Challenging Language Barriers

8

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8.1 Introduction

There are more than 20 officially recognised languages, more than 60 indigenous regional and minority languages and many nonindigenous languages spoken in Europe [1]. The use of native language helps preserve cultural heritage and identity and promotes social cohesion among those who share the common tongue. However, the diversity that is much celebrated is inevitably problematic when there is a need for communication but no language in common. These problems are no more profound than between users and practitioners of medical and criminal justice systems, where matters of health, justice and liberty are concerned [2]. Understanding how to overcome such language barriers is becoming increasingly important for healthcare providers around the world, and an increase in research on language barriers has been recently reported [3].

In this chapter we discuss areas in which language may be a barrier to effective communication and to the exchange of knowledge for clinicians. We discuss potential difficulties in communication in clinical and forensic settings and how they may be overcome, including clinical interviewing and psychometric assessments. We also discuss the barriers to professional mobility and the difficulties associated with the effective dissemination of research and information where language is concerned.

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8.2 Overcoming Challenges in Communication with Patients

Communication between patient and clinician is fundamental in healthcare but particularly so in the field of mental health where verbal communication forms the main channel by which to access the mind of the patient, to elicit and to interpret precisely what has been said and how.

Even before a consultation has even been arranged, for a non-native speaker, language may be a significant barrier to accessing healthcare, due to the lack of comprehensible information about the existence of services and how to access them. If this can be successfully overcome, the difficulties in communicating and being understood in the clinical setting are then brought into sharp relief. For example, it has been shown that poorer communication in consultations with non-native speakers can lead to misunderstanding and non-adherence to treatment [4, 5].

The availability of professional translation services are therefore recommended to overcome language barriers in the clinical setting, but the situation in European countries seems heterogeneous. In the United Kingdom, most health services have policies to support the use of translation and interpreting services for individuals who have limited proficiency in English. Similarly, translation services can be found at least telephonically in Spain. In Switzerland, Bischoff and Hudelson [6] found that the use of an interpreter should be seen as a central and obligatory part of the consultation.

While the requirement to provide interpretation or translating services is not explicitly set out in European legislation, there is a legal framework that supports equality of access to healthcare, which places a public duty on health systems to ensure staff and service users are treated equitably and not discriminated against on grounds of ethnicity (notably the European Convention of Human Rights [7] which has been incorporated in legislation across Europe (Human Rights Act [8], the Equality Act [9] in the United Kingdom and the Spanish General Law [10] in Spain). Although there may be an obligation on services to provide translating services, in practice this may not occur either due to limited funding, failure to identify need or lack of availability of an interpreter who is proficient in the required language.

Conducting a clinical interview with the help of an interpreter can pose its own challenges, and guidelines to assist clinicians working with interpreters have been published (e.g. [11]). Fundamentally, it is recommended that interpretation should be carried out by someone who is competent to do so. It is rarely acceptable to rely on the patient's friend, relative or child to provide the interpretation service unless in true emergency, due to issues of confidentiality, impartiality and the quality and reliability of the translation. Patients have a more positive experience of the consultation when a professional interpreter has been used, and they report the perception that they have been helped more [12, 13]. In addition, it has been shown that the use of non-professional interpreters can lead to less disclosure of sensitive information by patients and can lead to errors in the interpretation of information obtained [12].

Before a consultation in which an interpreter will be used, it is recommended that adequate time is allocated for the interview; approximately twice as much time will be required as compared with an interview with a native speaker. The clinician should first meet with the interpreter to check that there are no conflicts of interests, such as any previous knowledge of the patient through family, social or business relationships. It is also recommended that the subject matter of the consultation (if known) will be outlined to the interpreter, to check that the interpreter will be able to proceed as the subject matter in forensic assessments may be shocking to those not normally working within this field. It is also recommended that "ground rules" are discussed with the interpreter to discuss how the interview will proceed, especially the requirement that everything said by both parties must be translated.

At the commencement of the interview, it is recommended that the interpreter is introduced and their role is clarified. The patient should be informed that the interpreter is independent and impartial and cannot advise them or provide support. They should be advised that they will translate everything they say and that they do not have to pay for the service.

The clinician is advised to carry out the consultation using simple words. Any medical or technical terms should be explained. It is recommended that a maximum of one or two sentences should be spoken before pausing for the interpretation. The language used should be specific and direct and should avoid inferences (such as "passed away" instead of died) or culturally specific phrases, similes, idioms or jokes that may not translate with the intended meaning. The clinician should speak directly to the patient as in a consultation without an interpreter, and the interpreter should reply using a translation of the patient's exact words. It is also important to continually ensure that the patient has understood by assessing their comprehension regularly during the consultation. Once the consultation is complete, the patients' language preferences and communication needs should be clearly recorded in the patient's record to ensure staff are aware of the needs of the patient.

