

Connections

An information service of Immigration & Refugee Services of America's *National Alliance for Multicultural Mental Health*

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"No person in the United States shall, on the ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance." Title VI, Civil Rights Act of 1964

IRSA's National Alliance for Multicultural Mental Health (NAMMH) is pleased to bring you this issue of *Connections* devoted to mental health interpretation.

In August 2000, the Office of Civil Rights (OCR) of the U.S. Department of Health and Human Services (HHS) issued a written policy guidance to help ensure that persons with limited English skills can effectively access critical health and social services. The guidance outlines the legal responsibilities of providers who receive federal financial assistance from HHS. This "Policy Guidance on the Prohibition Against National Origin Discrimination as it Affects Persons with Limited English Proficiency" (LEP) applies to part of Title VI of the Civil Rights Act of 1964, which prohibits discrimination on the basis of national origin. LEP refers to the inability to speak, read, write, or understand English at a level that permits effective interaction with health and social services agencies and providers.

The Immigration and Naturalization Service estimates that 75 percent of the one million immigrants who enter the United States annually are LEP. Many of the gatekeepers of vital services are monolingual and have limited knowledge of the cultures of newcomers; thus, communication can be a major challenge. HHS estimates that 32 million people in the United States are LEP and, therefore, face many barriers to critical health and social services.

Language assistance is of particular importance to successful mental health services for refugees and immigrants. Such services depend on the establishment of a close relationship with the client or patient that is based on confidentiality and mutual trust. It is also important that interpreters be adequately trained, and that

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it is not left up to the client to provide an interpreter—who would often be an untrained family member or friend who should not be a part of any conversation requiring confidentiality.

Critics of the OCR guidance state that the high cost of the requirements will place an extra burden on physician practices. OCR officials, however, maintain that the guidelines do not represent a new initiative, but rather are intended to more fully explain existing policies that enforce Title VI of the Civil Rights Act of 1964, and that adequate interpretation can help practitioners come to the root of problems, enabling them to better find solutions.

According to the OCR guidelines, refugee and immigrant service agencies should provide a range of oral language assistance using trained and competent interpreters. The assistance must be timely and at no cost to the LEP person. Interpreters can be bilingual staff, staff interpreters, contractors, volunteers, or through a telephone language line, but all must have specific training. Clients should not be required to use family, friends, or minor children as interpreters. Documents should be translated into regularly encountered non-English languages; this is particularly important for vital documents such as application forms, enrollment forms, letters or notices about eligibility or any change in benefits, anything that requires a response, and medical or discharge information. All agencies should have effective methods for notifying LEP persons of their right to receive language assistance at no cost. If agencies receiving federal funds do not comply with these guidelines, they risk the withdrawal of funds or referral to the Justice Department.

The following is an example of a model language assistance program that is potentially useful for all recipient/covered entities, but is particularly appropriate for entities such as hospitals or social service agencies that serve a significant and diverse LEP population. This model plan incorporates a variety of options and methods for providing meaningful access to LEP beneficiaries:

- A formal written language assistance program;
- Identification and assessment of the languages that are likely to be encountered and, through a review of census and client utilization data and data from school systems and community agencies and organizations, an estimate of the number of LEP persons that are eligible for services and are likely to be affected by its program;

