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Chapter 9

From postmen to makers of meaning: a model for collaborative work between clinicians and interpreters

Philip Messent

Amato was an Italian author who migrated to New Zealand, where he wrote his fiction in English. He describes in his short story, *One of the Titans* (1992, p. 117), an encounter in Italy between an Italian and an English speaking bank-teller. The Italian, considering migrating to Australia, had asked the bank-teller what Australia was like. 'Si', she had said, 'La moneta é buona,' which, to an Italian, meant only 'Yes, the coin is good-hearted.' The bank-teller's meaning only became clear to the Italian some time later. As Amato goes on to comment: 'no Italian could understand unless he first understood what "Yes, the money is good" could mean.'

Interpreting goes beyond translating spoken sentences from one language to another, word for word. It demands a knowledge of the way in which both languages are used, which includes their idioms, their figures of speech, their metaphors, their similes, as well as the values, goals and communication styles of those individuals and groups using them. The irony in Amato's story is that his Italian migrant goes on to find the emphasis on the acquisition of money in his adopted homeland deeply alienating.

The myth of the interpreter as postman

Pearce (1989) suggests that the prevalent, though usually unarticulated, theory of communication in the west is that described by Miller (1986) as a 'post office' model of communication. The idea here is that even in a simple exchange between two people what is happening is that an idea occurs in one person's mind, it is 'wrapped' in words and sent off to the other person, who unwraps the words to discover the idea within. According to such a model

the role of the interpreter would be simply to carry the idea from one person to the other, re-wrapping it en route in order that it should be understood clearly. Such a model would have it that words can straightforwardly 'stand for' the ideas they refer to, that we all share a common set of such ideas, and that the personhood of the interpreter has no impact upon the message being communicated. We do not after all see the personality of our postman as affecting in any way the meaning of the letters he delivers. Clinicians wishing for their communications to be translated word for word, who mistrust interpreters when their utterances do not seem to correspond in length or tone to their own, are in effect adopting such a model of communication.

Such a model however does not do justice to the complexity of what is going on in communication in several important respects. Wittgenstein (1953) demonstrated that there is no simple correspondence between words and the ideas that they express. We cannot meaningfully talk about a world of ideas that exist in a 'pure' form, that we all somehow have access to, using words merely as a secondary means of expression of such ideas. 'Meaning is use': we give our ideas meaning only by the words that we use, and by agreeing together about the meaning that we are going to give those words. When a European clinician meets a client recently arrived from rural Bangladesh, for example, the two of them will share neither a common language, nor this agreement about a common meaning system. Both might agree, for example, that the nature of their relationship is one of help, but they may have very different ideas about what such 'help' is likely to consist of.

An English-speaking child psychiatrist was interviewing a Bangladeshi family through an interpreter about their concerns about one of the children in the family. One of the parents asked her: 'What will happen if he doesn't get any better?' The psychiatrist replied: 'We will work together until we find a way of helping him get better.' The interpreter, rather than translating this statement, indicated to the psychiatrist that he did not think this statement would have much meaning to family members, and asked the psychiatrist's permission to explain to them what this 'working together' might involve. The interpreter knew that the parents' initial expectation of their consultation with the psychiatrist would be that she would make a diagnosis and then a medical intervention. They would not have any expectation of the need for themselves to be a part of the treatment process, involved

in activities such as record-keeping and trying different ways of responding to their child, and the interpreter felt that he needed to spell out to them such expectations of the psychiatrist at this point in order to make her words intelligible. Thus translating one sentence involved a lengthy explanation, the interpreter making use of several years' experience of working in the agency to give a distillation of the sort of things that might be involved in this 'working together'.

