Using Interpreters in Diagnostic Research and Practice: Pilot Results and Recommendations

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Objective: This pilot study examined the impact and role of interpreters in videotaped and some live diagnostic interviews of Hispanic outpatients in an urban psychiatric service.

Method: The study, conducted from June 2002 to February 2004, included 98 bilingual or Spanish-speaking monolingual adult Hispanic outpatients who participated in live or videotaped diagnostic interviews with English-speaking, non-Hispanic (N = 33) or Hispanic (N = 16) clinicians. Interpreters provided assistance to patients and to non-Hispanic clinicians in 71 cases. After completing live interviews or watching videotaped interviews with interpreter assistance, clinicians independently filled out questionnaires asking for diagnoses and other information (questions about the clinical encounter and rating of symptom severity).

Results: Clinicians reported high confidence in their assessments because interpreters provided unbiased, accurate information. Without interpreters, clinicians reported that patient diagnoses and functioning would have been assessed as less severe or the same. Interpreters helped patients with limited English navigate mostly videotaped interviews and respond to clinician queries. Interpreters brokered cultural expressions and colloquialism, distinguished easily misunderstood words and concepts, and were challenged by patients with cognitive deficits and thought disorders.

Conclusions: Findings point to functions, process, and logistics of interpretation, including reaching for linguistic and conceptual fidelity and acting as unobtrusive, disciplined participants to maintain diagnostic accuracy. Recommendations for assuring useful research-quality data are applicable to diagnostic practice.

(J Clin Psychiatry 2007;68:924–928)

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Support for this article was provided, in part, by National Institute of Mental Health grant R21 MH065921.

The authors report no additional financial or other relationships relevant to the subject of this article.

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Clinician-patient language differences affect accessibility to mental health services and undermine quality of care.[1] With approximately 11.9 million individuals in the United States living in linguistically isolated households in which no one over the age of 14 speaks English "very well,"[2] diagnostic practice becomes a major challenge for today's clinicians. In diagnostic research, communication difficulties posed by language differences can also impugn data accuracy and quality, making interpretations a critical scientific component.[3] In the medical and psychiatric literature on culturally competent health services, the need for trained interpreters on staff has been widely stated.[3–5] The field is fraught with problems, from the use of nonprofessional ad hoc interpreters (e.g., patients' friends, family members, clinic staff, or other patients) to insufficient numbers or qualifications of medical interpreters.[6] These issues create not just problems of accuracy in interpretation but possible violations of privacy and other ethical dilemmas.[7] There has been an increasing emphasis on having professional medical interpreters in hospitals and clinics to reduce the impact of language and cultural differences in health disparities.[7–9] Yet, even with official medical interpreters, problems still remain. For example, 1 study on interpreters in pediatric medical encounters found no significant differences in the errors committed by professional or ad hoc interpreters.[8] Another study reported that medical emergency room providers who used interpreters were found by patients to be less friendly, respectful, or concerned for the patient as a person and less likely to make the patient feel comfortable than when no interpreters were present or when interpreters were used with bilingual patients to help with clarifications in the encounter.[10]

In psychiatric research, attention has gone to translation of measurement instruments and structured clinical interviews. Extemporaneous language interpretation of research diagnostic interviews (live or videotaped) has received much less attention. This article uses the term *interpretation* in referring to oral language (i.e., helping one person understand another person with a different language) rather than *translations* that refer to written language.[5]

Assuming that factual accuracy is sufficient can be dangerous in psychiatric encounters and potentially ruinous to

research data.[11] Interpretation includes converting words and other patient communications—verbal, nonverbal, conjectural, and cultural. Accuracy in psychiatric diagnosis in multicultural contexts requires that the cultural meanings of symptoms and the social context of distress be understood, particularly to distinguish between psychotic symptoms or cognitive impairments, for example, and culturally patterned expressions of emotional pain.[12] Indeed, the role of the cultural broker in interpretation and health services has been strongly advocated. The cultural broker bridges, links, or mediates between persons of differing cultural backgrounds and acts as a go-between, advocate, and/or negotiator for patients and health care providers for effective outcomes.[6] For scientific integrity, interpretations require precision and consistency. This article reports on clinicians' experience when assisted by interpreters while diagnosing adult, Hispanic, psychiatric outpatients from videotaped interviews and in some live situations in a pilot study.[13] Our findings may help inform psychiatric services and clinical research that use interpreters.

