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An Introduction to Mood Disorders for Interpreting

Clinicians around the world use the Diagnostic and Statistical Manual of Mental Disorders (DSM –IV-TR) as a guide to assess a patient so that there is consistency in the understanding of the many possible diagnoses. The process of diagnosis is based on a prevalent symptom(s) or behavior (s) observed and described by the patient's family and or clinician. So if a patient reports having lost significant amount of weight with no positive medical condition and states that she is forgetful, feels hopeless and worthless, a clinician is going to give her a differential diagnosis of a mood disorder. So a cluster of symptoms (weight, memory impairment, low self- esteem) serve as an anchor for more needed assessment and observation and a process of elimination so that clinicians can reach a diagnosis. Literally a clinician draws a differential diagnosis tree with yes and no symptoms and then begins to rule out disorders that do not apply.

Besides the cluster of symptoms, it is important to understand the age of onset, precipitant for change, length and family history related to potential diagnosis, and type of impairment one may have regarding love, family and work history. These are all important factors in combination with the patient's information, clinician's observation of patient's general appearance, speech, emotional state, thought process, sensorium and mental capacity and ability to show insight and judgment.

Mood disorders are so prevalent in our society that often one lives with the symptoms, does not feel good about oneself, may have some impairment, but this impairment may not feel serious enough to seek out treatment. Often, patients without severe impairments, without psychotic thinking, or without active suicidal ideation or history of attempts, see their providers at out-patient care facilities for medical symptoms that they "feel," but later these "felt" symptoms turn out to be not validated as medical conditions. This can be a source of discontent between the provider and the patient where the patient keeps saying:

"I know it is not in my head, I have these symptoms!"

Common psychosomatic symptoms are heart palpitations, fear of having a malignancy, headaches, and vague aches and pains all over the body. According to the National Health Statistics Reports Number 8 August 6th 2008, a large number of patients who seek help through emergency and ambulatory care seem to suffer from some type of mood or affective disorder. It is common for a person who suffers from a mood disorder to exhibit a few or all of the following symptoms:

- Feelings of hopelessness and/or pessimism
- Feelings of guilt, worthlessness, and/or helplessness
- Irritability, restlessness, elevated, expansive mood
- Loss of interest in activities or hobbies once pleasurable
- Fatigue and decreased energy
- Difficulty or impaired ability concentrating, remembering details, and making decisions

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- Insomnia, early-morning wakefulness, or excessive sleeping
- Significant weight loss or gain (overeating, or appetite loss)
- Thoughts of suicide, suicide attempts
- Persistent aches or pains, headaches, cramps, or digestive problems that do not get better, even with treatment

Within the mood disorders category, interpreters seem to be more exposed to patients who suffer from Dysthymia, which is a form of depression that has daily symptoms that have lasted for more than two years. These patients present with: poor appetite or overeating, insomnia or hypersomnia, fatigue, low self-esteem, impaired concentration and or feelings of hopelessness.

The distinction between **Dysthymia** and **Major Depression Disorder** is not always easy to make because these patients share very similar symptoms. In the case of Dysthymic disorder, symptoms last for at least two years and they seem less severe, and often times patients do not even notice their symptoms. With Major depressive disorder, a patient may have at least five of the symptoms listed above, plus they need to be present for at least a two week period. Also for it to be diagnosed a patient may have either one of the following symptoms: 1- a depressed mood, 2- or loss of interest or pleasure. (DSM IV-TR, page 356).

A common mistake made by a non-mental health trained interpreter is that of confusing Bipolar Disorder with Borderline Personality Disorder. A person may be Borderline and have a Bipolar illness but they are not the same. In general a Bipolar Disorder includes episodes of mania, euphoria, grandiose thinking and episodes of hypomania, with great feelings of "down," or feeling depressed. They can happen in a mixed form or by very distinct periods and features. Often, patients need to take medications for this condition besides the talk therapy. A Borderline Disorder is categorized differently and it is not a mood disorder! It is understood and described as a disorder when a patient has difficulty living with grey areas, emotions, feelings. When faced with conflict, a patient who may over idealize a relationship may drastically reject it, and may never find a balance in this relationship. This is a person who lives with extremes, whether it is love, hate or anger. Most people may feel upset if rejected or misunderstood, but borderline people have difficulty negotiating ambivalence and they may react in a gut driven overwhelming way. Through treatment a clinician helps the patient to connect their thinking with their heart, and gut, so that they may form a balanced approach to fear, and misunderstanding. In general, patients with this diagnosis seem to create an environment where there is a lot of blame and division among care givers, so interpreters need to be cognizant of this dynamic and share this feeling with the primary provider if it ever arises, because it may help with a diagnosis.

