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ABSTRACT

This paper discusses the use of bilingual workers who do not have formal mental health training as mediators and providers of mental health care for refugees. The introduction provides a background discussion of the need for refugee mental health services, the characteristics of bilingual mental health workers, and the work places and expectations of the bilingual worker. After a brief discussion of the problem of job title, the functions of bilingual workers are enumerated and described: translation, interpretation, culture broker, outreach and community education, and mental health counselor or cotherapist. The next section addresses special issues and problems arising with bilingual workers, beginning with the psychosocial and interpersonal dynamics of the bilingual worker's role as interpreter between patient and clinician. Other issues include training, certification and quality assurance, bilingual career development, burnout among bilingual workers, and the potential for the abuse of power by bilingual workers. The discussion concludes with considerations for the recruiting and hiring of bilinguals. References are included. (TE)

# The Role of Bilingual Workers without Professional Mental Health Training in Mental Health Services for Refugees

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Contents

# The Role of Bilingual Workers without Professional Mental Health Training in Mental Health Services for Refugees

## Introduction

This paper discusses the use of bilingual workers who do not have formal mental health training as mediators and providers of mental health care for refugees. This focus on the non-professional worker reflects the fact that professionally-trained mental health workers are rare to nonexistent in many refugee groups, and that training sufficient numbers of bilingual professionals for these groups could easily require a decade or more. Additionally, future waves of many different immigrant groups can be expected, which will make an understanding of the issues surrounding use of non-professional bilinguals in mental health important for many years to come.

It should be recognized at the outset that certain refugee groups, notably Cubans and to a lesser extent Vietnamese and Haitians, have available at least some bilingual mental health professionals. Although there are many special and difficult issues involved in utilizing these bicultural professionals for service to minority groups via the "mainstream" (c.f. Lefley and Bestman, 1984), the focus of this paper will be the special problems of the relatively untrained, non-professional worker. Therefore, for the sake of brevity in this paper, the term "bilingual worker" will refer specifically to the non-professional.

Bilinguals workers occupy a tenuous, ill-defined niche of status and responsibility because mental health services in our country are based on western models of mental health, and because of their lack of formal training or licensing. They are "paraprofessionals" while

frequently lacking training which would be required for usual paraprofessional status. Supervision is often inadequate due to the resource-poor service environment in which they operate, resulting in their having responsibility beyond what should be expected based upon their training and experience. They are often the only people within the agency who can communicate with and understand the patient from the perspective of the cultural expectations and social demands placed upon the patient and the patient's family.

Bilinguals represent the ideals, values and perspectives of the refugee community to the agency, and those of the agency to the community. If the bilingual cannot effectively communicate the need for and value of mental health services to the refugee community, the agency will be able to provide little service, even with the best intentions. The highly personal nature of mental health services, the degree to which mental health services seem alien, strange, and sometimes frightening to refugees, and the elusive, often culture-bound concepts of mental health make the bilingual's job extremely challenging.

For these reasons and others to be discussed, decisions about how to recruit, hire and train bilinguals, and the determination of what expectations should be held regarding their performance, degree of supervision, and level of responsibility is very complex. In this paper, the various roles of bilingual workers in mental health settings will be examined, together with advantages and pitfalls of having bilingual workers assume the responsibilities attendant upon those roles. In addition, methods and problems of selection and training will be briefly described, as well as potential strengths and

difficulties in the relationship between clinician and bilingual, bilingual and patient, and between the service agency and the refugee community.

The sources of information for this paper come from the literature, and from visits to fifteen refugee mental health programs located in nine states made by the authors and other members of the Refugee Assistance Program: Mental Health -- Technical Assistance Center, referred to hereafter as the TAC. The TAC is a resource development and technical assistance center funded by the U. S. Office of Refugee Resettlement and administered by the National Institute of Mental Health (NIMH) with the goal of increasing the availability and quality of mental health services to refugees.

## The Need for Refugee Mental Health Services

The need to provide mental health care to refugees is becoming increasingly pressing. Since the fall of Saigon in 1975, over 800,000 legally sanctioned political refugees from Southeast Asia have arrived in the United States. In addition, over 165,000 Cuban and Haitian refugees and entrants have arrived during that period as well as lesser numbers of Ethiopians, Afganis, Iranians and Central Americans. During this time, public and private human service agencies, both those specifically created or designated for the purpose of assisting refugees and those with general commitments to community service, have attempted to provide jobs, English education, social orientation, and welfare services to these refugees. The thrust of the Federal Government's refugee assistance program has been to provide skills and conditions necessary to enable refugees to become self-sufficient (off welfare rolls) in as short a time as possible.

Although the efforts of these agencies have enabled many of the

most capable, ambitious, and adaptable refugees to begin and succeed in their new life, it has become clear to workers in the resettlement field that many of those having difficulty adjusting to the United States, e.g., learning English, making friends, getting work, or dealing with those around them, are suffering from serious emotional disorders. These disorders frequently present as somatic complaints, but are usually diagnosable as adjustment disorder, depression, anxiety, and sometimes post-traumatic stress disorder. In addition, substance abuse, schizophrenia, paranoia, and other typically low base rate disorders are found (Kinzie, 1981; Kinzie, Fredrickson, Rath, Fleck, & Karls, 1984; Lee, 1985; Nguyen, 1985; Westermeyer, in press). A significant minority of those who have not been able to effectively utilize services provided to them under the refugee plan are suffering from disabling or near disabling mental illness. In addition, many who are or seem to be functioning well economically or educationally may still be suffering emotionally (Kinzie, Sack, Angell, Manson, & Rath, 1986; Westermeyer, Vang, & Lyfong, 1983; Westermeyer, Vang, & Neider, 1983).

Mental health services for refugees have been terribly inadequate, and remain so to this day. With a few notable exceptions, quality mental health services are still largely inaccessable to refugees. The reasons for this are several. First, many communities have small and/or newly arriving refugee populations, who have had insufficient impact or demand upon the mental health system to provoke a response. Second, the urgent need to address the physical, social, and language needs of the refugees has given mental health services a low priority in the prevailing resource-tight environment. Third,

cross-cultural expertise has been lacking in the mental health area, so that few providers have been available to develop and offer services to these new groups. This lack of expertise also reflects some level of disinterest; in some areas the TAC team visited, states have been unable to generate interest within community mental health centers in developing services to refugees, even when special resources were offered. Fourth, some communities or areas of the country do not appear highly committed to ensuring the availability of these services. Fifth, providing cross-cultural services requires the use of trained, highly skilled bilingual workers, who are very difficult to find and train. Sixth, American workers within these agencies do not know how to work through and with the non-professionally trained bilingual, and may feel uncomfortable attempting to do so. The present paper is concerned with the last two of these problems.

One broad consequence of these factors is that once a bilingual worker is hired at an agency, that person may become rapidly overwhelmed by the needs of the community and requests for service, assistance, and information by surrounding agencies. The worker may be the only ethnic mental health worker in a large community, and social service agencies, schools, the criminal justice system, or police may call upon a worker to interpret in a given case, to explain why people respond or behave in what seem to be strange ways, and to assist intervention in cases of suspected child abuse, and illegal activities such as gambling, drug abuse, or theft. Agencies and their workers have to attempt to balance such outside activities, which are important for primary prevention in the community, as well as for individual mental health concerns, with the necessary direct

work of the clinic.

The difficulty of the bilingual workers' tasks must not be underestimated. For example, interpretation is an extremely difficult task requiring extensive training when performed in other settings such as diplomatic or business transactions (Nishiyama, 1983). However, this function seems to be taken for granted and trivialized in some clinical settings, as when relatives or clinic personnel such as janitors are called in to translate for a psychiatric intake. (Marcos, 1979; Westermeyer, 1987). Even with well educated bilinguals, a command of English adequate for translating in primary health settings may not be adequate in mental health settings where connotations and subtle implications have extreme importance (Westermeyer, 1987). As will be seen, interpretation represents only a small portion of the mental health work that bilinguals are expected to perform, and therefore command of English stands as a necessary, but far from sufficient requirement for employment in mental health settings (Lum, 1985).

Characteristics of Refugee Mental Health Workers

For the majority of refugee bilingual mental health workers, their job in the United States as a mental health worker represents their first work and training in the area of mental health. This is particularly true of Southeast Asian refugees, who come from cultures where western notions of mental health are alien, and where there is no counterpart to the western mental health worker (Kinzie, 1985b; Tung, 1985). This is most notably the case for the Khmer, who lost many educated people during the time of Pol Pot, and for the largely preliterate Laotian hill tribes such as the Hmong, Mien, and Tai Dam,

who arrived with very few members having significant education in the western sense, and few to none with any training in western mental health concepts (Kinzie, 1985b).