8.3 Language Barriers in Forensic Psychometrics

Psychometric tools are a core component of forensic assessments, yet many tools published in English have not been translated to other languages. Furthermore, those translated into another language for use in another country may not have been validated for use with that population. It is imperative that the highest standards are upheld in selecting and administering appropriate psychometric measures and in interpreting the results in light of the known limitations of the instrument [14]. Those limitations may therefore be due to language, for example, that the instrument has been used with a non-native speaker or that the instrument has been translated but not validated for use in other populations.

The ethical standards for the use of assessment tools as articulated by the American Psychological Association (section 9.02) highlight the importance of using the tools

correctly on members of the population for which it has been tested on and appropriate to the individual's language preference and competence ("unless the use of an alternative language is relevant to the assessment issues"); if not, they should "describe the strengths and limitations of test results and interpretation" [15]. Only assessment instruments whose validity and reliability have been established for the particular population assessed should be used, yet forensic experts will invariably confront the challenge of assessing people who, by reason of ethnicity, culture, language or other factors, are not well represented in the normative base of frequently used assessment tools. In such circumstances, experts should interpret the test results cautiously, with regard to the potential bias and misinterpretation of such results [16].

Table 8.1 shows the translations available for IQ and personality assessments translated for common European languages. Several of the risk assessment instruments (Classification of Violence Risk (COVR) [17], Historical Clinical Risk Management (HCR)-20, [18] Level of Service Inventory-Revised (LSI-R) [19], Structured Assessment of Protective Factors (SAPROF) [20] and Violence Risk Appraisal Guide (VRAG) [21]) but not all of them, have also been translated into different languages. It appears that instruments that are frequently used in general psychiatry are more likely to be translated and validated for languages other than English compared with forensic instruments. Furthermore, specific training in the use of the instrument is frequently held in English, limiting the access of those professionals nonproficient in this language.

Nevertheless, even properly translated and validated psychometric measures may suffer as they may contain references to cultural idiosyncrasies. IQ tests and personality inventories may therefore be less reliable and valid with non-native English speakers, poorly educated individuals or those in non-Western cultures [22]. Furthermore, language barriers may not be appropriately compensated by

Table 8.1 Translations available for main forensic tools

Test/languages	German	French	Spanish	Italian
IQ measures				
Wechsler Adult Intelligence Scale-IV (WAIS-IV)	Hamburg-Wechsler-Intelligenztest für Erwachsene	Echelle d'intelligence de Wechsler pour adultes	Escala Wechsler de Inteligencia para Adultos	WAIS-IV
Personality inventories				
MCMI	MCMI	Inventaire clinique multiaxial de Millon	Inventario clínico multiaxial de Millon	MCMI
MMPI	MMPI	Inventaire Multiphasique de Personnalité du Minnesota	Inventario multifásico de personalidad de Minnesota	Inventario Multifasico della Personalità Minnesota
PAI	PAI	Inventaire d'évaluation de personnalité	Inventario de evaluación de la personalidad	PAI

using measures that do not require verbal instructions or responses [16]. Performance on non-verbal tests can vary significantly based on both cultural background [23] and educational level [24]. Indeed, the American Board of Professional Neuropsychology acknowledges that there are cases in which language barriers preclude valid test administration [25].

All of this highlights the dangers inherent in using psychometric instruments as a primary criterion in making critical decisions, ignoring the fact that they cannot possibly represent the individual as a whole being within his or her unique life context [26]. For the clinician, the most important thing to remember is that, while self-report measures have their place, they function best as screening instruments and should not be used in isolation as diagnostic instruments [27].

8.4 Language Barriers in the Criminal Justice System

Language barriers exist among those in contact with the justice system and have been described for both offenders and victims. The difficulties may be even more pronounced if mental health problems are involved [28, 29]. Concerns are particularly high among those whose competency is in question, as they may not even have the proper assistance of an appointed attorney and an accurate forensic assessment [28]. The European Committee on Crime Problems recognises that foreign offenders are more likely to be remanded in custody while awaiting trial and are more likely to be sentenced to terms of imprisonment after conviction than other offenders [2].

