FOUNDATIONS FOR DEVELOPING A MODEL TRAINING PROGRAM FOR U.S. MENTAL HEALTH INTERPRETERS

by

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ABSTRACT

ANDREW B GOODMAN. Foundations for Developing a Model Training Program for U.S. Mental Health Interpreters. (Under the Direction of DR. CHRISTOPHER MELLINGER)

Interpreters regularly help to bridge language barriers in many settings so that limited-English-proficient or non-English-speaking people can have equal access to English-dominant services in the linguistically-diverse U.S. To ensure quality interpreting services, several certifications have been developed, especially in medical settings. These provide an opportunity for interpreters to demonstrate their knowledge in essential areas; however, current certifications place limited emphasis on mental health interpreting despite its importance to overall wellbeing. Interpreters working in these settings face unique challenges that must be addressed in training programs in order to be prepared to work in mental health settings. Therefore, a model program for mental health interpreting education is proposed that focuses on the specific aspects required to successfully work in this area. In addition to language and interpreting proficiency required of all interpreters, this model also accounts for domain-specific knowledge, psychotherapeutic methods, codes of conduct, and professional practice. The model proposes several learning objectives and outcomes that can complement existing medical interpreting programs and suggests course and content sequencing to ensure adequate preparation for interpreters working in these areas.

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CHAPTER 1: INTRODUCTION

Ever since its beginnings as a nation, the United States has been home to a number of culturally and ethnically diverse populations. As the country has changed over the years through its growth and expansion, the specific populations and demographic profile have also changed as a result of a range of circumstances one of which being immigration. Immigrants who have come to settle in the U.S., especially immigrants who speak languages other than English, have continued to be an important part of the multicultural and multiethnic society that comprises this country in contributing their work and unique talents to provide basic services and fulfill societal needs (e.g., teachers, carpenters, firefighters). While most people in the U.S. self-identify as English speakers, there has been a steady increase in the number of Spanish-speakers that reside in the U.S. So much so, in fact, that members of this group exceed over 50 million, a number that is expected to increase to close to 100 million by 2050 (Rastogi, Massey-Hastings, and Wieling 2012). This population is typically associated with states such as Florida, Arizona, Texas, and California; however, other states will also see numbers rise (Castaño, Biever, González, and Anderson 2007).

Before proceeding, it is important to clarify several terms that will be used throughout this thesis. First are the terms related to the specific population under discussion, namely Hispanics and Latino/as. While the terms *Hispanic* and *Latino/a* are often used interchangeably, there are slight differences between these concepts. The term "Latino" usually refers to anyone who was born in Latin America or to someone who lives in the U.S. and has ancestors from that region, including Brazil. The term "Hispanic" is a more narrow term that includes individuals from Spanish-speaking Latin

America. Part of the confusion between these two terms lies in how the U.S. Census categorizes its population. For instance, in 2010 the census listed both terms together and listed Spanish-speaking areas, but left out areas such as Brazil, which is problematic for Brazilians, who could not understand which box they should check ("What's the Difference between Hispanic and Latino?"). In a similar vein, several other terms merit mention, including immigrant/migrant, Limited English Proficient, and refugee. The UN High Commissioner for Refugees website draws a clear distinction between the terms "migrant," "immigrant," and "refugee." Typically, the terms "migrant" and "immigrant" refer to someone who moves to a new country in order to find work, education, or for other personal reasons, while refugees are individuals who flee their home country due to armed conflict or persecution ("UNHCR viewpoint: 'Refugee' or 'migrant' – Which is right?"). Moreover, a person who is Limited English Proficient can either be a refugee or a migrant/immigrant, as Limited English Proficient refers to anyone living in the U.S. who speaks English "less than very well" (Castaño, Biever, González, and Anderson 2007; G. Kim et al. 2011).

In the United States, millions of Latino/as are fluent or fairly proficient in English as a result of being born here, and often speak Spanish in their homes and communities as well; however, a sizeable percentage have a limited proficiency in English and are mostly monolingual. For example, roughly 12.5 of the 26.7 million people who speak Spanish at home speak English with a "less than very well" proficiency (Castaño, Biever, González, and Anderson 2007). For those 12.5 million, the ability to carry out certain tasks (e.g., doctor visits, finding housing) can be more difficult than it would be for proficient English speakers.

For example, people who have limited English Proficiency may find it difficult to interact with the legal system in the United States. To ensure parties of all backgrounds receive equal access, interpreting services are available. During criminal proceedings, an interpreter may be present during the arraignment, opening statements, and cross examinations, and on occasion, might (sight) translate a range of documents such as waivers of counsel, witness statements, and letters. Mellinger (2017) highlights the elucidating effects that the translation of these types of documents can have on deciding the fate of a case as well as on macro-level issues such as due process, equal access, and ethics. In his study, Mellinger was curious in particular to the effects that translation of waivers of counsel can have on overall meaning from English to Spanish. In sum, he found that several shifts had occurred at the lexical and grammatical level because of source language residual effect or the differences in legal systems, and this in turn raises questions with regard to due process, equal access, and ethics.

Healthcare is another service that is essential to members of society. This umbrella term covers a broad range of services related to physical health (e.g., pediatrics, oncology) and also encompasses the field of mental health. Mental health is an important part of an individual's overall wellbeing, regardless of gender, race, ethnicity, or culture. For instance, stress and lack of sleep due to untreated or not fully-managed mental illness can lead to a lack of productivity at work. It has an obvious impact on a parent's ability to work and provide for their children, for instance (Ohrnberger, Fichera, and Sutton 2017). Likewise, excessive use of addictive substances (e.g., nicotine or alcohol) as coping mechanisms can negatively impact physical health, as well as lead to death or harm to others (*ibid*). Long-term acculturation for Latino immigrants, especially those who are

third generation, has also been closely tied to physical health symptoms. Generally speaking, the extended process of acculturation has been shown to often produce negative results such as depression and substance abuse, and the risks for physical ailments such as diabetes and hypertension are much higher than for foreign-born Latinos who have only just recently moved to the United States (Alegría et al. 2006; Falicov 2014). In Limited English Proficient (hereinafter, LEP) populations, untreated mental illness can lead to problems related to self-care and general functioning, as well as being able to do basic activities such as holding a job and finding housing (Snowden, Masland, and Guerrero 2007). In addition, untreated mental illness can impede learning English for immigrants who want to integrate fully into American life.

1.1. Barriers to Healthcare

To provide a more specific example of the physical effects of mental illness, Crezee, Jülich, and Hayward (2013) noted that refugees from Bhutan, Central Africa, and other areas who were aided by interpreters arrived at the Magere Refugee Resettlement Center in Auckland with mental illnesses ranging from anxiety, depression disorders, post-traumatic stress disorder, and schizophrenia. Some of the physical symptoms associated with depressive disorders include changes in weight, insomnia, or lethargy, while schizophrenia symptoms can include disorganized behavior, lack of motivation, and speech problems (SAMHSA 2014).These conditions, especially ones such as Post-Traumatic Stress Disorder can have a clear impact on interpreters, as interpreters take on the patients' voice and therefore can live their trauma as if it was their own. While refugees only make up a part of the overall LEP community, they provide a unique perspective into how closely physical and mental health are interrelated, and therefore

how important mental health can be to ensure a happy and healthy life. Vicarious trauma is a big issue in mental health interpreting and, while any patient who may come into counseling may be dealing with trauma (refugee or otherwise), refugees are often even more so, and clearly show how mental health interpreting has its own unique challenges.