- Posting of multilingual signs in lobbies and other waiting areas informing applicants and clients of their right to free interpreter services and inviting them to identify themselves as persons needing language assistance;
 - Use of “I speak” cards by intake workers and other patient contact personnel so that patients can identify their primary languages;
 - Requiring intake workers to note the language of the LEP person in his or her record so that all staff can identify the language assistance needs of the client;
 - Employment of a sufficient number of staff, bilingual in appropriate languages, for patient and client contact positions such as intake workers, caseworkers, nurses, or doctors. These persons must be trained and competent as interpreters;
 - Contracts with interpreting services that can provide competent interpreters in a wide variety of languages, in a timely manner;
 - Formal arrangements with community groups for competent and timely interpreter services by community volunteers;
 - An arrangement with a telephone language interpreter line;
 - Translation of application forms and instructional, informational and other key documents into appropriate non-English languages, and the provision of oral interpreter assistance with documents for those persons whose language does not exist in written form;
 - Procedures for effective telephone communication between staff and LEP persons, including instructions for English-speaking employees to obtain assistance from bilingual staff or interpreters when initiating or receiving calls from LEP persons;
 - Notice to and training of all staff, particularly patient and client contact staff, with respect to the recipient/covered entity’s Title VI obligation to provide language assistance to LEP persons and on the language assistance policies and procedures to be followed in securing such assistance in a timely manner;
 - Insertion of notices in appropriate languages, in brochures, pamphlets, manuals, and other materials disseminated to the public and to staff, about the right of LEP applicants and clients to free interpreters and other language assistance;
 - Notice to the public regarding language assistance policies and procedures, and notice to and consultation with community organizations that represent LEP language groups regarding problems and solutions, including standards and procedures for using their members as interpreters;
 - Adoption of a procedure for the resolution of complaints regarding the provision of language assistance and a procedure for notifying clients of their right to file a complaint under Title VI with HHS and how to do so; and
 - Appointment of a senior-level employee to coordinate the language assistance program, and ensure that there is regular monitoring of the program.¹
- Another important issue, not specifically covered in the OCR guidelines, is the code of ethics for interpreters. Such a code is important to professional interpreting, especially for those working in mental health interpretation. A code published by the Public Health Service includes the following guidelines:
- Confidentiality—Interpreters must treat all information learned during the interpretation as confidential, divulging nothing without the full approval of the patient and his or her physician.
 - Accuracy—Conveying the content and spirit of what is said. Interpreters must transmit the messages in a thorough and faithful manner, omitting or adding nothing, giving consideration to linguistic variation in both languages, and conveying the tone and spirit of the message. Word for word interpretation may not convey the intended idea. The interpreter must determine the relevant concept and phrase it so it is readily understandable to the person being helped.
 - Completeness—Conveying everything that is said. Interpreters must interpret everything that is said by all people in the interaction, but should inform the health professional if the con-

tent might be perceived as offensive, sensitive, or harmful to the dignity and well-being of the patient. Managers must be informed of perceived conflict.

- **Conveying Cultural Frameworks**—When appropriate, interpreters shall explain cultural differences to health providers and patients.
- **Non-Judgmental Attitude**—An interpreter's function is to facilitate communication. Just as interpreters should not omit anything being said, they should also not add their own personal opinions, advice, or judgment.
- **Client Self-Determination**—The client may ask the interpreter for his or her opinion. The interpreter should not influence the opinion of patients or families by telling them what action to take.
- **Attitude toward Clients**—The interpreter should strive, at all times, to develop a relationship of trust and respect with the patient by adopting a caring, attentive, impartial attitude toward the patient and toward his or her questions, concerns and needs.
- **Acceptance of Assignment**—Interpreters should disclose any real or perceived conflict of interest that would affect their objectivity in delivery of service. Additionally, if levels of experience or personal sentiments make it difficult to abide by any of the above conditions, the interpreter should discuss it with his or her manager. The interpreter may decline or withdraw from the assignment.
- **Compensation**—The fee or salary paid by the agency is the only compensation that the interpreter should accept. Interpreters should not accept additional considerations or favors for services.²

The articles included in this issue bring to light a broad spectrum of important concerns regarding appropriate mental health interpretation. From Sarah Alexander's interview with Joy Connell of the Massachusetts Department of Mental Health, we learn important lessons from a statewide interpre-

tation program. Robert Pollard, Ph.D., shares with us a popular curriculum for mental health interpretation developed by a multicultural team of interpreters and clinicians in Rochester, New York. Angela Vassallo brings us a poignant story of one client's experiences in a psychiatric hospital in Houston, Texas, and her challenges in getting treatment without a full-time interpreter. Wawa Baczynskyj highlights special considerations affecting the interpreter that should not be overlooked. She points out that, at times, interpreting stories of trauma can be traumatizing in itself. Elaine Quinn shares nuances of mental health interpreting that are particularly valuable to the provider and, in turn, of great benefit to the patient.

I have recently joined IRSA in the position previously held by Lyn Morland, as Senior Program Officer for the NAMMH. Having worked for many years in the field of international mental health, I am delighted to have the opportunity of turning my experience and attention to the extremely important issues related to refugee and immigrant mental health in the United States. I hope to hear from all of our readers—with suggestions for the newsletter as well as suggestions for my office's outreach to the community that serves our clients. I look forward to learning from each of you. ■

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¹ OCR's LEP Policy Guidance published in the Federal Register: 65 Fed.Reg. 52761 (August 30, 2000). Copies are available on OCR's website: <http://www.hhs.gov/ocr/lep/guide/html>.