The interpreter here needed to have a good working knowledge of the two languages, including their figures of speech, metaphors, similes and idioms, and he needed to appreciate that these did not simply translate from one language to the other. He needed to be familiar with the meaning systems of both clinician and family members – how they would hear each other's communications given their previous experience and beliefs, the kinds of techniques and approaches the psychiatrist might use, and the way in which these would be received. The interpreter had to interpret what he believed the clinician intended to communicate (based on the shared meaning system evolved over several years of working in the same agency) in a manner which he believed family members would be able to understand, make sense of, and welcome (based on their shared cultural meaning system).

Although this lack of a shared meaning system is particularly dramatic and stark in this circumstance, where the cultural difference between clinician and client is obvious, and the task of the interpreter particularly onerous), the very same difficulties occur where a culture is shared. It is equally true of white British families who come to a Child and Adolescent Mental Health Service for help that client and clinician will not begin with the same idea about what that help will consist of, and that if the contact is going to be productive, some shared meaning will have to be developed. And if the clinician is going to effectively 'join' (Minuchin and Fishman, 1981) with such a family, he/she will need to frame the nature of the help that is on offer in a manner that is sufficiently close to family members' ideas to be acceptable to them, in effect acting as his own interpreter. In all communication, but especially in therapeutic conversations, we are behaving as Pearce (1989) suggests more like poets than scientists. Rather than searching for words that 'truly' match an experience or an idea, we are looking more often for words, images, or metaphors that will reflect some aspect of an experience in a way that will be both true to the

client's experience, and move the client on, by helping him/her to view the experience in a new way. Where a parent comes with complaints about a child's behaviour, seeing something as 'wrong' with their child, the clinician will be looking for ways of making sense of such behaviour differently: in a manner that is true to the parent's experience, but also allowing for the possibility of change.

Another important way in which the interpreter's role inevitably goes far beyond that of a postman is the way in which their personhood enters the relationship between the client and the professional agency. Interpreters will still be seen by clients as members of their community, more or less similar to them in terms of their origins, age and gender, and their communications understood in the light of these judgments. A very common question asked by Bangladeshi families is about the village or town that our interpreters and their families originate from. This seems to be a way of placing them, perhaps because such clients are looking for a personal connection, perhaps because they are wary about the confidentiality of their consultation. It was noticeable that a young Bangladeshi male interpreter, who had never been to Bangladesh and who represented himself as having little interest and few connections there, remained relatively distant and disconnected from family members during the therapeutic process (and thus was able to operate more like that mythical being, the 'pure' interpreter). The fact that it is the community in Bangladesh that is the first point of reference, indicates something about the importance for this community of the connections with families 'back home'. Later on in therapy families may also want to know about where interpreters live in the UK. This is likely to be relatively close to family members, in as much as the community here is clustered in certain areas of London. This may sound obvious but interpreters are often members of the same community as their clients, whereas therapists are mostly outsiders, living elsewhere and leading different lives from the clients they are providing a service for. Such interpreters can speak with real authority about managing the business of living as part of this community: dealing with racism, missing family members in Bangladesh, the mysteries of the education system, the housing system, and the major preoccupations of everyday life. If interpreters are instructed by clinicians, anxious about their own role, to limit their role strictly to translating what is being said, then a vast repertoire of knowledge and experience can be lost to the therapeutic process. Surely we should instead

attempt to include such perspectives, which may connect powerfully with clients' worldviews in a way that is not possible for therapists from different cultures and communities.

A young Bangladeshi man married the eldest daughter in a family I had been working with for some time. He asked for advice about finding a job, and I referred him to our Bangladeshi interpreter, a man of mature years with much experience of managing the employment market in the UK, happy in the knowledge that the advice he got would be more relevant and acceptable than anything I could offer. This advice giving would at the same time further my therapeutic connectedness in my on-going work with the family in as much as the interpreter's advice was seen and valued by the wider family as a part of the service we were providing as a clinical team.