Other major barriers to mental health treatment, besides a linguistic one (i.e., a counselor who speaks English only and a patient who speaks Spanish only), are the various stigmas that are often attached to mental illness. In the mental health research community, researchers such as Fripp and Carlson (2017: 83) have addressed the phenomenon of stigmatization and characterize the term as an "internalization of stereotype," which they define as the actions and attitudes of others through social and behavioral interaction that cause stigma in the individual. Stereotypes about how people with a mental illness communicate, dress, or act not only affect their self-esteem, but also have damaging effects on their treatment options. These damaging effects can sometimes lead people to either never pursue treatment or stop treatment at some point during the process (Corrigan 2004). Patients often feel shame for their mental illness, both internally and from family, which can have a crippling effect on their ability to keep friends, hold a job, and achieve personal goals in their lives (Alegría et al. 2007, Corrigan 2004, Elkington et al. 2012).

This phenomenon of stigmatization, even though not limited to a specific race or ethnicity, is often more prevalent in individuals of color, such as African Americans and Latino/as (Corrigan 2004). From a different angle, Falicov (2014) suggests that stigma is a term that denotes shame, avoidance, or resistance to seeking treatment for mental health conditions One reason suggested by the author for stigma is the individuals' fear of being

labeled as "crazy" and a potential isolation from their communities. The reason behind this trend, especially for Latino/as, is multifaceted, but a major influence stems from families. Latino/a culture, in general, is very family-centered, and as a result, messages of stigma often are derived from their relatives (Elkington et al. 2012; Fripp and Carlson 2017; G. Kim et al. 2011; Rastogi, Massey-Hastings, and Wieling 2012). This stigma has a noticeable effect on the number of Latino/as who seek treatment and can harm self-esteem, which ties heavily to mental health (Corrigan 2004). The way the patient feels about him or herself has a marked impact on the direction of treatment, and thus an impact on the interpreter providing a rendition of the patient's words.

Familismo, or very close family ties for Latinos, sometimes makes it difficult for individuals to seek the help they need when living with extended relatives. Falicov (2014) states that part of this challenge may be the result of prioritizing financial contributions to the family unit, child rearing, and other family issues over their own needs (Falicov 2014). For parents, *familismo* also plays a big role in household cohesion in the way that they view their children. Because this phenomenon shapes parental views of their children and their behavior, parents may have a greater tolerance for problematic behavior that could be disruptive to family cohesion and general family functioning (Chapman and Stein 2014). In a similar vein, Latino families are less likely to perceive mental illness as being as important as a physical ailment. Consequently, a person in need of professional counseling may be encouraged to seek help from relatives instead of seeing a psychotherapist (Elkington et al. 2012). For those people who do seek treatment, family reactions are often mixed. For some, family relationships improve after treatment,

while for others the family dynamics were faulted (*ibid*). A worsening relationship to one's family often then exacerbates underlying mental problems.

A final barrier that prevents many U.S. immigrants from accessing mental health services is financial. Unlike other developed countries, the United States does not have universal healthcare and instead relies on a unique private/public system in which some services are provided by a public option (e.g., VA services or Medicare) and others are provided by private insurers and the individual is free to choose the insurance plan they want. As a result of this system, many Americans have some form of health insurance, but 29 million people under the age of 65 do not as private insurance plans can often be expensive (CDC Health Insurance Coverage). This disparity is further amplified when taking into account race and ethnic background. Whites are far more likely to be insured than any other racial group and are more likely to be insured through private plans, whereas the African American and Latino populations are more frequently covered through public options (Zuvekas and Tallaferro 2003). Alegría et al. (2007) also note the relationship between insurance coverage and the utilization of mental health services by the U.S. Latino/a population. According to their research, only 19.1% of uninsured Latinos used any type of service, versus 38.6% with private insurance, and around 51.6% covered by public insurance.

The challenge of getting insurance is closely tied to income levels and, by extension, employment. In some instances, health insurance is provided by employers. Since many Spanish-speaking immigrants are often limited in their ability to access higher-paying jobs, they are compelled to work low-paying, labor-intensive jobs. These positions do not always have health insurance provided as part of their employment, and

the low income levels make purchasing health insurance difficult. Moreover, linguistic barriers can also make it more challenging to understand all of the healthcare options and to apply for insurance (Alegría et al. 2007). Depending on insurance, a native Spanish speaker could be limited to mental health services that they can receive, and some may be deterred by a lack of money.

1.2. Mental Health Interpreting: An Underdeveloped Field in the U.S.

To address the linguistic challenges that LEP populations experience, interpreting programs have been developed to help prepare professional interpreters to mediate in a range of settings where relay of information between languages is crucial. In the United States, interpreting programs are often focused on legal or medical settings, while other areas such as education and social services are generally combined into what is referred to as *community interpreting*. At times, these programs do not receive the same amount of attention, and the opportunity to be certified is more limited. For example, the Middlebury Institute of International Studies has one of the few community interpreting specialization programs offered in the States. However, regardless of the context in which interpreting services are provided, the same basic modes of interpreting are used: simultaneous, consecutive, and sight translation. Each of these modes is used to convey information from one party to another. For example, the consecutive mode involves a speaker pausing every few sentences to wait for the message to be orally translated, which could occur as a patient is explaining their daily life to a therapist (Hwa-Froelich and Westby 2003). Sight translation, in contrast, is when an oral translation of a written document is provided by the interpreter (Hwa-Froelich and Westby 2003). Documents in mental health that often need to be sight translated include initial intake forms and mental

health evaluation questionnaires. Interpreters working in community settings regularly work with these modes of interpreting and, as such, need to be proficient in each of them.

As it has been established thus far, mental health is an important but often stigmatized, area of healthcare. Mental health interpreting is no different. Additionally, it is not optimal that mental health interpreting gets lumped into general healthcare interpreting certification programs without any real emphasis on its unique features. This thesis, thus, will focus on the specific context in which healthcare interpreting services are provided in mental health settings in the United States. While often overlooked, this area of interpreting is no less important than areas such as courtrooms or hospitals, and it encompasses a range of areas associated with mental health, such as counseling centers, psychiatric wards, and other mental health clinics. Interpreting in mental health contexts can sometimes pose challenges similar to those encountered in healthcare interpreting; however, it differs largely due to its more socially-oriented nature and the need for all members of the team to help co-create meaning (Angelelli 2004; Green, Sperlinger, and Carswell 2012; Mudarikiri 2003). To clarify, the overarching goal of therapy sessions is not to find a hidden truth or to administer a diagnosis, but rather to understand the patient's condition and help the patient cope with underlying mental issues. In other words, therapy is something that the patient and care provider (and interpreter when involved) engage in together because of the relational nature of mental health therapy (Bot 2006).