² C.E. Roat, ed., *Bridging the Gap: A Basic Training for Medical Interpreters* (Seattle, Washington: Cross-Cultural Health Care Program, January 1996, originally published by the U.S. Public Health Service Region 10, Seattle, Washington, 1995), 30-31.

An Interview with Joy Connell: Lessons from the Field

By Sarah Alexander, LICSW, of the
International Institute of Boston

The Massachusetts Department of Mental Health (DMH) has had a statewide interpreter-services program for over 12 years, providing services at state hospitals, outpatient state clinics, and residential and day programs. As Senior Associate at the Department's Office of Multicultural Affairs, Joy Connell has seen the program through numerous transitions over the past decade. This interview was conducted at her office in Boston.

What are the two biggest challenges for quality interpreter services?

One of the biggest challenges is having the actual manpower. For too many people, it (the job of interpreting) is seen as a temporary job, one you do while in transition or as a stepping-stone to something else. It's a tremendous challenge to have enough people.

Another challenge is getting the provider, the interpreter, and the patient to understand each other's roles. This includes expectations, boundaries, and maximizing the use of resources. We have seen interpreters used in so many ways—from a black box to surrogate therapist. There needs to be some sort of standard or medium so that the interpretation session is beneficial for everyone.

Overall, there is a basic issue that stymies efforts to develop and provide quality interpreter services. Interpreting is grossly oversimplified in the minds of too many people. Providers don't understand the complexity of interpretation, and individuals who are bilingual don't understand why they need training if they already speak the target language. Put the two mindsets together and you have the sort of thinking that leads to the use of family, friends, or the janitor as interpreters.

What has helped deal with those challenges?

The growing awareness of the need for interpreters generally in tandem with the professionalization of the field. This helps to clarify roles and sets up standards of practice. The Massachusetts Medical Interpreters Association (MMIA) has developed standards that have been adopted in other states as well as in Canada and Europe.

We are talking about a relatively new field. It's only been in the last decade that we have seen the emergence of the professional interpreter. Even colleges have developed special interpreter certification programs now. It would be fair to say that we have done incredible pioneering work in Massachusetts in terms of interpreter services. Frankly, it is really an exciting time to be in the field.

Do you think there is a need for certification of interpreters?

When we talk about certification and standards, there is a huge difference between interpreters of Western European languages and others. Yes, there needs to be standards, and also certification, but there also needs to be consideration for distinct cultural and linguistic traditions and resources.

Recently the state of Massachusetts took a survey of hospitals for the use of interpreters. What were some of the most interesting findings?

Virtually every facility claims to provide interpreter services, but when you start to get into details of how these services work, it varies tremendously. Even at the largest, best hospitals with diverse clientele and staff, several mechanisms are in place to make up a complete service: hospital staff, freelance interpreters, telephone interpreters, agency services—all these are utilized. It is amazing how many places say that they provide interpreter services, when what they do is rely on friends and family to do the interpreting!

Has anything happened to improve the acceptance of the use of interpreters?

Over time, I would point to changes in demographics; faces are changing, languages are changing. Also the big push for multiculturalism and cultural competence has had an impact. But it isn't "acceptance" of interpreters that we're talking about—it is a necessity for people. Providers can do nothing without interpreters. Someone (from a non-DMH facility) called me, desperate for an interpreter—the client had been in the hospital for three days and they couldn't even get the client's name.

Experience has been critical as well. I've had people call me up after a session to say, "That interpreter was so wonderful. He explained lots of things to me that I wouldn't have ever known." And that really works—the cumulative effect of good interpretation.

How have you developed clinician knowledge of how and when to use interpreters?

Several different ways. We do have informal guidelines, protocols, and trainings that we have taken across the state—what is an interpreter, times when an interpreter is necessary, how to use an interpreter, etc. But I would fall back on common sense. There is a big difference between a patient who has been in the country 3 months and speaks no English, versus someone who has been in the country 20 years and has some knowledge of it.

Do you feel trainings show perceptible differences in the way clinicians relate to non-English speaking patients?

