Working With Foreign Language Interpreters: Recommendations for Psychological Practice

H. Russell Searight and Barbara K. Searight

Given the growing linguistic diversity in the United States, many practicing psychologists will work with foreign language interpreters. However, few clinicians receive formal training in providing interpreter-aided psychological services. By federal law (88th Congress, 1964; PL-88-352), psychologists or their agencies are responsible for providing interpreter services. To maintain a patient-centered, rather than interpreter-centered dialogue, psychologists should initiate pre- and postsessions to orient the interpreter to the pending encounter, clarify expectations, and discuss cultural issues. Psychological testing, diagnostic interviewing, crisis intervention, family, child, and individual adult therapy present distinct challenges when an interpreter is involved. Mental health is a specialized area requiring advanced interpreter knowledge and skills. According to the American Psychological Association's (2002) "Ethical Principles," psychologists are responsible for ensuring that interpreters demonstrate competence and professionalism. Because there are relatively few interpreters trained specifically for mental health practice, psychologists and health care institutions may need to assist in providing specialized interpreter education.

Keywords: foreign language translation, language proficiency, cultural differences, multicultural education, education

Currently, 18% of Americans speak a language other than English at home, with 8% of U.S. citizens demonstrating limited English proficiency (LEP; Brach, Fraser, & Paez, 2005; U.S. Bureau of the Census, 2003). Although working with LEP populations should be included in psychologists' multicultural training and education, there are few instructional resources for working with foreign language interpreters (Kennedy, Jones, & Arita, 2007) Providing psychological services through an interpreter raises linguistic, diagnostic, cultural, and ethical dilemmas (Kennedy et al.,

2007; Mailloux, 2004). Given the U.S. population's linguistic diversity, many practicing psychologists will work with interpreters without the benefit of graduate training or continuing education on the topic. Most existing literature addresses a specific aspect of psychological practice with interpreters such as psychological testing, psychotherapy, or ethical questions. The current article's purpose is to present an organized overview of relevant research, practice suggestions, and ethical recommendations on working with interpreters for both practicing psychologists and those in training.

Recent studies suggest that individuals with LEP experience higher levels of psychological distress (Bennett, Culhane, McCollum, Mathew, & Elo, 2007; Snowden, Masland, & Guerrero, 2007). Language is a significant barrier to accessing mental health services (Gong-Guy, Cravens, & Patterson, 1991; Snowden et al., 2007) outweighing ethnicity and health insurance status (Sentell & Shumway, 2004). Although many psychologists had formal education in a foreign language, it is usually inadequate for the complexities of clinical practice (Westermeyer, 1990). In addition, the recent influx of war refugees with psychological trauma from countries such as Bosnia, Afghanistan, and Somalia has increased the demand for interpreter-mediated mental health services. Among recently arrived Bosnian refugees in Chicago, 74% met diagnostic criteria for posttraumatic stress disorder (PTSD; Weine et al., 1998) with nearly 40% exhibiting significant symptoms 1 year later. Although there are bilingual psychologists conversant in French and Spanish, many recent immigrants speak languages such as Bosnian, Dari, or Somali not commonly taught in U.S. educational institutions nor widely spoken by nonnatives. In addition, even in states such as California with high concentrations of Southeast Asian refugees, there are a limited number of bilingual mental health providers (Gong-Guy et al., 1991; Sue & Sue, 1987). Interpreter-assisted diagnostic interviewing, psychological testing,

H. RUSSELL SEARIGHT received his PhD in clinical psychology from Saint Louis University in 1984 and his Master's in public health from Saint Louis University School of Public Health in 2002. He is currently associate professor of psychology at Lake Superior State University in Sault Sainte Marie, Michigan and sessional professor of psychology at Algoma University in Sault Sainte Marie, Ontario, Canada. From 1989 until 2007, he was director of behavioral medicine at the Forest Park Hospital Family Medicine Residency and clinical associate professor of community and family medicine at Saint Louis University School of Medicine. His research and scholarly interests include the practice of psychology in primary health care, medical ethics, and cultural diversity.

