Effects of Interpreters on the Evaluation of Psychopathology in Non-English-Speaking Patients

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Non-English-speaking patients in need of psychiatric services are usually evaluated with the help of an interpreter. Discussions with psychiatrists and lay hospital interpreters who had experience in these interviews and content analysis of eight audiotaped interpreter-mediated psychiatric interviews suggested that clinically relevant interpreter-related distortions could lead to misevaluation of the patient's mental status. The author notes that pre- and post-interview meetings of clinicians and interpreters have been found useful in minimizing these distortions.

In New York City, patients whose primary language is not English constitute a significant proportion of the psychiatric population. A number of these patients speak enough English to allow some communication in this language. The problems involved in the psychiatric evaluation and treatment of this bilingual population have been the subject of recent experimental and clinical studies (1-5). However, many patients' competence in the English language is so low that communication can be established only with the help of an interpreter.

At Gouverneur Hospital and Bellevue Psychiatric Hospital, two New York City institutions affiliated with New York University, an average of 30 psychiatric interpreter-interview evaluations are conducted daily. In both hospitals the two most commonly spoken languages apart from English are Spanish and Chinese (i.e., Cantonese and Toisonese). Neither hospital has official interpreters (to my knowledge this is true of all psychiatric institutions) so any available individual who can speak the patient's language may be asked to interpret in evaluations of the non-English-speaking patient. The interpreter may be another patient, a patient's friend or relative, or a member of the hospital staff.

To my knowledge, the effect of the interpreter-mediated interview on the assessment of psychopathology has not been studied systematically, and an exhaustive literature review revealed only a brief description of the interview's process (6) and one clinical report (7). In that report, Sabin reviewed two cases of suicide by Spanish-speaking patients who were evaluated and treated by English-speaking psychiatrists with the aid of an interpreter. Because the evaluating clinicians had made the same clinical error independently of one another, Sabin ruled out clinician effect as an explanation for the outcome and concluded that the patients' emotional suffering and despair may have been selectively underestimated in the process of interpretation. His report was a retrospective study based on a review of the patients' psychiatric records, so it is difficult to evaluate the extent to which the clinician's written reports contributed to their conclusions.

A review of the general literature on interpretation and translation did not offer any particular information applicable to the special practice of psychiatric interviewing through an interpreter. Most authors in this field, however, concur that faithfulness is the fundamental object of interpretation (8). My purpose in this paper is to explore the process of interpreter-interview assessment of psychopathology and to identify the major distortions that arise in this common practice. I will present specific recommendations to aid English-speaking clinicians who examine patients through an interpreter in minimizing errors.

METHOD

Two consecutive procedures were planned. The first included open discussions with psychiatrists and lay hospital interpreters who had experience in interpreter-interview evaluations. The second procedure, the main focus of the study, consisted of content analysis of audiotaped psychiatric interpreter-interview evaluations. For the first procedure, eight exclusively English-speaking psychiatrists and six bilingual hospital employees with extensive experience in interpreter interviews participated in unstructured discussions designed to obtain their impressions about problems in interpreter-interview examinations. In these dis-
cussions particular emphasis was placed on the following questions:

1. What are the general problems involved in the process of evaluating psychopathology through an interpreter?

2. What areas of mental status examination are more apt to be distorted by this procedure?

3. What are the ideal characteristics of interpreters who translate in a psychiatric interview?

4. What type of patients tend to have more difficulty adapting to this interview procedure?

For the second procedure, a total of eight psychiatric evaluations of non-English-speaking patients conducted through an interpreter were audiotaped for content analysis. The patients' native languages were Chinese or Spanish. They were seeking psychiatric help for a variety of emotional difficulties: two patients were diagnosed as suffering from involutional depression, two from depressive neurosis, and four from chronic undifferentiated schizophrenia. Their average age was 50 years. The patients had previously expressed willingness to volunteer for the study. An English-speaking psychiatrist conducted the interviews with the help of an interpreter. The English language questions were identical and were presented in the same order. The questions are the items of the Psychiatric Evaluation Form Interview (9), a distillate of the common probes used in psychiatric evaluations. Three different types of lay interpreters who had no knowledge of the aims of the study participated in this procedure. Four interviews were interpreted by a psychiatric nurse with 10 years of experience in clinical psychiatry; two by a nurse's aide who was psychiatrically unsophisticated and worked in a different department, and two by the patients' relatives. All interpreters were proficient bilinguals, selected because they represented the type of individual commonly asked to participate as an interpreter in hospitals.