Only up to a point. First, there is a tremendous difference in the quality of trainings and their structure. Past a certain point, training becomes moot. I feel bad for people who have to take mandatory diversity training over and over again—it's pointless. I think it is the actual experience, the day-in and day-out of people working with people over time, that helps them learn and become culturally competent.

What is the average length of time for an interpreter to be with your system, and how many hours a year do they work, on average?

Impossible to answer. We've had one interpreter who speaks multiple languages, both Spanish and Kreyol (Haitian Creole) as well as French and Portuguese, and he has been with us since the program began. He puts in at least a half-time equivalent, but the work varies from week to week. He can be twiddling his thumbs one week and swamped the next. And we've had some interpreters we use maybe once or twice a year only, depending on language.

Is there public support of state-funded interpreters in Massachusetts?

We have been very fortunate that the state has passed the Emergency Room Interpreters Bill (which mandates the use of interpreters in the ER and acute psychiatric situations). Obviously, this is a boon to non-English-speaking patients, but more needs to be done.

What structures within your system have been most helpful in sustaining a quality service?

Consistent funding, long-term staffing, and a supportive state administration.

What advice would you give to other states about a service?

Training—training—training.

Sarah Alexander is the Coordinator of Social Services at the International Institute of Boston. Her email address is: salexand@iiboston.org. For more information about the MMIA, contact John Nickrosz, President, at 617-636-5479. ■

Mental Health Interpreting: A Mentored Curriculum

*By Robert Pollard, Ph.D., of the
University of Rochester Medical Center*

A multicultural team of interpreters and clinicians in Rochester, New York, have developed a popular curriculum for training foreign language interpreters to help them work more effectively in mental health service settings. Produced in 1998, the curriculum text and accompanying videotape of 11 interpreting vignettes is in use in over 350 settings in the United States, Canada, Australia, and several European countries.

The curriculum was developed through a grant from the Monroe County Office of Mental Health, awarded to the University of Rochester Medical Center (URMC). I run a program at URMC, the DeafWellness Center, that provides mental health services for deaf individuals, trains deaf individuals who are becoming psychologists, and engages in considerable research and training on mental health interpreting, healthcare interpreting, and other interpreting topics. Much of our work with sign language interpreters is equally applicable to foreign language interpreters because many of the challenges and processes of “translation” are similar, regardless of the languages and cultures you are moving between.

The grant mentioned above was specifically for the development of mental health training materials for foreign language interpreters. Having done similar trainings for sign language interpreters for many years, we felt that we had relevant expertise in this area, but needed the input of clinicians and interpreters who worked in various foreign languages to compliment our knowledge base. A multicultural team of bilingual clinicians and foreign language interpreters was assembled to join my existing team of sign language interpreters and, together, we developed this new curriculum.

One of the things we’d already learned from previous interpreter training efforts was that interpreters find information about mental health service environments much more useful (and new to them) than information about cross-cultural issues in men-

tal health per se. Interpreters usually already know a great deal about their “minority” language and culture, the “dominant” language and culture, and how they can clash at times, both in terms of effective translation and effective human interaction. On the other hand, most interpreters know neither about mental health nor the importance of language and communication in mental health diagnosis and treatment. For example, how language can be impaired by psychosis or what questions are most common in a diagnostic interview about depression. We have found that teaching interpreters about the norms and dynamics of different mental health service settings (e.g., emergency rooms vs. inpatient vs. outpatient programs), especially the types of communication events (e.g., a medication evaluation vs. a suicide risk assessment) and conversational goals they are likely to encounter in various mental health settings, helps them anticipate the translational and cross-cultural challenges they are most likely to face and, therefore, to do their job much more effectively. The curriculum was designed with this approach in mind.

The curriculum consists of a 139-page textbook (9 chapters and a resource list) with an accompanying 32-minute videotape. There is an open-captioned (i.e., fully subtitled) version of the video for deaf or hard-of-hearing viewers that is also popular with interpreters whose first language is not English. The “regular” version of the video shows subtitles only when characters speak in a foreign language and their comments are not immediately translated into English. The text and video are designed to be used together in a learning relationship between the interpreter-trainee and an experienced teacher or mentor. Ideally, the mentor will be an experienced mental health interpreter or a bilingual clinician. The mentor and interpreter need not share the same foreign language—we have found that as long as the mentor and interpreter are both bilingual (in any two languages) effective teaching can take place, since they both understand the fundamental nature of translation and cultural differences that interpreters must contend with. The curriculum format allows for study at the

interpreter's and mentor's own pace, although it has been used in traditional classroom settings as well. This design also encourages "learning to mastery" rather than the partial learning that often results from a workshop or lecture presentation.