METHOD

Informed by past research on psychiatric diagnosis with Spanish-speaking patients,[14] we examined the impact and role of interpreters assisting Spanish-speaking, Hispanic clinicians and English-dominant, non-Hispanic clinicians when interviewing or viewing videotaped interviews of adult Hispanic outpatients in an urban psychiatric clinic. This report is based on study data about the linguistic interpretation process of mostly videotaped interviews.

Spanish-speaking, bilingual, or English-speaking Hispanic walk-in patients or those with appointments were assigned to diagnostic interviews regardless of clinicians' Spanish abilities on the basis of clinic appointment schedule, on-call schedule, or walk-in schedule. This "quasi-random" approach maintained the natural procedures of practice in a busy, urban community mental health clinic. Informed consent was obtained, and research procedures were approved by our respective institutional review boards for human subject protection.

Ninety-eight Hispanic patients, mostly Dominicans and Puerto Ricans, participated in the study conducted from June 2002 to February 2004. Altogether, 49 clinicians (21 psychiatrists, 19 social workers, 4 psychologists, and 5 from other mental health disciplines) participated. Hispanic clinicians comprised 33% (N = 16) and non-Hispanic clinicians 67% (N = 33), with a mean (SD) of 10 (8.7) years of adult psychiatric practice. These clinicians were asked to simply interview patients following their usual practice approach; no attempt was made to dictate how clinicians should assess patients or what they should look for. In essence, we were looking for the most naturalistic psychiatric assessments possible. All interviews were videotaped. In some cases (6) the interpretation was done in the live interview situation, and in most (65) the interpretation was provided to non-Hispanic clinicians who were viewing Spanish-language videotaped interviews. Together, the live interviews and the videotaped ones were used as the basis for the assessments in this study.

After watching videotaped interviews or completing live interviews, clinicians independently filled out questionnaires asking for diagnoses and other information (e.g., open-ended, qualitative questions about the clinical encounter and 1 objective rating of symptom severity). Those clinicians (all non-Hispanic) who had been assisted by an interpreter answered 5 questions about the interpretation process. Three questions asked about the interpreter's impact on the clinician's confidence in his/her diagnosis and the perceived accuracy of interpretations ("I felt more confident about the diagnosis I gave this patient because of the assistance of the interpreter"; "I thought at times I was not getting an accurate interpretation of what the patient said"; and "I felt that the interpreter injected his/her bias in interpreting the patient's words and comments"). Responses were marked on a 4-point Likert scale from "Strongly Agree" (1) to "Strongly Disagree" (4). Two questions asked the clinician to mark how severe his/her diagnosis and assessment of patient functioning would have been without the assistance of an interpreter ("my diagnosis" and "rating of patient's level of functioning would have been" [more severe] [less severe] [the same] "without an interpreter assisting me").

Two bilingual mental health professionals (both psychologists, 1 at the master's level and 1 at the doctorate level) served as interpreters for non–Spanish-speaking, non-Hispanic clinicians interviewing or watching videotaped interviews of Spanish-speaking patients. The master's level psychologist had some formal interpreter training provided by a state-certified interpreter. In the few live situations, interpreters were only permitted to ask patients to repeat themselves if words were not understood or heard clearly. However, the interpreter could not ask the patient to repeat a statement in anticipation of making the diagnostic interview more informative for the clinician; that was the clinician's decision. The clinician could ask patients to repeat themselves for further probing and diagnostic process. In the videotaped interviews, interpreters and/or clinicians could rewind the tape when there were inaudible or unclear utterances. Videotapes were stopped to allow interpretation before moving on to the next statements. Interpreters could only provide linguistic interpretation and not contribute to the diagnostic process.

Descriptive analyses were conducted on questionnaire data. Qualitative impressions about the interpretation process were derived from interpreters' experiences and from discussions between the interpreters and coinvestigators during monthly team meetings.

RESULTS

Of the 98 patients, interpreters were used in 71 cases (72%). Of these, 65 interpretations were provided for videotaped interviews and 6 for live interviews. Most of the live interviews were conducted by Hispanic clinicians and reviewed by non-Hispanic clinicians, thus creating the situation in which there were more videotaped interviews being interpreted than live ones.