In the analysis of the recorded material, one English-Spanish and one English-Chinese bilingual psychiatrist listened to the respective audiotapes and compared the English portion with the Spanish or Chinese portion to assess their clinical equivalence. Specifically, these clinicians compared 1) the interviewing psychiatrist's questions with the interpreter's translation of them to the patient, and 2) the patient's answers with the interpreter's translation of them to the interviewing psychiatrist.

The clinicians who listened to the tapes were familiar with the conclusions of the first procedure (i.e., discussions with psychiatrists and lay hospital interpreters experienced in interpreter-mediated evaluations) and used those conclusions as the starting point in their comparative analysis. The rating clinicians were allowed to listen to the tapes as many times as they wished. Because this study was exploratory, no specific hypotheses were tested. The primary aim of this analysis was to identify patterns of distortions associated with the interpreter-interviewer procedure and with the different types of interpreters.

RESULTS

Psychiatrists' and Lay Interpreters' Views

General problems of interpreter-interview evaluations. All the psychiatrists who participated in the discussion agreed on frequent practical problems associated with the use of volunteer interpreters. Lay interpreters often consider this practice "too much of a responsibility," an imposition, and a bothersome interruption of their regular job activities. The psychiatrists emphasized distortions stemming from the interpreter's attitude toward either the patient or the clinician (e.g., an interpreter's overidentification with the patient leading him or her to challenge the clinician's suggestions to the patient). Dynamics such as these interfere with the faithfulness of the interpretation and create tension during the interview.

Most of the interpreters agreed that they often felt embarrassed or anxious about some of the clinicians' questions to the patient. These questions usually dealt with sex, financial matters, and the exploration of suicidal or homicidal tendencies. All of the interpreters felt overwhelmed by the responsibility of serving as translators. Both psychiatrists and lay interpreters expressed significant concern for the protection of the confidentiality of the patient's communications.

Mental status evaluation through an interpreter. Psychiatrists indicated that the assessment of formal aspects of thinking and of affect (specifically, emotional withdrawal and blunted affect) had a higher probability of being distorted by the interpretation procedure. Also, certain ambivalent attitudes on the part of the patient were difficult to evaluate through interpreters. Part of the problem appeared to be that untranslatable paralinguistic and vocal cues were not available to the clinician.

Characteristics of a good interpreter. Psychiatrists believed that competence in both languages as well as familiarity with the patient's culture were major requirements. It was also suggested that the interpreter's knowledge of clinical psychiatry could be helpful in diminishing distortions, particularly in the assessment of the formal aspect of thinking and affect. Psychiatrists thought that as a rule patients' relatives or friends did not make good interpreters because they lacked objectivity.

Patients and the interpreter-interview evaluation. With regard to the vulnerability of patients who undergo these interviews, there was agreement that severely paranoid and very anxious patients usually have difficulty coping with the interpreter-interview situation. Some psychiatrists, however, suggested that there are patients who react positively to this practice because they recognize in it extra interest and attention.

Analysis of the Recorded Interviews

The content analysis of the recorded interpreter-interview evaluations revealed a variety of distortions that, in many instances, confirmed the views expressed by the psychiatrists and lay interpreters in
their previous discussions. The findings will be organized according to three major types.

1. Distortions associated with the interpreter's language competence and translation skills. Although, in general, the interpreters were proficient in the source and target languages, various types of clinically relevant errors of translation were detected. These included omissions, additions, substitutions, and condensations. Such distortions appear to be related both to insufficient language competence and to deficient interpretative skills. Examples are given below.

   Clinician to Chinese-speaking patient: "What kind of moods have you been in recently?"
   Interpreter to patient: "How have you been feeling?"
   Patient's response: "No, I don't have any more pain, my stomach is now fine, and I can eat much better since I take the medication."
   Interpreter to clinician: "He says that he feels fine, no problems."

   Clinician to Spanish-speaking patient: "Do you feel sad or blue; do you feel that life is not worthwhile sometimes?"
   Interpreter to patient: "The doctor wants to know if you feel sad and if you like your life."
   Patient's response: "No, yes, I know that my children need me, I cannot give up, I prefer not to think about it."
   Interpreter to clinician: "She says that no, she says that she loves her children and that her children need her."