BARBARA K. SEARIGHT received her PhD in public policy and administration from Saint Louis University in 1998. From 1997 until 2008, she was executive director of the Saint Louis Office for Developmental Disability Resources in St. Louis, Missouri. She is currently an adjunct faculty member in political science and communication at Lake Superior State University and a sessional professor of psychology at Algoma University in Sault Sainte Marie, Ontario, Canada as well as executive director of North Star Habitat for Humanity. Scholarly interests include developmental disabilities, cultural diversity, and mental health policy.

CORRESPONDENCE CONCERNING THIS ARTICLE should be addressed to H. Russell Searight, Department of Psychology, Division of Social Sciences, Lake Superior State University, 650 West Easterday Avenue, Sault Sainte Marie, MI 49783. E-mail: hsearight@lssu.edu

and psychotherapy raise clinical, ethical, and diagnostic dilemmas while taxing psychologists' time and energy. Basic clinical questions may require reformulation for languages such as Urdu, often spoken by Pakistani immigrants, in which "anxiety" and "depression" do not have direct English equivalents (Tabassum, Macaskill, & Ahmad, 2000).

Legal Requirements for Interpretation

Title VI of the 1964 Civil Rights Act (88th Congress, 1964) prohibits discrimination based on national origin and guarantees access to linguistically sensitive health care services (Snowden et al., 2007). Individuals cannot be denied access to education, health care, or legal services because they do not speak English (Ku & Flores, 2005). Some states have developed "threshold" standards to determine whether an agency must provide interpreter services. (Snowden et al., 2007). In regions following this principle, interpreters are required if 5% or more of the agency's client population is non-English speaking.

Although these standards are infrequently implemented, providers remain responsible for securing interpretation services. Although interpreter access is a federal requirement, funding is inconsistent. Approximately 10 states pay for health care interpreters through Medicaid (Ku & Flores, 2005) with few private insurers covering language services. Typically, the psychologist or their institution bears the cost of professional interpreters. However, federal and state enforcement is rare, and clinics and hospitals often rely on untrained staff such as bilingual records clerks or relatives accompanying the patient. In medical settings, accurately interpreted patient encounters are associated with fewer diagnostic tests (Hampers & McNulty, 2002). Thus, there is hope that more private and government insurers will soon cover professional interpreters.

Interpreter error is a form of medical negligence. In a frequently cited case, a court awarded a $71 million settlement stemming from a paramedic's misinterpretation of the Spanish word, *intoxicado*, as "intoxicated" rather than "nauseated." The young male patient was in drug abuse treatment for several days while a ruptured brain aneurysm went undetected (Harsham, 1984).

Interpretation Versus Translation

The terms *interpreter* and *translator* are often used interchangeably but actually refer to distinct activities. Translation typically refers to converting written text from one language to another whereas interpretation involves a similar process with spoken language (Herndon & Joyce, 2004). Skilled interpreters go beyond literal wording and include attention to idiosyncratic meaning, accompanying nonverbal communication, and the cultural significance of spoken communication (Herndon & Joyce, 2004).

Varieties of Interpretation

Proximate Versus Remote

Interpreters may be proximate or remote. Proximate interpreters are physically present in the room with the clinician and patient. Ideally, they should be present for the entire encounter. In large, busy practices, interruptions often occur when the number of interpreters for a particular language is limited and the interpreter is summoned to another clinical encounter.

Remote interpretation is usually through a telephone-based service. Companies such as AT&T and Cyracom Transparent Language Services provide interpreter access through speakerphones or a headset with a microphone. Telephone interpretation is often expensive (up to $270.00 per hour) and there is no guarantee of an interpreter with knowledge of medical or mental health terminology A more recent development in some hospitals and clinics is the availability of live videoconferencing capabilities (Paras, Leyva, Berthold, & Otake, 2002). Psychologists seeing a non-English speaking patient over multiple visits should be aware that the same remote interpreter may not be available for each encounter. Although remote interpretation may frequently be the only practical option, available survey data suggest that health care providers prefer onsite interpreters for patients with psychological problems (Paras et al., 2002).

Simultaneous Versus Sequential

Interpretation may follow one of two conversational styles. In sequential interpretation, each person finishes a sentence or short sequence before their verbalizations are interpreted. In the simultaneous approach, often heard on broadcast media, the interpreter speaks concurrently with a slight time lag. Psychologists may find the simultaneous approach to be more time efficient but may experience difficulty concentrating with two people speaking concurrently.