The nine curriculum chapters focus on: how the curriculum should be used, the interpreter's role, interpreting ethics, types of mental health professionals, mental illnesses and the DSM-IV (*Diagnostic and Statistical Manual of Mental Disorders*) diagnostic system, mental health settings and related clinicians' objectives, the diagnostic significance of dysfluent (impaired) language in mental health and how to handle interpreting for patients with language dysfluency, the sometimes powerful dynamics present in mental health work (e.g., strong emotions, transference), and a number of broad and specific cross-cultural issues that commonly arise when foreign language users are served in mental health settings. Each chapter of the curriculum begins with a set of learning objectives and ends with a "learning check" or brief examination, so that educational progress can be documented. At the end of most of the chapters, there are instructions about which videotape vignettes to watch, followed by discussion questions for the interpreter and mentor to talk about together to facilitate deeper appreciation of the material and issues raised. The languages spoken by actors in the video include Spanish, Chinese, Vietnamese, and Russian. The curriculum text is written at a modest English reading level and is formatted with wide margins and line spacing to facilitate note-taking.

The curriculum is sold by URMIC at roughly what it costs to produce and mail. The price for the curriculum (text and video) is \$48. The text and video also are sold separately for \$24 each. When ordering, specify if you want the standard or the open-captioned video. Checks, MasterCard, and Visa payments are all acceptable. Make checks payable to the "University of Rochester" (U.S. funds only) or send an institutional purchase order. URMIC's tax ID number is 16-0743209. Orders and correspondence should be sent to Dr. Robert Pollard, URMIC Department of Psychiatry, 300 Crittenden Boulevard, Rochester, NY 14642 (Robert.Pollard@urmc.rochester.edu) The curriculum may also be ordered by contacting Linda Stone at 716-275-6785 or via fax at 716-273-1117.

If you are interested in some of our other work on interpreting or our work on deafness and mental health, you could obtain or request from us the articles below. Again, much of our work in the deafness field is applicable to other cross-language/cross-cultural situations. In fact, we do trainings around the United States and in other countries on mental health and healthcare interpreting for a variety of language populations. If you are interested in scheduling a workshop or lecture, please feel free to contact us. ■

Articles of Interest

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A Day in the Life of Marie Jose

*By Angela Vassallo of
YMCA International Services of Houston, Texas*

Interpreting has become an integral part of life in dealing with day-to-day issues for my clients. One woman in particular, whom I will call Marie Jose for the sake of confidentiality, is from the Democratic Republic of Congo and has had numerous difficulties maneuvering the system due to language problems. Although she understands and speaks some English, she expresses herself much better in French and Swahili. This has been extremely challenging for Texas public health facilities, despite the fact that both are widely spoken languages. People are dumbfounded by the fact that she is bilingual and that the other language she speaks is not Spanish. Within the past four months, Marie Jose has been in and out of several psychiatric hospitals, substance abuse programs, and even jail. She is a survivor of extreme trauma and torture. She is HIV positive and alone.

I had accidentally happened upon her intake interview when visiting her one afternoon on the dreaded 5th floor of the psychiatric ward at the county hospital. As I stepped off of the elevator to find the secured facility brimming with individuals who were praying to the walls and pretending to be rock stars, I couldn't believe that this was the best that Houston, the United States's fourth largest city, had to offer for refugees in need of mental health services. A phrase I have heard many times kept going through my head: She is just having a "normal reaction to an abnormal situation." Yet trying to explain this concept to someone who knows nothing about refugees is a bit difficult nonetheless.

When the receptionist and nurses learned that I

had arrived to see Marie Jose, they seemed relieved. "Great," they offered, "We are having a hard time communicating with her. We have just started her intake interview with the doctors and would really appreciate you interpreting if you don't mind." It seemed a harmless enough, yet odd request. They ushered me into a setting that took me by surprise. It was everything that I had learned would re-traumatize a survivor of torture. Most of all, why is it that the largest hospital in Houston had not arranged for an interpreter or even tried to use the AT&T telephone interpreter line?