Clinicians agreed or strongly agreed (83% [N = 5] live interviews; 77% [N = 50] videotaped interviews) that they felt more confident about the diagnosis given patients because of the interpreter's help (live mean = 1.83, SD = 0.75; videotaped interviews mean = 1.98, SD = 0.83). They disagreed or strongly disagreed (67% [N = 4] live; 89% [N = 58] videotaped) that the accuracy of the information was being compromised by the interpreter (live mean = 2.80, SD = 1.10; videotaped mean = 3.16, SD = 0.71). That is, clinicians generally felt they were getting accurate interpretations. Clinicians disagreed or strongly disagreed (100% [N = 6] live; 97% [N = 63] videotaped) with the statement that interpreters were injecting bias into their interpretation of patients' words and comments (live mean = 3.5, SD = 0.58; videotaped mean = 3.34, SD = 0.55). Stated differently, clinicians felt they were getting objective, unbiased interpretations.

In 59 cases in which clinicians were assisted by the interpreter as they viewed videotapes, most clinicians (92%) reported that their diagnoses would have been less severe (N = 15) or the same (N = 39) if they had not been helped by an interpreter. Less than 9% (N = 5) marked "more severe." The same pattern was evident in clinicians' responses to the question about their possible assessment of patient functioning. In the 51 cases in which the clinician answered this question, nearly all (92%) reported that without the help of the interpreter they might have assessed the patients' global functioning as less severe (N = 12) or the same (N = 35). Less than 8% (N = 4) marked "more severe." In each of these questions, clinicians who were assisted by an interpreter during live interviews (N = 4) were in agreement that their assessments would have been less severe or the same without the help of the interpreter. However, these results must be viewed with great caution due to their small number and since 2 clinicians marked "less severe" and 2 marked "the same," with none marking more severe.

Qualitative impressions indicated that in a few live interviews, it was the interpreter's impression that the Hispanic patients had enough English ability to answer questions and only relied on the interpreter to navigate some portions of the interview. In some cases, the patients' receptive English was superior to their expressive English abilities, and they asked for more interpreter involvement. The interpreters encountered situations in which they had to help patients explain their psychological and physical experiences as clearly as possible and respond to questions and probes from the clinician.

In videotaped situations, it was common for interpreters to broker cultural and linguistic nuances, such as cultural expressions and colloquialisms. One example was when a patient used the Spanish term *maleducado*, which literally translates as "poorly educated" but contextually was related to being "rude," "discourteous," "ill-mannered," or "impolite."

There were times when interpreters encountered challenges to explaining accurately the thoughts patients were conveying and to making sure of distinctions between words that sound alike but represent different concepts and could be misunderstood as having the same meaning. For example, a middle-aged Puerto Rican woman used the terms *aburrida* (bored) and *aborrecida* (abhor, loathe), which have similarities but, as shown by the interpretation, are very different. It was necessary to clarify the meanings when the terms were used because the word *aborrecida*, in the context of the patient's affective state, implied self-loathing, necessitating clarification to assess depression, hopelessness, and suicidality. In at least 1 case, a clinician asked if a male patient's behavior was due to machismo in Hispanic culture, but the interpreter was constrained from speculating.

Because of the presence of cognitive deficits and disturbance of thoughts among patients, interpreters were challenged to make sense of content that was illogical or confused. In 1 particular instance, the interpreter was unable to ascertain if a videotaped Guatemalan man was referring to having fought as a "soldier" or as a "guerilla" in the telling of his traumatic history in his country's war years. In another instance, a Dominican woman used words that were incoherent but not neologisms—simply words that had special meaning within the subcultural context she inhabited. This created confusion in the interpretation process that could not be clarified during the interview.

DISCUSSION

Clinicians in this study felt, in general, that their diagnoses of patients in mostly videotaped interviews benefited from interpretation services rendered by 2 mental health professionals who followed specific criteria about their role and activities. Clinicians reported that they felt greater confidence in the diagnoses they rendered because of the assistance of the interpreter and that they were getting accurate, unbiased interpretations. Interestingly, however, nearly all clinicians reported that, without the interpreters, their diagnoses and assessments of patient functioning would have been the same or less severe. This last finding seems to support the results of the questions about the accuracy and bias of the interpreters, which indicated that clinicians felt more confident about their

diagnoses because of the interpreter's help. It is possible that clinicians would have otherwise acted more tentatively in diagnosing, but with the interpreters' assistance, they could reach more realistic diagnoses and assessments.