These examples were extracted from recorded interviews conducted through psychiatrically unsophisticated interpreters. In both cases it is obvious that the clinician did not get an accurate impression of the patients' responses because of a combination of translation errors such as omissions, condensations, and substitutions. In the first case, the interpreter failed to communicate to the clinician that the patient had focused his response on his improved physical condition rather than his mood. In the second example, the patient's ambivalent answer about her feeling and life was not conveyed to the clinician. In fact, the interpreter's translation indicated signs of tangential thinking more than anything else.

Several distortions were also detected when the interpreters attempted to translate patients' long answers. Usually, interpreters' attempts to summarize answers resulted in a loss of important information.

2. Distortions associated with the interpreter's lack of psychiatric knowledge. The most frequent distortion in this category consisted of the interpreters' "normalization" of patients' thought disorders, such as circumstantiality, tangential thinking, loose associations, and blocking. It was obvious that interpreters often tried to "make sense" of the patients' disorganized statements, which prevented the clinician from detecting these important aspects of the mental status. The following verbatim example is self-explanatory:

   Clinician to Spanish-speaking patient: "What about worries, do you have many worries?"
   Interpreter to patient: "Is there anything that bothers you?"
   Patient's response: "I know, I know that God is with me, I'm not afraid, they cannot get me [pause] I'm wearing these new pants and I feel protected, I feel good, I don't get headaches anymore."
   Interpreter to clinician: "He says that he is not afraid, he feels good, he doesn't have headaches anymore."

Also, as suggested in the discussions with psychiatrists and lay interpreters, the quality and depth of the patient's affect could not be assessed reliably through the interpreter. This may be related to the fact that interpreters tend to limit their translation to what the patient says, neglecting how the patient says it.

3. Distortions associated with the interpreter's attitudes. Interpreters who were relatives of the patient tended either to minimize or emphasize psychopathology. For example, the daughter of a patient clearly emphasized the patient's psychopathology while expressing to the clinician her belief that her mother should be hospitalized. In another instance the interpreter expressed to the patient his own negative feelings about the medication the clinician had just suggested. Because this was done in the patient's language, the clinician did not notice it. Similarly, in another interview the clinician was exploring the possibility of a tubal ligation with a patient, and the interpreter openly expressed her disagreement with this procedure and suggested that the patient not go along with it.

Another common observation was that relatives serving as interpreters answered the clinician's questions to the patient without actually asking the patient. For instance, the son of a patient was asked to inquire about his father's possible suicidal ideation. Without asking his father, he insisted on a negative answer.

**DISCUSSION**

The above findings suggest that clinicians evaluating non-English-speaking patients through an interpreter are confronted with consistent, clinically relevant, interpreter-related distortions which may give rise to important misconceptions about the patient's mental status. In addition to the relative untranslatability of some communicative components (e.g., the formal aspect of speech, expression of affect, and paralinguistic aspects), three major sources of interpretative distortions have been identified: 1) deficient linguistic and/or translation skills of the interpreter, 2) interpreters' lack of psychiatric sophistication, and 3) interpreters' attitudes toward either the patient or the clinician.

It would be optimal if there were enough competent psychiatric interpreters so that English-speaking clinicians could reliably evaluate non-English-speaking patients. Failing this, it is important that clinicians be made aware of the interpreter effect on the translation
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of psychopathology. At this point some recommendations can be made to clinicians who must use the interpreter interview.

First, it is advisable that clinician and interpreter meet before the interview to discuss the goals of the evaluation, the focal areas to be assessed, and any particularly sensitive topic that may have to be explored (e.g., suicidal or homicidal ideation, hospitalization, family relations). At this time, the clinician should make sure that the interpreter has an acceptable level of competence in the two languages. It is also important to explore the interpreter's attitude toward the interview and the patient, particularly when the interpreter is a relative or acquaintance of the patient or has expressed some preconceived ideas about the patient's problems. The clinician should also discuss confidentiality and emphasize the significant role of the interpreter as an objective intermediary in the evaluation process.

The clinician should make an extra effort to clarify for psychiatrically unsophisticated interpreters the differences between formal and content aspects of the patient's verbalizations (e.g., how the patient says things versus what the patient says). The need for textual translation should be emphasized, as well as the danger involved in attempting to "make sense" of the patient's statements. Interpreters should also be encouraged to ask for clarification from the patient or the clinician at any time during the interview.

Similarly, a postinterview meeting should be arranged between the clinician and the interpreter. In this session the clinician should look for clarification of both the interview material and the dynamics of the interaction. Further, the interpreter should be given ample opportunity to verbalize and process any feelings that may have been aroused during the interview.

REFERENCES