In visits to agencies serving mental health needs of refugees, 23 refugee workers were interviewed. The characteristics of these workers are shown on Table 1.

Table 1 - Characteristics of bilingual workers in sites visited.

| Ethnicity | Number | Have College Degree | Prior experience in mental health | Plan to stay in mental health |
|---|---|---|---|---|
| Vietnamese | 9 | 7 | 2 | 5 |
| Hmong | 4 | 0 | 2 | 3 |
| Cambodian | 4 | 1 | 0 | 2 |
| Laotian | 3 | 1 | 1 | 2 |
| Mien | 1 | 0 | 0 | 1 |
| Haitian | 1 | 1 | 0 | 0 |
| Ethiopian | 1 | 1 | 0 | 0 |
| Totals | 23 | 11 | 5 | 13 |

Average Age = 35, range 21-46

Average Time in U.S. = 8 1/2 years, range 4 - 18

Gender: 13 women, 10 men

As can be seen, few had previous mental health related experience, and this primarily represented experience as volunteers in refugee camps. A few others had worked for resettlement agencies with some peripheral exposure to mental health, but none had prior formal mental health training. Previous occupations have included physician, teacher, nurse, student, clerical or construction worker, and army officer. Several, mainly Vietnemese, had college degrees either from

the U.S. or from their country of origin. About half planned to remain in the mental health field, the rest wanting to change careers (or resume their old one) or feeling unsure, for reasons which will be touched upon later. The bilingual workers in general had a high level of education, an unusually good command of English, and a high degree of adaptability compared to their ethnic cohort.

Work Places and Expectations of the Bilingual Worker

There are a variety of settings in which bilingual workers get exposed to mental health issues, but where their primary responsibility is not in mental health service. For example, bilinguals working as translators in hospitals or primary health facilities may be called upon to translate for psychiatrists when a refugee arrives in the hospital in a state of crisis, and during treatment or follow-up. In voluntary resettlement agencies, bilinguals are expected to assist new refugees in finding satisfactory living arrangements, work out problems between refugees and sponsors, and provide social orientation. In each of these areas, mental health issues can figure prominently. Refugees suffering from serious mental and emotional problems will be unable to make the best use of services, may become a problem for the sponsoring family or group, and will be frustrating and difficult to deal with for the resettlement worker. The resettlement worker is not usually given training in mental health and is not always sure whether referrals are needed or where to refer to. The same issue confronts those workers in private and public agencies attempting to perform job counseling and placement with refugees, as well as bilingual teachers working with adults in English as a second language (ESL) classes, or in schools providing

bilingual education to students.

Social service and child protection agencies within cities also hire bilingual workers who see instances of domestic violence, alcohol or drug abuse, and ineffectiveness and isolation. Again, these bilingual workers are usually not trained in mental health to the degree that would be required of their American counterparts. Initial hiring may have been based almost exclusively on demonstrated ability to speak English, irrespective of personal qualities and suitability to people-oriented work. These front-line workers will often be the first or only people other than family members to see the effect of mental health problems, but without training may be unable to deal effectively with these problems, or to recognize their seriousness.

The focus of this paper, however, is those agencies who hire bilingual refugees primarily for mental health work. These may include public, non-profit community mental health centers or specialty mental health centers created for persons of specific ethnic or racial groups (e.g., Asians, Cubans, Haitians, Vietnamese), and hospitals and psychiatric clinics which hire interpreters specifically for mental health work. They also include private agencies which have attempted to develop mental health services in response to what they saw as unfilled needs of the refugee community, or who were initially involved in other aspects of resettlement but observed and attempted to respond to the mental health needs they found. These latter agencies may not have a history of working in the mental health field. Each type of program tends to utilize the bilingual worker in a different way, with their own set of expectations and limitations.

This helter-skelter hiring and utilization pattern for bilingual mental health workers reflects the scattered, uncoordinated, and

tenuous nature of refugee mental health services in this country. Personnel within refugee mental health programs often feel out of touch with other refugee programs, and isolated from the mainstream of mental health. Refugee programs often operate on a shoestring budget, with little funding security (Lum, 1985). The quality of care in these programs is often not subject to the same degree of scrutiny that mainstream agencies receive. These factors have serious ramifications when it comes to developing the skills of bilingual mental health workers, preventing job burnout, developing standards or certification for them, and keeping committed workers in the field of mental health.

A further consideration in hiring and training bilinguals is whether the size of a specific ethnic group in a service area is large enough to justify hiring a full-time bilingual worker. Clearly, in areas which have only a few hundred refugees from a certain cultural-linguistic group, local mental health centers and hospitals will be unable to hire a full-time interpreter even for basic health services. For groups with small numbers, the unfortunate solution of using family members or friends for translation may have to be used (Westermeyer, 1987). For larger groups, the hospital may hold clinics at specific times during the week (e.g., Kinzie, Tran, & Breckenridge, 1980; Westermeyer, 1985), and utilize a part-time interpreter, or one perhaps shared with other local social service agencies. Providing such a worker sufficient training in mental health work to insure proper care is problematic, however. It is incumbent upon the clinician in this situation to develop sufficient experience with and knowledge of the patients' culture to work effectively with the

patients and the bilingual, and possibly to do so without special financial compensation.

## The Problem of Job Title

Bilinguals are viewed and utilized in somewhat different ways by different agencies. This tends to be reflected in the variety of names and titles by which they are called, including clinician, social worker, cotherapist, interpreter, counselor, social adjustment worker, mental health assistant, and mental health worker. The various functions of these workers will be described in detail shortly, although not within the context of job title. There is not a one-to-one correspondence between job title and specific functions or responsibilities. In fact, most of these workers tend to do very similar things, although relative amount of time devoted to specific tasks may vary. For example, persons called clinicians or counselors may spend more time within the clinic and do fewer home visits than those called social adjustment counselors or social workers. They might also be given more independence and allowed more authority, although this may not always be the case. They may be less likely to get involved in day-to-day, concrete problems in living, although even this will vary from agency to agency and even person to person within an agency.

Agency personnel often mention the dilemma over what the worker should be called, as no particular job title exactly fits what the workers do. In cases where they have a strictly determined role such as interpretation the choice is easy. That situation is rare, however, and more often the title reflects some combination of politics, philosophy, legal restrictions, and actual functions performed. Therefore, the titles are not reliably descriptive of

either functions performed or level of training or qualification in any given area. For example, an agency which seeks to increase the apparent status of its bilinguals might decide to call them clinicians or counselors. An agency wishing to avoid a medical model or the stigma of mental health may choose the title of social adjustment worker. Agencies in between may call them mental health workers. Some agency directors are adamant that their workers not be called interpreters, translators, or even paraprofessionals, believing that these terms trivialize their workers' importance and level of responsibility, and are somehow demeaning.

The problem with this terminology dilemma is that job titles become uninformative and potentially misleading. Persons working for surrounding agencies as well as the people the bilinguals serve have no idea of what the qualification or training of these workers is, nor of the type of work they can be expected to do. For example, the title "clinician" can be confusing because it seems to imply some specific clinical training, although legally the term is meaningless. Because of all this, I will not attempt to disentangle the job title - job training/responsibility confusion. Instead, it is suggested that professional and professional-sounding titles be reserved for those with appropriate training, and that until some other appropriate certification becomes available, a title such as bilingual mental health worker be used for the non-professional. Such a title gives some indication as to the content of the worker's job, but carries no specific implication as to level of training. While some may argue that the term demeans the work that bilinguals do, one must remember that in the great majority of cases these workers were

new to the mental health field when they started work, and generally have neither mental health degrees nor professional training. Advancement should be available through further formal training.

In the following pages, issues of job title will be left behind in favor of describing the various functions performed by bilinguals. These functions, as has been noted, are part of what almost every bilingual worker does, although the relative amount of each will vary according to time and agency priority. Each function will be discussed, together with the importance, needs, strengths and difficulties associated with that function.

## Functions of Bilingual Workers

Bilinguals working within mental health programs serve a large variety of functions, including those of translator, interpreter, paraprofessional counselor, culture broker, outreach worker, community educator, community advocate/organizer, and educator of service providers about the refugee's culture. Within the counselor role, bilinguals may serve to intervene in crisis situations, perform therapeutic interventions, administer tests, make referrals, and do case management. These various functions will be expanded upon in later pages. Based upon our visits to agencies across the United States, the extent to which bilinguals perform each of these functions varies greatly, although bilinguals within most agencies are called upon to perform most of these duties at one time or another.

