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A MENTAL HEALTH CLINICIAN'S PERSPECTIVE ON WORKING WITH AN INTERPRETER IN A CASE THAT WENT "WRONG"

I have been blessed to work as an interpreter in mental health settings. I am also a clinician who has collaborated with interpreters in the treatment of my own patients. Interpreters are often trained from an interpreter's perspective, and this article is a humble attempt to represent the **clinician's lens** when working with an interpreter in a mental health setting.

The presence of an interpreter is often perceived by the clinician as a mixed blessing. The clinician is thankful for the opportunity to communicate with the client, but the rush of worries soon begins: "Is my message being interpreted accurately? How am I going to work with a third person who is not a family member or a co-therapist?"

The physical presence of a third person in a mental health session changes the clinical dynamic. Thus, interpreters and providers need to reach a mutual understanding of roles and expectations before they meet with a client. The following is a clinical case of a volatile situation that occurred during an interpreted mental health session.

Presenting Problem

The clinician was called by the local school to cover for a colleague's client. Early that morning, the youngster had made remarks about wanting to burn someone with diesel, but expressed no specific target, date or time. This youngster was having **homicidal ideation** with a vague plan, but serious enough that the school or the clinic could not wait for the next day.

Mental Status on the day of the intervention

The youngster had, for some time, been in treatment for a reactive depression thought precipitated by immigration and family troubles. On the day of the emergency, however, the clinician noted some changes in the youngster. This information was gathered while meeting with the child and the school staff and reviewing prior clinical notes. In the past month, there had been new academic issues, such as failing grades and lack of completion of homework assignments. He was not seeking out his favorite teacher with the purpose of expressing his frustrations, as he had done so often in the past.

His affect was flat as he described waking up in the middle of the night, an absence of desire to socialize, and feelings of anger. He stated that he did not want to hurt anyone. He showed remorse over his impulsive behavior.

He was oriented in time place and person. He denied any delusions or

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hallucinations. His thoughts seemed congruent with his affect. He showed appropriate judgment when reflecting on the seriousness of his threat. He denied experimenting with substance abuse. He also denied any form of abuse by peers, family members and or teachers.

While waiting for the boy's parents to arrive, the clinician continued with the interview. Suddenly, the youngster disclosed that sometimes he felt he wanted to kill his father, but denied having a plan. He expressed a fear of going home, but denied any kind of abuse. He also denied having a weapon or access to a weapon.

The clinician told this youngster that he needed help and that together they would need to tell his parents about both his persistent sadness and the desire to kill his father. The boy requested that the clinician start this conversation.

Meeting with clinician, father and the interpreter

The father was already seated when the interpreter and clinician entered the room. The clinician began to disclose that the son seemed very sad and was having thoughts of hurting others. She then paused to wait for the father's reaction. The interpreter used this time to interpret the information. As the interpreter finished, the clinician continued to reveal that the son had expressed a desire to hurt the father. The father smiled and said that his wife was not able to come in and that he would prefer to have his son sent to a hospital outside the community in order to preserve the family's confidentiality.

HE WAS ORIENTED IN TIME PLACE AND PERSON. HE DENIED ANY DELUSIONS OR HALLUCINATIONS. HIS THOUGHTS SEEMED CONGRUENT WITH HIS AFFECT.

As standard procedure when evaluating a case where there is potential for volatile disagreement, the clinician told the father that when the son entered the room she would go over this information again with both of them and that although the father may feel upset, under no circumstances would he be allowed to hurt his son or anyone else in the clinic.

Meeting with clinician, client, father and interpreter

The son sat right next to the clinician, across from the father. The interpreter began to simultaneously interpret for the father as the clinician addressed the son in English. The clinician started the session by thanking both of them for agreeing to meet and by acknowledging that this may be a difficult time for both. At times, she explained, people ask for help in different ways. Our client had asked for this help and they had come together to support him through this time.

As the clinician started to introduce the discussion of sadness and homicidal thought, the father suddenly rose up and began to hit the son on his head. In a heartbeat, the boy maneuvered himself behind the clinician.

The clinician firmly told the father to leave the room, but the father kept coming towards the son and hitting him. When the clinician turned to ask the child to leave the room, she saw that his expression had changed. He foamed at the mouth. Then he put a knife to the clinician's neck.

