3 Cambridge J. Information loss in bilingual medical interviews through an untrained interpreter. *Translator* 1999; **5**: 202–19.

4 Divi C, Koss RG, Schmaltz SP, Loeb JM. Language proficiency and adverse events in US hospitals: a pilot study. *Int J Qual Health Care* 2007; **19**: 60–7.

5 Flores G. The impact of medical interpreter services on the quality of health care: a systematic review. *Med Care Res Rev* 2005; **62**: 255–99.

6 National Centre for Languages (CiLT). *Standards, Qualifications and Frameworks*. CiLT, 2005 (http://www.cilt.org.uk/home/standards_and_qualifications.aspx).

7 Aspinall PJ. Language ability: a neglected dimension in the profiling of populations and health service users. *Health Educ J* 2007; **66**: 17.

8 Archer D. Unspoken diversity: cultural differences in gestures. *Qual Sociol* 1997; **20**: 79–105.

9 Gile D. Conference interpreting as a cognitive management problem. In *The Interpreting Studies Reader* (eds F Pöchhacker, M Shlesinger): 162–76. Routledge, 1997.

10 Collados Aís Á. Quality assessment in simultaneous interpreting: the importance of non-verbal communication. In *The Interpreting Studies Reader* (eds F Pöchhacker, M Shlesinger): 326–36. Routledge, 1997.

11 Moser-Mercer B. Process models in simultaneous interpretation. In *The Interpreting Studies Reader* (eds F Pöchhacker, M Shlesinger): 148–61. Routledge, 1997.

12 Elderkin-Thompson V, Cohen Silver R, Waitzkin H. When nurses double as interpreters: a study of Spanish-speaking patients in a US primary care setting. *Soc Sci Med* 2001; **52**: 1343–58.

13 Khoei EM, Richters J. Concepts of sexuality and health among Iranian women in Australia. *Aust Fam Physician* 2008; **37**: 190–2.

14 Greenhalgh T, Robb N, Scambler G. Communicative and strategic action in interpreted consultations in primary health care: a Habermasian perspective. *Soc Sci Med* 2006; **63**: 1170–87.

15 Anon. *The 1986 Administrative Procedure Act (including subsequent amendments). Cited in Swedish Country report to EU Fundamental Rights Agency 1986*. Available at http://www.sweden.gov.se/sb/d/574/a/64892.

16 Mikkelson H. The professionalization of community interpreting. In *Global Vision: Proceedings of the 37th Annual Conference of the American Translators Association* (ed. MM Jérôme-O'Keefe): 77–89. American Translators Association, 1996.

Interpreting in psychiatry: a clinician's perspective

Commentary on . . . The need for measurable standards in mental health interpreting†

Seamus MacSuibhne[1]

The Psychiatrist (2012), **36**, 124–125, doi: 10.1192/pb.bp.111.038117

[1]St Luke's Hospital, Kilkenny, Ireland

Correspondence to Seamus MacSuibhne (seamus.macsuibhne@ucd.ie)

First received 1 Dec 2011, accepted 17 Jan 2012

Summary Cambridge *et al* describe the neglect into which consideration of the role of the interpreter in the encounter between patient and mental health professional has fallen. Much of what little literature exists on the topic is concerned with adverse events related to interpreting, rather than the interpreter's role *per se*. Cambridge *et al* are to be commended for a paper which may help bridge the gap between theory and practice of interpretation on the one side and psychiatry on the other.

Declaration of interest None.

Understanding what is being said in the interaction between doctor and patient is crucial for both parties. This is particularly so in psychiatry, where both the form and content of what is being said by both patient and doctor often relates to the most personal and private matters. The power of psychiatrists to, in certain circumstances, deprive a person of their liberty (a decision in which what the person says and how they say it plays a key role) gives a particular urgency to this need for mutual comprehension. All the terminology of which psychiatric assessments are constructed – 'suicidality', 'capacity', 'ruminations', 'preoccupations', 'delusions', 'overvalued ideas' and so on – depend on language for their assessment and articulation. And they depend on a confidence in the ability of the psychiatrist to understand what the person is saying.

When an interpreter is required, there is a further aspect to the interaction; the presence of an 'other' who mediates between the patient and the interviewer. A systematic review of the use of interpreters in medical practice overall found positive benefits of professional interpreters on communication (reducing errors and improving comprehension), healthcare utilisation, clinical outcomes and satisfaction with care.[1] Given this, and also the sociological interest in power disparities between doctor and patient in mental health, it is something of a surprise that the literature on interpreting in this context is so scanty.

Drennan & Swartz[2] provide, in a South African context, an ethnological account of the institutional management of

†See editorial, pp. 121–124, this issue.

multilingualism. For Drennan & Swartz, the status of 'the patient who requires interpreting' is an institutional construct, determined by the demands and routines of institutional practice. The requirements of each stage of hospital admission dictate whether or not interpretation is necessary. They argue that the dependency of clinicians on interpreting is more visible in a forensic than a general hospital setting.

