Making sense of three-way conversations: A qualitative study of cross-cultural counseling with refugee men

Mansha Mirza a,*, Elizabeth A. Harrison b, Hui-Ching Chang b, Corrina D. Salo c, Dina Birman c,1

a University of Illinois at Chicago, Department of Occupational Therapy, 1919 W. Taylor St., Chicago, IL 60612, USA
b University of Illinois at Chicago, Department of Communication, 1007 W. Harrison St., Chicago, IL 60607, USA
c University of Illinois at Chicago, Department of Psychology, 1007 W. Harrison St., Chicago, IL 60607, USA

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A B S T R A C T

Effective communication is essential in mental healthcare, where language often represents the primary means of treatment. In intercultural counseling sessions, communicating with Limited English Proficient (LEP) clients calls for skillful collaboration with language interpreters. However, best practices in medical interpretation may not be equally effective in mental health settings. This study examined the factors promoting and hindering successful communication during interpreter-mediated counseling sessions with LEP Bhutanese and Iraqi refugee men. Researchers observed eight substance use counseling sessions in real-time to make note of communication patterns and key communication breakdowns. Then, researchers conducted video-elicitation interviews with the client, clinician and interpreter immediately after each session to dissect communication events from each party’s perspective. Session videos and interview transcripts underwent qualitative analysis to identify factors that predict or prevent communication breakdowns. Findings indicate important differences between mental health interpretation and interpretation in other healthcare settings. Common practices such as simultaneous interpreting and first person interpreting were found to function differently in a mental health setting. Some therapeutically manipulative maneuvers, such as irreverence and humor, were difficult to employ cross-culturally. The adaptation and negotiation of interpersonal relationships between clinician, client and interpreter were central to the success of communication. Trust and flexibility were key to the functioning of the triadic relationship. Clinicians, clients and interpreters were found to adopt different roles and responsibilities throughout the session in an ongoing manner. Implications for the training of interpreters and clinicians are discussed.

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Corresponding author at: 1919 W. Taylor St., Chicago, IL 60612, USA.
E-mail addresses: mmirza2@uic.edu (M. Mirza), eharri20@uic.edu (E.A. Harrison), huiching@uic.edu (H.-C. Chang), csimon5@uic.edu (C.D. Salo),
vd.birman@miami.edu (D. Birman).

1 Dr. Birman began this work at University of Illinois but relocated to University of Miami midway through the project. Her current affiliation is: University of Miami, Department of Educational and Psychological Studies, 5202 University Dr., Coral Gables, FL, 33146, USA.

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1. Introduction

Linguistic diversity of the United States is ever-increasing (Shin & Kominski, 2010). More than 25 million US residents, nine percent of the total population, speak little or no English and are deemed Limited English Proficient (LEP) (Pandy, Batalova, & McHugh, 2011). This growing linguistic diversity is mirrored in other developed nations due to recent influxes of immigrants and refugees (International Organization for Migration, 2010).

The US accepts 50,000 to 80,000 refugees each year, most of whom are LEP (Office of Refugee Resettlement, 2011). Due to pre-migration trauma and post-migration stressors, refugees are at higher risk of mental health concerns, including post-traumatic stress disorder, anxiety, depression, and substance abuse (Ezard, 2012; Kirmayer et al., 2011; Porter & Haslam 2005). Despite increased need, refugees experience significant difficulties accessing relevant mental health services, with language barriers being a major obstacle (Morris, Popper, Rodwell, Brodine, & Brouwer, 2009).

Using qualified, trained language interpreters is one strategy for making healthcare, including mental healthcare, accessible for this population. This paper reports the findings of a qualitative study that explored how involvement of language interpreters affects communication during mental health encounters with LEP refugees.