The interpreter, worried for the clinician's safety, inserted herself between the clinician and the boy, where she became stuck. Finally, the clinician was able to get the interpreter out of this "sandwich" position and instructed her to run for help.

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As the interpreter ran, the clinician kept eye contact with the boy and repeated that he would be safe but that he could not hurt the therapist and that he needed to drop the knife. Simultaneously, the clinician ordered the father to leave the room.

The seconds seemed infinite. Eventually, the therapist was able to take the son out of the room while holding on into his hand with the knife. She locked herself with the boy in a room in which the father could not reach him.

Through police questioning, it became evident that the father had abused the boy over a period of time. The boy had to be hospitalized. The Department of Social Services became involved with the family.

Important clinical intervention in this treatment that may have been missed in the interpretation

This volatile situation was not the interpreter's fault. However, the outcome of the situation lends itself to reflection on the importance of the "clinical pause".

In her preliminary meeting with the father, the clinician made several clinical pauses while disclosing potentially painful information. The pauses are a technique for soliciting a reaction, and for allowing the assimilation of new information.

Looking back, the clinical pauses that would have existed in an English-only session were filled with the interpreter doing her job, interpreting. While the interpreter conveyed the clinician's thoughts, the clinician was so occupied with her next intervention that she did not notice the lack of silence.

It would have been helpful if both the interpreter and the clinician discussed the importance of the clinical pauses prior to the session. They might even have agreed on a simple gesture that the clinician could use to indicate the need for them. This case underscores the interpreter's need for clinical insight into the triadic encounter.

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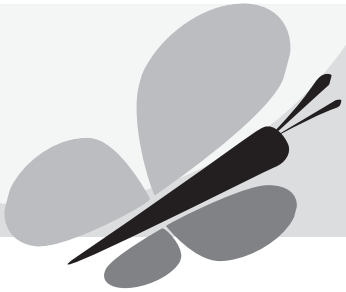
QUESTIONS TO RULE OUT DEPRESSION, SUICIDAL AND HOMICIDAL IDEATION

1. Tell me more about how you have been feeling.
2. How long have you been feeling this way?
3. Any changes in your life or health?
4. When do you feel like hurting yourself or others?
5. What do you about it?
6. Do you have plan?
7. Who knows about these feelings?
8. Have you ever acted on them?
9. What has stopped you from doing it?
10. Are you hearing voices?
11. What would you like me to do about these feelings?
12. Did you feel like this before?
13. What did you do?
14. What are you going to do when you leave this session?

If there is no plan just a feeling or ideation, client may be able to "contract", or promise not to act on the feelings, with very concrete steps of what to do and whom to call if the feelings occur. Clinicians will go over ideation and intent. When someone is clinically depressed they may have these feelings, the important piece is no to act on them. If homicidal ideation is towards a specific person, the clinician may have to report it to the "target" by following professional, state and federal guidelines.



MENTAL HEALTH VOCABULARY FOR INTERPRETERS

Affect - Facial expressions and gestures that represent feelings

Congruent - In accordance with

Delusions - False belief that is not part of a cultural or religious system. (For example, patient states, "I am the president".)

Depression - A mood disorder in which the patient feels worthless and/or extremely sad and shows significant changes in weight and appetite, as well as in daily and psychomotor functioning

Echoing - Repetition of words as a way to connect with the patient

Flat Affect - No facial expressions or gestures, usually with poor eye contact

Hallucinations - A false sensory perception absent an external precipitant

Homicidal Ideation - A feeling of wanting to kill someone

Insight - Ability to recognize and to express roots of problems

Presenting problem - Issues and concerns first presented by a patient

Rapport - The ability to connect (to trust) in a therapeutic encounter

Reactive Depression - Depression as a result of a major life event

Self-esteem - How one feels about one's own abilities and potentials

Suicidal Ideation - Thoughts of wanting to kill oneself

Therapeutic alliance - A therapeutic trust where the patient perceives the clinician as an important person in the process of healing

Understanding the clinician's thinking, tools for clinical interventions

In order to develop clinical rapport, the clinician first empathizes with the person or situation by repeating the words used by the client. This "echoing" of words and ideas allows the client to feel that he or she is being heard. It also allows clients to reflect on their own thoughts through another voice. This will allow the clinician to evaluate the client's "insight" or his/her ability to reflect by questioning personal thinking.

Clinicians are more active with their questioning when assessing an emergency situation, but an environment where trust is built is essential for a client's comfort with sharing intimate (sometimes scary) information. During on-going treatment sessions, clinicians are less active and there are more pauses and silences.