As Cambridge *et al*[4] point out, what literature exists on the topic mainly focuses on adverse outcomes related to interpretation; there is little empirical research on process and outcomes. One would hope that Cambridge *et al*'s work would stimulate further empirical research into interpretation in clinical experience. With services expected to become steadily more user focused, perhaps the old argument about the provision of specialist services for ethnic minority groups[3] could be informed by this linguistic issue. This area also strikes me as a potentially extremely fertile ground for service user-driven research.

Cambridge *et al* are to be commended for trying to bridge a gap between the practitioners of psychiatry and interpreters. They discuss the various schools of interpretative practice, which seem to me to range from ones aiming at as literal and 'value-free' presentation of the person's speech as possible, to ones which come closer to a form of advocacy. From my own clinical experience, these roles and visions tend to merge. My own most positive experience of an interpreter is one who provides a near-simultaneous account, and also could answer with apparent authority questions about the possible presence of a thought disorder. Of course, this authority may not have had a definite basis.

It is good to have concepts such as 'whispered simultaneous interpreting' explained. The article helps to both introduce and demystify other concepts of interpretation which clinical practitioners may not be familiar with, such as differences between subject–verb–object and subject–object–verb languages.

The potential ethical implications of the use of interpreters are many,[5] and in particular relate to the differences between status, power and ethnic group between patient and interpreter.[6] Fundamentally, there may often be an assumption on the part of clinicians that the interpreter will be a neutral, value-free conduit of questions and answers. It would be an interesting exercise to evaluate the note-taking by clinicians of interpreted interactions. To what degree is a simple noting of the presence of the interpreter seen as rubber-stamping the clinical interview described?

It could be argued that a bilingual psychiatrist is the ideal solution to this problem – indeed this is a statement of the obvious. Although this may seem a truism, there is surely room for some doubt. The issues of a mismatch of power and status could potentially be magnified rather than alleviated. As mental health practice is multidisciplinary, unless an entire team was bilingual, the presence of a single bilingual member on the team interacting with the patient in their own language may impede the provision of appropriate multidisciplinary care. And it may be that the potential advocacy role of an interpreter would be lost.

One area the authors highlight is the potential pitfalls of using family members as interpreters – the temptations to edit, sanitise, minimise, maximise or 'save face' are real ones. Which of us would be happy in the care of our patients for whom English is a mother tongue to communicate only with relatives?

Much of what Cambridge *et al* seem to be concerned with is a plea for clarity and for measurable standards in interpreting. Given the barriers, whether literal, sociological or cultural, that can get in the way of open and clear communication in the interaction between mental health professionals and service users, it seems logical that trying to minimise any linguistic hurdles will lead to improvements in practice and in clinical outcomes. One would hope that this paper may stimulate empirical research that would help support the calls for action the authors make relating to policy in this area.

In 1985, the philosopher Anthony Quinton observed that 'it is a remarkable fact that philosophers, in a sense the experts on rationality, should have taken so little interest in irrationality'.[7] This quote is now featured on the introductory page of the University of Warwick's website for its courses on philosophy and ethics of mental health, and in the years since there has been a renaissance of links and dialogue between psychiatrists and philosophers. Reading this paper, it struck me that the area of interpreting in psychiatric practice could be the nexus of a renewed dialogue between psychiatry, linguistics and sociology.

About the author

Dr Seamus MacSuibhne is Consultant Psychiatrist, St Luke's Hospital, Kilkenny, Ireland, and Visiting Fellow, School of Medicine, University of Cork, Ireland.

References

1 Karliner E, Jacobs EA, Chen AH, Mutha A. Do professional interpreters improve clinical care for patients with limited english proficiency? A systematic review of the literature. *Health Serv Res* 2006; **42**: 727–54.

2 Drennan G, Swartz L. The paradoxical use of interpreting in psychiatry. *Soc Sci Med* 2002; **54**: 1853–66.

3 Bhui K, Sashidharan SP. Should there be separate psychiatric services for ethnic minority groups? *Br J Psychiatry* 2003; **182**: 10–2.

4 Cambridge J, Singh SP, Johnson M. The need for measurable standards in mental health interpreting: a neglected area. *Psychiatrist* 2012; **36**: 121–4.

5 Kaufert JM. Sociological and anthropological perspectives on the impact of interpreters on clinician/client communication. *Sante Culture Health* 1990; **7**: 209–35.

6 Kaufert JM, Putsch RW. Communication through interpreters in health care: ethical dilemmas arising from differences in class, culture, language, and power. *J Clin Ethics* 1997; **8**: 71–87.

7 Quinton A. Madness. In *Philosophy and Practice* (ed. A Phillips Griffiths): 17–41. Cambridge University Press, 1985.

https://doi.org/10.1192/pb.bp.111.038117 Published online by Cambridge University Press