

WORKING WITH INTERPRETERS IN DEVELOPING COUNTRIES — IMPLICATIONS FOR PSYCHIATRIC RESEARCH AND TRAINING

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Cross cultural psychiatry is a burgeoning field. Almost universally cross cultural psychiatry has become synonymous for working with ethnic minorities living in developed countries. We tend to think that only white psychiatrists have cross cultural issues when working with ethnic minorities. It is rarely considered that as a psychiatrist from a different ethnic background, we also need to understand the 'culture' of the host nation. As an English speaking mental health professional, it is thought that we have adequate knowledge of the 'English' culture, gained perhaps from English medium system of education quite prevalent in subcontinent or Hollywood movies.

More interestingly, perhaps the cross cultural psychiatry and its applications are not considered in relation to the cultural differences for the many ethnically diverse populations living in large countries like India and Pakistan. We rarely, if ever consider the cultural differences when seeing a patient from a different province or a state which may have totally different language, cultural heritage and even a different world view. The vast literature on cross cultural psychiatry has very little, if any, research on the cultural differences and their relevance to mental health in ethnically diverse populations living in many developing countries.

An important aspect of these cultural considerations is the language spoken by the patients. Language is the principal investigative and therapeutic tool in psychiatry. Interference with communication impairs our ability to assess a patient comprehensively. Nowhere is this more evident than in the situation where patient and professional are separated by a language barrier, creating a state of dependency on an interpreter, who holds the key to mutual understanding. Although considered as an ethnic minorities' issue, I will argue that this is a major problem for many developing countries with large populations.

At least three entirely different languages (*not dialects*) are spoken in Pakistan's North-West Frontier Province, a relatively small province with population of about 20 millions. Similarly India is a potpourri of different cul-

tures, religions and beliefs and is home to many languages. Presently 22 languages are officially recognized by the Indian Constitution and it is estimated that there are more than 400 living languages in India. It is quite common for a psychiatrist to see a patient in these settings whose language is not shared by him or her at all.

A large number of internally displaced persons moving to different places within a country, as a result of number of conflicts, further complicate the issue. The number of refugees and internally displaced person world wide is estimated to be 25.1 millions with an unprecedented increase of 2.5 millions in one year only i.e. 2007¹. Most of these populations are unfortunately in the developing countries. A recent example is the crisis in Malakand which displaced a large number of Pashtu speaking people to areas where the language may entirely be different. Moreover, migrant populations exhibit a higher incidence of mental illness compared with native populations².

Nevertheless, the study of linguistics in relation to psychiatry is rarely mentioned in psychiatric texts and perhaps not considered at all in psychiatric training in our countries. While many services in Western countries have lists of interpreters and there are some guidelines on how to work effectively through interpreters, there is practically nothing in the literature from large developing countries.

A number of studies, mostly in medical settings, confirm that patients with limited English in Western countries, experience difficulties in communication^{3,4}. A systematic review of the evidence has suggested that quality of care is compromised when patients with limited English need but do not get interpreters. More interpreter errors occur with untrained, *ad hoc* interpreters⁵. Provision of trained professional interpreters and bilingual health care providers have been shown to have positive effects on patients' satisfaction, quality of care and outcomes⁵.

The reality of practice in most developing countries would mean that most of us will have to rely on use of a relative or friend of the patient or even another patient as an interpreter. It is therefore even more important for professionals in these countries to have training in the basic skills needed to work through interpreters. It should be remembered that the clinician's competence and familiarity with the use of interpreters is extremely

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important. The process will be further complicated if a clinician speaks quickly, uses long sentences or fails to use 'laymen's' language. Talking to the interpreter about the patient using the third person invites a conversation about them rather than with them and raises the interpreter from the position of facilitator to participant, distorting the process still further.

Simple steps can help. In the interview, addressing the patient directly instead of through the interpreter helps to establish a better rapport and give control of the interview to the clinician. Questions should be planned in advance so as to make the best use of the time available. Long questions, excessive jargon and use of the passive voice will make an interview more difficult. Breaks, while the interpreter is speaking to the patient should be used by the clinician to observe the patient's non-verbal behaviours, helping to gain non-verbal clues to the patient's mental state and enabling the next question to be framed more appropriately. Writing notes during these breaks wastes the opportunity to acquire valuable clinical data and should be avoided. A statement that is inconsistent with a patient's non-verbal behaviour should be explored by changing the wording, breaking down the question or asking about a related issue. A post-interview meeting with the interpreter is essential to clarify the interview material and the dynamics of the interaction. It must be remembered that the use of such emergency interpreters will greatly increase the number of errors, particularly those involving role conflict and normalization (a tendency on the part of interpreters to "normalize" the patient's responses). Responses such as 'does not know ...' or 'talks irrelevantly ...' should be explored further to look for errors or psychopathology. In such situations, a verbatim translation should be requested. The interpreter may have his or her own agenda or insecurities in such settings. During the interview, however, it is important to keep a focus on the patient. For further guidance on how to work effectively through interpreters please consult Farooq and Fear (2003)⁶ or visit <http://www.vtputp.org.au/>.

These considerations highlight only few of the issues which are important in working with interpreters. It is crucial that the postgraduate training programmes in low and middle Income countries incorporate the cultural and linguistic diversity found in many of these nations as an integral component of the training. The practical part of the postgraduate examinations should test

the ability to work with the help of lay interpreters, a common situation in these countries.

It has been claimed that transcultural psychiatry is an applied science, converting research-derived concepts into reliable health strategies⁷. This science has rarely been applied in the settings outside western or developed nations. It is essential for psychiatrists to recognize the complexity of the task. Living in a large country with seemingly one or two major languages should not blind us from the fact that patients may not share our language and culture, even though we may belong to one province or perhaps the same region. Talking to the patients does not always mean that we are communicating as well. The power that interpreters have to control the information being relayed back and forth and thus influence the outcome of the interview must not be underestimated, particularly when they have no training for the job and we have no understanding of what to expect.

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