Tung (1978) discusses the history and utilization of the Southeast Asian bilingual worker in mental health. In attempting to define what duties the workers should be expected to perform, he first defines those things they should not be: job counselor, social service aide, community worker, therapist, or psychiatric technician. In

other words, the workers must devote their time to those special services that only a mental health agency can provide, despite the temptation to work in these other areas which do have mental health implications. He says that environmental interventions must be specifically related to a treatment program. He says they should be expected to perform as detection, crisis intervention, education/information, referral, interpretation, other prevention, and reporting. His list of functions is consistent with those to be described below, although he has his own specific outlook and set of priorities. In fact, the needs and capabilities of each agency and the population it serves determines the specifics of how bilinguals are utilized.

Translation

Translation refers to producing a written document in a language different from the original source, whether the source was originally spoken or written. The function of translation has limited use in a mental health center. Typical opportunities for translation include translating psychological tests, outreach, prevention, or educational materials, and translating conversations or history information into a patient's chart. Such activities are difficult and vitally important when they are done, but they make up a small portion of a bilingual worker's overall effort.

Interpretation

Interpretation refers to a spoken product, such as when a worker interactively interprets for a psychiatrist during an interview. Interpreting can be extremely demanding because the interpreter does not have time to sit and consider the best translation, may not have a

dictionary available or time to use it, and is responsible for seeing that all parties in the room have a clear understanding of what the others are saying and meaning. Interpretation and translation are highly developed arts and skills, with formal education, certification, and licensure requirements.

In the mental health context, interpretation ideally requires that the bilingual utilize his or her expertise and sensitivity with respect to the differing languages and cultures, elaborating or explaining elements of the messages sufficiently to insure full understanding between the parties. The interpreter is therefore a partner in the exchange rather than a vehicle, and takes an active role in the exchange. In transactions between persons with differing linguistic and cultural backgrounds, the interpreter has the weighty responsibility of ensuring that all sides understand what is being discussed, and what special meanings are attached to key words, actions, and gestures by the persons involved in the transaction. In order to be effective, the interpreter needs to be familiar with both cultures and languages, and to some extent also with the specific topic under discussion (Ishisaka et al., 1985; Tung, 1985; Westermeyer, 1987, in press). One may consider a dimension of "degree of elaboration" during interpretation. A verbatim interpretation may be technically correct but miss a crucial point which is vital to a mental health assessment. For example, subtle meanings, things left unsaid, and culturally dissonant qualities of expression would be lost in such an interpretation. On such occasions, elaboration is needed to fully convey the implications of what is said. In addition or prior to the elaboration however, clinicians should ask for the more verbatim interpretation as well because the interpreter may not be as

sensitive to clin. lly important material or may consider important material irrelevant (Williams, 1985). Of course, even "direct" interpretation will require interpreting subtle meanings as well as idiomatic expressions, sayings, and metaphorical expressions which do not have direct translations. The degree of elaboration is quantitative, not qualitative, reflecting the degree of personal involvement expected or allowed of the bilingual in the patient-clinician exchange.

Bilinguals are rarely hired primarily as translators or interpreters in specialty refugee mental health clinics. The exceptions to this rule have been hospital-based psychiatry clinics, and in particular those established by Kinzie (1981) and Westermeyer (1985). In these clinics, the psychiatrists had a special interest in providing services to refugees, and undertook the training and supervision of bilingual workers to function as interpreters during psychiatric interviews and treatment sessions. Even in these psychiatry clinics, however, the bilinguals also function as culture brokers, community educators, and outreach workers. In other hospital settings, translator/interpreters are often provided for psychiatrists as needed for triage, crisis, and treatment work, but these workers frequently come from a "translator pool," and are not used primarily in the mental health area.

The need for interpretive services, even when the patient is capable of communicating in English has been noted by several authors. Westermeyer (1987) and Marcos (1976) have noted that patients may be able to express factual information in a second language, but not affective or personal information, especially if the second language

was learned late, or primarily in school, through books, or at work. Tung (1985) has found that refugees may think they do not know English well enough to use services, and that this concern may prevent them from seeking services. They may dread the laborious task of attempting to explain their distress in a foreign language. Persons experiencing high levels of stress, such as would be the case with patients experiencing anxiety, depression, delirium, or thought disorders, may lose their ability to communicate effectively in a second language while retaining effective use of the first (Peck, 1974, Westermeyer, 1987). Marcos, Urcuyo, Kesselman, and Alpert (1973) found that English-speaking patients with Spanish as a first language displayed more misunderstandings, greater disturbances associated with anxiety, and more content indicative of psychopathology when interviewed in English then in Spanish. Marcos (1976) also discussed an apparent emotional detachment observed in patients using their second language instead of their first (Spanish) in a psychiatric interview. This he ascribed to greater encoding demands associated with the second language, which in essence blocked out or distracted the patient from the emotions associated with what was being said.

Both under- and over-pathologizing has been reported to result from interviews conducted in the patient's second language (Del Castillo, 1970; Marcos, Alpert, Urcuyo, & Kesselman, 1973). Marcos et al. (1973) speculate that on the one hand, there may be outright misunderstanding of words, contexts and gestures by the clinician when interviewing the patient in the patient's second language, leading to over-pathologizing. However, it is also possible that a person with a thought disorder may respond in a more controlled, albeit limited way

when interviewed in a second language, thus giving a poorer sample of speech for the psychiatrist to analyze, and not revealing subtle signs of disorder (Westermeyer, 1987). Foulks (1979), has described numerous linguistic and conceptual difficulties in interpreting affect and feeling across cultures. It is unlikely that a person who speaks English only moderately well will be able to explain feelings of distress clearly and meaningfully to an English-speaking psychiatrist. Trained interpreters, on the other hand, will have experience bridging this gap, and will understand the points of view of both clinician and patient. Therefore, use of interpreters may be advisable even with patients with partial skill in English.

A number of authors have written about the difficulties and dangers, as well as the advantages of psychiatric work through an interpreter. Sabin (1975) reported the suicide of two patients whose suicide risk was underestimated during an interpreted interview. In this case, the interpreters were not trained in mental health, one being a family member and the other a member of the hospital staff. In each instance, vital information was lost during the interpretation due to both inadequate interpretation and lack of realization on the part of the clinician as to the significance of what was interpreted. In particular, the affective components of the patients' complaints were inadequately recognized. Kline et al. (1980) found that Spanish-speaking patients felt more satisfied with their interviews and more happy with the help received when interviews were conducted using interpreters than when they weren't used. However, clinicians felt the interpreted interviews were less satisfactory than non-interpreted ones, and erroneously thought the patients felt less understood and

satisfied as well. This points out that certain perceived problems and pitfalls of conducting interpreted interviews (particularly with professional interpreters) may be the result of interviewer discomfort with the situation rather than actual reduced efficacy with patients.

Fascinating examples of relatively minor alterations substantially altering the meaning of a patient's communication have been described by several authors (Marcos, 1979; Price 1975; Putsch 1985). Price quotes examples where the attempt of the interpreter to make a patient's reply more meaningful or intelligible masked the psychotic thought process of an hallucinating patient. Putsch provides examples of misinterpretation due to misunderstanding of terms, misleading paraphrasing, omission of details which the interpreter felt uncomfortable in repeating or which the interpreter felt were improper to repeat, and outright distortion of a physician's question in order to make it more culturally-acceptable to the patient. Marcos (1979) lists three major sources of interpretative distortions: 1) deficient linguistic skills of the interpreter, 2) the interpreter's lack of psychiatric sophistication, and 3) the interpreters' attitudes toward either the patient or the clinician. He provides examples of each type of distortion. The optimal solution to these problems is to hire people with excellent language skills, provide them with training in mental health and in the technical aspects of interpreting, and develop a close, trusting, long-term professional rapport between clinician and interpreter. Kinzie (1985b) has operated his clinic using such a model and states that he has not had the difficulties working with interpreters that many others report.

Unfortunately, this arrangement is rare within a hospital (Putsch,

1985; Santopietro, 1981; Williams, 1985). Marcos (1979) reported that in two New York hospitals associated with New York University, an average of 30 psychiatric interpreter-interview evaluations were conducted daily, primarily in Spanish and two Chinese dialects. In spite of the high number of cross-cultural interviews with non-English speaking persons, the hospitals employed no official interpreters and instead any individual speaking the patients language might be asked to interpret!