Although, both disorders are not the same, they can show similar features with patients who abuse substances and who are also depressed or euphoric as a result of a drug. So part of the differential diagnosis for mood disorders is to make sure that the patient is not abusing substances or has a history of a dual diagnosis, having a substance abuse and a mood disorder or a character disorder. As a result, dual diagnosis is a common concept among patients who abuse substances and have another diagnosis. Some patients if under the influence of drugs or withdrawing from them, may show borderline features such as:

- Frantic efforts to avoid real or imagined abandonment
- A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
- Identity disturbance: markedly and persistently unstable self-image or sense of self
- Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating)
- Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
- Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
- Chronic feelings of emptiness
- Inappropriate, intense anger or difficulty controlling anger

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(e.g., frequent displays of temper, constant anger, recurrent physical fights)
- Transient, stress-related paranoid ideation or severe dissociative symptoms

Copied from: http://psychcentral.com/lib/2007/symptoms-of-borderline-personality-disorder/

Interpreters that have been introduced to the clinical insight of differential diagnosis and clusters of symptoms that make up a disorder, need to be aware that we all have some of these symptoms and at times and it is the intensity, the type of impairment and the length that really turn these symptoms into a diagnosis. So avoid diagnosing yourself, your loved ones and most importantly the patients you are interpreting for. We hope that understanding some of the assessment dynamics will provide the interpreter with the ability to navigate through a mental health session, so that they will only have to worry about conveying a complete and accurate message and not have to struggle with understanding what patients and providers may be thinking.

Bibliography:

American Psychiatric Association. 2000. Diagnostic and Statistical Manual of Mental Disorders. (DSM- IV-TR). American Psychiatric Association, Washington DC.

http://www.cdc.gov/

http://psychcentral.com/lib/2007/symptoms-of-borderline-personality-disorder/

VOCABULARY

An Introduction to Mood Disorders for Interpreting

Adjustment Disorders	The development of emotional or behavioral symptoms in response to an identifiable stressor (such as immigrating to a new country, marriage, life changes and more), occurring within three months of theonset of the stressor(s).
Affective Disorder	A mental health category also known as mood disorder, characterized by problems that include depressive disorders. An individual may feel too down or overly elated, happy.
Agoraphobia	Fear of the outside space, or an anxiety disorder related to the fear of having a panic attack when one is in an open space. Also a Greek word that literally means "fear of the marketplace."
Amenorrhea	No menstrual periods.
Anorexia Nervosa	An eating disorder also called anorexia. An individual develops a distorted image of his/her body. Shows an intense preoccupation with gaining weight and most likely is 85% under weight.
Asperger's Disorder	One type of pervasive developmental disorder that is characterized by severe and sustained impairment in social interaction and the development of restricted, repetitive patterns of behavior, interests, and activities
Attention-Deficit/ hyperactivity disorder (ADHD):	A behavior disorder, usually first diagnosed in childhood, that is characterized by inattention, impulsivity, and, in some cases, hyperactivity.
Bipolar Disorder	A mental illness that causes extreme mood swings, also known as manic depressive disorder. An individual may feel very happy, over friendly, overspends, and over exposes one's body and soon may feel depressed, not able to get up in the morning, shows suicidal thoughts and behaviors.
Conduct Disorders	(Behavior disorders) A group of childhood/adolescent disturbances of repetitive and persistent antisocial activities that violate the rights of others.

