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Language barriers between nurses and asylum seekers: their impact on symptom reporting and referral

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Abstract

The objective of this study was to determine whether language barriers during the screening interview affected the reporting of asylum seekers' health problems and their referral to further health care.

Seven hundred and twenty-three standard screening questionnaires, administered by nurses to asylum-seekers at the time of entry into Geneva/Switzerland between June and December 1998, were reviewed, as well as information pertaining to language use during the interview. Language concordance between nurses and asylum seekers was assessed by considering the presence/absence of an interpreter, the type of interpreter present (trained, untrained), and the nurse's self-assessed proficiency in the language used during the medical interview. Nurses also recorded their own subjective assessment of the overall quality of communication during the interview.

More than half of the asylum seekers came from Europe, mainly the Balkan regions, and a third of them from Africa. Most asylum seekers were men (72%). The median age was 26.5 years, and 50% were younger than 25 years. Severe physical and psychological symptoms were reported by 19% and traumatic events prior to migration were reported by 63%. The nurses referred 36% of all refugees to further medical care and 6% to psychological care. Professional interpreters were used in 8% of the interviews and ad hoc interpreters in 16%. Adequate, partial and inadequate language concordance was reported for 54%, 27% and 18% of the consultations respectively. Adequate language concordance was significantly associated with higher reporting of past experience of traumatic events and of severe psychological symptoms, contrasting with much fewer referrals to psychological care when language concordance was inadequate.

These results suggest the importance of addressing language barriers in primary care centres in order to adequately detect and refer traumatised refugees. To address this problem, the use of professional interpreters is recommended.

Keywords: Language barriers; Asylum seekers; Migrant health; Interpreters; Switzerland

Introduction

In pluralistic societies with substantial migrant and refugee populations, interactions between patients and health professionals from different cultures are becoming routine. Nurses, in particular, are increasingly called upon to act as mediators and cultural brokers between patients and the health care system (Chalanda, 1995). Research has shown that quality of care depends on good patient-provider communication (Bensing, 1991; Flocke, 1997; Wensing, Jung, Mainz, Olesen, & Grol, 1998; Campbell, Roland, & Buetow, 2000; Stewart et al., 2000). Therefore, eliminating potential language barriers is the first task of cross-cultural care.

Health providers and patients often speak different languages. Language barriers may arise, especially when

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health professionals deal with migrant patients, refugees and asylum seekers. The lack of a common language between the health professional and the migrant patient is then likely to be an obstacle to adequate health care delivery. Previous studies comparing *language concordant* consultations (i.e. patient and care provider speaking the same language) with *language discordant* consultations (i.e. patient and care provider having no language in common) have shown that language concordance tended to be associated with better compliance, improved appointment keeping and fewer emergency visits (Manson, 1988), better chance to get appointments for medical follow-ups (Sarver & Baker, 2000), better health status assessments (Perez-Stable, Napoles-Springer, & Miramontes, 1997) and higher patient satisfaction (Morales, Cunningham, Brown, Liu, & Hays, 1999).

Linguistically adequate health care can be achieved, either if health professionals are proficient in several languages, and are used as bilingual resources when dealing with patients from other cultural and linguistic backgrounds (Bhui, 1998; Mitchell, Malak, & Small, 1998) or through the use of professional interpreters trained to work in health related settings (Diaz-Duque, 1982; Buchwald, Caralis, Gany, Hardt, & Putsch, 1993; Woloshin, Bickell, Schwartz, Gany, & Welch, 1995; Hornberger, Itakura, & Wilson, 1997; Riddick, 1998; Stolk et al., 1998). However, there are surprisingly few articles that look at the importance of language barriers in nursing, despite a prolific literature on the importance of culturally sensitive communication (Tripp-Reimer, 1984; Collière, 1990; Pottier & Perry, 1992; Chalanda, 1995; Leininger, 1997; Domenig, 1999; Horisberger & Disler, 2000).

The objective of this study was to address this gap in the literature, and examine to what extent language concordance affects nurses' assessment of asylum seekers' health problems and their subsequent referral to care.