When an interpreter is brought into a counseling setting, both counselor and interpreter work together to understand and treat the patient through a "working alliance." This alliance includes not only sharing important information between the interpreter and

care provider, but also showing respect and empathy to the patient and keeping an organized method of communication. Bot (2006) describes therapy as a "co-construction of meaning" and argues that mental health interpreting is different because there is a "therapeutic reality" in which everyone helps to make sense of the interaction, including the language interpreter. This differs from other forms of interpreting in that psychotherapy is more relation-based and treatment hinges on the interpreter and service provider's ability to provide effective services (*ibid*). Unlike in other healthcare settings, the psychologist in a mental health clinic also has a different level of controlling and monitoring power than in other health settings (Bot 2006). However, when working with an interpreter, Bot describes that there is a feeling of a loss of control in that the therapist immediately does not understand what the patient is saying, and they may feel that the interpreter has taken a role that was perhaps "reserved for them." To overcome this challenge when working with an interpreter, it is necessary to develop a healthy working relationship and a sense of trust between patient, interpreter, and care provider (Rousseau, Measham, and Moro 2011; Searight and Searight 2009; Tribe and Morrissey 2004; Tribe and Thompson 2011).

Another unique feature of mental health interpreting that is not necessarily found in other forms of interpreting is the practice of briefing and debriefing that can occur between the therapist and interpreter. In some instances, patients in counseling sessions, such as refugees, can share traumatic events in their lives. Most mental health interpreters, when given the opportunity to reflect on their profession, strongly agree that these briefing/debriefing sessions are needed to better prepare for what might come up in sessions (Crezee, Jülich, and Hayward 2011; Doherty, Macintyre, and Wyne 2010). In

essence, briefing sessions are short meetings before interpreting occurs in counseling that are put into place to prevent vicarious trauma by allowing interpreters to emotionally prepare themselves and better understand the patient's background (*ibid*). Recommendations about the time and structure of briefing sessions before and after sessions (pre- and post-sessions) vary across organizations, but Tribe and Thompson (2011) argue that about 10-15 minutes to discuss the purpose of the meeting and to bring up any relevant cultural issues is often sufficient. At the end of each session, about the same amount of time should be taken to review what was said in the counseling session to offer targeted support and potential supervision as needed for the interpreter (Tribe and Thompson 2011). On a similar note, Tribe and Morrissey (2004) put forth similar ideas, pointing out that the interpreter is not just a machine, but a living human being who needs proper support, and that a brief meeting after each session to discuss how the therapist and the interpreter worked together is essential in building trust and a good relationship.

These sessions are also established to protect the interpreter from vicarious traumatization. Vicarious trauma, which will be discussed further in later sections, is a state of mind in which interpreters connect emotionally with a traumatized patient and as a result, become traumatized themselves. This is an obvious concern for mental health interpreters, who may experience emotional distress that may render them unable to complete the interpreting job for a client. Vicarious trauma can occur with any patient who comes in for treatment, but it is markedly frequent when interpreting for refugees *(ibid).* Since a person's lived experience and potential trauma is relayed during a therapy or counseling session, the interpreters can be affected by recounting this information and it can become an obstacle that both the therapist and the interpreter have to work together

to overcome. This obstacle of vicarious trauma is especially relevant if the interpreter is also a refugee and both the interpreter and the patient have experienced similar events in their lives (*ibid*).

1.3. The Importance of Interpreter Training

While work has been done to try to eliminate training disparities in legal settings and healthcare that exist, current educational opportunities do not account for preparing interpreters to work in all of these fields. This notion of preparedness, especially in the context of role, is important, because interpreters are often seen as taking on a variety of roles, including cultural broker and bilingual professional. These roles, in turn, are a significant aspect of the interpreter's job. Without appropriate training, interpreters may not be able to maintain their role(s) or may not understanding what their role is in a given context. Some of the consequences of inadequate training could range from patient reluctance to use mental health services because of linguistic barriers and an overall feeling of powerlessness, the patient struggling to communicate needs, and the patient choosing family or friends to try to communicate for them, which raises ethical concerns (Baylav 2003). Mental health settings are also about building trust and confidence and creating a relaxing and safe space for the patient rather than focusing solely on providing information (Miletic et al. 2006). While this is not unique to the field of psychotherapy, mental health does raise additional concerns over information sensitivity and patient willingness to be treated by the mental health professional.

Therefore, this thesis proposes a model for training interpreters in mental health contexts in light of the increasing need for Spanish-English interpreters in the United States, the uniqueness of mental health interpreting, and a lack of significant training for

interpreters working in this field. In particular, a two-course add-on component to current healthcare interpreting programs is proposed. The goal of this work is to establish an effective model by looking at programs that exist both in the U.S. context and abroad and to integrate insights from the field of psychology. Acevedo, Reyes, Annett, and Lopez (2003) define success as a mental health interpreter as keeping patients coming to sessions (i.e., lower dropout rates) and improving client-therapist communication by making sure that appropriate documents are translated in the patient's language (for example). Angelelli (2017) also has reflected on some of the components necessary in dialogue interpreting training courses and also adds that students must be aware of discourse communities, power differentials, and be able to identify and solve problems in the classroom in order to be successful. These aspects will also be considered in the development of this mental health interpreting component.

The importance of this type of program extends beyond single interactions, and covers a wide range of other factors, including the elimination of healthcare disparities, especially disparities that can be quantified in relation to the amount of money lost due to a lack of adequate language services for LEP populations. For instance, in the U.S. from 2003-2006, it was estimated that disparities and inadequate healthcare treatment/access due to language and cultural barriers totaled $1.24 trillion because of a more disadvantaged population that often needs more treatment and lost productivity (CLAS Standards). In the context of psychiatric treatment, this figure is quite high if the American Psychological Association guidelines are taken into account, which state that a patient must have equal access to services in their native language (Acevedo et al. 2003). And despite the laws and policies that are in place to eliminate healthcare disparities,

such as Subchapter V, Sec. 2000d of Title VI of the 1964 Civil Rights Act, these types of disparities still exist. The proposed interpreting program aims to redress the lack of qualified interpreters who work in these settings to help ensure equal access to healthcare services.

CHAPTER 2: REVIEW OF THE LITERATURE

In the context of mental health interpreting, many researchers have tried to understand what role(s) interpreters play in relation to the patient and service provider/therapist. In addition, researchers have investigated the roles adopted by interpreters as they perform the various functions of their jobs. These roles must be considered when developing an educational program specific to mental health interpreting.

2.1. Roles of the Interpreter

One role that has been discussed in the literature, and is still debated today, is the advocate role for the patient. Essentially, the interpreter in this advocate role is more active than the traditional view of interpreters who function merely as a conduit. As an advocate, the interpreter negotiates between parties, gives advice and information to support informed decision-making, combats discriminatory practices, and supports and empowers the patient (Baylav 2003). While the interpreter should be as helpful as possible in order to provide a smooth experience for both the service provider and the patient, there are challenges that can arise when attempting to remain impartial and maintaining confidentiality, as well as when trying not to upset the patient.