Making the most of it

Rennie (1998) even argues that in psychiatric treatment working with interpreters is so very difficult that 'effective therapy in such cases may be impossible to achieve'. The contrasting view articulated here is that interpreters will rarely prevent important information from being exchanged, and should rather be regarded as a potential asset, enriching the contact between client and clinician, as exemplified above, by their presence. One study, which demonstrates that interpreters need not have a negative effect upon the quality of at least a psychiatric diagnostic interview, was carried out by Farooq et al (1997), who compared the accuracy in terms of the diagnostic information gathered during adult psychiatric interviews via an interpreter with that gathered by a psychiatrist who spoke the relevant Asian language (Mirpuri). Although some minor qualitative differences were noted, there were no significant differences in terms of the facts regarded for these purposes as crucial (symptoms, family history, etc.). In fact there were more differences in the information gathered by the two psychiatrists jointly interviewing the English patients who were the control group, suggesting that individual differences between clinicians made more impact than the necessity or otherwise of using an interpreter.

One example of making positive therapeutic use out of the presence of an interpreter is discussed by Harvey (1984) in working with deaf persons, where the very presence of an interpreter can represent a challenge to the way in which one family is organising

itself around the disability, ignoring the impact of the deafness. Simply by being a part of the therapeutic team, the interpreter is communicating to the client family that the therapeutic agency is viewing things in a way that is new for the family, treating the deafness as a disability which the agency is going to have to make special efforts to work with, to ensure the deaf person's full co-operation. The inclusion of an interpreter in this way contradicts the family's normal way of behaving towards the deaf person, thus challenging them to make more adaptations in their manner of communication with their deaf family member.

In a similar way having an interpreter present with an immigrant family in Britain is already communicating something about an agency's intentions and beliefs. Often in Bangladeshi families in Tower Hamlets, because of the pattern of migration and restrictions on women's role in communicating with external bodies, men and children are more fluent in English than women. Having an interpreter present allows for the possibility of women's views being heard and accorded respect in a way which in itself may be different from a family's normal organisation, encouraging other family members to view them in a new way, and allowing for the possibility of new solutions, in which women's power and authority is more acknowledged.

Interpreters will nearly always have specialist knowledge of the culture and religion they share with client families, knowledge which can be invaluable in therapeutic work. Very often interpreters have provided me with extremely important insights about cultural rules and advice about the appropriateness of particular metaphors and tasks; for example, who might most appropriately be asked to talk to a 10-year-old boy about how to control his temper, or to a 15-year-old boy about managing his sexual urges. This is not to say, however, that such workers should be attributed the status of experts on their culture, tempting as it might be to do so. Many is the time that I have caught myself turning to an interpreter during a break when we have left the client family to consider what to do, to ask about cultural norms 'How do most Bangladeshi families deal with rebellious adolescents?', as if such norms were unchanging, easily accessible and universally acknowledged. In fact of course individual interpreters will have very different perspectives: as Farooq et al (1997) point out, interpreters may have very different cultural values to a client family. Rather than treating interpreters as all-knowing experts in their own

culture, it seems to me more realistic to make use of their perspective in therapy as one amongst many that may be helpful to the family.

Rather than going away from families to ask such questions of interpreters in a separate conversation, it can be more productive to hold such discussions openly with the families involved, so that they have a range of different perspectives to draw from in thinking about problems and their solution.

A Bangladeshi father brought his 11-year-old eldest son for help. He had learning difficulties, and when at home would withdraw to his room, then go into an odd trance like state, in which he would speak to himself unintelligibly, and wet and soil himself. The father seemed resigned to this state of affairs, and my efforts to encourage him to stop his son withdrawing by engaging him more in family life at home had no effect. He would return for session after session, reporting the same pattern of behaviour in the same miserable yet resigned manner. His way of talking, however, changed dramatically when I began a discussion with him and our male interpreter about how he could teach his son to become a good Muslim, a task that was becoming increasingly urgent as the boy grew older. The father told us with real energy and spirit about his repeated and unavailing efforts to teach his son the first sentences from the Koran. Suddenly I was presented with a whole other side to this man, who I had previously seen as wholly uninvolved with his son. I invited the two Bangladeshi men, the interpreter and the client's father, to enlighten me about Muslim teaching on how people with learning difficulties could be expected to express their faith, and in the ensuing discussion a diversity of ideas emerged. This diversity seemed to help the father change his position so that he didn't view this recitation as the only way his son could express his faith, and his methods of engaging his son at home became more realistic and appropriate to his intellectual abilities. What was important in this discussion was that the interpreter offered some difference without ever implying that the father was wrong; indeed he was highly deferential about the father's religious expertise. It is in a climate of mutual respect of one another's knowledge and experience that different views and perspectives can be entertained.