Research on Interpreter Accuracy

Although limited, research in medical settings comparing trained and untrained interpreters have suggested that formal training does improve accuracy. Flores (2005) found that untrained interpreters misinterpreted or omitted up to 50% of physicians' questions. However, although formal education reduces mistakes, trained interpreters still make significant errors. In pediatric emergency department visits, Spanish-language interpreters made an average of 31 errors per patient encounter, with 63% of these mistakes potentially impacting diagnosis and/or treatment (Flores et al., 2003).

Full-time hospital interpreters made slightly fewer clinically significant errors (53%) than untrained interpreters (77%; Flores et al., 2003). Regardless of interpreter training, the most common error is omission of information with between 25% and 50% of physicians' questions not interpreted (Ebden, Carey, Bhatt, & Harrison, 1988).

Although the limited quantitative studies demonstrated conflicting patterns, interpreter errors are probably more common in mental health than in medical encounters (Flores, 2005). Interpreters over identifying with patients may minimize psychiatric symptoms whereas less culturally sensitive interpreters may exaggerate distress—particularly psychotic symptoms (Marcos, 1979; Sabin, 1975). Spanish-speaking patients, when interviewed in English, were perceived as functioning at a lower intellectual level and as exhibiting more psychotic symptoms than when assessed in their native language (Marcos, 1979; Olfson et al., 2002). However, among a group of Mexican American patients with schizophrenia, psychotic symptoms were more pronounced when interviewed in

Spanish (Oquendo, 1996; Price & Cuellar, 1981). Appropriate treatment has been delayed when medical problems were misdiagnosed as mental health conditions. A Spanish speaking patient exhibiting visual and auditory hallucinations, initially interviewed with a family member as an interpreter, was hospitalized in a psychiatric unit. Two weeks after discharge, the patient's symptoms worsened. After a second interview in Spanish, a pituitary tumor was found to be causing the hallucinations (Rueda-Lara, Buschert, Skotzko, & Clemow, 2003).

Working With an Interpreters: General Principles

The Presession

Particularly if working with a new interpreter or client, a brief presession with the interpreter is indicated. Obtaining the correct pronunciation of the patient's name facilitates rapport between psychologist and client. "Confidentiality" may have different meaning for the interpreter than the psychologist. Because ethnic communities are often small and because personal privacy reflects the norms of an individualist rather than collectivist culture (Sue & Sue, 1987), psychologists should be clear about confidentiality expectations and dual relationships. At a basic level, the psychologist should verify that the interpreter does not know the client socially (Miletic et al., 2006).

If the interpreter is previously unknown to the psychologist, answers to queries about certification, professional background, and prior training and/or experience working with psychologists will be helpful. The psychologist should briefly describe their plan for conducting the session and orient the interpreter to any testing procedures, interview protocols, or psychotherapeutic techniques that may be employed as well as any sensitive issues that may be raised such as suicidal ideation or abuse history (Farooq & Fear, 2003).

A fundamental principle guiding the encounter is that the interpreter, although sensitive to cultural issues, should not become a more central figure than the clinician or patient. This 1:1 interaction is facilitated by an appropriate seating configuration (Miletic et al., 2006; Westermeyer, 1990). A common configuration is with the interpreter seated beside, but slightly behind the patient. Although this arrangement physically conveys the centrality of the patient–psychologist exchange, the interpreter may miss some of the patient's nonverbal cues. The triangle configuration, although frequent, often leads to an interpreter-centered rather than client-centered interaction with both psychologist and client speaking directly to the interpreter (Miletic et al., 2006).

The Interview Process

As much as possible, the psychologist should conduct a typical session while looking at and speaking directly to the patient. Clients, whose experience has been limited to nonprofessional interpreters, may nonverbally draw the interpreter into the interview. However, if the psychologist continues to communicate directly with the patient, they will usually respond in kind.

