use of unqualified interpreters carries the risk of serious miscommunication and inadequate care (Ebden, Bhatt, Carey, & Harrison, 1988; Westermeyer, 1990); for example, Elderkin-Thompson, Silver and Waitzkin (1982) found that errors occurred frequently in interpretations provided by untrained nurse interpreters. Wilson (1993) and Tabassum, Macaskill and Ahmad (2000) and have recently shown how language barriers and lack of trained interpreters can contribute to incidences of mis-diagnosis and limited or no access to certain treatments as well as accounting for low referral rates to psychotherapy and counselling services. There remains, however, a pressing need for additional, robust empirical studies that examine working with interpreters in healthcare settings, as a large proportion of the developing literature is based on clinical experience or on guidelines emerging out of practice-based knowledge.

Training of interpreters and of health professionals is likely to increase both confidence and efficiency in working together. Training and skill development in working with interpreters should therefore form part of the curriculum of the basic training of health professionals and the recognised skills profile of all clinicians. The Royal College of Psychiatrists now features working with interpreters as part of the curriculum for their qualifying exams and the British Psychological Society have taken steps to address this

situation/requirement by stating that all training courses should incorporate working with interpreters as part of their curriculum and has commissioned the development of a set of guidelines on this topic for all applied psychologists. Equally encouraging is the British Association for Counselling and Psychotherapy's recent series of articles in their journal on working effectively with interpreters. The British Association of Social Workers states on their Values and Principles Statement (under the section on Cultural Awareness) that social workers must ''Communicate with users, other than in exceptional circumstances, in a language and by means which they understand, using an independent, qualified interpreter where appropriate'' (BASW, 2002).

Working with interpreters in couple and sex therapy

Cultures contain a multiplicity of world views and rules for living, from what is acceptable to take place in intimate partnerships to what is perceived as ''normal'' or ''dysfunctional'' in terms of sexuality (e.g. Bhugra, Mehra, de Silva, & Bhintade, 2007). However private we experience our intimate lives to be, a social constructionist argument would pose, these experiences are always already shaped by current public values, discussions, condemnations or approvals (see, e.g., Ussher & Baker, 1993). Sexual interactions may be conducted in private, such as within the inter-subjective realm of a close relationship, where nobody else is actually a witness, but the rules for action, the rules for feelings and the common language for sense- making are each indebted to dominant formulations and practices local to a specific culture (see, e.g., Tunariu & Reavey, 2003; Weeks, 2000). This means that interpreters not only have to interpret and accurately convey the actual talk and intent communicated within specific therapeutic exchanges, they also have to interpret across different world-views. These professionals have to factor in the workings of culture-specific norms and understandings in order to negotiate useful and ethical interpretations on behalf of their clients and in relation to the overall purpose of the setting.

The interplay between language, culture and psychotherapy's hermeneutic enterprise is complex (e.g. Gergen & Kaye, 1992). How the task of interpreting and the relationships between the therapist and the interpreter and client/s are negotiated is likely to be important to the therapeutic process. Early preparation in the form of a pre-session meeting between the interpreter and practitioner is therefore likely to be highly beneficial. Couple and sex therapy operating as a specialised service within Western societies, for example, may be experienced as culturally alien by some interpreters; some may be hostile to it, some may be uncomfortable being asked to interpret in such a context. Issues raised within this context may be seen as taboo (e.g. domestic violence, abuse) or problematic in some cultures, including auto erotic activities such as masturbation, any sexual acts beyond sexual intercourse undertaken in the missionary position and sexual encounters outside marriage or between same-gendered individuals. If protocols are not in place to ensure issues such as these are considered away from the client, the interpreter may find her/himself surprised, embarrassed or outraged and these reactions are liable to add unforeseen complexity to the therapeutic encounter. Likewise, gender politics and the associated roles and injunctions may also be positioned differently and these may be consciously or unconsciously played out in some way with in the triad. The gender of the interpreter should be considered before a booking is made, with reference to the presenting problem *per se* and the gender of the person(s) presenting it, as well as trying to ascertain any potentially disrupting sub-cultural differences (e.g. known ethnic or religious tensions across the interpreter's and clients' backgrounds). The therapist may expect a level of disclosure from the couple that the interpreter feels is not appropriate or that they feel inhibited or ashamed about interpreting, particularly in front of members of the opposite gender. Interpreters may lack the lay or technical vocabulary that may be used in couple and sex therapy as they may have not have had to use them in

English. Clients often use slang or personalised pet words for parts of the body or sexual acts and an interpreter may be hard pressed to interpret these into appropriate English. Also, an interpreter may feel that they have to filter what is said by a client into what they view as more ''appropriate'' or formal language. This action can change the nuance or meaning of what is being said and may inadvertently act as a distancing mechanism within a therapeutic encounter. Therefore the actuality of the context and the intra-personal issues of the interpreter need to be considered in relation to the client or couple; as does the training that the interpreter has had in both working in a health setting and specifically in couple and sex therapy. In this way the culturally endowed nuances grounding the interpreter's interactions with the narrative being interpreted can be monitored and their implications for the therapy process identified.