The increasing numbers of foreign inmates in European prisons provide a challenge in communication for those detained. In addition to the isolation for non-native speakers in prison, the European Council's European Committee in Crime Problems has stated that the "inability to communicate in the language most commonly spoken in a prison is a severe barrier to foreign prisoners' ability to participate in prison life". It is the root cause of many problems, such as isolation, lack of access to services, work and other activities, and an inadequate understanding of prison rules and regulations. Therefore, it is vital that prison authorities make every effort to facilitate communication and to enable offenders to overcome language barriers. The problem is exacerbated in those prisons that allow only one language to be used which could be considered against human rights. In fact, the European Court of Human Rights considered this aspect combined with the lack of personal space to decide that a Tajik inmate's detention conditions in Russia went beyond the threshold tolerated by Article 3 of the European Convention of Human Rights, prohibiting torture or inhuman or degrading treatment or punishment (European Convention of Human Rights 2005) [30].

Difficulties increase when several relevant aspects converge, such as suffering a mental health problem, having committed a crime and not sharing the common language. Furthermore, it has been suggested that poor language skills associated with an authoritarian system increase the likelihood of conflicts within the prison population [31].

8.5 Professional Language-Based Barriers: Communication with Colleagues

While non-native English speakers struggle to communicate effectively in English, native English speakers try hard to understand the many variants of non-native speakers, overcoming different accents and accepting the language mistakes inevitably made. Getting lost in translation is a problem for both sides.

At a professional level, a clinician's skills, expertise and knowledge can remain hidden by language due to difficulties in communication, which may also be a barrier to international mobility and collaboration. Professional experience outside one's own country is generally highly appreciated; professionals frequently decide to study or work abroad, and the amount of multilingual teams is increasing. Even research funding frequently highlights the importance of multinational studies to get a comprehensive picture of the phenomena studied. With the increasing development in collaborative work, lack of language skills inflicts a particular handicap on professionals wishing to work internationally. Due to the dominance of English in the scientific world, this can be harder for those whose primary language is anything other than English.

Regarding collaborative work, several studies have described language barriers in terms of lower social integration, reduced knowledge sharing or power-authority distortions [32]. It has been noted that language-related issues can significantly impact on the formation of trust within teams, with a perceived connection between language proficiency and the trustworthiness or competence of team members. It has been found that negative attributions are made about a colleague's competence based on their command of language, with a clear correlation between the magnitude of these negative attributions and the proficiency of their language [32].

Furthermore, there are "rules" that language is used in an expected and particular fashion in a given environment and context. If these expectations are not met, adverse attributions may be made as to the personality of the speaker who may inadvertently fail to conform to these rules [32]. In addition, less proficient speakers within a multilingual team may feel negative emotions, avoid native-speakers and switch to their mother tongue and group with fellow speakers, excluding others. Hostile stereotyping and emotional conflicts may then ensue, increasing miscommunication, uncertainty and anxiety [33].

Given the increasingly diverse nature of many forensic patient populations, multilingualism in forensic teams may be a future need, and therefore an awareness of the potential issues may help to mitigate problems.

8.6 Professional Language-Based Barriers: Professional's Mobility

Doctors frequently seek employment in countries other than where they trained. In 2011, Dr. Bollen Pinto, president of the Permanent Working Group of European Junior Doctors, stated that some regulatory bodies were "expressing concerns

regarding the language skills of migrating doctors and might push in the direction of mandatory language testing". He went on to say, "This issue is particularly evident in the UK, where recent cases of alleged malpractice with disastrous results by foreign doctors came out in the media. Communication problems between doctor and patient were pointed out as the cause of the problem" [34]. There is no uniformity for the assessment of language proficiency across Europe. Some regulators require a formal language assessment test post-registration, and some require no language assessment at all. Requirements by other regulators include a review of language proficiency by a panel, formal interviews, assessed discussion of a video, evaluation of the employers or a medical inspector or simply a declaration of proficiency by the individual [34].

Directive 2005/36/EC from the European Commission already provided for the obligation of professionals to have the necessary language skills. However, the review of the application of that obligation showed a need to clarify the role of competent authorities and employers, in particular in the interest of ensuring better patient safety. That Professional Qualifications Directive of the European Commission was updated in 2013, and several issues regarding language skills were modified [35]. It was made compulsory "for professions that have patient safety implications, a declaration about the applicant's knowledge of the language necessary for practicing the profession in the host Member State". The new Directive acknowledges "professionals benefiting from the recognition of professional qualifications shall have a knowledge of languages necessary for practicing the profession in the host Member State". Therefore, after the recognition of a professional qualification, a Member State shall ensure that any controls carried out by, or under the supervision of, the competent authority for controlling compliance with this obligation shall be limited to the knowledge of one official language of the host Member State or one administrative language of the host Member State provided that it is also an official language of the Union. Controls carried out in accordance with the Directive may be imposed if the profession to be practised has patient safety implications, but they shall be proportionate to the activity to be pursued.