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Delusions	A perception that is thought to be true by the person experiencing it, although the perception is wrong. A constructed belief system that is not based on reality. "I am the president of the Unites States"; this is called a grandiose delusion. A persecutory one is: "I know the FBI is after me". There are many different types of delusions.
Depression	a mood disorder characterized by extreme feelings of sadness, lack of self-worth, and an inability to cope with daily activities, such self grooming, feeding, work and social activities, sleep disorder and more.
Dementia:	Deterioration of intellectual functioning and personality changes due to physical causes as in Alzheimer's and Parkinson's Disease.
Dissociative Disorders:	A group of disorders characterized by alterations, typically sudden in onset and of temporary duration, of the normally integrated functions of consciousness or identity. Individuals who have suffered intense abuse, may develop this disorder as they way to cope with the abuse. For example, often therapists hear the stories of children who when at the moment of being abused, looked up at the ceiling and imagined watching one of their favorite TV shows. This dissociation is a defense mechanism that becomes more permanent.
Dysthymia:	A type of an affective disorder or mood disorder that may be less severe, but yet more chronic than the clinical depression. Individuals with dysthymia may also experience major depressive episodes at times.
Eating Disorders:	A group of disorders in which there are significant disturbances in eating. Two common examples are Anorexia Nervosa, a refusal to maintain an acceptable body weight for one's age and height; and Bulimia Nervosa, uncontrollable binge eating which may be followed by purging or forced throwing up of food. Individuals may induce vomiting, take laxatives or diuretics.
Endorphins:	Chemicals in the brain which are responsible for positive moods. Chocolate is known for having a great amount of endorphins.
Generalized anxiety disorder (GAD):	A mental disorder characterized by chronic, excessive worry and fear that seems to have no real cause. Children or adolescents with generalized anxiety disorder often worry a lot about things such as future events, past behaviors, social acceptance, family matters, their personal abilities, and/or school performance. For example, a child might not want to go to school for fear of losing his mother or being hit by a car.
Hallucinations:	A strong perception of an event or object when no such situation is present; may occur in any of the senses (i.e., visual, auditory, gustatory, olfactory, or tactile). A false sensory perception without a concrete external stimulus. For example an individual hears voices telling him that he needs to "take a shower."
Identity:	Self-knowledge about one's characteristics or personality; a sense of self.
Incest:	Sexual relationships among family members.
Illusion:	False perception and misinterpretation of an actual sensory stimulus. This may occur individually, as part of and involving the family unit, and/or in a group setting. (is this correct?)
Insight:	Conscious awareness and understanding of an individual's own psychodynamic. An example is an individual that after complaining of serious headaches arrives to the conclusion that his/her headaches are a way for him/her to stop a stressful relationship with a boss who is abusive.
Insomnia:	A pathological inability to sleep.

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Learning disorder: Learning disorders are characterized by difficulties in an academic area, either reading, mathematics, or written expression, such that the child's ability to achieve in the specific academic area is below what is expected for the child's age, schooling, and level of intelligence.

Major depression: Classified as a type of affective disorder (or mood disorder), that goes beyond the day's ordinary ups and downs, and has become a serious medical condition and important health concern in this country. A person notices major changes in their sleep, eating, work and social habits. S/he develops a lack of "gusto" for life.

Mania: A mood disorder which may be characterized by extreme elation, impulsivity, irritability, rapid speech, nervousness, distractibility, and/or poor judgment.

Obsessive-compulsive disorder (OCD): An anxiety disorder in which a person has an unreasonable thought, fear, or worry that he/she tries to manage through a ritualized activity in order to reduce the anxiety. Frequently occurring disturbing thoughts or images are called obsessions, and the rituals performed to try to prevent or dispel them are called compulsions. A common obsessive disorder is the need to wash hands more often that normal.

Panic disorder: Chronic, repeated, and unexpected panic attacks, bouts of overwhelming fear of being in danger when there is no specific cause for the fear. In-between panic attacks, persons with panic disorder worry excessively about when and where the next attack may occur.

Personality Disorders: Refers to habitual ways of seeing and relating to self and the environment that are so fixed and rigid as to cause a significant degree of personal distress, and limits the individual's ability to effectively cope with the day-to-day demands of life's situations.

Phobia: An uncontrollable, irrational, and persistent fear of a specific object, situation, or activity.

Post-traumatic stress disorder (PTSD): A flash back, a feeling, image, or experience that was dormant (a terrifying physical or emotional event or trauma causing the person who survived the event to have persistent, frightening thoughts and memories) in one's conscious, that is awakened and characterized by an intense anxiety. Persons with PTSD often feel chronically, emotionally numb. It is a common feeling among people who were exposed to a violent incident.

Self-esteem: Feelings about one's self.

Suicidal attempt: Actions taken by one who is trying to end his or her own life.

Suicidal ideation: Thoughts of suicide or wanting to take one's own life.

Suicide: The intentional taking of one's own life.