Uncertainty or ambivalence about working with interpreters

The question of why interpreters are not used as often as they might be opens up several important lines of discussion. Changes that challenge traditional, established practice can be experienced as threats or additional work by busy practitioners (Tribe, 2007), not least due to further possible resource implications in a health and social care contexts where resources are often scare and there are many competing requirements for them. As such, at the micro level (which will, of course, have been affected by the macro level in various ways), working with interpreters can lead to anxieties on the part of clinicians (Raval, 1996). The presence of an interpreter in the consulting room may be viewed as a difficulty or a ''necessary nuisance''. It may also lead to a sense of being scrutinised or even feelings of embarrassment or inferiority, as the interpreter may be experienced as being far more knowledgeable and familiar with the client's culture. As a result, the presence of an interpreter can feel threatening to a therapist (Spector, Briedis, & Rebori, in press). Also, when working with an interpreter issues of intimacy are ever present in that they are constantly being negotiated, as the only person who can fully understand the client's self-disclosures at any one time is the interpreter. This could make the therapist feel excluded and uncomfortable until they gain some experience of working with interpreters. Blackwell (2005) writes of the time when clinicians first begin to work with interpreters as a time when they may have a tendency to project their own critical superego on to the interpreter for the above mentioned reasons.

The presence of an interpreter in the room will therefore inevitably shape the dynamics and routes for establishing intimacy and the overall therapeutic alliance. The intimacy – with its prerequisites: trust, authentic disclosure (by the client) and sensitive responsiveness (by the practitioner) – that can be forged between the client and the practitioner is already filtered through, and so in turn either hindered or facilitated by, the practitioner's engagement with the interpreter and the interpreter's engagement with the client. This engagement entails various communicative elements ranging from accurate factual interpretation of what is being said from one language into another, to transferring sufficiently attuned information so as to ensure high empathic accuracy (practitioner towards client). In the longer-term, this ''turn taking'' or filter of engagement, with its offer of additional consultation time, makes available additional reflective space. The benefits of having extended reflective time allows for more attention to be given to what is being said by the client and also to non-verbal communication and the processes in the room.

Some theorists have argued that it is not possible to undertake ''real'' work using an interpreter, although there is no robust research that has actually systematically investigated this claim; it appears to be a belief, an intuitive concern rather than a verifiable, experimental fact. There is no doubt that the presence of an interpreter changes the dynamics in the room and that this requires additional vigilance, for example issues of transference or splitting can occur. Patel (2003) writes about interpreters and therapists or clinicians as professionals engaged in a complex web of mutual dependencies, with the explicit aim of alleviating distress for the client and this must surely be the chief goal for all parties. There are clear advantages to working with an interpreter. They can be an asset or an additional resource who can make their work possible and may actually enhance clinical practice in a number of ways. For example, a well trained interpreter provides crucial cultural and/or contextual information

(Blackwell, 2005), is likely to become someone who the client feels they can trust (Razban, 2003) and relate to (Drennan & Swartz, 1999) and can serve as a positive role model for clients (Saxthorp & Christiansen, 1991), as well as many other possibilities.

A case example: crossing boundaries[4]