With regard to psychiatry, proficiency in the local language can be considered compulsory to practise. Evaluation of psychopathology, as discussed, is done to a large extent through observation of language use, which may be difficult to assess for a non-native speaker. Furthermore, specific communication styles may be especially complex: the use of sayings and proverbs can provide information with direct relevance to clinical assessment and even treatment, but they can be easily overlooked by non-native speakers.

8.7 English Dominance in the Scientific Field

Chinese, Spanish, English, Arabic and Hindi are the most widely spoken languages in the world by the estimated number of native speakers [36]. In Europe, the most widely spoken mother language is German, followed by Italian, English, French, Spanish and Polish (European Commission 2012) [1]. Nevertheless, English is the

most widely used "second" and "learning" language in the world and is the foreign language that Europeans are most likely to be able to speak (European Commission 2012) [1]. It is extensively used for international communication in business, finance, technology and, of course, science.

Whether language diversity leads to language barriers depends on the speakers' proficiency levels [32]. Governments in non-native English-speaking countries understand the relevance of this issue, and the majority of them have increased the extent to which students are required to learn foreign languages in the recent years. Indeed, learning English is mandatory in several European Member States within primary education; 93.7% of all European students in secondary education learn English as a foreign language [37]. On the other hand, the global popularity of English has had an adverse impact on native English speakers' learning of other languages [38], with the United Kingdom having the highest share of upper secondary school students not learning a foreign language (52%) [37]. Interestingly, this may damage the prospects of UK professionals in the employment market.

8.8 Language Barriers in the Dissemination of Knowledge

Language barriers may limit scientific discussions. At international scientific meetings, discussions are normally held in English in order to reach as many people as possible. No matter what language is being used, being a non-native speaker usually means less fluency of communication; limited vocabulary inhibits fast intellectual debate and may even prevent the non-native speaker from participating. This may cause frustration, but more importantly, it prevents ideas, experiences and knowledge from being shared.

Furthermore, scientific literature is predominantly published in English (including, as you have noticed, this text). A search of PubMed (one of the most popular bibliographic databases for published journal articles and citations) in October 2015 found there were over 21 million articles indexed. Of these, over 97% were in English, with only 1.5% in Spanish, 1.2% of articles in Chinese and only a handful of articles in Hindi and Arabic. Similarly, another international bibliographic index, Scopus, showed an overwhelming predominance of articles in English (over 98%) and only 1.2% in Spanish, 0.6% in Arabic and virtually no articles in Hindi. Global dominance of English is also found in forensic psychiatry. Figure 8.1 shows the number of published articles in the main European languages indexed in Scopus, containing the term "forensic psychiatry". Out of a total of 25,275, 84.5% were published in English.

Furthermore the best-rated journals are published in English according to the Scimago Journal Citation Index. In fact, there are no non-English medical journals ranked among the top 1000. It follows therefore that authors will reach a larger audience if they publish in English, and there is clear evidence that even non-native