For instance, interpreters found being impartial to be problematic when working within the context of mental health services for Kurdish refugees in the United Kingdom. In fact, Green, Sperlinger, and Carswell (2012) describe that five participants in their study experienced difficulties being impartial and thus clashed with Kurdish cultural norms related to help-seeking and giving. These challenges were not in relation to their

ability to perform their jobs, but rather to the neutral role that they needed to adopt. Hsieh (2007), in this regard, comments on the problems that can arise if the mental health interpreter takes on an advocate role, particularly since job responsibilities differ between mental health professionals and mental health interpreters. Interpreters who take on this role may, for instance, get too involved in the patient's personal life. Both care provider and interpreter are seen by patients as authority figures, and as a result, they may feel obligated to share privileged or sensitive information with the interpreter that should only be shared with the mental health professional (*ibid*). However, the interpreters' responsibility to maintain confidentiality and impartiality can be at odds with this perceived role, which gives them more authority than appropriate.

There are, however, researchers who have recognized the uniqueness of the triadic relationship in mental health sessions, and these researchers have described the possibility that an interpreter can take on the role of a co-diagnostician when interpreting in counseling (e.g., Hsieh 2007). These researchers draw on Wadensjö (1998) to address the co-construction of meaning during interpreting interactions, which refers to meaning as a joint product, and interaction as being multi-directional and multi-layered. Angelelli (2006) also describes the interpreter, not only as a co-constructor of meaning, but also as a co-conversationalist. Furthermore, Angelelli (2006) presents some of the basics in the development of skills in at least six different areas: cognitive, interpersonal, linguistic, professional, setting-specific, and sociocultural in creating a curriculum for healthcare interpreting that addresses issues surrounding the interpreter's role. She warns that if student interpreters are not fully aware of what it means to be a visible and active co-participant, then these students may not be fully prepared to work as interpreters in

medical contexts. This in large part relates to the interpreter's need to go beyond word transfer and to help to create engaging conversation (Angelelli 2006). Bot (2006) and Mudarikiri (2003) also have stressed the role that the interpreter has in helping to both keep the conversation flowing and help establish a "therapeutic reality" in which all members of the triadic team come together to understand the patient's situation.

Closely related to the co-construction of meaning in mental health interpreting sessions is the idea of a therapeutic alliance between the clinician and the patient. Miller et al. (2005) define the therapeutic alliance as a positive, collaborative relationship based on trust and a shared commitment to the patient's growth and healing. In the cases of many patients in Miller et al., having the same interpreter throughout the therapeutic process was considered to be important, not only for the sake of convenience or consistency, but also to not interrupt the dynamics of the triadic relationship that had already been established and not have to develop rapport afresh. As a result, it was sometimes challenging for the mental health patient to relax and begin to trust a new interpreter (Miller et al. 2005). In a similar vein, Hitesh (2006) recommends that the same interpreter should always be used each session. Tribe and Thompson (2011) add that mental health patients should be given the right to switch the interpreter and request a new one if they feel uncomfortable in any way. Yet, despite the efforts to build an effective team, there are additional challenges due to a lack of professionalization and certification opportunities for interpreters who work in mental health settings. These challenges will be addressed in the sections below.

In addition to the role of advocate, co-diagnostician, or ally to all members of the triadic relationship, there is another role that is perhaps the most obvious: the bilingual

cultural broker. According to the American Psychological Association's *Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally-Diverse Populations* (2018), one area that psychotherapists must be knowledgeable about when treating patients is culture and ethnicity. More specifically, the guidelines suggest that therapists must understand how culture and ethnicity can factor into the sociopsychological, political, and economic development of the group or groups with which the patient identifies and how these groups might, in turn, affect patient behavior. This type of cultural awareness and knowledge has been addressed in the literature on interpreting in mental health contexts, due to the fact that interpreters must have extensive knowledge of not only both languages but both cultures (Angelelli 2006, 2017; Castaño et al. 2007; Green, Sperlinger, and Carswell 2012; Hsieh 2007; Hunt and Swartz 2016; Hwa-Froelich and Westby 2003; Tribe and Thompson 2011). Much like with language, culture is not a fixed concept that can simply be transferred and interchanged mechanically, but rather has many specific nuances that interpreters must be aware of in their daily work. One specific issue that can arise in therapy sessions is how the very structure of the psychotherapeutic methods that are used may conflict with the patient's culture. These methods were designed in the context of Caucasian, upper middle-class frameworks and often do not account for other cultural, ethnic, or economic groups, which can ultimately affect how easily they are utilized with patients who are not part of this demographic (Castaño et al. 2007).

Closely related to the structure of therapy sessions is placement, which is a construct that helps to guide interaction that involves relying on the interpreter. Traditionally, psychotherapy is based on a dyadic relationship between patient and therapist; however,

this dynamic becomes a triadic relationship when an interpreter is required for communication purposes. Researchers have suggested that the seats in these triadic interactions should be placed in a triangular arrangement (Crezee, Jülich, and Hayward 2011; Miletic and Piu 2006; Searight and Searight 2009; Tribe and Morrissey 2004). In this way, each member of the team is visible and equally spaced from one another, which, in turn, eases communication (Crezee, Jülich, and Hayward 2011; Miletic and Piu 2006) and it gives equal importance to everyone in the room.

Nevertheless, other configurations are possible. For instance, researchers have proposed that the interpreter sit beside, but slightly behind the patient, with the therapist directly across from the patient (Searight and Searight 2009), or to have the interpreter sit directly behind the patient and merely act as their voice by using the first person singular (Tribe and Morrissey 2004). With the interpreter sitting behind the patient, there may be less distraction for the therapist who wants to focus mostly on the patient, but this is problematic for several reasons. As explained in previous sections, treating the interpreter as simply an additional voice in the room and not a valued member of the team runs contrary to research that advocates for an ally role that helps establish meaning in therapeutic interactions. A therapist who sees an interpreter as just a patient's voice is also perpetuating the well-known notion in Interpreting Studies of the interpreter's "invisibility." While this may be okay in some circumstances, an interpreter often needs to be visible to others in order to help ease the flow of communication.

2.2. Visibility and Communication Management

One researcher who has written extensively on the interpreter's role and the topic of visibility is Claudia Angelelli. When examining medical interpreting interactions, she

acknowledges that language interpreters are often portrayed as "invisible language facilitators" or "switchers" (Angelelli 2004:84). This characterization is problematic because it not only assumes that there is only one way to interpret, but it also assumes that no interaction apart from mechanical language processing occurs, such that interpreting can occur in a "social vacuum" (Angelelli 2004:23). As such, Angelelli contends that there are a number of ways that interpreters help shape the interaction and visibly interact. For instance, an interpreter facilitates access to communication given that each member of the session brings their own societal factors (e.g., gender, race, and religion) to the session, which affect the way each person communicates. Angelelli (2004:26) also presents evidence from qualitative interview studies that demonstrate that the different settings in which interpreters work can change their perceptions of visibility. Medical interpreters, for instance, often view themselves as being more visible than conference interpreters (Angelelli 2004:73). These differences in visibility for medical interpreters are therefore attributed to the hospital's (or health clinic's) less scripted nature.

