# Rethinking Interpreter Functions in Mental Health Services

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Interpreters improve access to care for patients with limited English proficiency (LEP), but some studies have reported poorer cultural understanding, relationship quality, and patient satisfaction than with language-concordant care. Use of interpreter roles beyond linguistic conversion (clarifier, cultural broker, or advocate/mediator) may enhance interpreter-mediated care by improving cultural understanding and the therapeutic alliance. As reported in this column, pilot data on interpreter-mediated evaluations of 25 psychiatric outpatients with LEP support this position. The authors found that clarification of the interpreter's role and the session structure improved provider-interpreter collaboration, with two perceived benefits: improved assessment through elicitation of clinically relevant information and stronger therapeutic alliance through "emotion work." Strategies for effectively enhancing provider-interpreter collaboration are discussed.

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As the number of migrants and refugees grows worldwide, providers must increasingly bridge linguistic and cultural differences to treat patients from all over the world. In 2017, individuals with limited English proficiency (LEP) composed 8.5% of the U.S. population. Language barriers impede patient-clinician communication and collaborative decision making and are associated with lower satisfaction with care and negative patient ratings of providers (1). In mental health care, which relies primarily on verbal communication, language discordance affects symptom assessment, interpretation of cultural idioms of distress, the working relationship, disclosure of stigmatizing information, and patient-centered communication (2). These negative effects of language discordance increase misdiagnosis, empathic failures, and poor working alliances, worsening treatment outcomes (1, 3).

Professional interpreters are crucial for overcoming communication gaps. However, interpreter-mediated services still report worse patient participation, relationship quality, cultural understanding, treatment engagement, and patient and provider satisfaction than language-concordant care (4).

We argue that efforts to enhance the outcomes of interpreter-mediated services should transcend basic communication functions to target cultural and interpersonal factors. Fuller use of interpreters' capacities to overcome linguistic and relational barriers to care can rely on interpreters' roles beyond the conduit role (simple linguistic conversion). Interpreters are also clarifiers (independently eliciting clarifying information), cultural brokers (providing information on sociocultural contexts), and advocates/mediators (acting on the patient's behalf to promote quality of care) (5). Beyond technical competence, attention to relational processes (e.g., empathy) is crucial to clinician-interpreter collaboration.

Despite long-standing discussions among interpreters about these more active interpreter roles, few health care institutions promote interpreter-clinician partnerships that fully utilize them. Barriers include mistrust and misattunement resulting from differing professional roles, communicative goals, working styles, and relational stances. Interpreters can find clinicians rigid and culturally insensitive, and clinicians often fear losing authority and control over the therapeutic process, especially in maintaining clinical boundaries (6). Tensions in the power dynamics of the clinician-interpreter relationship may be felt but are rarely addressed. Clinicians hold institutional authority, which can affect interpreters' employment, but interpreters' relational power can shape the therapeutic alliance and patients' and clinicians' views of each other (7). Too often, this dynamic results in interpreters' hesitation to challenge clinical authority, even to address cultural misunderstandings, leading some interpreters to intervene in nontransparent ways that exceed their expertise, with potentially adverse consequences.

Qualitative research suggests that ambiguity surrounding interpreter role boundaries worsens the clinician-interpreter

relationship and overall treatment process, especially when institutional limitations constrain parties from negotiating their respective roles—sharing power and expertise—and from establishing a model for resolving conflicts (8). However, few studies have examined how interpreter-clinician power struggles may be reconciled in practice to enhance triadic (patient-clinician-interpreter) communication and treatment process.

## Empirical Investigation

We conducted a quasi-analog study to explore whether tensions in the patient-clinician-interpreter triad might be resolved if interpreters were empowered to assist clinicians in addressing cultural and relational misattunements. Interpreters were empowered to assume their more active functions (clarifier, cultural broker, and advocate/mediator), and clinicians were trained to consider interpreters as resources for improving cultural understanding and the therapeutic relationship. We explored how patients and clinicians negotiated these newly drawn role relationships and what clinicians, interpreters, and patients felt were the benefits of this collaborative model of interpreter-mediated care. Written informed consent was obtained from all participants; the study was approved by the institutional review board of the New York State Psychiatric Institute.