With trained and experienced interpreters it becomes more possible to draw on their ideas and suggestions. The ability to reflect on

how one's own context has a bearing on the work is another important skill for interpreters to be able to develop, as this prevents them from becoming too rigid in what they feel is going to be helpful to a family. Interpreters bring their personhood into the work and need to feel comfortable enough with the clinician's views and ideas in order to be able to convey these to the family.

I would see working with an interpreter as no more than a special example of the sort of co-working that is common in multidisciplinary teams, where two team members, often from different disciplines, collaborate in seeing a particular client together, making use of their own particular skills. With any co-working relationship one is considering the particular age, gender, culture and personal style of one's colleague, and considering how one can operate most effectively together as a therapeutic team.

A 14-year-old Bengali girl was reluctant to get out of bed in the morning, and was missing a great deal of school. She remained virtually monosyllabic in family interviews, and so a series of individual sessions was arranged for her in school, with an English female therapist and a Bengali female interpreter. During these sessions the girl was able to discuss a number of anxieties about growing up, and appeared in particular to appreciate the perspective offered in the interviews by the interpreter, who was closer to her own age and who had lived through many of the difficulties she described. The interpreter was encouraged by the therapist to communicate about her own experiences when growing up, and not stick strictly to her interpreting role.

Emotions

It is interesting that in Raval's study (1996) there is a complaint from therapists about a loss of emotional effect when working through an interpreter, mirrored by a comment from the interpreter interviewed in the study that she was on the receiving end of the 'emotional impact' from client families, rather than the therapist. What is going on here? The interpreter can sense the emotional impact of what the service user is experiencing, and some of this is lost to the therapist. This can have an advantage in protecting the therapist to think things through, but it may also result in the therapist not being fully in touch with the emotional experience of the service user.

Papadopoulos and Hildebrand (1997) describe the way in which the therapist who did not know their clients' language could maintain a more systemic role, keeping in mind the whole family system, rather than getting very involved in the individual's narrative. Similarly, I have at times been very grateful for the way in which interpreters have borne the brunt of client families' emotions, which I have found difficult to manage even in their muted form.

A four-year-old boy was referred because of the traumatic effects of a dispute with neighbours. The father of the child came to the centre on his own, then proceeded to recount at great length the whole story of this dispute, going back several years. In the course of telling his story through our young male locum interpreter, he made a powerful emotional connection with this young man. It was to him that he was communicating his distress, and even though the father appeared to understand the limitations of the interpreter's role, it was still to the interpreter that he seemed to look for aid and solace, asking at the end of the interview for his telephone number, rather than my (the therapist's). I had little doubt afterwards that it was the interpreter bearing this emotional weight that gave me the freedom to think, so that I was able to see the problem as most effectively dealt with at the level of a community intervention by the local housing officer, rather than being drawn into a therapeutic relationship, which would most likely have been unproductive due to the problem residing in the family's external relationships.

While training can help, interpreters will need to have a certain amount of resilience to weather such experiences; this young man needed some time to de-brief after this interview, to make sense of what had happened to him. Sometimes therapists will need to intervene, sharing more of the load by insisting that clients' communications are briefer and translated at shorter intervals, but intense emotional expression is by its nature not always amenable to such re-arrangement. As one colleague pointed out, it may be important for a client to tell his story in an uninterrupted way to another person, and this need not be the clinician.