During mental health interpreting sessions, many potentially disturbing events such as rape or abuse may be discussed, and emotions can heighten. In order to address therapist confusion, a consecutive turn-taking strategy should be discussed between all individuals involved. Angelelli (2017) advises that students of interpreting need to be aware of the notion of turn-taking and how it affects interactions among the various parties. In healthcare-related interpreting interactions, the focus or goal of meetings is to address patients' needs, and therefore the turn-taking strategies may be different than in other contexts. For instance, the turns taken by healthcare providers may need to be

longer or shorter depending on a patient's needs (Echuari 2014). Nevertheless, the varied nature of different patients' needs may require turns to change based on patient feelings, attitudes, and conditions such as their predisposition to converse and their ability to assimilate the message (*ibid*).

Regardless of the variation in length of utterances by each member of the team, there are some ways in which the interpreter can help to ensure that sessions run more smoothly. One way to avoid problems during the interpreting encounter is by knowing how general turn-taking occurs. In general, the interpreter provides his or her rendition after either the provider or patient speaks (Bot 2006; Tebble 2012). In addition to a solid knowledge of speech patterns and the overall direction of the conversation, the interpreter should also be aware of the various parties' body language and eye movement relative to other speakers in the room. Mason (2012) finds that gaze shift is key to turn management as an important signaling device and that turns can be initiated solely by head movement by the interpreter. Therefore, this type of non-verbal cue can be an important factor in turn management during the encounter. Moreover, Mason (2012) found that one of the parties other than the interpreter – i.e., an immigration officer in his paper – could also encourage turn-taking with gaze.

Similarly, Bot (2006) affirms the role of gaze and gesture in turn-taking, and especially how these non-verbal cues affect and direct the therapist in mental health settings. In these settings, Bot (2006) argues that interactions are varied and complex. For example, therapists are in a secure position to direct turn-taking by using gaze and gestures, yet they will never be able to fully direct turn-taking due in large part to the course that the interaction takes (*ibid*). Moreover, the therapist must be cognizant that

their patients may be prone to hallucinations and psychotic episodes as a result to their mental health. If the patient has a sudden outburst, the interpreter must be able to remain professional and let them speak. This added layer of complexity may result in a shift in typical turn-taking behavior, since the session may need to shift to accommodate the patient's needs. Bot (2006) suggests that interruption of the patient is far more acceptable than misunderstandings that may arise, and thus the interpreter and the therapist should discuss how the interpreter should react in these cases during a pre-session meeting. Generally, the only time an interpreter should interrupt the flow of communication is if an unpredicted outburst by the patient occurs, clarification needs to occur, or if he or she is experiencing cognitive overload due to lengthy turns.

2.3. Vicarious Trauma

As briefly discussed in Chapter 1, interpreters working in mental health settings face the possibility of encountering vicarious trauma. While this type of trauma can occur with interpreting in many settings, it is more common in interpreters who have had similar traumatic events happen to themselves (Crezee, Jülich, and Hayward 2011; Doherty, Macintyre, and Wyne 2010; Green, Sperlinger, and Carswell 2012; Miletic and Piu 2006), or in interpreters who are in socially similar circumstances (Crezee, Jülich, and Hayward 2011; Miller et al. 2005; Searight and Searight 2009). The reasons that vicarious trauma occurs are also twofold. Interpreters who have a personal history with disturbing events in their lives can often become re-traumatized from hearing unpleasant accounts from patients. Those interpreters who do not have a previous history of traumatic events in their lives are still at risk of traumatization due to the very personal and empathetic role that the interpreter plays in mental health encounters. Crezee, Jülich,

and Hayward (2011) specifically note that the use of the first person when interpreting helps to connect with the patient and avoid confusion as to who is speaking. This practice, however, also can make what interpreters say more personal, thereby causing a larger personal impact upon themselves.

There are numerous reasons why vicarious trauma is detrimental to the mental health interpreter and why understanding it is crucial to those who are working in psychotherapy. Arguably, one of the most important reasons why therapists should be able to understand and identify vicarious trauma in the interpreter is that it can impact the interpreter's personal wellbeing. In addition to being generally stressful work, traumatic events shared by the patient can have a negative impact on the interpreter and can manifest symptoms that range from anger and nightmares to paranoid ideas, anxiety, and stress (Crezee, Jülich, and Hayward 2011; Doherty, Macintyre, and Wyne 2010). These negative results can significantly impact interpreters' job performance and interferes with their ability to adhere to the code of ethics in aspects covering impartiality, accuracy, and the need to disclose conflicts of interest before undertaking an assignment (Crezee, Jülich, and Hayward 2011). Negative emotions and the disclosure of traumatic events by the patient can also cause the interpreter to have a more pessimistic view of the world around them in hearing of how horrible things happened to the patient who was left with no hope of reparations. Green, Sperlinger, and Carswell (2012), for instance, were able to demonstrate this effect in their study with Kurdish refugees. In their study of six interpreters with a Kurdish background, all reported their work to be emotionally-demanding, and were encouraged to remain as neutral as possible when interpreting. This need to be neutral directly conflicted with Kurdish norms around help-seeking and

giving, and thus some interpreters felt helpless that they could not give patients all the help that they needed.

Not unique to the field of mental health interpreting, but nevertheless a reality in this field, is burnout or cognitive overload, which can interrupt the interpreter's ability to provide renditions and slow down the flow of communication (Tribe and Morrissey 2004). All of these factors must be addressed and appropriately handled when closely working with interpreters in mental health contexts.

A strategy whereby many mental health interpreters may deal with the stress and negative emotions that stem from patients who have suffered traumatic experiences in their lives is to simply detach or ignore it (Crezee, Jülich, and Hayward 2011). This strategy, while seemingly easy, raises many issues, however, relating to impartiality and accuracy in that choosing to distance themselves demonstrates an unwillingness to fully convey the patient's message It also drives a wedge between members of the team if the patient or care provider suspects the interpreter is not being honest in his or her renditions, and greatly damages the trust that the interpreter should be trying to establish in therapy.

2.4. Briefing and Debriefing

Earlier in this paper, the idea of establishing pre- and post-session meetings between therapist and interpreter was acknowledged, and across the literature, it is agreed that these meetings should be scheduled not only to help to give the interpreter an idea of some of the vocabulary and cultural nuances that may appear, but also to help avoid vicarious trauma in the interpreter (Crezee, Jülich, and Hayward 2011; Doherty, Macintyre, and Wyne 2010; Green, Sperlinger, and Carswell 2012; Miletic and Piu 2006;

Miller et al. 2005; Raval 2006). Because mental health interpreting has yet to be formally established as a field such as conference or courtroom interpreting, there is a lot of work to be done with respect to establishing standards and there are several studies that indicate that interpreters in mental health are not receiving the proper attention that they need in understanding what these standards should look like, or how to deal with the emotional baggage that interpreting in mental health brings (Crezee, Jülich, and Hayward 2011; Green, Sperlinger, and Carswell 2012; Hunt and Swartz 2016; Miller et al. 2005).

Establishing standards is an important step forward in ensuring that interpreting sessions in mental health settings run as smoothly as possible for everyone involved. First and foremost, it is paramount that the organization or clinic involved in hiring an interpreter be familiar with both how to find an interpreter, and how to test their language and interpreting skills before making a decision to hire, among other factors. Miller et al. (2005) stress that potential mental health interpreters should have many of the same qualities as effective therapists, including high levels of empathy, good interpersonal skills, and a "high level of psychological mindedness." In this manner, the idea of the interpreter as a valued team member and a significant contributor to meaning and treatment is reinforced.