Methods

Refugees seeking protection in Switzerland can file an asylum application at one of the four reception centres of the Federal Office for Refugees. There, while at the same time undergoing a first round of summary questioning concerning the reasons for asylum, asylum seekers attend the border health visit carried out by nursing teams. It includes tuberculosis and Hepatitis B screening, as well as basic immunisation (OFSP, 1995). Later the asylum seekers are allocated to different cantons where the medical follow-ups are provided. At present, some 155,000 asylum seekers and refugees live in Switzerland, representing 10% of the migrant population (1.5 million) (BFF, 1999). A recent survey revealed that asylum seekers accounted for a third of all patients attending the outpatient department in Geneva (Bischoff, Tonnerre, Loutan, & Stalder, 1999). In the canton of Geneva, nursing staff of an interdisciplinary team systematically interviews the asylum seekers using a screening interview topic guide. The questionnaire is intended to facilitate (a) the asylum seeker's first-time contact with the health service, (b) the systematic detection of signs related to post-traumatic stress disorder and finally (c) referral to further health care which meets the refugee's needs (Loutan, Bollini, Pampallona, Bierens de Haan, & Gariazzo, 1999). The questionnaire had been previously validated including 76 interviews (analysed in the unpublished Biostatistician's report on the Validity Study, by S. Pampallona, 1997)

We reviewed 723 screening interviews with asylum seekers conducted between June and December 1998, including all asylum seekers attending the health facilities of Geneva for the first time during the study period. Social and demographic characteristics (origin, sex, age, marital status), physical and psychological symptoms experienced during the week prior to the interview, exposure to violence before arrival in Switzerland and the referral to medical or psychological care were recorded. Headache, backache, dyspnoea, abdominal pain, loss of appetite, dysuria and palpitation were classified as physical symptoms, and insomnia, nervousness, sadness, nightmares and loss of memory were classified as psychological symptoms. All of these items were part of the questionnaire designed for interviewing asylum seekers and were recorded by the nurses. Only severe symptoms (i.e. symptoms experienced *very often* during the week prior to the interview) were used in the analyses.

In addition, information was collected on the language used during the interview, the use and type of interpreters, and the quality of the communication as rated by nurses, and the nurses' ability to speak the language used in the interview. The nurse's ability to speak the different languages was assessed by one of the authors (A.B.). A team of six nurses conducted the interviews. If the nurse and the asylum seeker shared a common language (French, German, Italian, English, Spanish or Portuguese), this language was used for the interview. If not, relatives or friends of the asylum seekers had to act as ad hoc interpreters. Professional interpreters were available mainly for Albanian-speaking asylum seekers from Kosovo and Albania (at specific times during the week). We measured four aspects of language use during the interview: the language used during the interview; the presence or absence of an interpreter (and whether the interpreter was trained or ad hoc); the quality of communication as rated by the

nurses (*good*, *sufficient* or *poor*); and language concordance which was defined as:

- *adequate*, when there was either a trained interpreter or the nurse was fluent in the language of the interview;
- *partial*, when there was either an ad hoc interpreter or the nurse had only notions of the language of the interview;
- *inadequate*, when there was no interpreter and the nurse had no ability to speak the language of the interview.

Cross-tabulations were used to describe the relationships between socio-demographic characteristics, presence or absence of symptoms, self-reported quality of communication and language concordance. Logistic regression models were used to estimate the adjusted odds ratios of symptom reporting and of referral to further care while taking into account patients' origins, sex, age and clustering on nurses. All tests were two-tailed, with a significance level of 0.05.

Findings

More than half of the asylum seekers (57%) came from Europe, mainly the Balkan region (Table 1). A third arrived from Africa, mainly from Sub-Saharan countries. Smaller numbers came from Asia and from Latin America. Almost three-quarters of the asylum seekers were men (72%). The median age was 26.5 years ($\pm$8.8), and 50% were younger than 25 years; 55% were single, 41% married and 4% separated, divorced or widowed.