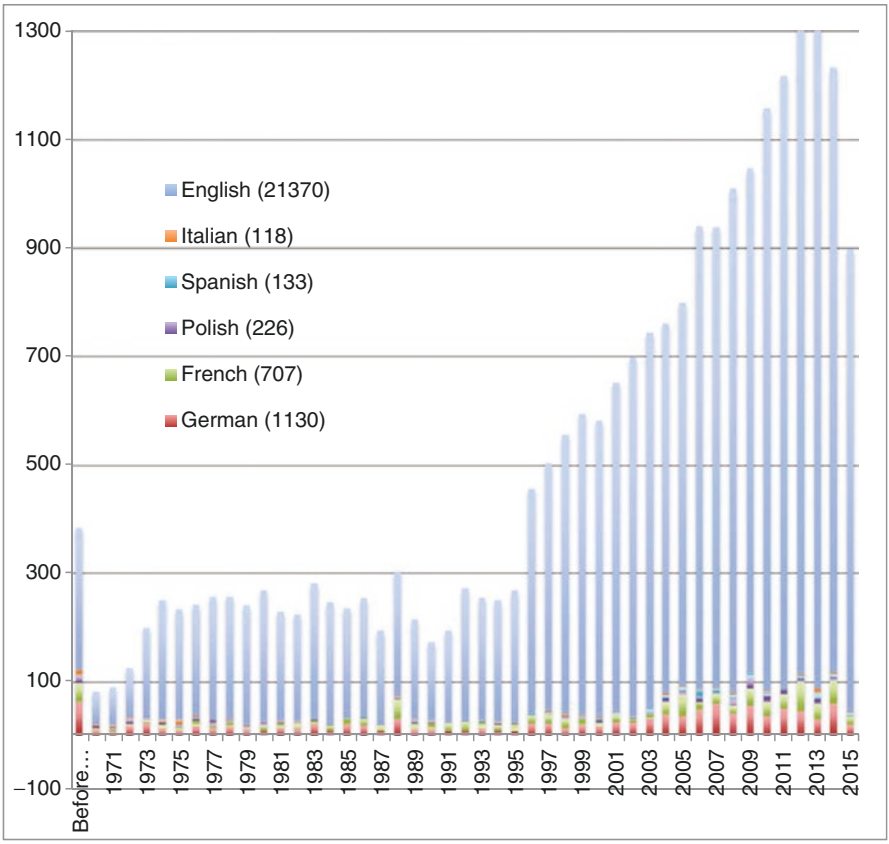

Fig. 8.1 Forensic psychiatry articles in Scopus by European languages

English authors chose to do this. According to the Scimago Journal and Country Rank reports, the English-speaking countries, the United States, Canada, the United Kingdom and Australia between them, accounted for 41% of published academic literature between 1996 and 2014, yet around 97% of scientific papers were published in English. It is evident therefore that authors from non-native English-speaking countries tend to publish in English; however, for others, it may prevent researchers and clinicians publishing at all, leaving important findings unpublished. Although non-native English-speaking authors may make an effort to publish in English, it does not necessarily follow that all of their non-native English colleagues are multilingual. Language barriers may therefore prevent professionals in a given country from accessing published information about research in their own country because it has been published in a different language.

8.9 A Spanish Forensic Psychiatrist in Wales

Wales welcomed me (Dr Esperanza L. Gómez-Durán), with open arms several years ago, despite the language difficulties. Having been born in the south of Spain, in an area of intense tourism, English can be considered obligatory and has always been in my life. However, when trying to develop yourself in the professional field in another language, you feel almost gagged. In addition to the logical pressure to adapt to a new environment, there is an obvious limitation to communicate as you wish.

The cultural differences between Spain and the United Kingdom can seem like an abyss when you approach your English colleagues in an excessively close, too direct and probably even impolite manner from the English perspective. This manner and sometimes a confusing speech is an obvious barrier. I remember surprising myself, offering an international referent the incomparable opportunity to collaborate with me, when in fact I was trying to ask for her appreciated supervision of my project. Fortunately, I always found understanding.

Cultural differences also act when you do not behave as your patients expect or you are unable to interpret their gestures or behaviour, something essential in psychiatry.

All this is surely more important than the difficulties with the content of the speech, but the content is also important. The fluency and rapidity of the reaction, the correct and measured choice of words and the mastery of the dialectic are of utmost necessity in clinical psychiatry but even more so in the forensic environment. Language as a tool of communication but also of analysis and management of the situation in psychiatry limits exercise in a non-native language.

From my perspective, practising as a forensic psychiatrist in an environment that communicates in another language and is culturally driven otherwise is an important limitation of the service you can offer. The same must be kept in mind when it is the patient who has to handle in a language and culture that is not his own. Our obligation is to provide a quality service; therefore, professionals must train, and the system must provide the necessary resources to save barriers, irrespective of the origin and language of the different actors in the process.

Conclusion

The inability to communicate effectively as a clinician, whether with patients or with colleagues, can provide an isolating experience for those involved. Incorrect and usually less favourable judgements and inferences may be made of those who cannot speak the native language by those who do. This can be particularly problematic and can have significant consequences for those involved in the forensic mental health or criminal justice systems. An awareness of this bias (including the limitations of clinical assessments and psychometric instruments in non-native speakers), and the imperative to provide adequate systems and resources to enable effective communication, may reduce the disadvantage that the non-native speaker experiences.

Take-Home Messages

- There is a bias towards incorrect and often unfavourable judgements towards individuals who do not speak the native language in a given country.
- The use of a professional interpreter is essential if patient and clinician do not share fluency in a common language; there may be a legal as well as practical and ethical imperative to do so.
- Administration and interpretation of psychometric tests must consider limitations of the test, such as whether it has been validated for the relevant population or used with a non-native speaker.
- Language can be a barrier to clinicians' international professional mobility, their ability to integrate with clinical teams and to communicate with patients. The dominance of English in the scientific community may also be a barrier to participate in scientific debate and dissemination of knowledge among non-native English speakers.

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