A clinician/therapist who is also well-versed in the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS Standards) is also at an advantage when preparing to work with an interpreter. These standards help to advance equity, improve quality, and eliminate health care disparities through the principal standard of providing effective, equitable, understandable, and respectful quality care to a number of different cultural groups and diverse populations

(*ibid*). The CLAS Standards also help to provide guidance in other areas, including governance/leadership (e.g., recruit, train, and promote diverse leadership in CLAS Standards), communication and language assistance (e.g., informing clients of availability of language services, and ensuring competence of individuals), and engagement/accountability (e.g., culturally and linguistically appropriate goals and policies, and conducting assessments of CLAS usage and community health assets (*ibid*). More insight into health care inequities and the role this paper plays in their elimination in the context of mental health will be analyzed more in Chapter 5.

A method for assessing language skill competence in an interpreter has been suggested by Acevedo et al. (2003) and is an adaptation of the Wechsler Intelligence Scale for Children (WISC). During the test, the interpreter candidate would be tested by a language service provider in a number of ways, including verbal comprehension, writing skills, reading comprehension and spoken language ability. In order to properly evaluate a person who is able to administer the test to an interpreter, he or she must: have documented writing and oral proficiency in the target language, should be recorded and asked questions in the target language in a practice mock session, required to write answers on paper, asked to read clinical documents/psych evaluations, and asked to record him/herself speaking about background and experience in the field. Tribe and Thompson (2011) also recommend that the clinician should take training in working with interpreters before relying on an interpreter, and that if this is not possible, to allocate time for research into the topic and to discuss any potential issues with a more experienced colleague. They also recommend that a good way for a therapist to prepare

for sessions with a LEP patient is to research the specific language makeup of their area (*ibid*).

2.5. An Overview of Current and Past Programs in Health Care Interpreting

In the United States, several major cities and various states have taken the initiative to address linguistic barriers in mental health settings. In Philadelphia, the Nationalities Service Center offers a sixty-hour program called Core Medical Interpreter Training (or CMIT) covering culture, ethics, and interpreting skills (to name a few). However, mental health does not seem to be covered. The Wisconsin Department of Children and Families offers some general medical interpreter training, and Seattle's Health Education Low Literacy Program is a thirty-hour course that provides generic training to those who have already worked in healthcare settings (Hale and Ozolins 2014). At the university level, the University of Texas at Austin has a comprehensive, forty-hour program in medical interpreting with ten modules that cover subjects ranging from oncology to ethics, but only offers mental health topics as a component, and not as a standalone program (Angelelli 2006). The Middlebury Institute of International Studies in Monterey, CA offers a MA in Translation and Interpretation with the option to add a ten-credit Spanish community interpreting specialization, but as community interpreting covers various settings, it includes general medical and legal interpreting courses (Angelelli 2006). At the University of Massachusetts Medical School, a sixty-hour medical interpreting training program is currently in session and covers a wide range of topics, including roles, ethics, cultural competency, and anatomy. Despite ample time dedicated to practical exercises with language coaches, there does not appear to be any time dedicated to research in interpreting or mental health topics. In Tennessee, the

University of Memphis offered a mini healthcare interpreting program for four weekends in October 2018, which comprised two courses: Level 1 and Level 2 medical interpreting. Level 1 is a sixty-hour program that covered topics such as role, protocol, terminology, and legal regulations. It also had a ten-hour minimum practicum requirement that students completed in local medical settings (St. Jude's, Compassion Clinic, Methodist Hospitals, among other health centers). Level 2 is a forty-hour program that covered more specialized areas, like the Intensive Care Unit, Pediatric Oncology, and Mental Health.

On a national scale, interpreters only have a few options. Medical interpreting certification can be obtained either through the National Board of Certification for Medical Interpreters, DSHS Washington, or the Commission for the Certification of Healthcare Interpreters (CCHI). While these programs often include topics and strategies specific to mental healthcare, they are bundled with other topics and not addressed on their own. Since mental healthcare is different from other types of healthcare, the gap in this type of medical expertise for interpreters needs to be addressed.

2.6. Review of Books that will be Used in Proposed Courses

The English-Spanish Manual for Mental Health Professionals (2010)

This book is a short volume (83 pages including references), written by Verónica Gutiérrez, Cher Rafiee, Erin Kelly Bartelma, and Verónica Guerra, that takes the professional through the various stages of the therapeutic process with Spanish-speaking patients. The book is divided into 10 lessons, ranging from a short introduction and a passage on cultural considerations, to initial intake forms and the process of diagnosis.

There are also a number of appendices that include useful examples of various medical form types an interpreter in this setting might encounter as well as a brief glossary of relevant terms related to mental health. Lessons are divided into a learning objective, relevant terms, a learning activity and various scenarios and responses, and any additional questions that may come up in a session. The two main strengths to this book are its choice to opt for forms and checklists written in Spanish instead of English (e.g., Lesson 4's Mental Status Exam Checklist), which is useful for those who also work extensively in English-Spanish translation, and its inclusion of an answer guide toward the back of the book, which is helpful in the learning process. The volume however, has two shortcomings: its lack of a Spanish-English glossary (Only English-Spanish included) and its lack of explanations on how to work with interpreters in a significant way. For example, at the beginning of the book, it lists common "illnesses" often encountered in the Latino/a community, like *mal de ojo*, or *susto*, but does not give strategies or treatments to overcome them. The book also does not mention how the therapist should react in a calm manner when an interpreter switches to simultaneous mode in order to address a patient's psychotic episode, which can be confusing for the psychologist, and does not address how to deal with potential vicarious trauma that the interpreter may face when dealing with disturbing content. Overall, this manual seems to all but erase the interpreter, which is fairly problematic. It is understood that this is a manual focused mostly on therapists, social workers, and others, but those who are doing the translating of forms and interpreting are the interpreters, not the therapists themselves. For those who wish to go into mental health interpreting (or medical interpreting in general), this book is a helpful guide. For mental health professionals this book should be seen only as

a supplement, and other resources should be consulted regarding the interpreter's roles in these settings and how to maintain a healthy triadic relationship when conducting sessions.

The Bilingual Counselor's Guide to Spanish: Basic Vocabulary and Interventions for the Non-Spanish Speaker (2013)

This book is 185 pages long (excluding references and index) and is written by Roberto Swazo. It starts off with an introduction, layout of the book, and the benefits of learning Spanish in the United States. The book then is divided into 7 areas: 1. Who are the Latinos?, 2. Cultural Norms, 3. Introduction/Review of Spanish, 4. Counselors/Social Workers/Psychologists, 5. Interventions for School Counselors/Psychologists, 6. Substance Abuse Professionals, and 7. Developing Materials/Working with an Interpreter. The first two chapters, while not necessarily rich in vocab-building or hands-on practice, are helpful in order to give the mental health professionals a rudimentary background on the Latino/a population, including interesting statistics and demographic information. In chapters that focus on counselors or substance abuse professionals, for example, a basic synopsis is given, followed by cultural hints, practice, vocabulary, and examples of forms/evaluations (e.g., Intake Interview on pg. 57). The vocabulary lists included in each chapter are very detailed and cover multiple areas. For example, on page 135, a breakdown of alcohol-related vocabulary is listed, covering short- and long-term effects, and a few slang terms. In chapter 7, the author lays out additional knowledge that a mental health professional must have, including suggested recommendations for bilingual materials, what qualifications to look for in an interpreter, establishing rules and pace in sessions, and interpreting techniques and positioning. Overall, this book is a fairly comprehensive volume that every counselor that encounters Spanish-speaking patients

should own. The only two issues that could be fixed are its lack of a Spanish-English/English/Spanish Glossary, and an absence of a suggested answer key for practice activities.

