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

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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

- 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

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 interpretation 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

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 some-

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

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 Deaf Wellness 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 mental 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

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 URMC 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. URMC's tax ID number is 16-0743209. Orders and correspondence should be sent to Dr. Robert Pollard, URMC 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

Pollard, R. Q. (1998). A consumer interview seminar that enhances medical student attitudes toward persons with disabilities. *Journal of Behavioral Science in Medical Education, 5*(1), 27-31.

Pollard, R. Q. (1996). Professional psychology and deaf people: The emergence of a discipline. *American Psychologist, 51*(4), 389-396.

Robert Pollard is an Associate Professor of Psychiatry (Psychology) at the University of Rochester School of Medicine. There, he heads the Deaf Wellness Center, home of numerous initiatives pertaining to healthcare, mental health services, and professional education opportunities for people who are deaf or hard-of-hearing. His email address is: Robert_Pollard@URMC.Rochester.edu. ■

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

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 ■

By Wawa Baczynskyj, LICSW,
Coordinator, Massachusetts Association for Mental Health
Refugee and Immigrant Committee

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

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 burnout 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.

Wawa Baczynskyj, LICSW, is the Coordinator of the Massachusetts Association for Mental Health Refugee and Immigrant Committee. Her experience in cross-cultural counseling includes training, curriculum development, consultation, 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. ■

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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.