The psychologist's wording of questions also encourages or inhibits developing a direct relationship with the patient. Rather than communicating with the interpreter about the patient ("Can you ask Mrs. Lopez to describe her mood?"), the interviewer

should speak directly to the patient ("Mrs. Lopez, how is your mood?"). Even trained interpreters may require encouragement to speak in the grammatical first ("I am feeling sad") rather than third ("He says he is feeling sad.") person (Cross Cultural Health Care Program, 1998). Even when instructed to interpret verbatim, the interpreter and patient may drift into cross talk or side conversations leaving out the clinician. Because these exchanges often include relevant information, the psychologist should politely request that the side conversation be shared ("What you're both saying sounds important. Could you please share it with me?"). Further side conversations may necessitate a firmer request (Clinician to interpreter: "It is very important that everything be interpreted and nothing left out.").

The clinician's verbalizations should be succinct. In particular, compound or multiple questions should be avoided. Typically, during the interview's course, a conversational rhythm rapidly develops in which the psychologist speaks, the utterance is interpreted, the patient responds, the response is interpreted, and the cycle continues.

Although these exchanges should be patient centered, occasions may arise when the psychologist and/or interpreter want to speak directly to one another. These exchanges may arise if the interpreter needs to clarify a word's meaning or provide relevant background information (e.g., "Even though Mrs. Huvic was able to get to a U.N. safe area during the war, Bosnian Muslims were still harassed in these places."). The person initiating the exchange should signal that a two-way conversation is about to occur and briefly describe the topic to the patient. Professionally trained interpreters often preface their comments with "Interpreter would like to say" indicating that they are speaking from their own perspective and not that of the patient. (e.g., "Interpreter would like to say that Mr. Mohammad believes that spirits may be affecting his mood and energy. In Pakistan, ghosts and spirits commonly cause what you call 'depression.'"; Cross Cultural Health Care Program, 1998; Tabassum et al., 2000). To maintain respectful transparency, these exchanges should also be interpreted.

Postsession

After the client has left, a postsession with the interpreter is recommended. Although there are differing opinions, it is often useful to begin with an open-ended query seeking the interpreter's general impressions of the session. The psychologist may also seek clarification about the significance of cultural and historical content. Asking the interpreter for feedback about the conduct of the session and providing the interpreter with any observations can help both professionals improve their skills in cross-cultural exchanges (Miletic et al., 2006).

Clinical encounters involving traumatic memories require particular sensitivity to the interpreter's reaction. Psychologists must be alert to the possibility of secondary traumatization to the interpreter (Miletic et al, 2006; Miller, Martell, Pazdirec, Caruth, & Lopez, 2005). For example, when interviewing patients who are war refugees, psychologists should be aware that the interpreter may have their own traumatic memories (Miller et al., 2005). Because the interpreter is also likely to be a war refugee, they, too, may be experiencing PTSD symptoms. As a result, the interpreter may exhibit fear, anger, or dissociation as they interpret the pa-

tient's war trauma narrative (Miller et al., 2005). However, for most interpreters, this period of distress is brief and not debilitating (Miller et al., 2005). Psychologists should be alert to this possibility, provide emotional support, and after discussion, recommend to the interpreter that they refrain from working with traumatized patients until they have satisfactorily addressed their own trauma history.

Interpreters in Specific Clinical Situations

Psychological Testing

Although some psychological tests such as the Wechsler Intelligence Scale for Children–Fourth Edition (Wechsler, 2003), the Wechsler Adult Intelligence Scale–III (Wechsler, 2008), and the Beck Depression Inventory (Beck, Steer, & Brown, 1996) have been translated into languages such as Spanish, most translated versions should be used with caution because linguistic equivalence is often difficult to achieve. For example, a Spanish version of the WAIS–III, developed and normed in Spain (Renteria, Li, & Pliskin, 2008; TEA Ediciones, 2001), demonstrated adequate overall internal consistency reliability and criterion validity with a U.S. Spanish-speaking sample. However, the coefficient alpha for the WAIS–III Letter–Number Sequencing subtest was not adequate in the U.S. sample—probably because of the differences in pronunciation of "B" and "V" between the two Spanish dialects.

The Mini-Mental Status Examination (MMSE; Folstein, Folstein, & McHugh, 1975) has been translated into multiple languages. However, it has been difficult to ensure that linguistic equivalence does not alter clinical validity. For example, the English words ("apple," "penny," "table") used to assess short term recall are two syllables. When the MMSE was translated into Portuguese, alternate words were selected ("car," "vase," and "ball") to maintain this difficulty level (Lourenco & Veras, 2006). Although the Japanese median MMSE score is similar to that in U.S. samples, there was cross-linguistic variation among individual items (Dodge et al., 2009). The Japanese sample scored significantly lower on the sentence writing task, which was more demanding because of three different types of letters, yet more sensitive, to cognitive deterioration (Dodge et al., 2009).