Latino Families in Therapy, Second Edition (2015)

Building on decades of research and firsthand experience, this second edition to Celia Falicov's original 1998 release is a 445-page volume that includes extensive new, and updated information that is a valuable resource to those who work and are interested in how being Latino affects the psychotherapeutic process. After a brief introduction, the book is divided into 6 parts consisting of 2-4 chapters, bringing the total number of chapters to around 14. Part 1 is a general overview and covers the multidimensional ecosystemic comparative approach (MECA), and Latino diversity. Part 2 covers migration and acculturation with topics presented ranging from stress, family separations, and implications for practice. Part 3 lays out an ecological context which includes information on mental health disparities, religion/spirituality, discrimination and challenges with work/school. Part 4 then shifts to family organization within Latino culture from extended kin to providing insight into the various aspects of couple's therapy (e.g., divorce, gay couples, abuse and trauma). Part 5 is the last main section of the volume, pivoting slightly to the family life cycle, from the raising of newborns and children, to adolescent issues and perspectives, and concluding with adulthood and maturity. The last part of the book offers concluding remarks, suggesting creativity and always valuing and keeping in mind personal experiences in order to effectively treat Latino patients. The author does a very effective job of weaving personal experience, providing relevant examples with the topics covered, and using a wide variety of charts

and diagrams in order to help convey pertinent information. One of the ways in which this book might be improved is in further addressing the Trans and Gender Non-Conforming population. Falicov does an overall good job in bringing up important topics related to gender in Latino communities (e.g., home life, homosexuality, couples) but she does not go into detail into their experiences and strategies for the clinician in working with this sector of the community.

CHAPTER 3: PEDAGOGY

When looking at the strategies in achieving a greater emphasis on mental health in current healthcare interpreting programs, and how Latino/a populations fit into mental health treatment in general, it then becomes necessary to discuss the literature related to pedagogy in both Psychiatry and Mental Health. This necessity to discuss literature connects back to the main method of this add-on component proposal, which is to create a set of two courses by means of reviewing the literature. In conjunction with previously discussed information regarding stigmas toward mental health in Latino/a individuals, there is also evidence to suggest that stigma (or perceived stigma) also exists in psychiatrists themselves regarding their occupation from other fields of medicine, and these stigmas have noticeable impact on the field of psychiatry. Although 80% of psychiatrists see their jobs as beneficial to society, a mid-1990s survey showed that 45% felt that other medical specialists saw psychiatry as "less than moderately important" (Höschl and van Niekerk 2011). A number of years have passed since this survey was conducted by the American Psychiatric Association, but demonstrating that this level of stigma existed as recently as a little over two decades ago shows the difficulty of recruiting psychiatrists in general.

For individuals who decide that psychiatry is the right career choice for them, there are various qualities that they should possess before entering the field. Höschl and van Niekerk (2011), in the context of recruiting psychiatrists, note that those who choose psychiatry typically are more reflective, more responsive to abstract ideas, more open-minded, and more interested in social welfare than perhaps students in other fields. Clinical placements of undergraduate students have also been shown to be an effective

way to enhance recruitment into the field. Essentially, by providing students the opportunity to carry out specific tasks in either mental health wards or clinics gives them a sense of purpose and importance, as long as the proper supervision and feedback is given (*ibid*). The strength and recognition of the psychiatry department and the credentials of faculty are also beneficial in motivating students to enroll in these programs as these positive aspects show clear leadership and a desire to succeed (*ibid*).

One way to strengthen mental health and psychiatry education, and thus, attract interest in students is to recruit individuals that have been service users in the past in order to more clearly demonstrate how someone from the "real world" can contribute to topics discussed in class. By doing so, service users can not only share their actual experiences in health care to students, but also can help bring to light their own involvement with mental health stigma, and stigma from accepting prescribed medications that they did not fully understand, for example (Foreman and Pringle 2007). The benefits from including service users have also been noted in Robert et al. (2002). In their study, thirty-seven organizations around the Yorkshire area of northern England took part in a mental health collaborative project that sought to give mental health service users more involvement in decisions about their own care. In short, they found that incorporating these service users gave new insight and perspectives regarding treatment to mental health professionals. In addition to providing firsthand experiences, service users have developed a number of coping mechanisms that have been able to suggest alternative approaches that can help to advance the field of mental health (Robert et al. 2002). Including service user perspectives can, therefore, enrich mental health and psychology curriculum because students may see patients as humans outside of clinical

settings, instead of only seeing them through the lens of diagnosis. In a field that relies heavily on the patient/provider relationship, this empathetic view is crucial.

While the inclusion of service users enhances psychiatric and other mental health interpreting programs, there are some negative aspects that should be taken into consideration as well. For example, allowing a service user to help teach students requires a significant shift in power for those that may have higher credentials (e.g., professors and doctors) and thus may require instructors to exercise more patience toward the individual, who may not have expert training. Foreman and Pringle (2007) elaborate on this issue further and suggest that involvement of service users in education continues to be about putting them in the spotlight to deliver their experiences, but that service users usually only have limited input into actual curriculum design or the modules in which they offer expertise. This willingness to keep the status quo and only allowing limited input by service users implies that their insights are not as important as the instructor's. This refusal to change mentality keeps a barrier between linking theory and practice that educators are constantly trying to achieve in relating course content to the outside world. It is certainly true that there can be downsides to integrating service user involvement in education programs, including sheer cost and time consumption, problems with "representativeness," financial insecurity, and a lack of formal training in user groups themselves, and these topics must be integrated into discussions before service user implementation (Robert et al. 2002). However, notwithstanding potential barriers, the positive impacts that service users bring to the discussion through providing real-world experience and developing a collaborative teaching partnership, far outweigh

the negatives for instructors who wish to make learning more inclusive (Foreman and Pringle 2007; Robert et al. 2002).