In communications going the other way it is not my experience that the emotional effects are blunted by going through a third person. On the contrary it is my view that they can sometimes be amplified by the repetition involved in translation. Usually some

family members will understand English easily and others will understand the odd word. With non-verbal gestures and expressions they will often get the gist of what I am communicating first time round, with the interpreter's version then adding weight and emphasis by going over the same ground in a different language.

Sometimes however a communication from the therapist will be viewed as far more emotionally loaded by the interpreter than the therapist. In such circumstances it may be necessary to pause and 're-group'.

I had been working for several years with a Bangladeshi family with two children with learning difficulties, whose behaviour could be difficult for the parents to manage. A 'parent advisor' had acted throughout that time as interpreter during interviews, also taking on other roles in helping the family over this time. After some months of gradually extending the period of time between interviews, and the intensity of the problems lessening, I thought the time had come to start talking about ending my contact, and attempted to ask, via the parent advisor, about the parents' views about this. I was somewhat bemused when instead of asking this question, the parent advisor got involved in talking with the parents some more about the remaining areas of difficulty. When I asked her about this she told me that she felt the family would be 'too upset' if I started talking about ending my contact at this time. The idea was at that time simply untranslatable. At the next interview when I raised the matter again, however, my ending was accepted with resignation by all concerned, evidently having been discussed by the parent advisor with the family in the interim.

I had again here committed the cardinal error of treating my colleague like a messenger, with no thoughts and feelings of her own. Apart from her ideas about the impact of my ending on the family, she would also have had feelings of her own about my ending my co-working relationship with her, leaving her to continue unsupported with a case that she would have much greater difficulty in closing, given the more extensive nature of her role. And here was I expecting her to translate these words without any prior discussion with her about their impact on her and on the family.

One way in which clinicians can shorten the emotional distance between themselves and their clients while using an interpreter is to address their clients directly ('you should do this'), rather than through the interpreter in the third person ('she should do this'). This is recommended as good practice by Shackman (1984) and by Freed (1988). Another way is to make use of seating positions, placing the interpreter so that the client is facing the clinician – Shackman (1984) indicates that common practice in Australia when she wrote her book was for interpreters to sit behind the clients. Such working methods would clearly increase the intensity of the interaction between client and clinician, but this would be at the expense of making therapeutic use of the knowledge and personality of the interpreter, and his/her relationship with the client. Such an understanding of interpretation makes it more an art than a science or as Geertz (1983) put it, 'rather closer to what a critic does to illumine a poem than what an astronomer does to account for a star'.

Getting on the same wavelength

Of course it is only with interpreters that one is working alongside regularly that one can develop such mutual knowledge and working practices over the course of time. Like any other form of co-working, initially there will be more of a need for planning time before interviews with clients, in which some of these mutual beliefs and working practices can be explored. Both therapist and interpreter will need to orientate themselves to one another, in order to maximise the effectiveness of their collaboration. Before commencing an interview with a family with an adolescent girl where there are concerns about her eating, for example, it is likely to be helpful to explore in a pre-planning session ideas about what such behaviour may mean, as well as what is likely to be helpful in overcoming such difficulties.

There will be times of course in which interpreters, in attempting to bring about greater understanding between the two parties, will cause misunderstanding. Farooq et al (1997) checked on the accuracy of one Mirpuri speaking interpreter by a Mirpuri speaking psychiatrist scrutinizing the audiotapes of the interpreter's interviews, in which she interpreted between Mirpuri speaking patients and an English psychiatrist. A number of 'common errors' were noted, such as omission (where a message was deleted), condensation (where lengthy responses were simplified), and 'subtle changes' in the way questions were asked. Many of these 'errors'

can be understood as the interpreter making a judgement about what the clinician's intention is in asking certain questions (to make a psychiatric diagnosis), and selecting and extrapolating from what is being said accordingly. For example one exchange is quoted as follows:

PSYCHIATRIST: Do you feel happy or sad in your spirits?
PATIENT: If I am not unhappy or sad . . . (pause) . . . then I am happy
INTERPRETER: (without interpreting this response) You feel sad now?
PATIENT: Yes
INTERPRETER: She is unhappy

One way of making sense of this interchange is that the interpreter is working on an assumption about what information the psychiatrist is interested in, and tailoring how she interprets accordingly. Hence she ignores the reference to happy feelings in the patient's communication, focusing instead on the symptoms that she supposes the psychiatrist is seeking to identify. A 'brief solution' clinician (de Shazer, 1988) would be more interested in eliciting positive talk from clients, identifying 'exceptions' where clients have achieved some mastery over their problems. If the interpreter had been working with such a clinician and if she had been familiar with this way of working, she might have picked up on what the patient initially said differently, highlighting the statement about happiness rather than drawing forth more communication about the unhappiness.

Two into three won't go

Rachel Tribe (1991) mentions that in support groups run for interpreters an issue raised was the way in which someone is always 'left out' in the interpreting triangle. Both the therapist and the client will have periods of waiting for the others to finish speaking, not understanding what is being said. This experience can be extremely uncomfortable: Freed (1988) describes an interpreter giving 'painfully brief' translations of her interviewee's long answers.

The 'pain' here is presumably caused to the interviewer because she is feeling excluded from a significant part of her interviewee's communications, which is causing her frustration and resentment. The context she describes (conducting interviews in a foreign country) made it difficult for her to make sense of her interpreter's brevity, and to find a more satisfactory form of collaboration. Such feelings will be less likely to arise where clinicians and interpreters have developed a relationship of mutual trust over a period of time, but even with such a relationship there will be times when a clinician will need to ask about such discrepancies. Clients too at times will feel unsure that their communications have been properly interpreted (many bring their own unofficial interpreters in the form of family friends or relatives to begin with). Clients should also be encouraged to question the clinician or interpreter, and check that the interpreter or clinician has accurately understood their concerns.

Power, professionalism and the place of training

I suspect some of the pain described above is down to the interviewer feeling powerless, not a comfortable position for professionals who are used to feeling in charge of the interviews they are conducting. Freed's (1988) solution to such difficulties involves the training of interpreters, and for other workers to view interpreters as fellow professionals, rather than subordinates. She adds that interpreters need a sense of participation and accomplishment, for data to be assembled with reasonable accuracy.

In any working partnership a sense of both parties being valued and appreciated for their contribution will add to the cohesion of the partnership, and limit the potential for mutual distrust and competitiveness. Training and professionalisation of interpreters is one concrete way in which organisations can show that these workers are valued. It could go some way to decrease the types of problems described that can arise in the work (Block, 1996; Raval, 1996). Westermeyer (1990) suggests that psychiatric interpreters should be familiar with (and hence need training in): medical, psychiatric, psychological and social terminology; techniques of interviewing; the importance of non-verbal communication; normal and abnormal psychology; therapies used in psychiatric care; cultural influences on mental status examination; and methods of asking about matters that do not come up in ordinary communication, like hallucinations and sexual problems. As Shackman (1984) argued, the employment of interpreters should be viewed as a 'step towards appropriate provision, rather than the solution', this being the training and employment of ethnic minority staff for

more traditional, highly valued professions. Miller and Krause (1995) describe one model for the creation and training of such staff.

However, clinicians also need training in being able to work with interpreters. One example of a useful joint training exercise encouraging self-reflexivity in clinicians and interpreters has been to study videotapes of interviews, with the interpreter re-interpreting back into English his interpretations of the clinician's utterances. One such revision exercise revealed striking differences, particularly for longer utterances, with the interpreter placing more emphasis on the parts of the clinician's communications that meant more for him. Discussion of such differences led to the development of a more self-conscious practice, with more checking out of one another's meaning during interviews.