Linguistic disparity may, in part, account for the over representation of children with LEP in special education settings (Gersten & Woodward, 1994; Lopez, Lamar, & Scully-Demartini, 1997). The common practice of concurrently translating test content during the assessment session is strongly discouraged (Lopez et al., 1997) because test content and validity may be significantly altered by the interpreter's unintended omissions, additions, and substitutions. Although Spanish is the second most common language in the United States, there is considerable variation in pronunciation and meaning by country or region of origin. A linguistically appropriate test for Puerto Rican children may have limited validity with children from Central or South America. Lopez et al. (1997) concluded that because of these issues, bilingual examiners should permanently replace interpreter aided testing for children with LEP.

Tests such as the Bilingual Verbal Ability Test (BVAT; Munoz-Sandoval, Cummins, Alvarado, & Ruef, 1998), are initially administered in English with any missed items repeated in the child's native language. A composite score, bilingual verbal ability (BVA), is based on items correctly answered in English added together with additional correct responses in the child's native language (Munoz-Sandoval et al., 1998; Rhodes, Ochoa, & Ortiz, 2005). Another strategy is to integrate direct observation of a child's competencies in the classroom, playground, and home with performance on nonverbal cognitive measures such as the Leiter International Performance Scale (Leiter, 1979) and the Test of Nonverbal Intelligence–2 (TONI–2; Brown, Sherbenou, & Johnson, 1997; Lopez et al. 1997).

Diagnostic Interviewing

Oquendo (1996) described two concepts, language independence and language switching, to consider when conducting interviews or psychotherapy in a second language. In language independence, material acquired in the first language may be inaccessible in the second language. Language switching, in which clients alternate between their first and second language, may be a strategy for managing emotions associated with emotionally difficult interview content. Verbal recall of early experience is likely to be more vivid when done in the client's first language. However, patients may also distance from painful material by switching to their second language. When material is emotionally overwhelming, shifting to the second language may help the client use cognitive resources in modulating emotionality, thereby allowing them to continue to discuss difficult content.

Some interpreters, either deliberately or unconsciously, act as client advocates. They may believe that they are protecting clients from shame and embarrassment by selectively not translating descriptions of hallucinations, delusions, flashbacks, and homicide or suicidal ideation. Clues that this censoring may be occurring include nonverbal indications of distress or embarrassment and/or a persistent pattern of vague, tangential interpreted responses to specific questions. If this pattern persists, a second interview with a different interpreter is indicated (Westermeyer, 1990).

Individual Psychotherapy

The limitations of the "black box" approach, in which the interpreter is a "translation machine" (Miller et al., 2005), with no relationship to the client or psychologist, is particularly evident in multisession psychotherapy (Miller et al., 2005; Westermeyer, 1990). Interpreters may enhance or impede the therapeutic relationship. Because many clients with LEP are from regions in which psychotherapy is not as common or socially acceptable as in the United States, the interpreter's attitude towards the process can help or hinder clients' investment in treatment (Miller et al., 2005). By conveying empathy and warmth, rather than disinterest or dismissiveness, the interpreter becomes a trusted witness to a client's distress and its impact. More important, the interpreter should be consistent from session to session. In their qualitative study of interpreter-aided psychotherapy with war trauma survivors, Miller and colleagues (2005) noted that some therapists felt excluded because clients appeared to form a stronger alliance with the interpreter. However, over time, this trusting relationship broadened to include the therapist. Occasionally, when therapists were exploring emotionally intense traumatic memories, interpreters challenged therapists about "pushing" clients too far. In successful therapeutic relationships, psychologists and interpreters

were able to address this issue openly and although not necessarily agreeing, respected each others' perspectives.