Quality of communication with asylum seekers

The quality of communication was assessed by the nurses as good in 37% of all interviews, sufficient in 28% and poor in 35% of the interviews. Communication ratings varied widely according to the asylum seekers' origins. While the quality of communication was rated as poor in almost half of the interviews with asylum seekers from the Balkans, Eastern Europe and the Middle East (44%, 41% and 41% respectively),

Table 1
Characteristics of asylum seekers according to the quality of communication ($N = 723$)

	N	(%)	Quality of communication, as rated by nurses			*P* value[a]
			Good (%)	Sufficient (%)	Poor (%)	
Origin						<0.001
Europe						
Balkan	379	52	29	27	44	
Russia and Eastern Europe	39	5	13	46	41	
Asia						
Middle East	59	8	19	40	41	
Far East	25	4	8	63	29	
Africa						
Sub-Saharan Africa	125	17	66	17	17	
Northern Africa	20	3	95	0	5	
Horn of Africa and Sudan	65	9	45	36	19	
Latin America	12	2	75	25	0	
Sex						0.98
Men	519	72	37	28	35	
Women	204	28	38	28	34	
Age						0.003
15–19 years	147	20	29	32	39	
20–24 years	218	30	34	27	39	
25–29 years	155	22	42	25	33	
30–34 years	106	15	51	21	28	
>34 years	96	13	33	40	27	
Marital Status						0.10
Single	386	55	39	27	34	
Married	287	41	36	31	33	
Separated, divorced, widowed	24	4	50	42	8	

[a] Pearson's Chi-square-tests, assessing differences within groups (origin, sex, age, marital status).

communication was rated as good most often in interviews with Africans (66%, 95%, 45%) and Latin Americans (95%). No differences were found according to sex distributions and marital status. Good communication increased along the different age categories, was highest in the 25–29 years age group (42%), and decreased again in the >34 years age group (33%).

The nurses' ratings of the quality of communication varied also greatly according to the asylum seekers' mother tongues (Table 2). In 45% of interviews conducted with Albanian-speakers the communication was rated as poor; similar and higher percentages were found in the Kurd, Russian, Portuguese (refugees from Angola and Guinea-Bissau), Serbo-Croatian and Armenian language groups. Fewer consultations were rated "poor" with Tamil, Peul, Amharic, Somalian, Lingala and Arabic mother-tongue patients.

When the subjective quality of communication was good or sufficient, symptom detection was significantly higher (Table 3). When communication was rated as poor, the number of reported symptoms (physical and psychological) was two to three times lower than when the quality of communication was good. In 3 out of 4 interviews (76%) no interpreter support was available. Relatives and friends served as ad hoc interpreters in 16% of the interviews, while trained interpreters were present in 8% of the interviews, mainly with Albanian-speaking asylum seekers. The presence of trained interpreters was associated with high levels of symptom reporting, the presence of ad hoc interpreters with a higher reporting of physical symptoms, but significantly lower percentage of psychological symptoms. Lower levels of both types of symptoms (physical or psychological) were associated with the absence of an interpreter.

Language concordance was adequate in 393 (55%) consultations, partial 196 (27%) and inadequate in 123 (18%) consultations. As for the detection of symptoms, similar frequency distributions to those appearing in the different types of interpreter support were found: higher percentages of reported symptoms in interviews were associated with adequate and partial concordance, and, on the other hand, lower proportions of reported symptoms in interviews with inadequate concordance. Partial concordance was associated with lower levels of psychological symptoms than in physical symptoms.

Subjective rating of communication strongly correlated with language concordance (Fig. 1). The better the language concordance, the better the communication between asylum seekers and nurses was, as perceived by the nurses themselves. Most of the good communication ratings were found in the interviews with adequate concordance (64%), less in those of partial concordance (27%) and almost none in those of inadequate concordance (4%). Sufficient quality of communication correlated with partial concordance (48%). Conversely,

Table 2
Asylum seekers' mother tongues, according to the quality of communication ($N = 723$)