Transference: Unconscious event or experience in which the feelings, attitudes and wishes that were experienced in an individual's early life are now projected onto others. The transference can be of a positive or negative nature. For example: you had a teacher that was not very respectful of you, thus invoking feelings of anger. Now, as an adult, you met someone that reminds you of that teacher, or you are in a similar dynamic and you begin to have negative feelings towards the person.

PRESIDENT'S CORNER

Dear Interpreter and Colleagues:

Please join the nation in its effort to work on identifying, assessing and treating those in need of Mental Health Services. In 2006, the Substance Abuse and Mental Health Services Administration's (SAMHSA) dedicated May as Mental Health awareness month. This effort helps promote "positive youth development, resilience, recovery, and the transformation of mental health services delivery for children and youth with serious mental health needs and their families."

The work of a qualified interpreter is always essential in any encounter but the presence a of a trained face to face mental health interpreter is crucial in a mental health encounter. The interesting challenge is that in fact it is not so easy to separate how the mind affects the body and vice versa. Therefore a great majority of medical encounters in fact include some kind of mental health assessment. Patients come in with all kinds of psychosomatic disorders; they do not even know that there is a psychological component to their "real" physical symptoms.

...A GREAT MAJORITY OF MEDICAL ENCOUNTERS IN FACT INCLUDE SOME KIND OF MENTAL HEALTH ASSESSMENT.

According to the Minnesota Department of Mental Health, "Mental disorders are common in the Unites States, affecting 1 in 2 Americans every year. Approximately 44 million adults and 13.7 million children experience a diagnosable mental disorder each year." Diagnosable mental disorder means that there exists an impairment that can be linked to a mental disorder.

The impact of immigration and the struggles that many of our immigrant LEP (Limited English Proficiency) population go through are very difficult, and as a society we compound these challenges by many times sending them mixed messages. For example, on the one hand we welcome newcomers and yet on the other, we often see them as a burden, a challenge, or a threat. We as a society value those who can communicate efficiently and assertively. This essential skill is not always present in our LEP population and especially for those who suffer from a mental health disorder. There are so many parallels that one can make between LEP individuals and Mental Illnesses. Many of these individuals often feel stripped of their dignity, or powerless as opportunities become closed off to them or their voices become muted, all because they speak a foreign language!

Interpreters who are working or want to be trained as Mental Health interpreters need to understand how mental illness has impacted them personally, because if it impacts one out of two Americans, it has impacted all of us directly or indirectly. Let's look into ourselves and understand our fears, our frustrations, our assumptions and then later on do research so that we can develop a greater understanding of all the voices trying to assist those who suffer from a mental illness.

An interesting facet of mental health interpreting is that interpreters find that mental health providers are more available for pre and post session interviews. Having these few minutes available in fact makes the interpreter work go smoothly and assures the interpreter that although s/he is not a clinician one can play an important role in effective communication.

If an interpreter feels respected as an integral part of a team of professionals caring for a LEP patient, then all the challenges one may perceive become opportunities for personal and professional growth. There are some mental health disorders, when a patient is decompensating, showing some psychosis or is under the influence of a substance or withdrawing from a drug, where interpreters may feel challenged regarding their comfort zone as human beings and accurate interpreter. But contrary to many myths regarding mental health interpreting, it should not be viewed as dangerous. That being said, a patient may not be aware of breaking space boundaries and may get too close to an interpreter or may make personal remarks about one's appearances or how one feels. Also, patients may sometimes speak lacking logic, or speak too fast, or have slurred speech, making it impossible for the interpreter to work on the consecutive mode. There may be instances that a patient's suffering or a story share may awaken sleeping feelings or thoughts on an interpreter.

There may be times where an Alzheimer's patient who is being assessed for safety competency may kindly ask for the interpreter's help with the words and tasks asked of him/her and the interpreter can only interpret the request but can not assist with the request. These are all challenging situations that trained mental health interpreters will be able to manage and grow from.

Understand that all rules that you have learned about consecutive interpreting and managing the flow of the session as an interpreter may not apply to all mental health situations or settings. An interpreter is not going to encourage eye contact between patient and provider during a mental health session or is not going to ask a patient who speaks in word salads to stop speaking and explain what he or she is saying. But an interpreter will not be intimidated if s/he understands that there are patients who speak by using word salads and that the interpreter needs to convey that spirit as accurately as possible to the provider by using perhaps the simultaneous and summarization mode of interpreting. It takes understanding oneself as a person an as a professional interpreter to be able to convey a full, accurate message in any encounter and in particular when working with mental health patients!