Crisis Intervention

When impacted by the emotional arousal and cognitive disorganization triggered by a life event, many patients may temporarily experience diminished competence in a second language (Oquendo, 1996). Because crises are emergent and unpredictable, psychologists may not have ready access to a formally trained interpreter. Westermeyer (1990) described balancing privacy concerns with clinical requirements for rapid assessment. Demographic information and responses to closed-ended ("yes" or "no") queries about specific symptoms of sleep disturbance, energy, mood changes, and memory deficits can often be reliably obtained in the patient's second language or through a bilingual relative or staff member (Westermeyer, 1990). However, unless there is concern about imminent harm, questions regarding suicide, hallucinations, delusions, or a detailed social history can be deferred until an appropriate interpreter is available or using one of the telephone interpreter services.

There is considerable variability both within and across cultures in responding to crises (Sandoval, 2002). Some verbal and nonverbal behaviors may appear confusing to a psychologist of White European background. Among clients of Middle Eastern background, saying "no" only once may mean "yes." "No" may be conveyed by repeating the word forcefully. Emotional stress may also be conveyed by repeating phrases (Sandoval, 2002).

A common crisis therapy strategy is to encourage clients to express their feelings fully while the therapist summarizes and verbally reflects the content. However, many cultures place particular value on maintaining dignity and emotional strength under duress (Sandoval, 2002). Interpreting these nonverbal behaviors as denial or minimization of the significance of a loss, could be erroneous (Sandoval, 2002).

Child and Family Therapy

Development, culture, and language are dynamic influences when working with children and families. During the process of learning a second language, children may temporarily demonstrate reduced proficiency in their primary language (Lopez et al., 1997; Schiff-Meyers, Djukic, McGovern-Lawler, & Perez, 1994). Generational differences in bilingual skills are common with younger family members more likely to be acculturated and relatively fluent in English. Children and adolescents have often served as interpreters for parents. In medical settings, minors have been placed in traumatizing positions such as an adolescent explaining a terminal cardiac disease diagnosis to a parent (Levine, Glajchen, & Cournos, 2004) or a 7-year-old informing her mother of fetal demise (Paras et al., 2002). Recognizing the psychological harm to children, several states have passed or are considering legislation preventing children under age 16 from serving as interpreters (Flores, 2006).

The ability of an adolescent to speak directly to the therapist, while their parents rely on an interpreter, may contribute to an incongruous family hierarchy (Bjorn, 2005; Minuchin & Fishman, 1981). In addition, if the presenting problem is the child or adolescent's behavior, information may be filtered to the therapist by

the young interpreter. Placing themselves in a parental role, interpreters for children may become concerned about the child's behavior during the session and may verbally correct a child for common behaviors such as fidgetiness or inattention that the interpreter perceives as disrespectful behavior towards the psychologist (Bjorn, 2005).

Ethical Issues

In providing services through an interpreter, psychologists will often confront ethical dilemmas in which providing mental health services necessary for the welfare of clients with LEP must be balanced with the psychologist's professional responsibility to insure interpreter competence. APA's Ethical Standards (APA, 2002) specifically mention interpreters in describing requirements for delegating professional activities (§2.05; Delegating Work to Others). In selecting an interpreter, the psychologist must limit the interpreter's involvement to activities that they can competently perform based on their education, training, and experience (Standard §2.05(2)). The interpreter's professional competence must be continually monitored and reassessed (Standard §2.05(3)). Because delegated services are not to be provided by persons having a dual relationship with the client, friends and family are not appropriate (Ethical Standard §9.03 (c); Standard §2.05(1); Mailloux, 2004).

At present, because relatively few well-trained professional interpreters are available, psychologists practicing according to APA's Ethical Principles (2002) will likely have to address the conflict between promoting client welfare (Principle A: Beneficence and Nonmaleficence) and insuring competence when delegating services (Principle B: Fidelity and Responsibility). In practice, well-reasoned professional judgment will be necessary about whether to proceed with an untrained interpreter or wait for the possibility of a better qualified interpreter. In an emergency, it may be necessary to temporarily rely on an untrained interpreter to protect a client from harm (§2.02; Providing Services in Emergencies). If this option is necessary, a more extended presession, in which the psychologist educates the untrained interpreter about their role, would be valuable. Ideally, this option should only be employed in rare, time-limited situations (Westermeyer, 1990). Telephone-based medical interpreters are another possibility when adequately trained interpreters are unavailable.