The study was conducted at two urban psychiatric clinics specializing in bilingual services. Because research suggests that some professional interpreters struggle to transcend their engrained roles as "neutral channels," we recruited bilingual/bicultural clinicians to serve as interpreters. Because these "clinician-interpreters" have clinical expertise that professional interpreters lack, they can discern what information may be most helpful to the clinician in the diagnostic and engagement process while supporting their clinical authority. Thus, working with clinician-interpreters in this pilot study, we could study the effects of a more active interpreter approach.

Twenty-five outpatients with LEP (14 Mandarin-speaking and 11 Spanish-speaking) were evaluated by a study clinician who did not speak their language and who was assisted by an interpreter proficient in the patient's language. Patients were told that the evaluation was being conducted for research purposes and would not affect their clinical care. The nine mental health clinicians (five women and four men, eight of whom were non-Latinx white and one Latinx) included two psychiatrists, four psychologists, two social workers, and one psychology intern.

Eleven bilingual/bicultural clinicians (six Spanish-speaking and five Mandarin-speaking) served as interpreters and are referred to here as "clinician-interpreters" for clarity. They included two psychiatrists, four psychologists, three mental health counselors, and two social workers. Most were women and foreign born; five were Latinx, five Chinese, and one non-Latinx white. Five had worked professionally as interpreters in mental health settings. They had completed a 3-hour training session on active strategies to enhance cultural understanding and facilitate the working relationship. Developed with an expert in bilingual health communication and medical interpretation, the curriculum included critical incidents with suggested interventions. For example, mention of *ataques* by a patient allowed discussion of the term, which could refer to a fit, a panic attack, or *ataques de nervios* (a cultural syndrome among Caribbean Latinxs). Possible interventions, including cultural brokering, may involve alerting the clinician to the various meanings of the word to encourage clarification and exploration with the patient.

Clinicians and patients met face to face; remote video interpretation was delivered via Skype. Sessions lasted 1 hour and were videotaped. Afterward, separate semi-structured debriefing interviews with each participant in the patient's preferred language assessed perceptions of interpreter activities that promoted linguistic and cultural understanding and the working alliance between patient and clinician and evaluated how members of the triad negotiated their respective roles to promote collaboration. Feedback regarding specific session structures and procedures guided refinements of these elements in later sessions.

Using theoretical thematic analysis (9), we analyzed qualitative data from 74 debriefing interviews with patients (N=24, one missing), clinicians (N=25), and clinician-interpreters (N=25). We also explored each group's experience of the session and perceptions of the benefits of empowering interpreters to take a more active role in facilitating cultural understanding and interpersonal processes of care.

Each clinician conducted one to four patient evaluations (mode=2), often with multiple clinician-interpreters. Most struggled at first to implement this approach. As found in previous work (7), we observed initial resistance due to concerns that higher levels of interpreter activity would undermine the clinician's authority. This led to clinicians' feeling marginalized and frustrated. As one clinician noted, "The patient was talking to the interpreter and not to me. I felt the relationship was with the interpreter, and I was the computer that was supposed to figure out what was going on." However, with practice, clinicians and clinician-interpreters explored how to disrupt normative interpreter-mediated clinical processes and experimented with more active collaboration. These new interactional routines often yielded deeper and more useful patient disclosures, leading clinicians to become more receptive to the clinician-interpreters' involvement and strengthening collaboration and openness to the approach.

As expected, role ambiguity and clinician ambivalence emerged as chief impediments to the clinician-interpreters' use of more active roles. However, role clarification, session structure, and skill development increased interpreter activity over time, resulting in two perceived benefits (Table 1).