Even when a hospital does employ some interpreters, there may be occasions when there are no translators available for the particular language needed (Marcos, 1979; Putsch, 1985) In that case, family, friends, or sometimes clerical or service staff are utilized as interpreters. The results can be disastrous due to the inability of the intake person to understand and address the problem (Sabin, 1975). Many difficulties occur when family members, friends, or untrained strangers perform the interpretation (Faust & Drickey, 1986; Marcos, 1979; Westermeyer, 1987). Family members have a stake in the outcome of the interview and may tend to either enlarge or minimize the pathology of the patient depending upon their personal agenda. In addition, they are not trained as interpreters, which can lead to serious problems which may be partially overcome with appropriate instructions and following certain recommendations (Marcos, 1979; Santopietro, 1981; Williams, 1985; Westermeyer, 1987). These include having a meeting between clinician and interpreter before the interview to discuss the goals of the interview, focal areas of the assessment, and the sensitive areas that may be explored. The initial session allows the clinician to determine where problems in the

interpretive process may arise, and allows an initial assessment of the English skill of the interpreter. Matters of confidentiality and the vital role of the interpreter may also be discussed. Also recommended is having a final wrap-up session in which concerns and questions may be cleared up between the clinician and interpreter, and in which final impressions may be shared.

Westermeyer (1987) notes that incomplete language competence, interpretation skills, attitudes, and lack of psychiatric knowledge contribute to distortions in interpretation. For such reason, Santopietro (1981) recommends using simple sentences, and sentence-by-sentence interpretation during an interview. These problems are especially notable with lay interpreters, who may try to "normalize" the patient. Some of the drawbacks to lay interpreters may be ameliorated by anticipating these problems, but even in the best of such circumstances concern with regard to confidentiality or shame on the part of the patient, lay interpreter, or family member-interpreter may still influence what is omitted or altered. Because of the difficulty the clinician has in knowing whether or not accurate interpretation is taking place, Westermeyer (1987) recommends that a clinician learn at least a few words of the patient's language as a check against gross interpretation errors.

In spite of the problems working with interpreters, Westermeyer (1987) notes that there can also be significant clinical advantages to the interpreted interview process. One advantage is the opportunity the clinician has to reflect on what has been said, to consider how to proceed, and to observe non-verbal behaviors while the interpreter and patient are conversing. Another advantage comes when the clinician and interpreter have been working extensively together, have a great

deal of mutual trust, and can operate as "a highly effective and efficient team, much like a surgical team." Under these circumstances, he believes the process of cross-cultural assessment can become as sophisticated and effective as intra-cultural assessment, and psychometric evaluation and psychotherapy become quite possible.

In summary, the use of interpreters in psychiatric work presents difficulties which can be overcome. In the ideal situation, cross-cultural work via an interpreter may be equally as effective as intra-cultural work. This ideal case rarely seems to hold, not because the obstacles to achieve it are insurmountable, but seemingly because institutions do not recognize the importance of high quality interpretation, or the level of sophistication and difficulty involved in performing psychiatric interpretation, and do not seem ready to recognize and respond to the need for providing such a service for their patients.

Culture Broker

Culture brokerage is not a specific function, role or responsibility. Rather, it is something that pervades all that bilingual workers in a mental health center do, from interpreting to community outreach. A specific role definition for and job title of culture broker has been described by Weidman (1978) and by Lefley and Bestman (1984). In Weidman's service model, culture brokers are bilingual, bicultural, professionally-trained social scientist (ideally from the ethnic group being served) who lead a mental health team serving the community. The responsibilities include community organization, cultural consulting with both mental health

professionals and community service agencies, directing preventive activities, and ensuring that needs of the community are dealt with in a culturally appropriate manner. Most programs across the country do not have personnel working specifically as culture brokers, however, and therefore rely on the ethnic workers on staff to serve in that capacity. Accordingly, the term will be used in the broad sense in this paper, referring to the myriad ways in which bilingual workers attempt to bridge the cultural gap between the refugee population and the staff and services of the mental health agency.

As mentioned, bilingual workers fulfill the role of culture broker in virtually all aspects of their jobs. They operate to ensure that the services offered by the center are accessible and appropriate for their specific ethnic communities. They attempt to link the mental health centers with community networks and aspects of the ethnic culture, such as native faith healers. Specific efforts in the areas of community outreach and education, which clearly include a culture brokerage aspect, will be discussed shortly.

In the clinical setting, the role of culture broker takes many forms (Kinzie, 1985b; Westermeyer, 1987, in press). In a sense, the degree of cultural elaboration provided by an interpreter during an interview reflects the degree to which the bilingual is operating in the culture broker role. During an interview, an interpreter is often relied upon to put patients' remarks in a cultural context so that the clinician understands context, connotations, and subtle meanings. The culture broker can assist the clinician to determine if a patient's ideas, behaviors and responses are congruent or not with respect to the culture (Westermeyer, in press). In addition, the interpreter can inform the clinician of potential negative consequences of asking

questions which may seem very inappropriate to the patient, or asking them before sufficient trust has been established. Questions on such topics as sexual matters or traumatic experiences must be pursued carefully and with sensitivity (Faust & Drickey, 1986; Hoang & Erickson, 1985; Ingall, 1984). The culture broker can also inform the clinician about courtesies and body language which are vital to understanding the patient and to maintaining appropriate clinician-patient roles. Bilinguals can also assist the clinician in generating appropriate items for mental status examinations. For example, bilinguals can think of sayings common in their culture which may be used to screen for abstract thinking ability (Westermeyer, 1987), and information items which can be used to check long-term memory function.

Culture brokers can help explain and clarify treatment plans and goals to patients and their families in such a way as to increase compliance with treatment. Achieving treatment compliance with refugees has frequently been reported to be problematic (Breitenbucher, 1980; Kemp, 1985; Kinzie, 1985b). Reasons cited for this include the belief, particularly among Vietnamese and Chinese, that western medications are "hot," and should be used sparingly and only when experiencing symptoms. This has led to problems in compliance such as reduced dosages, and taking the medication sporadically (Ishisaka et al., 1985; Muecke, 1983; Tung, 1985). Kinzie (1985a) reports that it is very difficult to explain the concept of maintenance medication to Southeast Asian clients, and that a common practice is to stop taking the medication as soon as some improvement is noted, or in response to experiencing side effects.

Other problems in compliance may reflect the very different outlook on mental illness that refugees have when compared to the Western practitioner (Ishisaka et al., 1985; Kinzie, 1985a; Westermeyer & Wintrob, 1979). Consequently, the culture broker has a vital role in explaining the treatment plan to the patient, and in making sure that the clinician is aware of the patient's attitude toward the medication.

Outreach and Community Education

The presence of significant barriers between refugees and mental health services has been described by many authors (e.g., Hoang & Erickson, 1985; Ishisaka, et al, 1985; Kinzie, 1980; 1985b; Lin, Inui, Kleinman, & Womack, 1982; Tung, 1985; Westermeyer, 1985). The presence of these barriers has resulted in underuse of mental health services by refugees (Nguyen, 1985; Sue & McKinney, 1975). One major barrier is the common view among refugee groups that only "crazy" people need mental health services. Mental health services are not seen as appropriate for someone who is able to cope, even if their day-to-day life is miserable. Receiving mental health help, or having a family member in treatment is highly stigmatizing (Ingall, 1984). Another barrier is simply lack of awareness that such services exist, what they can provide, and how they might be accessed. Refugees may also be unaware that the agency is able to provide services to non-English speaking refugee clients. Western concepts of mental health are unfamiliar to refugees, and mental health services may only be accessed as a last resort, after the avenues of family, traditional healers, and general medicine have been exhausted (Kinzie, 1985b; Nguyen, 1985). For all these reasons, agencies attempting to deliver services to the refugee community have often found it necessary to

utilize their bilingual workers for community outreach, as a culture broker between the agency and the target community.

The role of the refugee bilingual as an outreach worker is not as well described in the literature as that of interpreter, although most agency directors acknowledge the importance of this function. Lefley and Bestman (1984) provide descriptions of several multi-cultural outreach and community organization efforts directed by culture brokers in Miami. These include organizing neighborhood groups to advocate for the community in areas such as housing, crime prevention, educational services, and immigration assistance. Similar functions provided by indigenous paraprofessionals serving a multi-ethnic community in New York have been described by Tarail (1979), who noted the special usefulness of indigenous paraprofessionals in a variety of outreach, prevention, and intervention efforts.

