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The psychiatrist and the interpreter

I am glad to see such a positive response to the editorial on interpreting practice.¹ Psychiatry and speech and language therapy are two of the most challenging areas of practice for interpreters.

Australia has an honourable tradition in the field of language support for its diverse population, as I experienced in New South Wales a few years ago. Andrew Firestone's description of using a triangular seating arrangement but having changed to sitting the interpreter next to him is interesting.² I have found that if I sit next to either the clinician or the patient, problems in the doctor–patient relationship can still occur. If closer to the patient, it is more likely that they will address questions directly to me, trying to draw me in 'on their side', such as 'Are you married?' or 'Do you have children?' If closer to the clinician, my impartiality can seem to the patient to be compromised.

In the UK almost all interpreters in the public sector are independent freelance workers. Being seen by the service user as directly employed by a state institution, whichever it is, can cause them to distrust our interpretation, especially if they have arrived from a totalitarian state. Seating the interpreter at the apex of an isosceles triangle, in which the clinician and patient are closest together and directly facing one another, allows eye contact to be maintained between them, and keeps the interpreter out of direct line of sight. Interpreters who are taking notes will be busy with their notebooks and not available for eye contact. They still need to be able to see the speakers' faces, of course.

It would be interesting to know whether interpreters and clinicians maintain direct speech during clinic sessions, such as 'How are you feeling?' rather than 'Ask her how she feels'. This is another way of keeping the interpreter out of a direct relationship with either party during the interview. It is very important that the interpreter introduces themselves and briefly explains how they work, at the beginning of the session. This, and everything else that is said, should be done in both languages. If the patient is reminded at the outset that 'I will interpret everything I hear' and 'I will speak to you as the doctor does, with "I" and "you"; they are his words', ownership of what is said remains with the primary interlocutors, not the interpreter.

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Death and risk in adolescent anorexia nervosa

Responding to Robinson's article on avoiding hospital deaths from anorexia nervosa,¹ the most helpful context to consider this in relation to teenage patients is to place it within a broader concern about risk. Robinson states that a 'very unwell' patient should be admitted, but crucially, the definition of that is still not sufficiently clear. How risk is perceived, including what is severely disabling as well as what may be 'life-threatening', is a key issue.

Using death certificate data provided by the Office for National Statistics about 18 years ago, I observed 112 certified deaths in England and Wales over a 5-year period; however, only 7 of these individuals had been below their 18th birthday. Notwithstanding the uncertainty of death certificate methodology,² in this instance, suggested by the observation that a third of the 112 deaths had occurred after the person's 65th birthday, these 7 deaths approximate to only around 1 in 5000 adolescents with anorexia – an important finding to set in context fears about these young patients.

That death-data enquiry had been to establish a better empirical understanding about risk following our team's decision (which I supported) to recommend the de-commissioning of a psychiatric in-patient unit that had often provided long-term treatment for teenagers with anorexia. It had previously participated in the UK's first prospective multicentre study of adolescent psychiatric admissions, which demonstrated disappointing treatment effects for those with anorexia nervosa.³ But without such a facility, might there be a local increased risk of fatal outcomes for this condition? Reassured that the probability of death was unlikely to be significantly increased by closing the unit, a substantial change in practice was possible, relocating therapeutic skills to enhance outpatient treatment capacity. Gower *et al*'s subsequent treatment study² confirmed our view that without hospitalisation the disorder should not usually be regarded as hard to treat, untreatable or life-threatening.

Declining death rates observed for anorexia nervosa over the past two decades have been attributed to its more effective and earlier introduced treatment, but not necessarily because the treatment was hospital based.⁴ A careful review of the literature provides two lessons less prone to grab media headlines than premature deaths. First, in adolescence at least, chronicity rather than death is by far the more likely adverse outcome of failing to effectively treat the condition. In comparison with adults, in whom medical complications are not uncommon and excess mortality rates have been observed compared with the normal population, the only significant medical complication (as opposed to biological adaptation to starvation) during adolescence is progressive loss of bone mineralisation. Yet published studies on adolescent admission imply that hospitalisation was most often considered essential