	N	(%)	Quality of communication, as rated by nurses		
			Good (%)	Sufficient (%)	Poor (%)
Albanian	330	47	30	25	45
Somali	38	6	50	34	16
Serbo-Croatian	35	5	23	34	43
Arabic	35	5	74	20	6
Armenian	24	3	13	46	42
Peul	24	3	42	33	25
Kurd	23	3	4	39	57
Lingala	22	3	82	9	9
Tamil	21	3	5	62	33
Amharic	17	2	35	47	18
Portuguese	16	2	38	19	44
French	15	2	93	7	0
Spanish	12	2	75	25	0
Russian	11	2	18	36	46
Other language groups[a]	83	12	48	28	24
Total	706	100	37	28	35

[a] Language groups with less than 10 speakers.

Table 3
Communication between asylum seekers and nurses ($N = 723$)[a]

	N	(%)	Reporting of physical symptoms		Reporting of psychological symptoms	
			% with one or several severe symptoms	P value[a]	% with one or several severe symptoms	P value[a]
Nurses' rating of quality of communication				0.001		<0.001
Good	263	37	24		28	
Sufficient	200	28	23		16	
Poor	243	35	11		10	
Interpreter support				0.079		0.029
Trained interpreter	57	8	25		32	
Ad hoc interpreter	113	16	26		16	
None	553	76	18		18	
Language concordance between asylum seeker and nurses				0.090		0.23
Adequate concordance	393	55	19		20	
Partial concordance	196	27	24		18	
No concordance	132	18	14		14	

[a] Pearson's Chi-Square-tests, assessing differences between groups (quality of communication, interpreter support and language concordance).

communication was rated as poor in 88% of the non-concordant interviews (15% in those of partial and 11% in adequate language concordance).

Reported symptoms and traumatic events by asylum seekers

Among the interviewed asylum seekers, 140 (19%) reported one or several severe physical symptoms, 135 (19%) one or several severe psychological symptoms, and 455 (63%) exposure to traumatic events. More women than men (24% vs. 18%) and more married people than singles (25% vs. 14%) reported one or several physical symptoms. The highest proportions of patients reporting physical symptoms were found among asylum seekers from Latin America, Northern Africa and the Middle East (42%, 25% and 24%, respectively). Similar trends were found in the reporting of psychological symptoms.

Physical symptoms (headache, abdominal pain and backache being the most frequent) were less likely to be reported when language concordance between asylum seekers and nurses was inadequate (Table 4). The same trends were also observed for psychological symptoms. The most frequent symptoms (insomnia, nervousness and sadness) were more likely to be reported when language concordance was good. As for the detection of traumatic events, differences were even more significant: the asylum seekers' reporting of war situation, violence, detention, death of or missing relatives increased drastically with good language concordance between nurses and asylum seekers.

As Albanian-speaking people made half of the study population up, we adjusted for the asylum seekers' characteristics (origin, age, sex) along with the clustering of the nurses. In multivariate analysis, the quality of the communication, as perceived by the nurses, was significantly associated with higher detection of symptoms (physical and psychological) and of traumatic events (Table 5). The relationship with language concordance showed similar trends: the association with the reporting of physical symptoms was not significant, of borderline significance with the reporting of psychological symptoms, and of statistical significance with higher reporting of traumatic events.

Referral to medical and psychological care

Following the interviews, nurses referred 314 (43%) asylum seekers to further medical care, and 85 (12%) to psychological care. The medical referral rate was higher for women (53% vs. 40% of men), for married (48%)