When you get a few minutes we encourage you to look over some of the following websites:

www.samhsa.gov is excellent for explaining the challenges that face individuals who suffer from substance abuse and mental disorders.

The website found at www.cdc.gov provides ample information so that you can understand the clinical thinking behind mental health assessments and treatments.

You can look into the voices of the patients and consumers and their families and loved ones by checking out www.nami.org.

UPDATES FROM INTERPRETER RESOURCE & Q.A DEPTS.

It has been a very busy year so far! As the profession continues to be refined, we strive to make the necessary adjustments in order to remain one of the leaders in quality interpretation and translation. This not only involves keeping up with new laws and regulations but also includes foreseeing the probable future demands that go along with the profession. Here is an outline of some of our goals and adjustments.

Our first goal was to change the status of our pool of interpreters from Freelance Interpreters to Per Diem Employees and we successfully completed this goal.

Our next goal was to create a more rigorous hiring and screening process. We already had in place a very good hiring process for interpreters, but we wanted to make some improvements. In the past, applicants were required to take a written exam which included translating more than 280 comprehensive medical terms into their target language. We also assessed their language proficiency through the use of role plays, and measured performance against industry standards, such as those outlined by the American Society for Testing and Materials (ASTM) and the American Council on the Teaching of Foreign Languages (ACTFL).

But, since the interpreting profession is changing and more demands are being made of interpreters and companies like ours, we decided to create two new written exams. One of the new exams we include in the application package and the other one that is conducted at our face-to-face interview with the applicant. The new exams have a total of 520 questions including quizzes. An important feature of the exam is the portion that pertains to such subject matters as ethical, moral, cultural and professional interpreting standards and Codes of Ethics as presented by NCIHC, IMIA, and CHIA.

We also review general knowledge of anatomy and terminology in the following areas: medical, common diseases, immunizations, pathology, symptoms, conditions, laboratory, tests, diagnostic/ treatment procedures, medical supplies, treatments, mental health disorders, general vocabulary and idiomatic expression. We continue to use the oral proficiency assessment as stated above and we also assess their sight interpretation skills.

We also made some changes to our 8 Hour Interpreter foundation assessment seminar. This is the Final Assessment; during this assessment CCCS reviews the guidelines and policies (including dress code), conducts role-plays, and discusses ethical, moral, cultural and professional interpreting standards and Codes of Ethics as presented by NCIHC, IMIA, and CHIA.

Another topic covered is hospital safety standards which help our clients meet The Joint Commission's requirements for training contracted staff. Some of the topics discussed include fire safety, hand hygiene, blood borne pathogens and emergency codes. This program concludes with a final oral screening and analysis of skills.

This hiring process is a long and extensive process; but CCCS is very proud of its high standards and on-going trainings which ensure that our interpreters are current and up-to-date in the emerging interpreting profession.

Lastly on a different note, we would like to mention that we recently started our on-going shadowing program, where we observe the interpreters during their interpreting sessions. The shadowing evaluations include areas of improvement, concerns and positive feedback to our interpreters and clients. These visits have been a great experience and have proven to be very successful, as we use our evaluations as a tool to provide on-going support to both our interpreters and clients. It takes a team to build a future.

Sincerely,

Amanda Duross
Director, Interpreter Resources.

Preparing for the Joint Commission's New and Revised Hospital Elements of Performance in Support of Language and Culture

The Joint Commission has for many years researched and written about hospital quality improvements recognizing how important the area of effective communication is to both the patient and provider and at the same time this helps to ensure patient safety. Based on years of research data and studies, The Joint Commission identified several important key elements that would advance "individual–centered care," and approved new and revised hospital standards to support language and culture as an effective means of advancing communication.

As a result, the Joint Commission with funding from the Commonwealth Fund developed "Hospital Standards to Advance Effective Communication, Cultural Competence, and Patient- and Family-Centered Care." The new and revised elements of performance (EP) standards include issues of diversity, culture, language and health literacy. For example, included in the new and revised elements of performance (EP) are the relevant components of effective communication (language, cultural differences, hearing or visual impairments, health literacy, cognitive impairment, disease or disability) that would impact effective assessment and treatment. The following are the new and revised EP's addressing the following issues:

1. Addressing qualifications for language interpreters and translators (HR.01.02.01, revised EP 1)
2. Identifying patient communication needs (new PC.02.01.0X*, EP1)
3. Addressing patient communication needs (new PC.02.01.0X*, EP2)
4. Collecting race and ethnicity (RC.02.01.01, revised EP 1)
5. Collecting language data (RC.02.01.01, revised EP 1)
6. Patient access to chosen support (RI.01.01.01, new EP Y*)
7. Non discrimination in patient care (RI.01.01.01, new EP Z*)
8. Providing language services (RI.01.01.03, revised EPs 2 and 3).