2. Literature review

Federally funded healthcare systems in the US are legally mandated to provide linguistically accessible services under Title VI of the Civil Rights Act (Chen, Youdelman, & Brooks, 2007). Title VI and its pursuant Executive Order 13166, require that all healthcare providers receiving federal funds (including the two largest public health insurance programs, Medicare and Medicaid), must ensure that their services are accessible to LEP individuals (Youdelman, 2008). The Culturally and Linguistically Appropriate Services (CLAS) standards issued by the Office of Minority Health provide additional guidance. The CLAS standards include suggested practices for language access in healthcare, such as translated written materials, provision of competent interpreters free of charge, and ensuring patients are informed of available language services (Lo, 2011).

Despite federal mandates and standards for language access, there exists wide variability in provision of linguistically appropriate services in healthcare (Schiavino, Al-Amin, & Schumacher, 2014). This variability is largely attributed to lack of financial incentives and weak legal enforcement of language access mandates, as well as concerns related to feasibility and cost of interpreters (Chen et al., 2007). As a result, widespread gaps in interpreter availability persist across healthcare settings in the US (Chen et al., 2007). Even when interpreting is available, quality of interpreters varies widely. There is a lack of federally-recognized standards governing certification of language interpreters. Several healthcare facilities and states have established their own policies and standards for qualification of interpreters (Chen et al., 2007), although there is growing momentum toward a national certification process (NBCMI, 2012).

In the absence of federal standards for interpreter competency, best practices in healthcare interpreting draw upon available research evidence. Overall, research suggests that trained professional interpreters are more effective than ad hoc interpreters, such as family members, bilingual volunteers, or bilingual staff. Compared with ad hoc interpreters, use of trained, professional interpreters is associated with fewer interpreting errors and misdiagnoses, better quality of care, and greater satisfaction among clinicians and patients (Bischoff, Perneger, Bovier, Loutan, & Stalder, 2003; Flores, 2005; Jacobs, Chen, Karliner, Agger-Gupta, & Mutha, 2006; Lee, Batal, Maselli, & Kutner, 2002). Most professional interpreters undergo training in medical terminology and interpreting skills such as: word-for-word interpreting, first-person interpreting, and positioning themselves to be minimally intrusive to patient-provider interaction (e.g. California Healthcare Interpreters Association, 2002). While professional training is believed to enhance the quality of healthcare interpreting, there is limited research on whether training in general healthcare interpreting applies to mental health settings.

A second factor that can influence quality of healthcare interpreting pertains to whether interpreting is conducted in-person or remotely via phone or video. While all modalities are deemed adequate for basic exchange of information, remote interpreting is considered less satisfactory than in-person interpreting for interpersonal aspects of communication, such as rapport building, and when healthcare communication includes predominantly psychosocial components (Price, Pérez-Stable, Nickleach, López, & Karliner, 2012).

A third consideration for quality of healthcare interpreting is whether interpreting is consecutive (interpreter translates after the speaker has completed speaking) or simultaneous (interpreter interprets at the same time as the speaker) (Gany et al., 2007). Simultaneous interpreting may save time during appointments and decrease medical errors and remote simultaneous interpreting compares favorably with consecutive in-person interpreting in primary care, emergency department (Gany et al., 2007), and obstetric services (Hornberger et al., 1996). However, there is limited research evidence to determine whether remote simultaneous interpreting might be appropriate for all patients and all settings, including mental health.

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The available evidence suggests that using trained interpreters can boost patient satisfaction, improve clinical outcomes, decrease medical errors, and enhance healthcare access and utilization for LEP patients (Jacobs, Agger-Gupta, Chen, Piotrowski, & Hardt, 2003; Karliner, Jacobs, Chen, & Mutha, 2007). However, there is a dearth of empirical guidance on which interpreting practices are best suited for mental health settings. While effective interpreting practices are essential for all healthcare settings, they are especially important for mental health services, where communication represents not only a means for sharing medical history, facts and symptoms; but also a means of treatment (Hsieh, Pitaloka & Johnson, 2013). Involving trained interpreters in mental health care can improve patient-provider communication for LEP clients (Paone &
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