A male patient in his mid-30s, originally from an Eastern European country, presented with premature ejaculation to a sex and relationships problems clinic. Neither he nor his wife were comfortable in the English language and therefore requested an interpreter. The interpreter provided by the health trust was a man from the same country of origin as the couple and who was a similar age to the male client. From the onset the male client showed embarrassment in the presence of another man from his own culture. He was tense and vague in the descriptions he gave of his difficulties. As the session continued, the wife expressed frustration towards her husband's reticence and ''spilled out'' the symptoms. The interpreter began translating the wife's account to the therapist. Animated by conversation he then switched languages and took on a role of an advisor. He moved to explaining to the male client what is normal and appropriate in terms of a man from his country's ability to sustain an erection and the criteria by which good sex is measured. When the therapist enquired as to the nature and scope of the apparently long and animated exchange between the two of them, the interpreter clarified how he explained to the couple as to the ''expected length of time for sex and how many times a week 'a real man' ought to be able to perform.'' The wife joined in this discussion nodding approval for the interpreter's picture of the situation, so developing her own, distinct alliance with the interpreter. The therapist asked for the session to be interrupted and invited the interpreter outside the room to consider together the parameters of his role. The therapist emphasised how his translation needs to be neutral and stay within the parameters of what is being said by client(s) and refrain from offering advice or indeed treatment. The interpreter agreed but continued to find difficulty remaining neutral in his engagement. He encountered difficulties in accepting instructions given by a woman, whatever her qualifications, on matters of sex, its problems or its significance to masculinity. The interpreter's comments reinforced for the client his sexual difficulty as an individual ''pathology'' and personal failure, which had the unintended effect of moving the focus away from also exploring the relational aspect of the presenting problem. An additional difficulty was that the husband was now worried that the interpreter might disclose his personal information to the small community that they both were a part of in London. Professional boundaries were crossed on the back of the fact that the interpreter shared a language with the couple. The encounter would have benefited from more proactive preparedness on the part of the therapist. If, for example, the therapist had organised an initial discussion with the interpreter, this would have given both parties the opportunity to appreciate whether the task at hand would be a suitable match for the interpreter's skills. It is important to emphasise that the practitioner holds clinical, ethical and professional responsibility for the session, regardless of whether or not an interpreter is employed. This in turn emphasises the need to consider the presence and management of power dynamics prior to and within a therapeutic encounter when an interpreter is used. These dynamics may be mediated by issues of gender, age and cultural background; transferential dynamics will also become more complex (Tribe & Thompson, 2008). In order to ensure that professional boundaries were maintained the therapist asked for a change of interpreter. A new male interpreter was brought in (gender agreed with the couple). Once the competitive element propped up by the idea of ''good sex equals proper man'' was unpacked and processed, the therapist was able to begin to explore gender-based cultural understandings and associated myths. This was done

in an open discourse with both partners.

A case example: challenging boundaries

A woman in her late twenties presented with sexual aversion and possibly a somatisation of her difficulties. Within her self-narrative the presenting issue was understood as a medically-based sexual desire problem. Both partners were originally from the Middle East. The couple required a woman interpreter, ideally over the age of 40. The health trust was able to accommodate this need. As part of the preparation for the first session with the clients the therapist endeavoured to establish a transparent working relationship with the interpreter. In the pre-session meeting, the interpreter indicated willingness to participate but acknowledged apprehension in working with sex therapy cases. In response, a list of technical words likely to emerge was provided and her understandings of these words were confirmed with the therapist. The woman interpreter spoke the same language as the clients yet she came from a neighbouring country. Therefore there were some potential linguistic and cultural differences but the interpreter was extremely alert and aware of possible differences. Relevant contextual information included the fact that the husband spoke reasonable English, but the wife had a limited use of English. On some occasions the husband did not use the interpreter and spoke English directly to the therapist. For the wife this disempowerment could have been continued within the therapeutic session if the therapist had not taken appropriate action. The husband became angry when the therapist asked him to speak in his own language so that the wife could have equal access to what was being discussed. His complaint was that going through an interpreter was just wasting time. The solution to this was for the therapist to insist that only the therapist speaks English and the interpreter only communicates directly with the therapist. The interpreter's chair was subsequently placed even further behind the couple, so physically and psychologically emphasising the structuring of the therapeutic space. The husband disclosed that part of his dissatisfaction with their sexual relationship lay in his wife's lack of interest in ''motivating him sexually'' and her refusal to be ''a good wife''. The wife's response expressed sadness, shame and guilt as well as resentment. Possibly in relation to these emotions she came to believe that he had an infection in his body that he passed on to her whenever he touched her and she was very angry with him for this. Here the medical discourse is mobilised in an attempt to manage personal and inter-personal tensions grounded by cultural values and injunctions.

Another aspect that is relevant here is the disclosure of an activity practiced by the couple that was acceptable in their local culture but was not acceptable by western norms. During a later session the wife challenged the husband's complaints with her own complaint: combining into the account relevant English words she indicated her indignation to being hurt by him and to having her refusals to sexual advances ignored. The therapist explained that what was being described is not acceptable within the norms governing a western culture and it is seen as an erroneous entitlement to controlling another. Naming such actions as domestic violence and abuse provoked aggression and indignation from the husband, but it also marked an important shift as new possibilities for sense-making were opened up. Western concepts were used to name behaviours and so begin to destabilise taken-for-granted assumptions. Over time, and with support, both partners took up this challenge and used it to clarify and expand boundaries. The husband was able to reflect upon and take ownership of his actions. Recognising each other's position, both became invested in trying to establish more open and helpful negotiation strategies. Together they found ways to hold on to philosophies of life embedded in their culture of origin while integrating aspects they liked and found personally significant from the new culture. They began to re-configure relational and sexual practices that best served their long-term intention of affection and a long-term engagement on an equal footing.