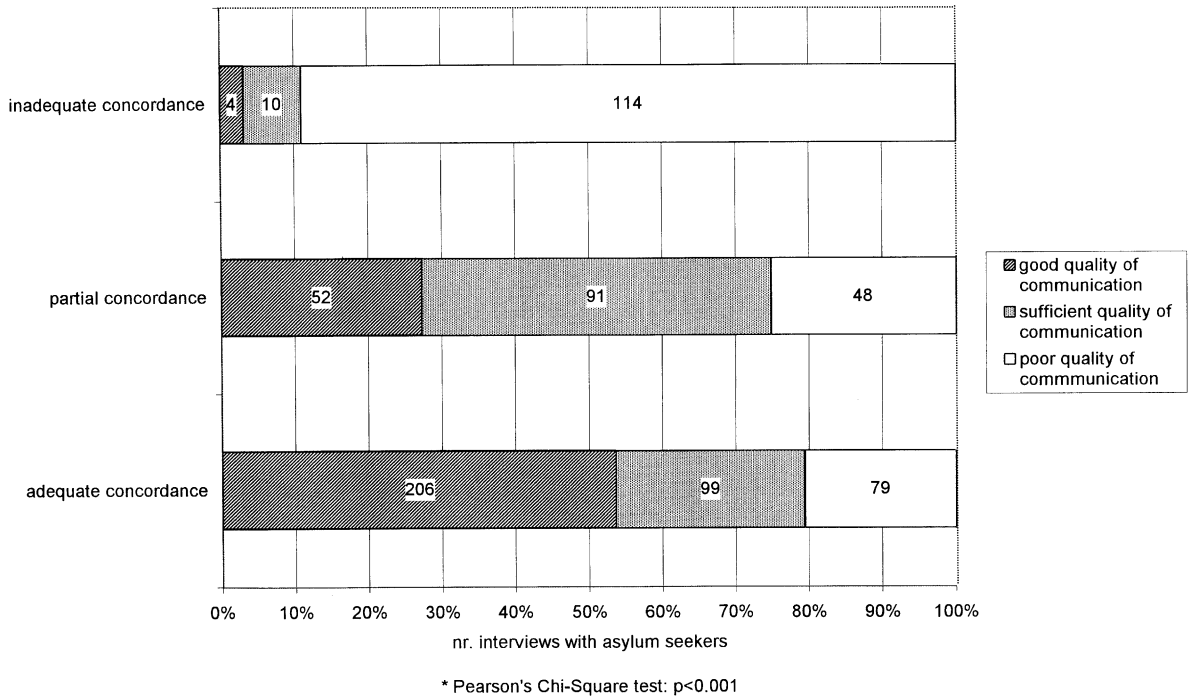

Fig. 1. Subjective rating of communication by nurses, according to language concordance.

and for widowed or divorced people (67%); it increased with age (58%), and when severe symptoms or exposure to traumatic events (63%) were reported. The highest referral rates were found among Africans (60%) and asylum seekers coming form Russia and Eastern Europe (54%). As for psychological care, similar patterns were found: nurses proposed a follow-up with a mental health specialist more often to married and widowed people, to women, to older people, and when severe physical and psychological symptoms and traumatic events were reported.

In logistic regression models taking into account the effect of age, sex, origin, clustering of nurses, referral to medical care was not associated with language concordance (Table 6). As for psychological care, referral was higher only when language concordance was adequate.

Discussion

On methodological issues

We expanded the concept of language concordance found in previous studies (Manson, 1988; Perez-Stable, Napoles-Springer et al., 1997), by introducing three categories of concordance instead of only two (concordance vs. disordance). We defined adequate concordance not only as both parties speaking the same language, but also as the two parties being able to speak in their languages, via professional interpreters. The intermediate category—partial concordance—was introduced when the nurse had only limited proficiency to speak a language understood by the asylum seeker or when a relative or friend acted as proxy interpreter. To put the proxy interpreters automatically in partial concordance category may be considered as an arbitrary decision, but is based on the grounds of professional interpreters being trained, supervised, monitored and accredited, while the proxy interpreters have no recognised language skills whatsoever, were not selected to act as an interpreter by the nurse and did not necessarily translate in the main local language (French), but rather into other European languages, including English, German and Italian). Even so, the three-level-categorisation of language concordance may seem too rough and has limitations: patients could not comment on either their own language ability nor on the nurses' one; and the language abilities by the nurses have not been assessed by a proficiency tests, but by one of the authors.