One agency which places particular emphasis on outreach as a prevention effort, and which serves a large surrounding refugee community is Asian Community Mental Health Services in Oakland, California (Lum, 1985). Lum notes that bilingual employees at the agency are allocated approximately 50 to 70% of their time in efforts such as consultation, community education, referral, community organization, and client advocacy. He believes that this is an appropriate structuring of community services because workshops, seminars, and consultation are less stigmatizing than direct mental health services, and can be held in community centers, churches, and temples within the refugee community. This is an effective forum in which to educate refugees not familiar with mental health services. Having the bilingual mental health worker conduct these workshops

rather than special "outreach workers" has the advantage of allowing refugees the chance to talk to and assess in a non-threatening environment the person from whom they would be receiving services. As workers get positive exposure in the community, barriers to coming in to receive treatment are reduced. One problem in conducting such outreach, however, has been the lack of reimbursement for such activities.

Taking an active role in community organization such as assisting establishment of MAA's has also produced many benefits (Lum, 1985). MAA's have played a major role in disseminating information about the services of the mental health agency. They have also assisted in outreach and referral for those at risk in the community. In general, the relationships with MAA's allow the agency to interact with and respond to the community needs more effectively.

Various forms of programmatic outreach efforts conducted by a variety of refugees agencies have been described by Murase, Egawa, and Tashima (1985). These efforts have included informational mailings such as brochures and bilingual newsletters, radio shows, and community workshops. Another form of outreach consists of locating satellite offices and clinics within ethnic community centers and agencies. These offices are frequently located within multi-service complexes which include many service, health, and educational agencies such as ESL programs, Department of Social Service offices, nutritional programs for women, infants and children (WIC), and other community agencies. According to Murase et al (1985), this "satellite programming" has been employed particularly effectively and extensively in the Los Angeles area. Such efforts can also extend to having bilingual workers hold office hours within schools, work on

programs within schools, and make home visits with their clients (Lum, 1985). The net result of these efforts is to bring the programs into direct physical contact with refugees, and to develop close networks between agencies such that referrals are easily made and followed-up.

The bilingual worker is usually the person most involved in implementing the networking with surrounding public and private service organizations. Bilingual workers represent the bridge between existing American agencies and the refugee community. Requests are frequent from local agencies and schools for bilingual workers to educate their personnel about the refugee culture and how to deal with refugee clients. Concerned agencies which lack knowledge about their local refugee communities may become extremely frustrated as they find themselves unable to develop rapport with their refugee clients (Santopietro, 1981), and unable to deal with the complaints brought before them. They naturally come to the bilingual/bicultural staff of refugee mental health service agencies for assistance and guidance. Bilingual workers may also become directly involved in patient advocacy with various agencies, and the ability to deal effectively with these agencies is vital (Lum, 1985; Murase et al., 1985).

Other forms of outreach include specific environmental interventions that bilinguals perform on behalf of their clients. These can include tasks for which paraprofessionals have traditionally been utilized, such as assisting clients with concrete problems such as transportation, housing, job-seeking, recreation, or shopping, as well as helping them obtain welfare, and medical services (James, 1979). This enables agencies to provide services which could not be provided through the use of professionals. Providing such interventions

is important for a variety of reasons. Alleviating major stressors in a patient's life is recognized as vital in many forms of intervention, even if a therapist does not get personally involved in addressing such problems. Lefley (1979) demonstrated that such interventions were highly effective in assisting treatment progress in community mental health center patients. With patients who confront such a variety of stressors, it is questionable whether treatment solely within the confines of a clinic can be fully effective (Tarail, 1979; Tung, 1978).

A second vital reason for getting personally involved in concrete aspects of problem solving is the establishment of rapport and trust with the refugee client. Even though the bilingual worker must be careful not to get caught up in trying to solve all the problems of their patients, assisting them with a few concrete, vitally important problem tasks will build trust, alleviate stress on the patient, and help convince the patient of the good intentions and sincerity of the worker (Tung, 1978). This fact was reported almost universally by those agencies visited by TAC. It also reinforces the importance of professional supervision and specific training to help the workers in determining where to draw the line between neccesary concrete action and over-involvment in the patient's life.

In summary, bilingual workers in most agencies have a vital responsibility as outreach workers, making themselves and their agency accessible to the refugee community, and educating the refugee as well as the majority community. As such, these workers need particularly effective communication skills, they need to be well informed about the cultures they are dealing with, they need to be persons who can be viewed with respect and trust by the refugee community, and they need the necessary outgoing personality attributes to conduct outreach.

These requirements have major implications when it comes to hiring and training bilinguals for work in mental health agencies.

Mental Health Counselor or Cotherapist

Little has been written about what is probably the most common use of refugee bilingual workers — that of a semi-autonomous mental health worker. This role of the refugee worker has been little described in the literature, for what are probably a variety of reasons. First, much of the literature and expertise in working with refugees has come from the medical profession, including psychiatry. Medical persons describing their work have most often utilized bilinguals primarily as interpreter/translators and culture brokers. They also tend to see only the most severely disturbed individuals. For this reason, their clientele is not appropriate for paraprofessional care (although the same can be said for many of the clients of community centers employing bilingual paraprofessionals), and their work reflects problems associated with cross-cultural work using bilingual interpreters. Directors of community or specialty refugee mental health centers employing refugee paraprofessional counselors are operating in non-academic settings, and report much of their time as being taken up with problems of agency survival. Also, judging from conversations with program directors, the training, level of responsibility, and degree of supervision of refugee workers is in a constant state of flux within these agencies due to vagaries in funding and heavy rates of utilization. Additionally, the model adopted in a community agency may have been adopted as a temporary response to need rather than as part of a long-term strategy. Given these factors, it is not surprising that the current form of bilingual

worker utilization has not been well described. In addition, each agency operates in its own, idiosyncratic way.

In spite of the differences between agencies, it has become clear that in most non-psychiatric settings bilinguals work with a high degree of independence, and usually one-on-one with the patient/client. This is true for ideological reasons as well as practical, economic ones. Reasons for utilizing bilinguals in this capacity include the cost of having patients seen simultaneously by interpreters and professionals, the desire to serve larger numbers of refugees within a given budget, and a belief in the power and ability of the paraprofessional in mental health work to render quality service if provided sufficient training and supervision (Wong, 1985).

Given this reality, and the fact that it is unlikely to change until persons from the refugee culture achieve professional degrees, it behooves us to consider the ways in which they are being used and misused, and how the situation might be improved.

There are studies on the use of paraprofessionals in mental health service, and evidence that paraprofessionals can perform counseling effectively with non-psychiatric populations (Durlak, 1979; Nietzel & Fischer, 1981). This is, however, still a controversial conclusion. Given the possibility that paraprofessionals can function as effective counselors in certain situations, however, it is worthwhile to consider the similarities in roles and responsibilities of American and refugee paraprofessionals.

The perspective of many advocating use of paraprofessionals in alcohol, drug, or family counseling has been "that even the high level of social skills demanded in individual psychotherapy could be mastered by persons with limited professional training (Siegel, 1973,

p. 139)." Paraprofessionals who were similar in terms of race, culture, social class, value, and experience were considered equally or more capable of developing the kind of genuine, empathetic, supportive relationship demanded in therapy (Siegel, 1973). With an appropriate fit, and with sufficient training of the paraprofessional, disadvantages stemming from the lack of professional training could supposedly be overcome. This view of the importance of a match or fit between helper and client is extended to the refugee situation by Lum (1985) and Wong (1985). Wong believes it is extremely unfortunate that certain agencies have chosen to provide mental health and counseling services through interpreters rather than training a pool of bilingual and bicultural personnel. He views the use of interpreters as detrimental both because there is a poor cultural/linguistic match between patient and provider, and because it delivers a tacit message to the refugee community that they are unable to help themselves. Wong (1985) recognizes that training bilinguals as paraprofessionals is only a temporary and non-ideal situation, but views it as the best way to proceed at the present time.

It cannot be doubted that having a linguistic and cultural fit between patient and therapist is advantageous. At the least, there has to be a common language and some understanding of each other's perspectives in order to avoid misunderstanding. Applying the goodness-of-fit model to the refugee paraprofessional situation has certain particularly problematic areas, however, especially with regard to whether the "fit" can compensate for lack of professional training. These problems stem from two main sources: 1) the high rate of severe pathology found in the refugee paraprofessional caseload,

and 2) the great difficulty in providing training and supervision to the refugee bilingual worker.