*Benefit 1: Strengthening assessment through elicitation of clinically relevant information.* Participants noted that interventions to clarify information were the most frequent type of interpreter intervention. Clarifying interventions

**TABLE 1. Participant perceptions of key benefits of active interpreter involvement beyond the conduit role**

| Theme and subtheme | Example | Type of intervention |
|---|---|---|
| Facilitate assessment | | |
| Elicit information | "I asked what the [Chinese] patient did in his spare time, and he indicated that he 'played.' The clinician-interpreter clarified this to mean video games. This was helpful since I would have thought that he was having social interactions in a way that he wasn't." | Clarification |
| Patients felt understood | "Clinicians need to understand what the Chinese immigrants' experience is." "[Because of the clinician-interpreter], the clinician was more able to understand my cultural background and where I am from." | Cultural brokering |
| Meaning of symptoms | "In the Dominican Republic, *susto* refers to fear/dread and is not a cultural syndrome as [it is] in parts of Mexico and Central America." | Cultural brokering |
| Enhance alliance through "emotion work" | | |
| Amplification of patient's tone and affect | Clinician said the clinician-interpreter conveyed tone and context of what patient said, which "helped me in drawing [the patient] out." | Relational |
| Direct shaping of affective climate | Clinician offended Latinx client by refusing to shake hands, saying "I have a cold." The clinician-interpreter explained the clinician's intent to help repair the relationship. | Relational |

aim to enhance understanding by requesting additional information (if the interpreter has not fully understood the patient), alerting parties that a message has been misunderstood (despite being accurately conveyed by the interpreter), or actively tailoring the interpretation to enhance understanding. Examples included suggesting that the clinician explain confusing concepts (e.g., suicidal thoughts) or introducing culturally informed questions to elicit clinically relevant information (e.g., the clinician-interpreter asking a Chinese patient, "Do you have friends you go out to eat with?" when the clinician asks if the patient has people "to talk to").

Cultural brokering interventions were also described as helpful in eliciting culturally grounded, clinically relevant information. Cultural brokering requires greater interpreter involvement, including introducing information to explain the significance of patients' idioms of distress and life experiences. Cultural brokering interventions that contextualized patients' immigration experiences were described by clinicians and patients as particularly useful. One Chinese patient noted the following:

> The clinician was able to know me well (in terms of) my background and the difference of my past and current life. I told the clinician that I had been working in restaurants in other states. He was asking me whether I was making any friends and my social life, such as "Happy Hour." His questions showed our cultural differences and the interpreter was able to explain to the clinician the circumstances of Chinese immigrants working in restaurants in other states. We had no car to drive. The only way we could make friends was to have dinner with some colleagues. We don't have "Happy Hour." The broker was able to explain that to the clinician and that was helpful.

*Benefit 2: Enhancing alliance through "emotion work."* Participants commented on the clinician-interpreters' role in enhancing the patient-clinician working alliance, specifically by representing speakers' tone and affect, described elsewhere as "emotion work" (10). One Spanish-speaking patient stated, "I didn't expect to feel as much trust (*confianza*) with the clinician to share as much about myself as I did. This was a pleasant surprise. The tone used by the interpreter helped me feel comfortable."

Clinician-interpreters reported two ways of deepening the patient-clinician bond by monitoring and shaping the affective climate. First, they increased attunement to the patient's affective states by amplifying affective messages. Here, the interpreter serves as an affect conduit by mirroring body language and emotional tone or by narrating what she observes ("he seems frustrated"). Second, clinician-interpreters directly shaped the affective climate. Examples include conveying warmth and respect to the client in culturally appropriate ways, even if the clinician does not. Several Chinese clinician-interpreters described choosing their words carefully to minimize patients' shame or offense during discussions of sensitive topics.

*Adaptation to new interactional routines: "This is only going to get better."* As clinicians experienced first-hand the benefits of more active interpreter intervention, they invited more involvement. Clinicians came to describe their collaboration with the clinician-interpreters as "a partnership," "an unspoken bond," as though "there was a team meeting going on in the session." One clinician described the interpreter as an "extension" of himself, making the communication "seamless" and allowing him to connect with the patient "in a verbal and nonverbal way." Given the patient's LEP status, he assumed the information obtained would be very basic, but he "got a lot more." "I see the level of comfort we were able to get in one session, and that [this is] only going to get better." The positive working relationship was observable to patients, who described instances of effective brokering that helped cultivate a climate of cooperation and understanding.