Thus, generalisations about the study findings should be made with caution. Apart from the above-mentioned potential limitations, the study was retrospective, and therefore does not have the analytical strength of a prospective and experimental trial. The questionnaire is a screening tool, not primarily a research instrument and

Table 4
Reported symptoms and traumatic events by asylum seekers during interviews, according to language concordance ($N = 723$)

	Overall ($N = 723$)		Language concordance			P value[a]
	N	(%)	Adequate (%)	Partial (%)	Inadequate (%)	
Physical symptoms						
Headache	42	6	6	7	4	0.525
Abdominal pain	42	6	5	10	4	0.024
Backache	33	5	4	5	5	0.91
Loss of appetite	24	3	3	4	3	0.789
Dyspnoea	22	3	2	5	4	0.203
Dysuria	12	2	2	1	1	0.35
Palpitation	8	1	2	3	0	0.008
Psychological symptoms						
Insomnia	74	10	12	8	9	0.364
Nervousness	58	8	9	7	8	0.691
Sadness	45	6	8	6	2	0.022
Nightmare	20	3	4	3	0	0.068
Loss of memory	8	1	2	1	0	0.347
Fear	1	<1	1	0	0	0.658
Traumatic events						
Situation of war	327	45	50	43	36	0.021
Personal violence	199	28	32	27	15	0.001
Imprisonment	160	22	27	20	13	0.003
Sudden death of relative	128	18	24	12	6	<0.001
Missing relative	83	12	15	12	2	<0.001

[a] Pearson's Chi-Square-tests, assessing differences between groups in each symptom and traumatic event.

Table 5
Symptom reporting by asylum seekers: associations with communication and language concordance, using multivariate logistic regression analyses ($N = 723$)

	Physical symptoms OR (95%CI)[a]	Psychological symptoms OR (95%CI)[a]	Exposure to traumatic events OR (95%CI)[a]
Nurses' rating of communication (vs. poor communication)			
Good communication	2.1 (1.2–3.6)	3.7 (1.5–4.8)	4.7 (3.0–7.5)
Sufficient communication	2.2 (1.2–3.8)	1.7 (0.9–3.0)	3.6 (2.3–5.8)
Language concordance (vs. no concordance)			
Adequate concordance	1.5 (0.8–2.8)	2.0 (1.1–3.8)	3.8 (2.3–6.3)
Partial concordance	1.9 (1.0–3.6)	1.3 (0.7–2.7)	2.0 (1.2–3.5)

[a] Odds ratio (with 95% confidence interval), adjusted for asylum seekers' age, sex, origin and for nurses.

not designed to assess linguistic features. The study population entails all asylum seekers attending the sanitary visit in Geneva during a given period, reflecting actual asylum migration in Switzerland; thus the sample does not amount to a classical primary care population with the usual gender ratios and age means, let alone the diverse socio-cultural backgrounds. While this may be considered as a study limitation, it is all the more noteworthy that in the multivariate logistic regression analyses which were adjusted for confounders, the outcome measures remained still significantly associated with language concordance.

The quality of communication, although subjective, can be considered a global assessment of the quality of the interview. Interestingly, even though the quality of communication was only assessed by the nurses, it

Table 6
Referral to medical and psychological care of asylum seekers: associations with language concordance, using multivariate logistic regression analyses ($N = 723$)

Language concordance (vs. no concordance)	Referral to medical care OR (95% CI)[a]	Referral to psychological care OR (95% CI)[a]
Adequate language concordance	1.0 (0.6–1.5)	3.2 (1.2–8.6)
Partial language concordance	1.2 (0.7–2.0)	1.6 (0.5–4.9)

[a] Odds ratio (with 95% confidence intervals), adjusted for asylum seekers' age, sex, origin and for nurses.

strongly correlated with language concordance. Inadequate language concordance was associated with the underreporting of important symptoms and a risk indicator for under-referral to psychological and medical care. Conversely, good language concordance significantly improved the appropriate referral to further health care.

On interpreting as a means of addressing language barriers

While medical examination of asylum seekers arriving in host countries often consists of screening for infectious diseases such as tuberculosis and hepatitis B, little attention has been paid to language barriers and their possible impacts on medical interviews. The analysis of the 723 interviews with asylum seekers, conducted by a team of nurses in Geneva, suggests that language concordance and the use of interpreters can increase the detection of traumatic symptoms among asylum seekers and the likelihood of referral to mental health care.