Because mental health services are used as a last resort, and are viewed as stigmatizing and unfamiliar, clients are usually seen only after significant pathology has developed and family members are no longer able to cope with the disturbed individual (Kinzie, 1985b; Tung, 1985). This, together with the high risk for severe psychopathology found among refugees, means that refugee mental health agencies are likely to see higher rates of severe psychopathology than agencies serving the non-refugee population. Particularly in the earlier stages of operation, agencies are likely to get referrals for psychotic or depressive conditions which are otherwise unmanageable (Kinzie, 1985b; Westermeyer, 1985). Although statistics across agencies have not been published, many agencies visited by TAC personnel reported that 60-70% of their caseloads were chronic patients with seriously disabling psychiatric diagnoses such as psychosis, major depression, or severe post-traumatic stress disorder. This means that refugee paraprofessionals are dealing with the most difficult class of psychiatric patients to treat, people who typically respond only slowly and sporadically to verbal counseling even in the best circumstances. This is not the population that Western paraprofessionals are expected to treat, nor for whom the quality of paraprofessional treatment is equal to professional care.

The second major difficulty is in providing adequate training and supervision. Traditional supervision techniques used for training Western paraprofessionals, such as quietly observing sessions and listening to audio or video tapes of sessions, are clearly less useful when the supervisor is unable to understand what is being said. When

a bilingual is functioning as an interpreter, some level of check can be in place, such as observing interpreter-patient verbal and non-verbal interaction, and discussing issues and questions with the interpreter during the session. In training the bilingual to engage in unsupervised intervention, however, these checks are gone and the supervisor must rely upon the recollection of the bilingual about the session to generate comments and suggestions. Since effective approaches to treatment with Southeast Asians tends to be directive, and task-oriented (Kinzie, 1981; Kinzie et al., 1980; Lum, 1985; Tsui & Schultz, 1985; Wong, 1985), this is not as bad a problem as it would be in insight-oriented therapy, but it is still far from ideal. Ways to address this problem could include having bilingual professional supervision when possible, having group supervision when more than one person from a given ethnic group works at an agency, and promoting more academic training in mental health. In general, a team approach which guarantees that the bilingual worker will not be "abandoned" with the client would seem to be a minimal requirement, even if the bilingual often sees the client one-on-one. In any case, however, the agency should plan on spending extra time in supervision, with recordings still useful in assisting the workers' recall of the session when the client permits such recording.

How might non-professional refugee counselors be utilized effectively given these constraints? One approach is to conduct the initial triage, history-taking, and assessment with a professional present most of the time. For certain elements of the interview, the professional may not need to be present, and during this time the bilingual-patient relationship can be developed as somewhat distinct

from the professional-patient relationship. After the initial assessment, the bilingual and clinician can discuss the case, develop a treatment plan, and determine how the bilingual can proceed. If a psychiatry or psychology referral is indicated, the bilingual can function as an interpreter. Otherwise (or in addition), the bilingual may initiate work along the lines of a treatment plan, receiving supervision along the way. Most programs appear to operate in roughly this fashion, and it should be noted that there is evidence that paraprofessionals working under close psychiatric supervision can achieve outcomes equal to or better than those of therapists with master's degrees, and possibly as well as doctoral level therapists for specific problems (Nietzel & Fisher, 1981). However, it is doubtful that most bilinguals working as paraprofessionals are receiving the necessary level of supervision. On our visits, insufficient supervision and training were frequent complaints by bilingual workers.

There are other pitfalls with this method as well. As bilinguals get used to working somewhat autonomously, they can come to object to working as translators in situations where it is warranted, and may take initiatives without appropriate consultation with their supervisor. Perhaps an even greater danger is that the agency begins to rely too heavily upon the bilingual worker, who is seriously lacking formal training but appears to be doing a good job. Inappropriate responsibilities such as having bilinguals administer psychological testing unsupervised and without training in psychometric principles has been reported to occur, as well as insufficient supervision of treatment sessions, and infrequent revision of treatment plans and reviews of progress. In some agencies

where case loads are overly high, it is left up to the bilingual whether or not to receive supervision on a given case at any given time, and there is insufficient time to review all cases with the supervisor. Although everyone involved seems to mean well and to be concerned with these issues, the result is that patients cannot be guaranteed quality care, and quality monitoring is frequently impossible.

One interesting approach to this problem has been the use of bilinguals in one agency as co-clinicians. The labels of "interpreter" or "translator" are avoided in order to emphasize the critical role of the bilingual worker, but the worker normally works using a team approach including bilingual, patient, and professional. Initial evaluations are always conducted in the presence and under the supervision of a professional. During later sessions, a professional may only be present for a brief period of time, but will almost always be present for at least part of the treatment session. The amount of professional participation is dictated by the stage of treatment, level of need of the patient, and experience of the bilingual. This system provides a necessary element of supervision, while still maximizing the possible size of the agency case load, and therefore increasing its cost-benefit ratio. The bilingual is given a high level of respect and responsibility, but is not left abandoned with the patient.

In those instances when a refugee is employed strictly as a "social adjustment" counselor, the autonomy is more warranted. In this case, the psychiatric cases are referred to other agencies, and workers deal with practical issues of finding employment, dealing with

transportation and schools, and generally handling the intricacies and legalities of life in the United States. Mental health issues such as depression frequently come up in this context, and the bilingual must be trained to screen cases that need further assessment. However, the bilingual, even if following up such a case, would not be treating the depression per se, but rather the practical ramifications of the depression. Home visits and telephone calls are a frequent aspect of such work, which tends to fall along the lines of community outreach.

## Special Issues and Problems

### Psychosocial Dynamics of the Bilingual Role

Work involving bilinguals as interpreters allows for a very complex interplay of interpersonal dynamics. In addition to the triad, there are the three dyads of patient-interpreter, interpreter-clinician, and patient-clinician. (Faust & Drickey, 1986; Westermeyer, 1987). Trouble in any of these relationships can damage the effectiveness of the intervention. Critical aspects of the interpreter-patient relationship may involve extra-clinic influences. For example, in a tight-knit refugee community, the refugee may well be acquainted with either the interpreter or members of the interpreter's family, and be reluctant to divulge personal, possibly embarrassing or shameful information. As a general rule, the interpreter should not be personally involved with the client outside the treatment situation (Richie, 1964). The patient may not have confidence in the confidentiality of information volunteered at the clinic. Other problems may occur when the interpreter and patient are of different sex, social status, if the interpreter is younger than the patient, or if the interpreter is unmarried and the patient is concerned with issues related to marriage (Faust & Drickey, 1986;

Ingall, 1984; Kemp, 1985; Santopietro, 1981; Westermeyer, 1987). It is unlikely that a patient will express objections to a given interpreter, however, so the clinician must rely on the worker to be aware of such problems and to communicate them to the clinician when appropriate. All these factors may influence the trust and respect the patient will accord the interpreter, and therefore influence the potential for succesful intervention.

The quality of the interpreter-clinician relationship is vital. Baker (1981) quotes a resettlement worker as saying "It is more important to have a good relationship with your interpreter than with your spouse" (page 393). The strength and power of having an efficient team as described by Westermeyer (1987) was noted earlier. For this reason, the stability of a team and the mutual trust which can develop from having worked together over a long period of time is extremely valuable.

As already mentioned, there can be difficulties with respect to the difference in status between clinician and interpreter (Baker, 1981). It is frequently the case that refugees, upon arrival, must accept employment in a much lower status job than they had in their country of origin. For example, refugee physicians have had to take jobs as interpreters or paraprofessionals, a highly significant drop in status. This can understandably create friction if the professional appears to look down upon or devalue the service of the bilingual. When one considers that those hired for bilingual positions tend to have been some of the most educated persons in their country, the status drop must be regarded as serious.

Friction may also be encountered when a bilingual, used to

working relatively autonomously, is asked to translate for a consulting psychiatrist either at the agency or at hospitals receiving referrals from the community. The psychiatrist may not be used to working with interpreters, and the bilingual may resent being placed in a subordinate role. MacKinnon and Michels (1971) also caution that physicians who are not used to working with interpreters may feel that their role is threatened because they cannot deal directly with the patient and may begin to relate in a dependent way upon the interpreter rather using him or her as an assistant. Perhaps some of these problems could be ameliorated by training the professionals in utilizing interpreters, and by increasing the respect both of agency and professional people for the interpreter role, which is truly an advanced and sophisticated one.

It is somewhat of a mystery why there seems to be a devaluation of the interpreter role in many clinical settings, both by physicians and bilinguals themselves. It makes sense that bilinguals may perform duties beyond that of interpreter, but this should not devalue the role of interpreter. Even some agencies which are very concerned with elevating the status of their bilinguals seem to do so by demeaning the interpreter function, rather than elevating the status of interpretation to the level it deserves. In so doing, their bilingual workers are bound to develop resentment over the role when it is asked of them. Agencies which utilize interpreters, and which consider the interpreter role to be a valued and difficult one, do not report the same degree of difficulty between clinician and bilingual (Kinzie, 1985b). One kind of evidence that the difficulty of interpretation is valued would be that efforts were made to provide training for the task rather than to assume that any bilingual should be able to handle

it. It must be recognized that not all bilinguals are going to be effective interpreters, that on occasion the interpersonal dynamics may simply not work, and that incompetent interpreters should be replaced if necessary (Williams, 1985).