Selecting and Hiring Interpreters

Because only a few states currently certify or license language interpreters, psychologists must use available information from local agencies and certification programs together with their own judgment in assessing an interpreter's competence. Certification typically indicates that an individual has had some formal interpreter training, but does not necessarily verify competence. Bridging the Gap, (Cross Cultural Health Care Program, 2009) one of the most common interpreter training programs in many states, is a 40-hr course, which may include some mental health content, but principally focuses on medical encounters. Although training and certification in medical interpretation is beginning to be addressed, there are few recognized standards for mental health as a specialty area for interpreters. A few specialty mental health programs have been developed ranging from 2 hr of videotaped training to six

college credit hours of classroom instruction (The Center for Health and Health Care in Schools, 2008).

As Westermeyer (1990) noted, even a highly qualified medical interpreter is a novice for mental health encounters. Even among those interpreting long-term psychotherapy, only about 20% of the interpreters had any formal mental health training (Miller et al., 2005). Interpreter service agencies usually view an appointment with a psychologist as a type of medical encounter. This view is also reflected in the absence of salary differentials for the few interpreters with specialized mental health training. According to a 2007 report, medical interpreters earn an average of $41,690 with a range from $21,500 to $67,070 (U.S. Department of Labor Statistics, 2007). For interpreters acting as independent consultants, hourly rates are often determined by supply–demand ratios with English Japanese interpreters commanding up to $200.00 per hour.

Ideally, besides bilingual proficiency, mental health interpreters should have training and education in the following:

1. U.S. culture;

2. Native language speakers' culture and values;

3. Personal qualities, including empathy, caring, respect, and sensitivity;

4. Psychological terminology;

5. Ethical expectations and professionalism;

6. Ability to facilitate communication between the client and psychologist without becoming a barrier (Buwalda, 2009; Mailloux, 2004).

If a psychologist or agency can consult with a knowledgeable bilingual professional who can evaluate a potential interpreter's skills, mental health organizations may conduct their own assessments of interpreter competency. An evaluation could include asking the candidate to interpret a tape recording of a mock clinical interview and/or psychotherapy session as well as translating a psychological report (Acevedo, Reyes, Annett, & Lopez, 2003).

At present, it is reasonable to assume that most clinical interpreters will have little formal training in mental health. As previously suggested, psychologists can provide limited training in mental health during the pre- and postsessions. In addition, if the same interpreter(s) works with the same psychologist over time, these instructional discussions can systematically cover multiple topics. Psychologists can also become involved with local interpreter agencies in developing specialized training for mental health settings as well as assisting in the development of guidelines for specialty certification.

Conclusions

Given the internationalization of psychology (Kennedy et al., 2007) and the increasing LEP population in the United States, practicing psychologists are likely to work with interpreters. However, many aspects of interpreter aided practice remain unclear and should be topics for research and further analysis. At a policy level, the impact of legislation and population threshold standards on availability of services for persons with LEP should be deter-

mined (Snowden et al., 2007). Although it appears that there is an association between LEP and psychological distress (Bennett et al., 2007), further assessment would help determine the magnitude of mental health and interpreter service needs. It is hoped that interpreter availability would reduce the significance of language as a barrier to mental health services, current evidence is lacking.

Similarly, a number of fundamental questions with practice implications remain unanswered. These include interpreter accuracy, their influence on client and psychologist behavior, as well as their impact on psychotherapy process and outcome. Although training does appear to improve accuracy among medical interpreters, clinically relevant mistakes were still common (Flores et al., 2005). As specialized mental health interpreter training becomes more common, psychologists should conduct similar evaluations. Although there are suggestions that bilingual therapy and interpreter-aided treatment can be equally effective (Schulz, Resick, Huber, & Griffin, 2006), replication and a better understanding of the processes involved would benefit both psychologist and interpreter.

Both interpreters and psychologists would benefit from further education. Knowledge and skills in working with interpreters should be included in graduate courses on multiculturalism as well as practica and internships. Psychologists can contribute to interpreter education by working with local interpreter agencies to establish courses and workshops specific to mental health issues. The first author has regularly participated in a local "Bridging the Gap" interpreter course. Although time constraints limit breadth and depth, training includes a brief overview of the mental health professions, an orientation to the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychological Association, 2000) system, and the psychological interview.

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