The room was set up with approximately 12-15 persons sitting in a semi-circle. She was in the hot seat, underneath the chalkboard, at the front of the room facing the group. Watching the medical staff fire questions, I was astounded by her resilience. The group consisted of only two doctors. The rest were medical students, pharmacists, and even pharmacy students. She must have been funny material for the pharmacists considering the fact that she does not like anti-depressant medication and believes that they are an unnatural way to solve personal problems.

The interview began by the doctor asking her questions like:

"Marie Jose, what are you feeling right now? Why are you sad? How did the war make you feel? What do you want us to do for you?"

And after each question, I would interpret her well thought-out answers such as:

"I am feeling sad and alone. I am sad because I lost my son in the war. He is now somewhere in a refu-

gee camp and I have not seen him in over four years. He is only five years old. The war was like nothing you can ever imagine. I hope none of you ever experience such a thing. I want you to pray for me—each of you, go home tonight and thank God for everything you have.”

Then after each answer she gave, the room would be overcome by a stifling silence with heads bobbing as each person took notes on their pad. What are they writing, I kept wondering? At the end of the long and emotionally grueling session, the doctor asked Marie Jose if there was anything else she would like to say and she replied, “Yes, I would like to thank each of you for wanting to help me

make my life better.”

The room quickly emptied and she and I were left to look at each other in silence. She has been in and out several different facilities since. Her English has not improved much either.

Angela Vassallo is the Medical Case Management Coordinator for all HIV-positive clients at the YMCA International Services in Houston, Texas. Angela has extensive experience working with African refugees, in particular with survivors of trauma and torture. She speaks fluent French and proficient Spanish and Italian. Her email address is: angelav@ymcahouston.org ■

Language, Culture, Memory Intertwined

*By Wawa Baczynskyj, LICSW,
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Bilingual people are often perceived as “enriched” because they can think of things in different ways; they have access to a different language—a different way of capturing reality. The common Ukrainian equivalent to the phrase “red as lipstick” is the phrase “red as raspberries,” found dotting both folksongs and conversation. This demonstrates how the relational context of words and comparisons is colored by culture, in the Ukrainian case reflecting a strong agricultural orientation.

Playing with allegories and comparison on a literary level is fun and intriguing—and somewhat luxuriously theoretical as one analyzes what the author really meant and how the author communicated their native environment.

It takes no great imagination to see the relevance to mental health interpreting. When first hearing words in one context, one has to interpret these words into another language and somehow either find an equal context or explain its lack. When a bilingual person speaks one language it taps into one culture, the other language taps into another.

The clinical triad of client/provider/interpreter is

instrumentally multicultural. Interpreters are valued for their bilingual skills. In mental health, symptom description leads to diagnosis. Why and how clients formulate that which troubles their spirit, their description of the “culture” of their problem, contains in it all the clues for treatment. Mainstream providers are relieved to find a person who can make the client’s foreign words and gestures understandable, and appreciate a translator’s ability to formulate a cultural context for the client’s expressions and imagery. Ideally, there is a capable bilingual-bicultural interpreter who enables communication flow between the provider and the client; thus contributing towards assessment and treatment.

Managed health care reminds providers constantly of the cost of a session and of the fact that a session with an interpreter takes longer. Providers, however, need to remind themselves of the “session cost” to the interpreter. Interpreting, in and of itself, demands a lot of effort from the translator. Something said in one language has to be phrased in another language in a way that connote the same meaning and intention—a cultural transposition of literal meaning from one language to another needs to happen.

Many bilingual people say that they naturally speak to babies in their native language, that all the fairytales or children’s rhymes they know they know only in their mother tongue—since that is the way they themselves heard them as children.

Recently, on a visit to Ukraine, the Pope, who is multilingual, broke into a Polish children's song during a rain downpour at a youth rally. While all his public speeches were delivered in Ukrainian, he reached into his childhood and his native Polish language to share a tune that promised to chase the rain away. Just the right words there and then—from his own native sphere and specific to a certain period of his life.

A person's native language can retrieve and communicate pleasant times, childhood wishes and magic formulas. Too often for the refugee interpreter, however, their native language connotes a time and a place filled with terror, suffering, and loss. As a result, in a psychiatric encounter a refugee interpreter may hear not only the words and cultural context, but may also relive their own time of terror and suffering.