The above information can be found in The Joint Commission Perspectives, January 2010, Volume 30, Issue 1 c 2010 Joint Commission on Accreditation of Healthcare Organization.

*X, Y or Z designations will be replaced by EP numbers which will be determined prior to final publication.

As an example of how the revised standards pertain to language interpreters, the standards for interpreters do not require the interpreter to be "certified" but rather meet the following criteria:

Qualifications for Interpreters: Standard HR.01.02.01

Elements of Performance:

1. The hospital defines staff qualifications specific to their job responsibilities.

Under the new and revised standards, Note 4: Qualifications for language interpreters and translators may be met through language proficiency assessment, education, training and experience.

In addition to new and revised standards, Amy Wilson-Stronks, principal investigator and project director for The Joint Commission Division of Standards and Survey Methods, has indicated that in collaboration with National Health Program, they have developed an **implementation guide** to provide guidance with "example practices and resources that have been found valuable in improving patient-provider communication." As indicated, the guide will provide additional resources and examples to support the efforts of stakeholders and will be will be available for downloading for free, from The Joint Commission's website at the end of May 2010.

According to the Joint Commission, implementation of the new and revised EP's will not occur in 2010, but will go into effect in 2011.

The above information is for information purposes only. To get additional information, specific dates and answers to other questions, visit The Joint Commission website at: www.jointcommission.org/patientsafety/hlc/

NH CORNER

We would like to extend a warm welcome to Dr. Trinidad Tellez, a New Hampshire family physician, as the new Director for the Office of Minority Health with the Department of Health and Human Services. Dr. Tellez, a graduate of the Dartmouth Medical School in New Hampshire, trained at the Salinas-UCSF Family Practice Residency Program and completed a two-year Robert Wood Johnson Clinical Scholars Fellowship in health services research and health policy at UCLA*.

Dr. Tellez will guide the DHHS Minority Health Office Diversity Task Force whose resposabilities include that of "increasing awareness of diversity issues and vulnerable populations in New Hampshire through collaboration, advocacy and education. The Diversity Task Force aims to promote a healthy environment for all individuals, families and communities and to mobilize internal resources, community partnerships and actions to identify and solve health problems."

DHHS Diversity Task Force has six over-reaching focus areas: Training and Development, Public-Private Partnerships, Work with Community-Based Organizations, Advocacy, Diversity and Cultural Competency, Work with other NH Government Agencies.

We at the New Hampshire Cross Cultural Communication Interpreter Training Institute (CCCI) (a department of CCCS Embracing Culture, Inc.) welcome Dr. Tellez as the new Director, Office of Minority Health, NHDHHS. CCCS/CCCI has been a strong supporter of the many efforts developed by the New Hampshire DHHS Office of Minority. Welcome Dr. Tellez to your new journey.

Lastly, we are excited to once again be offering The Art of Medical Interpretation in its intensive format in Nashua. Students will have the opportunity to complete the course in only 8 days, compared to the regular 15 weeks. For more information please contact Linda Demmons at 781-497-5066.

*From Lawrence Family Residency Biography page.

From the Accounting and Billing Dept.

In order to quickly process your forms and pay you in a timely manner we need to keep up to date your contact information in our records. We thank you for always sending us your most current contact information and for doing so in a timely manner. Just as a reminder though if any part of your contact information changes such as; name, address, telephone number, email address, please let us know as soon as possible because if our information on file is not the most recent then your check may not go to the correct address. These changes can be made by phone or fax. We also ask that you provide us with documentation showing the changes. Unfortunately, if you ask us to stop a payment that was already issued then you will be assessed a fee of $30.00. Thank you for help in this matter.

From the Interpreter Services Dept.