The same dynamics that operate between interpreter and patient may also operate between clinician and interpreter. For example, a male interpreter may have difficulty respecting the authority of a woman therapist, and an older interpreter may have difficulty respecting a younger clinician. Conversely, the same may be said about the clinician's attitude and trust of the bilingual. In addition, subtle and semi-conscious cultural biases may interfere with the clinician-interpreter relationship (Westermeyer, 1987). Westermeyer recommends that clinicians contemplating cross-cultural work consider their own biases, make them conscious, and not allow them to interfere with their clinical work.

One problem brought out during TAC visits to several agencies was the tendency of some interpreters and bilingual workers to stray from agreed-upon agendas, to give advice, criticism, and guidance to patients without informing or getting the consent of the clinician. This was especially a problem when the worker did not respect the expertise of the clinician, when the cultural values of the bilingual worker were at odds with the suggestions of the clinician, or when the worker was inexperienced or untrained in the task. Such topics as wife or child abuse and the appropriate actions to take in such cases can pull the clinician and worker into direct cultural conflict.

The clinician-patient relationship, as mediated verbally via interpreter, relies heavily upon the skills of the interpreter, the

understanding on the part of the clinician of the refugee's culture, and the many forms of non-verbal communication. Several authors have discussed appropriate forms of clinician interaction with refugees (Brower, 1980; Kinzie, 1980, 1985a, 1985b; Santopietro, 1981; Tsui & Schultz, 1985; Westermeyer, 1987). When using interpreters, the clinician should speak directly to the patient, not to the interpreter. Steady eye contact is generally to be avoided with Southeast Asian clients. Such actions as crossing legs, pointing, or beckoning may be considered very rude, as well as touching patients on the head without first asking permission. When talking with family groups, the elder should be respectfully addressed first (Santopietro, 1981). As a general principle, the appropriate etiquette assists in developing a trusting, beneficial relationship. With adequate rapport, other barriers become much less significant. The bilingual worker can be a valuable asset in providing instructions and interpretations regarding proper behavior, phrasing questions in an appropriate manner, and informing the clinician about the "diplomatic" status of the interview. Fortunately the role of Doctor is a familiar one to most refugee groups, and strong therapeutic bonds are possible when the relationship is used in a culturally congruent manner (Kinzie, 1985b). However, the same disparities that can affect the patient-interpreter relationship are also factors in the patient-clinician relationship. Again, these include such things as age, sex, marital status, education, and social class (Westermeyer, 1987).

Another problematic aspect of the patient-clinician or patient-paraprofessional relationship concerns issues of transference and countertransference. Transference refers to the projection of feelings and attitudes by the patient upon the therapist based on

previous experiences of the patient. Countertransference refers to such projections by the therapist onto the client, and more generally to the feelings toward the client aroused during treatment. For example, the history of the Vietnam war, with the varied emotional responses it engendered may influence the approach of Western therapists to Vietnamese patients. Conversely, the Vietnamese patient who had unpleasant war or refugee experiences involving Americans may project negative feelings upon the American clinician (Brower, 1980). Similar issues may be present with other refugee groups, such as Laotians, Hmong, and Khmer.

One of the most serious problems in the process of history-taking and treatment is the clinician and/or interpreter's own inability to deal with the horror stories that one is likely to hear from those refugee groups which suffered particularly traumatic times such as the Khmer (Kinzie, 1984, 1985b). The difficulty in listening to and responding to these stories is compounded for bilinguals for whom the tales bring back memories of their own traumatic experiences. A common sequela of emotionally traumatic events, reflected in the diagnostic criteria for post-traumatic stress disorder (APA, 1980) is that reminders of the trauma can cause a re-experiencing of some of the affect and anxiety associated with the event (Horowitz, 1986). For refugee survivors acting either as interpreters or as paraprofessional counselors, listening to these stories can be very painful, and may result in resistance on the part of the bilingual to bring up or encourage discussion of painful events. Within at least one agency visited by TAC, a recognition of this problem has led to holding weekly group meetings of the bilingual staff, moderated by an

outside psychiatrist, intended to help the bilinguals deal with their own experiences which are brought to mind during counseling sessions. Even within this agency, there has been great reluctance on the part of the bilingual staff to discuss traumatic events with their clients, even when functioning as interpreters. This is problematic because a thorough history is a prerequisite of quality care and assessment, and because treatment may eventually involve discussing the traumatic events at least to some extent (Kinzie, 1981, 1985a; Kinzie et al., 1984).

Training

Given that bilingual workers have generally received no prior training or experience in mental health before going to work in these agencies, the issue of training is a vital one. One particularly detailed account of a well coordinated and supported training program for bilinguals can be found in an article by Wong (1985). However, funding for bilingual training programs has turned out to be sporadic at best, and tends to be scanty when available.

During the course of TAC visits to a variety of agencies, we asked about training practices. Stated briefly, most agencies do not have coordinated, standardized training programs for their bilingual workers. Instead, training tends to come in the form of on-the-job case supervision (not always in adequate amounts), occasional (ranging from every other week to much less than monthly) lectures from outside or within agency psychiatrists, psychologists, and social workers, and occasionally some coursework at local schools and universities. Only rarely does a worker receive substantial training prior to seeing clients, although it seems common practice to give new personnel less complicated cases and smaller caseloads whenever possible. In general, agency personnel were aware of the deficiencies in training,

but were caught in a resource-poor environment with high demand for service, and time and money set aside for training competed directly with service capability.

The issues involved in training bilinguals are many, and are currently being addressed by the TAC. TAC personnel are reviewing the various training programs that have been developed and are operating in the United States, and will be developing suggested procedures and curricula for training both refugee bilingual paraprofessionals and mental health professionals. Materials from this effort will be generated over the next year. Given the high level of responsibility accorded the bilingual worker, and the lack of prior mental health experience characteristic of the refugee bilingual, training is a vital issue. Training programs must not only provide bilinguals with knowledge of Western mental health concepts (including diagnostic categories and processes, and concepts of etilogy, treatment, and prevention), but also some understanding of the use of medications, legal procedures regarding reporting child or spouse abuse, concepts and processes of networking with surrounding agencies, and transference-countertransference issues. And of course bilinguals called upon to act as translators, interpreters, and culture brokers need training in how to effectively carry out these tasks.

There are currently very few schools or training sites which can train a refugee to become a bilingual paraprofessional provider (there are some agencies which offer relatively short mental health seminars for refugee providers, and some schools with cross-cultural coursework in social services). There are also insufficient numbers of refugees entering college programs in the mental health field. Therefore, the

service agencies themselves frequently have to provide the training to their new workers. In a time of insufficient resources, training suffers directly. Wong (1985) provides a good example of what a training program for bilingual workers can be. Trainees received classroom instruction, supervised mental health practice in a variety of settings, and were placed in refugee mental health service programs after completing training. This effort only received funding for one year, and now the agency which developed the program is financially unable to follow its own model.

Certification and Quality Assurance

This issue will only be mentioned in passing. One of the problems of the sporadic refugee mental health service delivery "system," and the inconsistency of training efforts, has been a lack of quality assurance. This is not to say that quality is always poor, but rather that effective monitoring and control has been lacking. Considering the problems, however, it would be surprising if quality of service even approaches that which the majority population would find acceptable for themselves.

This is not intended as a criticism of the agencies and personnel involved. The bilingual workers at these agencies are by and large very talented, dedicated people, or otherwise they wouldn't find themselves in their position. However, programs have been insufficiently funded, and have experienced such severe disruptions in funding that they have not had the opportunity to develop consistent, high-quality training and supervision procedures (Lum, 1985).

One approach to quality assurance is certification. Certification implies that standards and training programs exist for the occupation in question. One agency which works with a variety of

ethnic groups, though not specifically refugees, provides its own internal certification of paraprofessionals once they have received a certain amount of training. This provides both a sense of accomplishment and a demonstration of having received at least a certain amount of training (Tarail, 1979). Although legal certification might be advisable, training is lagging far behind. By the time such certification is established and functioning, the advent of refugee professionals and continuing acculturation of the present refugee population may render it unnecessary. However, given that other refugees and immigrants can be expected to arrive, the development of plans and curricula would still be beneficial. One possibility might be for certain 2-year Associate of Arts programs in the mental health area (e.g., Psychiatric Technician) to develop special programs for cross-cultural and cross-language service.