Interpreters' qualitative impressions suggest that there are particular challenges in psychiatric interviews. For instance, some idioms of distress may be so linguistically and culturally bound as to elude even knowledgeable interpreters. Additionally, clinical features, such as psychotic symptomatology or cognitive impairments, pose challenges to accuracy that would, in turn, influence treatment planning. Interpreting gestures, cultural practices, norms, and values presented by patients and associated with their Hispanic cultural group are further challenges to the interpretation process.[15]

There are some limits to generalizability inherent in this study. Of course, diagnosing from videotapes is not customary in clinical practice, and interpreting videotaped interviews is only a proxy for the dynamic, live experience with its rich, flexible context. Our interpreters were clinicians, not professional medical or psychiatric interpreters. This is a matter that has both strength and weakness insofar as the 2 interpreters acted in a disciplined manner to provide interpretation of words, gestures, cultural idioms, and other nuanced behaviors without interfering with the questions asked by providers or influencing the diagnosis that the reviewing clinician assigned.

The small number of clinicians and patients, uneven number of non-Hispanic and Hispanic clinicians, and imbalance of clinicians diagnosing from live interviews versus videotaped interviews (more data drawn from videotape observers) also restrict generalizability. Likewise, the number and types of questions asked regarding interpreters' utility in the interviews and the unstructured nature of the qualitative analysis point to the need for additional research that can provide conclusive results.

In spite of the limitations, when we combine the results of our experience with those of the extant literature, there are several recommendations that can be gleaned on the role and use of interpreters in diagnostic practice and research. First, in keeping with previous reports on interpretations in clinical service—both medical and psychiatric—interpreters function to help patients explain their psychological and physical experiences as clearly as possible and respond to questions and probes from the clinician and, ultimately, to enable patients to feel understood. Interpreters must insure that clinicians formulate the clearest clinical picture of the patient as possible for diagnosis and treatment planning. Cultural brokers, by helping make sense of the patient's world through cultural explanations and contextual interpretations and by clarifying colloquialisms normative in the patient's sociocultural context, improve the diagnostic process.[6] When cultural interpretation of terms, words, sayings, maxims, or proverbs is needed, the interpreter should utilize culturally appropriate analogies to maintain the quality of the interpretation.[7] In this study, the interpreter clarified culturally nuanced patient communications when asked by the clinician or when it appeared necessary.[16] These functions can improve research precision and the scientific utility of interpreted interviews.

Second, interpreters should provide as close a grammatical facsimile as possible, while allowing for moments when interpretations must be adjusted to explain accurately the thought that the client is conveying and to distinguish between words and concepts that could be misunderstood as having the same meaning. Interpreting in the manner presented by the patient assures accuracy in the conversation and reduces interferences or potential miscommunications. Care is necessary when words that may mask or overstate pathology are presented by patients. Common challenges are words and terms that appear "untranslatable" or that refer to experiences that have no easily accessible comparable frame of reference. When the interpreter does not know a cultural term or its meaning, this must be acknowledged.

Third, interpreters' effectiveness is reduced when patients cannot provide logical, coherent, or sequential information, fundamental elements of the mental status examination. Correcting this problem necessitates distinguishing when words or terms are used improperly in the native tongue (e.g., malapropisms) from thought or language disorders (e.g., neologisms, executive functions). In such cases, the interpreter must acknowledge the difficulty following the ideas or information.[17] Interpretation must reflect as accurately as possible the manner in which the patient presented the information. Trying to make more coherent descriptions of what patients say may artificially reduce indications of thought disorder, delusional process, or language processing problems, thus obscuring pathology. The challenge is to translate material such that it neither *increases* nor *decreases* the appearance or magnitude of psychopathology.

In summary, interpretation in research or clinical interview is mediated communication that retains the fidelity of the verbal and nonverbal interactions between patients and clinicians. The interpreter's goal is to present the clinician's questions and patient's replies as faithfully as possible, despite incoherence, cultural nuances, and other symptoms of psychiatric distress that can confound the interpretation process.[7,11] While further research is needed, especially in live diagnostic conditions, recommendations from our pilot project may help optimize the use of interpreters, minimize interference, enhance diagnostician-patient communication and relationship, and render greater confidence in outcomes in diagnostic practice and research.

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