### Strategies for Enhancing Clinician-Interpreter Collaboration

Results from this pilot study involving clinician-interpreters suggest the potential benefits of empowering professional interpreters to actively assist clinicians in attending to cultural, relational, and linguistic barriers to care. Paired with other cultural competence training for clinicians, maximally using the interpreter's skills may be a logical step to help individuals with LEP overcome linguistic and cultural barriers to care.

Participants' feedback helped us tweak the approach to preserve the clinician's authority and deepen rapport with the patient, while introducing more session structure and guidelines for collaborating with the interpreter. Lessons learned for future exploration of this approach involve clinician training, session structure, and interpreter training and systems interventions.

*Clinician training.* Clinicians—not interpreters—should take the lead in orienting the patient to this enhanced model of interpretation. Clinicians also should be trained to assess the patient's cultural background to facilitate interpreters' cultural brokering efforts. To counteract concerns about diminished clinical authority, clinicians can be educated about how more active interpreter involvement can facilitate a culturally informed diagnostic process and stronger alliance.

*Session structure.* During sessions, include check-in periods during which clinicians summarize their understanding of the patient, elicit feedback and clarification from the patient and interpreter, and invite interpreter input on cultural-relational misattunements. This allows interpreters to focus on the content and process of communication, rather than on whether and when to intervene. Where possible, arrange for the same interpreter to work with the same clinician over time to build trust and strengthen collaboration.

*Interpreter training and systems interventions.* It is necessary to build on professional interpreters' training in the clarifier, cultural broker, and advocate/mediator roles by providing advanced training modules on culture and mental health and on clinical helping skills to facilitate the working alliance. With the growing use of remote interpreting technologies, interpreters with this enhanced training could be accessed from a centralized location, overcoming access barriers in underserved areas.

### Discussion and Conclusions

Our pilot study had several limitations. First, we tested this approach with the two largest LEP groups (Chinese- and Spanish-speaking individuals); people speaking other languages and from other cultures may respond differently. Second, we could not examine the effect of clinician and clinician-interpreter discipline. Third, because clinician-interpreters played the role of interpreters in this study, professional interpreters without training and experience in mental health may not be as competent in identifying and addressing cultural and relational misattunements in the dyad.

Fourth, we used remote video interpretation to reflect its increasing use in hospitals and everyday life. Stakeholders endorsed this modality with high levels of acceptability (data not shown), as previously reported. However, future tests should examine the impact of different modes of interpretation (video vs. phone vs. in-person) on stakeholders' experience.

In conclusion, a collaborative approach that leverages interpreters' more active roles may help overcome linguistic and cultural barriers to mental health services for individuals with LEP. Using clinician-interpreters in this pilot study allowed us to begin to test a model of practice that leveraged their clinical, cultural, and linguistic knowledge and expertise. Although our findings are consistent with those of previous studies of the relational dynamics between clinicians and interpreters, the next step is to examine this approach with professional interpreters by strengthening their culturally informed clinical knowledge and relational intervention skills and examining the processes and outcomes of more active involvement to improve patient care.

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## New Column: Controversies in *Psychiatric Services*

*Psychiatric Services* is pleased to welcome Matthew D. Erlich, M.D., Patrick Runnels, M.D., and Rachel M. Talley, M.D., as coeditors of the Controversies in *Psychiatric Services* column.

Controversies in *Psychiatric Services* highlights topical areas to the field of psychiatry where there may be debate, disagreements, or divisiveness. Submissions will focus on a specific topic and will feature two separate columns with differing viewpoints on that topic. The goal is to foster new perspectives, promote further discourse, and, hopefully, generate new conclusions while maintaining the civility and intellectual rigor appropriate to an academic journal. Topics will be chosen by the editors based on the timeliness and importance of the controversy. Interested authors may submit papers describing one viewpoint on the topic (limited to 1,200 words and 5 references that are core to the argument; no abstract, tables, or figures). The editors may also reach out to individuals to request column submissions based on specific topics.

> **Topic 1:** A value-base system of payment for psychiatric services that places financial responsibility for behavioral health outcomes on the treating clinician is the best way to promote better outcomes and reduce unplanned care.

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