Clinicians working in potentially volatile situations strive to convey clear, precise messages in a calm, but firm, tone of voice. In the case mentioned above, as physical violence erupted, rather than maintain the calm demeanor of the clinician, the interpreter panicked.

Although violence is not always predictable, should the clinician have taken time to review with the interpreter the clinical pausing, appropriate body language and the special configuration of the session? When violence escalated, should the interpreter have left the room in search of help or physically

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intervened to "save" the clinician? These are all questions generally addressed by clinicians prior to co-therapy for potentially violent families. Regardless of the number of members on the treatment team, clinical literature refers to one leader, one "voice" in time of crisis, and this should that of the primary therapist in the session. So if therapist tells the interpreter to leave the room, he and she should do so, no questions asked.

In summary, the ability of an interpreter to mirror the therapist in her/his choice of words, their order of presentation, clinical pausing and demeanor is crucial to the success of triadic and group mental health sessions.

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This article was adapted from an article appearing in the Cross Cultural Communicator Vol. 7 (CCCS 2005), an article also published in the ATA Chronicle (2005).

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2007 INTERPRETER PORTFOLIO UPDATE

The January 2007 edition of the Communicator Express announced the CCCS system-wide Immunization Drive. All CCCS interpreters are required to submit proof of MMR vaccination and a yearly PPD (TB) test as a pre-requisite to ongoing work eligibility. In addition, interpreters are strongly encouraged to undergo vaccination against other communicable diseases.

We want to thank the interpreters to readily submitted proof of vaccinations. Your continued cooperation is evidence of your professionalism. CCCS did, however, receive a few calls from interpreters who question the need for vaccination.

The Massachusetts Department of Public Health's Bureau of Communicable Disease Control recommends that individuals with questions on adult immunizations talk to their doctor, nurse or clinic, or local board of health. In addition, the state Immunization Program can be reached toll-free at (888) 658-2850, or on the MDPH website at www.mass.gov/dph/. Protect yourself and the patients you serve by keeping your immunization record up-to-date!

TRAINING OPPORTUNITIES

CCCS has completed a revision of its **Medical Interpreter Foundations Training** manual and orientation program. All active CCCS interpreters contracted prior to 2007 will soon be required to attend an 8-hour interpreter reorientation session at CCCS Woburn or CCCS New Hampshire. Contact Gail Marinaccio, Interpreter Resources Associate, at gmarinaccio@cccsorg.com or 781-729-3736 x.106 to reserve your spot in the February or March sessions.

CCCS is committed to the ongoing education of its interpreter workforce. Coming Fall 2007, under the supervision of Medical Director Dr. Rick Lane, CCCS will host a series of one-day advanced skill workshops for interpreters at its Woburn and NH locations. Topics include:

- Interpreting in Pediatrics
- Interpreting in OB/GYN
- Interpreting End-of-Life Issues
- Advanced Note-taking for Interpreters

CCCS

cross cultural communication systems, inc.

PO Box 2308, Woburn, MA 01888
www.cccsorg.com | cccsinc@cccsorg.com
phone 781-729-3736 | 1-888-678-CCCS | fax 781-729-1217
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NEW RELEASES!

The Cross Cultural Communication Institute at CCCS has released two new provider-training videos, described below. To view video trailers, visit our website www.cccsorg.com.

1 Practical Tools for Working with a Limited English Proficient Patient Population – Vol. 1: Working with an Interpreter

More than 44 million people living in the United States speak a language other than English at home. Successful communication in the triadic encounter is possible, and there is much the provider can do to promote a therapeutic alliance and the wellbeing of each patient. In this 20-minute video presentation, we present providers with practical tools for working with a Limited English Proficient (LEP) patient population. This information can be used to anchor, partner and set the tone for the interpreted clinical interview and treatment session.

2 Meeting the Challenge of Delivering Culturally Competent Services – Vol. 1: Using Names as Tools for Communication

In this first installment of "Meeting the Challenge of Delivering Culturally Competent Services", we explore use of names as a key to improved communication with patients, students, employees and coworkers. This eye-opening 17-minute presentation outlines the linguistic and cultural implications of a name, and demonstrates how the few minutes it takes to master the pronunciation of a name will generate much in the way of better relationships in the workplace, schoolroom and healthcare settings.