Bilingual Career Development

The bilingual, non-professional worker is in an awkward career position. There is an inherent time limitation on the need for such persons, the job as presently construed provides little in the way of salary, benefits, or security, and there is no true opportunity for advancement. It is truly a dead-end job unless training is provided or allowed which can lead to a professional degree. Many bilinguals find their jobs to be greater than full-time, and are unable to devote additional time to schooling. This is doubly unfortunate because those experienced people who have weathered the storm, dealt with an extremely difficult period in mental health services, and who still feel committed to the field are the ones most needed. Their very practice in the field at the present time is preventing development of

their future in the field, and delays the advent of the refugee professional worker. Many are supporting families on a low income, have English skills which are still barely adequate for an academic setting, and are unable to pursue school without the assistance of scholarships or other financial assistance programs. Because of English difficulties, most refugees may opt for less verbally-demanding majors, such as electronics, computer science, math and engineering. If a social goal is to develop refugee mental health professionals, a deliberate program should be created to serve that purpose. At the very least, bilingual workers should be allowed time to attend workshops and conferences, and to receive further schooling.

As an additional note, many minority-oriented scholarships and fellowships are not made available to "Asians" due to the success of Japanese, Chinese, and other Asians in our country. This means that until disadvantaged Southeast Asians are specifically included for consideration, they are not eligible to receive the awards.

Burnout among Bilingual Workers

Burnout is a condition characterized by "a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who do 'people work' of some kind (Maslach & Jackson, 1981, p. 99)." Depersonalization used in this way refers to an unhealthy emotional detachment from the persons being served as a defense against further exhaustion and frustration. Burnout in human services has been implicated in high turnover rates, loss of morale, and reduction in quality of patient care (Maslach, 1976, 1978; Muldary, 1983). There is every reason to believe that burnout is taking its toll among refugee mental health workers.

Factors identified which correlate with high burnout rates in

mental health centers include high case loads, high percentages of chronic or seriously ill patients, low potential for achieving a cure, inability to emotionally escape from the demands of the job or the clients, lack of sense of success, and low levels of support from co-workers (Maslach, 1978, 1982; Pines & Maslach, 1978). Based upon these factors, the bilingual worker faces an extremely high risk for burnout. Their jobs are typically characterized by high levels of almost all these risk factors, in addition to being undertrained for their task. Additionally, an interpreter working in a hospital or other setting, whose contribution is not acknowledged, and who is the only one from his culture working in that setting would be at very high risk for burnout.

A major problem expressed by bilinguals during our TAC visits to programs was the sense that the needs of their community were great, and that they must be available to help people whenever called upon. Such a problem is also discussed by Baker (1981), who notes that the Western notions of the 8-hour mental health work day, and of "detached concern" do not have a Southeast Asian counterpart. Bilingual workers interviewed during TAC visits frequently indicated that they worked extra hours for clients and their families over evenings and weekends. Baker reports that bilingual workers who fail to provide such services for clients "are subject to accusations of dishonesty, lack of concern, and 'selling out to the Americans'" (p. 395). In addition, bilingual workers may often be the victims of severe backbiting, gossip, and alienation from their community, as the refugee community fails to understand how the person got their "cushy" job, why the worker isn't more responsive to individuals needs and

demands, and how difficult the bilingual's job is. Such difficulties within their own community can seriously affect the emotional well-being of the worker and contribute greatly to burnout (R. R. Jones, personal communication, March 26, 1987). Several bilingual workers indicated they had to move out of their communities to get away from the wearying demands of the people around them (a very adaptive move), and others have gotten unlisted phone numbers. Clearly these workers are functioning in an environment ripe for burnout.

The presence of burn-out may be reflected in the fact that only half of the bilingual workers surveyed during our visits were planning to continue in the mental health field. Other factors such as greater status and pay in other jobs are probably also important factors in their leaving mental health work, however. In any case, the potential for burnout must be seriously considered by agency directors and supervisors, and measures should be taken as part of training to guard against the experience of burnout.

Abuse of Power

Little has been written about the abuse of power by bilingual workers, but this does represent a danger that must be watched for. Such abuses as requiring extra fees for appointments, intimidating clients, showing favoritism to family and friends, and providing special access to other services via network connections must be guarded against. Conducting extra, unsupervised work out of the home on weekends and evenings for a fee under the auspices of the employing agency is another possibility for abuse. Some of these practices may have been commonplace in their native countries, but are not considered ethical in the United States. Training with regard to Western mental health ethics must be provided.

Another problem relates to confidentiality. Confidentiality is sometimes a difficult concept to explain both to the bilingual worker and the patient. The notion that information should be kept from relatives of the patient, particularly elders, is a foreign one. In the tightly knit refugee communities, there is a fear that the information gained might spread through the community. If such were to happen, the ability of the agency to function effectively would be severely compromised. Again, thorough training in the area of confidentiality is necessary.

Recruiting/Hiring Bilinguals

Because the bilingual represents the agency to the community, and because the refugee community will be receiving services from or through that bilingual, it is of utmost importance that the person selected has the trust, confidence and respect of the community (Lum, 1985). Ideally, an agency will hire both a man and a woman for bilingual services, as barriers between the sexes can be difficult to cross (Brower, 1980; Ingall, 1984; Santopietro, 1981). Other considerations such as age and marital status are also important. In addition, those responsible for hiring should be aware of factions in the community, whether religious or political, as well as clans. If a bilingual is hired who is strongly identified with one faction or group, persons from the other faction may be unwilling to utilize the worker's services. While this problem cannot be completely avoided, careful hiring to bring in people who can work with the different groups as much as possible is essential.

In attempting to identify "natural leaders" and respected individuals within the community to hire, a variety of sources should

be consulted. One agency copes with this problem by inviting representatives from all MAA's and other refugee organizations to sit in on round-table hiring interviews. In addition, members of a clan's power structure as well as religeous leaders may need to be included. This keeps the hiring practice in the open, enables the agency personnel to see how the candidate deals with all parties, and satisfies the various groups that they have had an influence on the decision making. Another agency privately consults with various sources and leaders in the community. This agency once had the experience of nearly hiring a charismatic, intelligent, bilingual person with excellent command of both languages and cultures. The hiring process for this person was brought to an abrupt halt when it was determined that several members of the community recalled the person as being highly ranked in the army and seriously abusing his powers, and terrorizing people in his native country. Even if the information were untrue, hiring someone with that reputation would have done serious damage to the agency's ability to serve.

## Conclusion

The role of the bilingual worker in refugee mental health is a difficult and sometimes confusing one, and the situation is not likely to improve very much until funding becomes more stable, bilinguals start receiving professional degrees, and refugees develop the political or legal clout to require states and counties to supply services to them commensurate with their need and numbers. In many sites, services are provided directly by bilingual paraprofessional workers who have received little training in mental health and who may not receive a great deal of supervision. The workers are dedicated and hard working, but they work at a serious disadvantage.

Many people believe that bilinguals should function as direct counselors rather than interpreters for political and philosophical reasons. However, even if this is perspective is not adopted, few agencies have the resources to provide interpreted intervention for their monolingual clients. Therefore, bilinguals are utilized as paraprofessional counselors (primary therapists) in most agencies.

Bilingual workers perform jobs beyond the scope of what is asked of English-speaking paraprofessionals, and beyond what should ideally be asked of them. Refugee caseloads tend to be heavily chronic or acute crisis. Workers see severely psychotic, depressed, and anxious patients who would present major challenges to the most highly trained professionals. Therefore, regardless of whether or not bilingual paraprofessionals operate as primary therapists in a given clinic, a patient should always receive a thorough, professional assessment prior to development of a treatment plan. The high incidence of severe disorder demands that the assessment be done as professionally as possible, and that bilinguals receive close supervision as well as personal and professional support throughout the intervention process. Such support can increase quality of service, and may help prevent or reduce problems of staff burnout.

The nature of the bilinguals' job, their own history as refugees, and their commitment to and close ties with their community puts them at high risk for burnout. To reduce levels of burnout, efforts should be made to increase the level of training, supervision and support bilinguals receive, to provide a career path for those who wish to stay in the mental health field, and to eliminate the inappropriate demands made of them. It is vital that the difficulty of their job be

appreciated and respected by the mental health professionals who work with them, and that the unique contributions bilinguals have to offer be recognized.

It is probably inevitable that certain culturally as well as personality-based tensions and conflicts between American clinicians and bilingual workers will arise due to differences in outlooks and belief systems. The clinician must be sensitive to such issues, and they must be dealt with constructively so that both persons can operate with clarity and uniformity of purpose, and a sense of personal integrity in their challenging roles.

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