The inadequate language concordance and the poor quality of communication, as perceived by nurses, may have lead to low referral rates to psychological care. The assessment, a crucial stage in the nursing process (Chalanda, 1995; Cortis, 2000) could not be done properly, and the subsequent process was likely to be hampered. Our findings indicate that symptoms suggesting a post-traumatic stress disorder may be underreported. Therefore important cues may be missed, as well as the opportunity to provide adequate and timely care.

In order to address language barriers, health services depend mainly on the internal language resources by using their bilingual health professionals as cross-cultural mediators (Musser-Granski & Carillo, 1997; Mitchell, Malak et al., 1998), and only rarely use professional interpreters (Ginsberg, Martin, Andrullis, & Shaw-Taylor, 1995; Pöchhacker, 1997; Bischoff, Tonnerre, Eytan, Bernstein, & Loutan, 1999). The problem of using health staff speaking foreign languages may be that they rely on their own linguistic skills, which they can hardly evaluate themselves. Neither can they ensure that patient and health professional have understood each other, especially when culturally sensitive issues are addressed which would need cross-cultural mediation (Haffner, 1992). A recent study found that interpretation errors occur frequently when bilingual nurses (untrained in interpretation) double as interpreters. The authors strongly recommend specific interpreter training for nurses acting as medical interpreters (Elderkin-Thompson, Cohen Silver, & Waitzkin, 2001).

A survey of nurses and other health professionals working in a culturally diverse mental health setting concludes that "given the importance of language in every aspect of the clinical process, it is surprising that it has been so neglected in consideration of professional education, service planning, staff deployment, recruitment and continuing education. It is first necessary that the importance of language as a skill relevant to clinical practice be recognised" (Minas, Stuart, & Klimidis, 1994, p. 257).

In our study, the presence of interpreters significantly influenced the detection of symptoms and exposure to traumatic events, as well as the referral to further care, especially mental health care. At the same time, the study provides some evidence suggesting that relatives serving as ad hoc interpreters do not improve psychological screening and are thus not a promising strategy when addressing language barriers. Asylum seekers apparently feel uncomfortable acknowledging psychological suffering in presence of family members; because they want either to protect them from painful narratives or avoid some kind of stigmatisation (see also examples in Marshall, Koenig, Grifhorst, & Van Ewijk, 1998).

Various studies confirm the drawbacks of using relatives as ad hoc interpreters: they may lead to serious communication problems (Ebden, Bhatt, Carey & Harrison, 1988). They may be proficient in two languages, but may not know how to interpret, their deficient translation leading to misunderstandings (Launer, 1978) or to low compliance (David & Rhee, 1998). Lacking a critical understanding attitude towards both cultures, relatives are not able to provide the necessary

cultural mediation between health providers and migrants. Relatives, especially children, are themselves at a high risk of stress disorder, when they have to translate in emotionally charged interviews (Westermeyer, 1990; Jacobs, Kroll, Green, & David, 1995).

Presently, there are generally institutional constraints by which organisation decide not to dismiss the use of unqualified personnel and not to implement qualified interpreter services. Usually financial considerations are put forward and it is argued that qualified interpreter services are an economical burden for the already strained health provision budgets (Tang, 1999). But further research might address the question whether, considering that ad hoc interpreters are not an adequate solution to address language barriers, the costs of inadequate diagnosis and referral due to the use of unqualified interpreters are higher than introducing qualified interpreters.

In conclusion, our results suggest that addressing language barriers by using trained interpreters in primary care centres may improve the detection of traumatised asylum seekers and increase their appropriate referral to mental health care. Therefore, we would recommend, as do others (Bollini & Siem, 1995; Woloshin, Bickell et al., 1995; Jones & Gill, 1998; Verrept & Louckx, 1998; Breen, 1999) the use of qualified interpreters and the provision of routine interpreter services in primary care settings with high numbers of asylum seekers and refugees.

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