Interpreters will often say that they are very tired at the end of a day. Talking in two languages means thinking in two languages means feeling in two languages. It's working "double time." Depending on the interpreter's skill, training, and personal development, it is possible to open and close those cultural doors and go on; however, the cost exacted still exists. The memories, thoughts, or feelings engendered by an encounter often get pushed away unresolved because one has to go on; for others, they become overwhelming, haunting their private thoughts or dreams at night; and for some, every refugee story—instead of being the client's story—becomes the translator's. Boundaries get blurred, with the meaning of the client's words assumed by the interpreter to be identical with the meaning of the interpreter's words. Soon the provider is hearing the cultural context of the interpreter and not that of the client.

Mental health professionals devote much supervision time to transference and counter-transference, as well as secondary traumatization. Too often interpreters are simply seen as the "language people" and these issues are only validated for them at conference workshops. However, on an everyday basis, is there the needed support and supervision to process through such situations? Every mental health provider knows that learning to deal with these issues is a big step in their professional growth.

Shouldn't the same contribution be made to interpreters' professional development?

Seeing interpreters as a "means to an end" is fine in a professional encounter where interpreters should be as invisible as possible in facilitating client/provider communication; however, for an agency, clinic, or hospital not to have a mechanism to enable a review of some sessions, guarantees either burn-out or an intertwined merging of the client and the interpreter. Language is a way of expressing culture, although by no means the only one. Tapping into a language, especially one's native language, means tapping into a whole world of beliefs, customs, norms, and taboos—it provides an instinctive means of making sense of the world and defining one's relationship to others. Though the client and interpreter may share a common perspective though their shared language, the monolingual provider is at the same time operating in an entirely different world, whether it be their general culture or a special "professional" culture. This makes the interpreter's job that much more difficult since, in order to facilitate the client/provider relationship, they also have to make the provider's world more understandable to the client.

Again, this task may be daunting. It may demand "acting" in one culture towards the provider and in another towards the client. It may demand from the interpreter the ability to overcome those instinctive native taboos and cross into a forbidden territory of questioning—perhaps issues regarding sex. It may demand thoughtful consideration concerning how to explain to the client the provider's dominant culture or the treatment protocol. It may sometimes demand resigning from an assignment because of a mismatch of age or sex in relationship to the client. It always demands communication with both sides.

The clinical/cultural nature of interpreter involved mental health services challenges providers to broaden their cultural spectrum and invites creativity. Agencies, clinics, and interpreter associations have an ethical responsibility to recognize the emotional and psychological "session cost" of cross-cultural interpreting to the interpreter, and to offer them an avenue for support and professional development.

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and advocacy. She speaks Ukrainian, German, and Russian and is a certified trainer for "Bridging the Gap" interpreter training program. Her email address is: WawaMSW@aol.com ■

Skilled Interpreters are Essential for Meaningful Communication

By Elaine Quinn of the Texas Department of Health

In the mental health setting, access to care and delivery of care would not be possible without meaningful communication between patient and provider. Mental health providers must take the responsibility to ensure that meaningful communication is facilitated, such as through the use of an interpreter for the deaf or hard-of-hearing or, more commonly, an interpreter for the patient's native language.

The chief concern in communicating between languages is ensuring that what one person intends is what the other understands. It is also important to ensure that both verbal and nonverbal information are communicated. Interpretation is complex and, as such, requires practice for skill development as well as a thorough grasp of both languages.

Problems can occur when untrained interpreters are used. Some problem areas are a lack of familiarity with psychiatric terms or with counseling knowledge and attitudes. Other problems are more specific and include distortion, deletion, omission, and a lack of corresponding words between languages. By taking the following steps, providers can proactively help themselves:

- Contract with an agency to provide interpreters who are trained and have had their language skills assessed;
- When accepting a client referral, establish which languages the person speaks and their skill level—limited English proficiency (LEP) patients speak enough English to do day-to-

day activities, but lack the English skills required to express themselves adequately in specialty medical settings;

- Schedule an interpreter for the first appointment; and
- Spend time building rapport between yourself and the interpreter and the interpreter and the client.