Recommendations for interpreters working in couple and sex therapy

Translating, therefore, involves interpreting words but more so conveying the language-used together with its associated cultural formulations and collectively recognised norms and social practices, as illustrated in the above cases. In addition to a recognised training qualification in interpreting and specific training in mental health issues (a possible curriculum for the latter can be located in Tribe and Sanders [2003]), interpreters will also require updates on the technical and colloquial language likely to be used in relationship and sex therapy. Health professionals also require training in working with interpreters if they are to be competent and resourceful practitioners. Prior to starting work in sex and relationship therapy, interpreters may benefit from attending workshops on considering their own assumptions about gendered sexuality, sexual identity and sexual practices. Left unexamined, biases and assumptions can usher the development of distinct relationships between the interpreter and the client(s) negatively impacting upon the therapeutic working alliance. In addition, such a workshop could usefully cover skills on talking about issues of relationship and sexual difficulties. This can have the benefit of educating both practitioners and interpreters on different cultural views and behaviours. A heuristic or rule of thumb could be to match up the gender of the presenting client with the gender of the interpreter for two reasons: firstly more accurate empathy and secondly the reduced likelihood of collusion with the other partner.

Conclusion

The provision of good practice guidelines and appropriate training for clinicians and interpreters will benefit the service offered to service users as well as enhancing the confidence and skills of all involved (Burnett & Fassil, 2002; Kiramayer, Groleau, Jaswant, Caminee, & Jarvis, 2003; Stolk et al., 1998; Tribe, 1998; Williams, 2005). While much of the current research identifies a need for interpreters and notes the benefits they can bring to health and therapeutic settings, little information is available as yet on the practice of commissioning interpreting services. Information in the client's own language and associated socio-cultural parameters, such as commonly valued health beliefs and dominant practices, are important and can be resource efficient (e.g. a multi lingual appointment card can be downloaded from www.communicate-health.org.uk/card/). This paper set out to explore the crucial role of language, cultural context and interpretation in understanding clients' narratives and of ensuring that this component of good practice is understood and utilised appropriately in therapeutic work with patients. The paper also briefly reviews the legislative context and discusses some of the research relating to how interpreters can facilitate access to services and improve service provision. Tensions, uncertainty or ambivalence about working with interpreters are examined and the intricate relationship between language and culture outlined. In doing so, the intention is to emphasise and support the need for trained interpreters, if our health and social care services are to be inclusive, accessible and appropriate to the whole population.

Notes

1. There are three National Deaf Services for England and Wales: (1) Old Church, Balham, London, (2) Denmark House, Queen Elizabeth Psychiatric Hospital, Birmingham and (3) John Denmark Unit, Prestwich Hospital, Bury, Manchester. For more information on working with deaf people in a mental health setting see the NIMHE report: *Mental health and deafness, towards equality and access* (2005), available at http://www.dh.gov.uk/en/Publicationsandstatistics/Pressreleases/DH_4104006. The RNID can also offer support in finding an English language interpreter for deaf people and they can be found at http:// www.rnid.org.uk, telephone: 0808 808 0123, Email: information@rnid.org.uk. For more information on working with interpreters in British Sign Language see

http://66.102.9.104/search?q=cache:G1iKfmvdc9UJ:www.aucc.uk.com/journal_pdf/aucc_summer
_3.pdf+deaf+interpreters+in+the+mental+health+setting&hl=en

2. Suggestions about training within a mental health context and a possible curriculum for such training can be found in Tribe and Ravel (2003, pp. 54–69).

3. Suggestions about the specific dilemmas of working with an interpreter in the context of relationship and sexual problems are discussed here, the interested reader is referred for detailed good practice guidelines on working with interpreters in a ''mental health'' or therapeutic context to Tribe and Lane (2008) or to the Good Practice Guidelines written for psychologists working in health settings to be found from Autumn (2008) on the British Psychological Society website: www.bps.org.uk

4. The two case studies presented here are based on real cases but in order to ensure clients' anonymity *all* personal details have been removed and particularities such as gender, presenting problems, place of origin have been changed.

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