As professionals it is important to be organized, and in order to be a successful interpreter we need to take pride in every aspect of our work, not just the linguistic portion. By far the majority of our interpreters are organized and professional, but we would like to remind everyone of a few key components. We ask that when you accept an assignment that you take the time to write down all the key information regarding that assignment. Another thing to keep in mind is that professionalism is not demonstrated if we solely rely on the courtesy calls as a reminder that we have an appointment. As professionals we want our professionalism to be evident not just to our clients, or to our agency, but also to the institutions where we interpret.

Lately we have noticed that the volume of calls has gone up dramatically. Although this is very positive, it also means that we depend more and more on your cooperation in order for things to run smoothly. We thank the interpreters that faithfully send in their Service Verification Forms on time but there are still a few that tend to send them in late. As a reminder, as it says on the Service Forms they need to be mailed or faxed within 48 hours of having completed the assignment. We thank you for your hard work and your cooperation in this matter.

THE ART OF MEDICAL INTERPRETATION: 60-HOUR CERTIFICATE PROGRAM

Intensive Summer 2010 ($695 plus materials).....AMII0610MA
Ludlow, MA (Springfield area): June 3-5 and 7-11, 9 am – 5 pm (hours include orientation)

Intensive Summer 2010 ($695 plus materials).....AMII0610NH
Nashua: June 14 – 19 and June 21 – 22, 9 am – 5 pm (hours include orientation)

Intensive Summer 2010 ($695 plus materials).....AMII0610MA2
Brockton, MA: June 28 – July 1 and July 6 - 9, 9 am – 5 pm (hours include orientation)

Summer 2010 ($695 plus materials).....AMIE0710MA
Woburn: Tuesday and Thursday, July 6 – August 24, 6 pm – 10 pm
Orientation: Tuesday, July 6, 5 pm - 6 pm

Pre-requisites: Applicant must be at least 18 years of age, with a minimum of a HS diploma or GED, and must pass a mandatory screening examination in English and the target foreign language(s) prior to acceptance in the program. Applicants must pass the screening at a minimum of "Advanced Mid-Level" according to the industry standards. There is a $40 non-refundable fee for the screening examination.

As professional standards for interpreters evolve, here at CCCI we do our best to stay up to date. For this reason our well known course entitled CCCI Art of Medical Interpretation class has now expanded from Fifty-four (54) to sixty (60) hours. These additional hours allow for more in depth coverage of topics and more practice time for essential skills. The program targets interpreters at all levels and fosters an environment that gives each individual a measure of control over the learning process. Training sessions focus on interpreting technique, cultural competency, interpreting ethics, mastering medical terminology through the Samurai! method, developing specialized glossaries and increasing memory power. Learning is measured through role-play and interpreter evaluation tools. Class size is limited to 30 students and features spoken languages only. Language coaches will assist students develop target language glossaries through role-playing exercises. Language Coaches will be provided to groups of 3 or more interpreters working in each target language.

A new training manual supports the classroom work; The Art of Medical Interpretation was designed to accompany this course and includes over 875 pages of interpreter practice guidelines, medical terminology, disease information, exercises, diagrams, quizzes, and over 90 role-plays. It serves as a resource guide to best practices and terminology for interpreting and is also an essential tool for developing professionals after they complete the classroom course work.

The American Translators Association has approved the Art of Medical Interpretation 60-hour training program for 10 Continuing Education Points.

For more information contact: Linda Demmons
Email: Linda_contracts@cccsorg.com
Phone: 781-497-5066 Direct Line
Website: www.EmbrancingCulture.com

UPCOMING CONFERENCES:

May 19-22, 2010 ALC (The Association of Language Companies) Miami, Florida Intercontinental Hotel www.alcus.org

May 22, 2010 NETA: 14th Annual New England Translators Association Conference Exhibition

8:00 am-7:00 pm
Boston University, School of Management
595 Commonwealth Avenue
Boston , MA 02215

June 11-13, 2010 3rd Annual Southeast Regional Medical Interpreters Conference 2010 Charleston, SC

June 17, 2010 1st North American Summit: Interpret America, Washington DC www.interpretamerica.net

June 18-19, 2010, SEMIA/MING/TAPIT/TAMIT joint conference in Lexington, KY

Aug 5-7, 2010, NATI (Nebraska Association for Translators and Interpreters)
University of Nebraska at Lincoln East Campus
www.natihq.org

August 13-14, 2010 TAHIT (Texas Association of Healthcare Interpreters and Translators) Houston, TX

Sept 3-5, 2010, IMIA (International Medical Interpreters Association), Boston, MA