Another way in which the power imbalance can be addressed is by the therapist's attitude and demeanour towards the interpreter during interviews. The interpreter quoted above (p. 144) felt used, in a way that did not allow for any degree of mutuality in the work. A practice in which interpreters' knowledge and expertise is included in the therapeutic process, being accorded due respect as a perspective that may have particular usefulness because of the interpreters' shared experience with clients, would carry a very different message about the status accorded to each party. This interaction between the co-workers carries with it an important communication to clients about the clinician's intention to respect other perspectives, and not to impose his/her values and ways of seeing things.

An alternative model: making meaning together

Such a practice rests upon a very different model of communication from the 'post office' model described above; communication is 'lived in' rather than something we stand outside and make use of (Pearce, 1989). Rather than a means by which 'internal' states are expressed and 'objective' facts represented, communication is seen as the process by which we construct together a shared way of understanding such states and facts. Interpreters, rather than being seen as the impersonal agents of clinicians (avoiding at all costs contaminating the purity of the clinician's communication), become a vital part of the construction of a shared meaning, whose own history and personhood are a vital part. Rather than attempting to 'filter out' this personhood, its impact upon the ongoing work is recognised, appreciated and embraced as something that will enrich and enhance this work.

Pearce (1989) used the term 'cosmopolitan communication' to describe a style of communication that in no way assumes the superiority of our own ways of making meaning, based on the premise that we have all been shaped by the particularities of our own culture and historical experience, which has given us all a different view of reality, a different way of describing it, of making sense of it. He points out that major differences exist even within groups, that we often underestimate the 'otherness' of other people, from whom we are 'separated by the use of a common language'.

According to such a model good practice in working alongside interpreters with clients with a different language is no different in essence from good practice in working with clients who share the same language; in the way that nothing is taken for granted about each individual's unique way of seeing the world, their values or their use of language, and each person's world-view is accorded equal status with our own. If anything such a practice is easier to maintain with clients who speak a different language, as we are far less likely to make assumptions about what is meant. It comes far more naturally to ask a client from rural Sylhet in Bangladesh via an interpreter what they mean when they use words like 'independence' or 'honour', than it does for a client sharing a common language with us, though differences may be just as great. Also discussing openly with one's interpreter the words he/she is using in translating such concepts is in the spirit of such 'cosmopolitan communication': conveying an appreciation of the different ways in which experience is understood; adding to the depth and complexity of the work undertaken; and allowing clients more of a choice of possible meanings to draw from, in thinking about their lives.

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Chapter 10

The role of the interpreter in child mental health: the changing landscape

Rosemary Loshak

In the early 1980s, changing patterns of immigration resulted in a rapid increase in the Bangladeshi population of East London as wives and children came from Bangladesh to join their husbands in an established though small and mostly male community, which had existed in the area for 20 to 30 years. The massive demographic changes that followed had consequences for the organisation and delivery of services in health, education and social services with each agency struggling to find its own response to the challenges posed by differences of language and culture. Today over 60 per cent of the school age population in the area are of Bangladeshi origin. Although for these second generation immigrants their first language is now English, for their parents and for those children newly arrived from Bangladesh their first language remains Sylheti. The provision of an effective and sensitive child mental health service to this population has presented professionals and their managers with the need to examine their practice and adapt to rapidly changing needs. The efforts of a multi-disciplinary team to develop its work with families across this linguistic divide are the subject of this chapter.

An early research initiative examined parental perceptions of the service among Bangladeshi families (Hillier et al, 1994). In all areas of health care it is increasingly understood that mutual sharing and understanding of treatment goals between patient and therapist facilitates compliance with treatment and hence positive outcome. This study, examining a small sample of families referred to the service, supported this view noting that good communication, leading to a shared understanding of the problems, led to parental satisfaction and was correlated with positive outcomes. A process