During interpreted sessions, mental health providers should utilize a strategy that supports the primary relationship between them and the patient. The strategy should include:

- Talking directly to and maintaining eye contact with the patient, while speaking in first person (e.g. I would like you to tell me about the time when...);
- Speaking in a natural tone and volume, and keeping speech evenly paced;
- Pausing often (after three or four sentences) so that the interpreter can translate what he or she hears (known as consecutive interpreting);
- Avoiding idioms and jargon—speak in plain language; and
- Planning for more time, as an interpreted session can take almost twice as long as a regular session.

Using a trained interpreter is the most appropriate choice for the provider's translation needs; however, because mental health interpretation is an emerging field, a supply of trained mental health interpreters may not be available. Spending the time in advance and offering training on specific vocabulary would help the flow of the session considerably. Training translators to perform interpretation in a medical set-

ting is becoming more common throughout the United States; partnering with an agency to offer mental health training would increase the mental health community's capacity to care for LEP clients who require translation services. Common mistakes the provider must avoid are:

- Using a family member, friend, or minor child to interpret;
- Using colleagues who are not trained as interpreters—such as secretarial, custodial, or domestic staff; and
- Not offering an interpreter free-of-charge, as per Title VI responsibilities.

In conclusion, the provider has a vested interest in talking with and listening to the client and their concerns. A trained interpreter, familiar with the concepts and practiced in the skills of interpreting, is an essential member of the team when providing services to LEP clients. Providers must also play their part by facilitating access to the interpreter and understanding how best to work with the interpreter.

Elaine Quinn is Manager of Cross-Cultural Programs and Refugee Health Screening for the Texas Department of Health. Prior to joining the Department, she opened a refugee health-screening clinic in Austin, Texas. Her email address is: Elaine.Quinn@tdh.state.tx.us. ■



ANNOUNCEMENTS

SAVE THE DATE: *The National Alliance for Multicultural Mental Health* will be holding its next annual conference **in Atlanta, Georgia, June 7-11, 2002**. The Bridging the Gap Project will co-host the conference. Watch for more information on the IRSA website: www.refugeesusa.org. If you would like to be on a mailing list for additional details as they develop, please contact emercer@irsa-uscr.org.

This conference follows the very successful one held June 4-6, 2001 in Galveston, Texas on the theme: "Local Heroes: Supporting Refugee Resilience and Adaptation." Some of the topics covered were: Bicultural Caseworkers as Mental Health Providers, Domestic Violence, Long-Term Alternatives for Refugees with Serious Mental Illnesses, Outreach Strategies, Funding Issues, Working with HIV+ Refugees and Their Families, Caring for the Caregiver, Needs of Older Refugees, Model Services for Detained Asylum Seekers, and Innovative Methods of Working with Survivors of Torture and Extreme Trauma. The evaluations indicated that the conference subjects and presenters were very well-received and appreciated, and scores were very high. One concern repeatedly mentioned was the need for more time since there is so much to learn. To that end, the 2002 meeting will begin with a one-day "Institute" with simultaneous in-depth training sessions for those who want to participate for an extra fee.

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The *National Alliance for Multicultural Mental Health* offers expert technical assistance through:

On-Site Training and Consultations tailored to each agency's needs. Topics have included:

- Refugee mental health
- Cultural backgrounds of newly arrived groups
- Integrating resettlement and mental health services
- Innovative approaches to working with special populations:
 - Children and adolescents
 - Refugee women
 - Older refugees
 - Survivors of torture and extreme trauma
- Addressing family conflict
- Models for using interpreters
- Working with the schools
- Community approaches to mental health
- Working with natural support systems and indigenous healers
- Creative therapeutic approaches using the arts and media
- Spirituality and mental health
- Stress management and self-care for service providers

Community Workshops aim to increase communication and coordination among refugee-serving agencies in communities. IRSA and its partners will work closely with your agency to organize a workshop, tailoring it to agency and community needs.

National Training Conferences—Local and national service providers and experts in the field offer sessions crafted to participant needs. These gatherings have proved an excellent opportunity for networking, sharing experiences, and learning from one another.

Best Practices Documents have been and are being prepared on a number of subjects, including "Lessons from the Field: Issues and Resources in Refugee Mental Health" and "Mental Health and the ESL Classroom," currently on the IRSA website: www.refugeesusa.org. Additional documents are in preparation and will be announced in future newsletters.