Language and Cultural Barriers in the Assessment of Enemy Prisoners of War and Other Foreign Nationals

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The authors describe difficulties encountered in the assessment and treatment of enemy prisoners of war and foreign civilians during Operation Enduring Freedom and Operation Iraqi Freedom. Of prime concern was the complexity of evaluating and working with patients through translators. Secondary concerns included self-protective behaviors of and fears experienced by patients, which complicated the patient-provider relationship. Future difficulties could be reduced by training translators in medical interviewing, training providers in the skills used by translators, informing providers of command and political policy, and producing concrete, portable information in written or other forms for enemy prisoners to reduce inherent mistrust. (*Psychiatric Services* 57:258–259, 2006)

As the United States continues to provide medical care to foreign nationals, the need for mental health assessment will continue. There are two singular difficulties in the mental health assessment of enemy prisoners of war. First is the need for interpreters to be sensitive to emotional nuances. Second is learning how to adjust for individuals' inherent anxiety from their incarceration. In this report we describe how we were able to resolve these issues by establishing interpreter-provider teams and adjusting our evaluation of anxiety of enemy prisoners of war. We also propose recommendations to maximize the rapid integration of assessment and treatment into the care of enemy prisoners of war and of foreign civilians.

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Setting

The U.S. Naval Ship Comfort was activated in January 2002 for Operation Enduring Freedom and Operation Iraqi Freedom. During the latter operation, the medical staff of the Comfort provided care to 680 casualties, of whom 200 were Iraqi enemy prisoners of war or civilians, including women and children. The mental health team, which consisted of a senior psychologist, two psychiatrists, and a psychiatric clinical nurse specialist, were called upon to offer advanced assessment and treatment to both allied casualties and Iraqis.

Finding the right words

The first two interpreters on the team had been raised in Arabic-speaking households and were aware of many Arabic customs, but each had spent much time outside this culture. They had difficulty understanding Iraqi language and culture. Although the base language was the same, the accents, idioms, and several base words were different from the language they were taught in Lebanon and America. They often had to use approximate or basic words for more complicated ideas. In addition, the Iraqis sometimes had to alter their words or seek other Arabic speakers to convey their thoughts and feelings. These changes may have led to communication errors (1,2).

Beyond these issues was the difficulty of interpreting medical and mental health vocabulary to sometimes unsophisticated or illiterate patients. Most injuries and treatments had to be described in rudimentary fashion—"lung sickness" for pneumonia. According to our interpreters, no precise words existed for many concepts and symptoms that we were trying to evaluate, or else the interpreters did not know the precise words. With the practitioners' agreement, depression was translated to the Iraqis as sadness, which does not have the same connotation in English. "Flashback" could not be interpreted without the Iraqis' understanding it as "remembering," which made assessing traumatic stress difficult, because many of the symptoms, such as agitation and insomnia, could be construed as normal in an enemy prisoner.

Because of the skills of our interpreters, conceptual translation was better than literal translation. Questions and responses were broader than could be translated literally. The provider told the interpreter the concept behind a particular question. The translator posed the question on the basis of his conceptual understanding. After discussion with the patient, the interpreter provided an answer.

The use of conceptual translation can lead to misdiagnosis. Disorganization and unusual answers may be lost as the interpreter unintentionally "makes sense" out of the patient's response.

Conversely, the interpreter can amplify the patient's disorganization if the interpreter has difficulty following the patient's response (because of issues such as limited fluency or unfamiliarity with idiomatic expressions) and construes his or her own lack of understanding as the patient's having disorganized thoughts or tangential responses (3).

Variations across interpreters

As with providers, each interpreter had a different style and also a different interpretation of the Iraqis' nonverbal communication, agitation, and rate of speech. For example, one interpreter labeled a patient as having rapid speech and disorganized thoughts, whereas the other interpreter regarded the same patient as "just anxious." We began to use the same interpreter with each patient, which eliminated interpreter variance (4). In addition, as more time was spent with individual patients, the interpreter was able to provide better insight into daily shifts in mood, affect, and thought process.

We found that working in Westermeyer's "triangle" model and acknowledging the three-sided relationship between the translator, our patient, and ourselves was more beneficial than the "black box" model, in which the interpreter is seen as a word unscrambler with no part in the relationship, or the "bilingual worker" model, in which the interpreter is seen as an independent mental health practitioner (5). The last two models did not apply to our situation because our interpreters lacked the language skills for literal translation. In addition, their lack of knowledge about mental health and the skills needed for medical interviewing precluded their independent assessment of patients.

Difficulty with fear

The unknown of being held prisoner on "a boat to take us away," as one enemy prisoner said, introduced fear about the future. Guarding and fear were prevalent in the interviews conducted with the enemy prisoners and among the Iraqi civilians, although to a more limited extent. Some enemy prisoners refused to discuss their physical and mental state because they feared interrogation or torture. Some believed that they were being removed from Iraq so that they could be killed outside the view of the media or allied armed forces. However, over time boundaries lowered and symptoms were acknowledged, which raised the question of whether the symptoms had been present from the beginning or had just emerged.

No research has examined Iraqi cultural beliefs about psychiatry. The closest resource about Islamic beliefs and Middle Eastern cultural issues related to psychiatry is from an analysis of Egyptian culture. Okasha (6) noted, "Eastern cultures emphasize social integration more than autonomy. . . . How one appears to others becomes vital and shame becomes a driving force more than guilt." He also noted that "the man is required to play a superior, confident, dignified role, which may challenge his power of adaptation." Okasha also pointed out the higher rates of conversion disorder (that is, physical manifestation of psychiatric symptoms) among his Egyptian patients than among patients in the West. We suspect that such role identification led many of our patients to report fewer symptoms, aside from pain, or to deny symptoms altogether. We also noted much higher use of narcotics and sedatives among the Iraqis than among Allies with similar injuries, which led us to question whether the somatic treatment was in part addressing the unconscious dependency needs of patients with conversion disorder.

Recommendations

The primary change that would benefit future assessment of non-English-speaking enemy prisoners of war or civilians is the routine education of interpreters in medical terminology. We educated our third interpreter, a Kuwaiti native, in medical terminology and the objectives of medical interviewing. He then found it was easier to alter his questioning to gain conceptual information than to ask literal questions and risk misunderstanding.

Woloshin and colleagues (4), working in New York City, were able to significantly reduce interpreting errors by providing as few as 70 hours of medical training to interpreters, which reinforces our experience in training interpreters. Having interpreters with medical training would benefit not only assessment and treatment at evacuation sites but also triage and treatment of enemy casualties in the field.

Supplementary training should be offered to providers in how to work with interpreters to aid cohesion of the practitioner-interpreter unit. Training should include introduction to conceptual interpretation, limitations of interpreting, and potential cultural biases in the population being treated.

To combat the fear and anxiety in the Iraqi population, we developed three solutions. First, we established a principle of "no promises." We told the Iraqis only information about which we were sure. The team was thus identified as providing only the truth, which led to increased interaction and less guarding from the Iraqis. Second, we provided early warning of patient transfers, including movement off the ship and transfers of contagious patients to quarantine. Early warning helped defuse fear of the unknown.

Finally, we recommend that some form of written, portable information be prepared for prisoners and civilians to decrease anxiety about where they are and what may happen to them. Such information should include the treatment setting, the name of the commander, potential treatments, expected care, and rights and responsibilities of the patient. Then prisoners might not rely solely on acquired misinformation, which would allow practitioners to break through propaganda of the opposition forces.

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