In both Chapters 1 and 2, the idea that "meaning" in mental health settings is co-constructed by each member of the therapeutic triad is not completely unique to the field of translation/interpreting research. This phenomenon of the co-construction of meaning in psychotherapy, or "discursive therapy" has been well-documented in the field of psychiatry and continues to play a role in how researchers and practitioners see and understand the treatment of mental illnesses. Discourse as defined by Wahlström (2018) is a dynamic conversation in which meanings are produced and modified, which closely mirrors Wadensjö's (1998) argument that meaning in interaction is a joint product that is multi-layered. Sutherland (2007) adds that discursive therapists are skeptical that there is a singular objective truth, and these therapists view problems and solutions as constantly evolving in relation to changing sociocultural practices. Because therapists often have a rhetorical and argumentative discourse pattern, this can create difficulties for a patient who feels like they are not being fully listened to. Strong (2006) describes this attribute in therapists as discursive flexibility and emphasizes that these professionals can become discursively flexible in how they propose and co-develop with these alternative discourses in clients through learning to better understand others on their own terms. Avdi and Georgaca (2018) also comment on the benefits of discursive therapy in that the co-construction of alternative discourses sustain more powerful subject positions than other therapeutic methods and allow for therapist flexibility in terms of discursive positioning and conversational turns in the process of psychotherapy. They also go on to note that what makes discursive therapy unique is its attentiveness to the role of ideology

and culturally dominant discourse in client distress, and discursive therapists strive to exercise reflexive awareness in the discursive processes of therapy. Thus, discursive therapy is important in two main ways. First, because it further demonstrates the uniqueness in mental health interpreting of meaning as a joint product, rather than an objective truth. Second, it is uniquely tailored to be especially aware to cultural sensitivities that might be brought up that exist in Latino/a communities (e.g., migration, culturally-bound illnesses).

As it has been suggested so far, the process of recruiting students, challenging stigma related to mental health, deciding how best to intertwine theory and practice in mental health education, and being sensitive to cultural differences can be challenging for educators. Being able to combine all of these components, however, is essential to develop curriculum and a necessary part of a mental health educator's job. In the late 90s a new medical program for students at the University of Glasgow was implemented. In this program based substantially on Problem-Based Learning (PBL) and Student Selected Modules (SSMs), students learned through service users the nuances of coping with mental illness and how volunteering at psychiatric settings can be beneficial in building practical experience (Atkinson 2007). In terms of the composition of the Glasgow program, two introductory sessions were held covering basics in what students might expect in their visits to mental health settings, as well as 6 total visiting days to the settings and corresponding debriefing sessions in which students reported on their volunteer experiences (*ibid*). The program also required students to read the autobiography of someone with a mental health problem or who works in a mental health career, as well as a 2500-3000 word literature review of a topic that was related to course

content. The way that this program was structured and the topics that it covered can easily serve as a model for future mental health interpreting courses in the U.S. context, as some components have already been successfully implemented in the U.S. (i.e., the University of Memphis' practicum component).

Service users in equal partnership with instructors, again, have been able to provide valuable insight and experience to students in mental health programs and to the development of curriculum, despite differences in power (Foreman and Pringle 2007). For instance, Breeze and Repper (2007) bring up the issue of power struggles but place them within the context of a service user who may have just been quickly briefed before the class, and thus they may feel like they lack the proper preparation to teach compared to the instructor. For those who may have had previous teaching experience, the power differentials may still be present, for example, in more credence from the students being given to teacher-led lectures (*ibid*). Equal partnership between both the instructor and service provider, therefore must be stressed.

During classroom time in Glasgow, service users presented mini lectures to students, which were then accompanied by group exercises, and homework was assigned every week based on the discussions held in class (*ibid*). In terms of structure of these service user mini lectures, there were two main parts. Before class time, students were given the service user's written story to read and formulate questions, and then were directed to ask these questions in the form of a group discussion with the service user as well as with the main lecturer. This helped to guide students to take what they learned and apply it to their own practice situation as the service user gave them a more personal understanding to counseling (*ibid*). Although service user inclusion may require careful repositioning of

power between the instructor and the students involved, it further demonstrates psychotherapy's discursive nature and how meaning must be agreed upon without exclusion of the patient's voice.

One way in which educators can truly connect with their students and enhance their curriculum is by incorporating a Values-Based Practice (VBP) approach that will help to guide important classroom discussions. According to Fulford and Woodbridge (2007), VBP is a way of working in health and social care that starts from respect for individual differences of values and provides a clear process for coming to balanced decisions where values are in conflict. There are also a number of principles that guide VBP, and these principles range from awareness and reasoning to communication and partnership. The educator will also have to know what "values" means to them, and how to educate others on those values in turn, due to the word being abstract in nature and within a wide range of cultural contexts. Fulford and Woodbridge (2007) suggest that one of the best ways to come to an agreement on the meaning of values is to hold workshops before the first classes are held. Besides providing a basis and setting to discuss values, these workshops can also be used to generate change in roles and relationships, underpin the essential capabilities for mental health practice, and develop teamwork and team operational policy (*ibid*). There are also a number of factors that must be properly addressed in order to ensure successful implementation of common values that are established through the workshops. These include keeping detailed notes, encouraging diverse participation, time management, and animating participants to share and apply personal experiences (*ibid*). By holding value-based workshops, instructors will be more

prepared in how to overcome value differences, and thus be able to translate that knowledge to students of interpreting.

Too often in healthcare, experts working in the field (nurses, doctors, and teachers) struggle to find a balance between using and applying their technical expertise and knowledge, and being aware of the "human," or empathetic side of treatment. This phenomenon is especially true in the field of mental health. Therefore, while the more mechanical task-based approach is helpful, mental health education should also heavily rely on emotional intelligence to allow for deeper connections and more personal experiences (Freshwater and Stickley 2007). There are several ways that values of emotional intelligence can be conveyed by the educator. One of the most obvious ways is in the teacher-student relationship, which can be demonstrated in a genuine care and respect of the student and their perspective, as well as a commitment to listen and be an empathetic listener (*ibid*). This empathetic understanding in the instructor to students models one of the most important qualities required in mental health practice (*ibid*). Another way in which educators can help students develop emotional intelligence is through using role play in the classroom, discussing service user artwork, and reading literature, which can range from fiction (poetry or prose) to non-fiction works like personal narratives, written by those who have struggled with mental illness or experienced it through others (e.g., family or friends) (*ibid*).

Besides the traditional classroom setting as the primary source of learning, some universities and organizations have found other ways to educate students, including work-based learning. By establishing these work-based programs, individuals reflect upon learning with a more hands-on approach, and these learning programs are based on

workplace needs and the individual instead of a steadfast, controlled university curriculum (Beadsmoore and Basset 2007). While work-based programs can vary in scope and size across the board, there are many general aspects that are shared by all. They may include a partnership between the university and an external organization (e.g., mental health clinic or psychiatric ward), learners have a formal relationship with the organization (e.g., work or volunteer activities). Further, the learner's work is the curriculum, and the university sets learning outcomes based on a universal (not subject specific) set of standards (*ibid*). Planning and design are necessary first steps when creating work-based programs, and the way that educators decide to execute these projects is tailored by each individual. Some examples of individually-tailored execution have included exploration of aspects of mental health service systems, policies and procedures at clinics, training approaches, and internal communications between the different members of the service location (*ibid*). As a point of discussion, an example of work-based study in action is a diploma program in community mental health that was set up at Middlesex University in 2001. The diploma, which is 20 hours, is divided into six modules that cover topics like communication skills, holistic assessment, and contemporary issues for current practitioners (*ibid*). Giving students more of a personal responsibility for their education through work-based learning (through working and maintaining a job), is a good way to not only link education to "real world" experience, but to also help them to develop professionally.

All of these areas of focus are related to working as an interpreter in mental health settings, as well as many interpreter-specific nuances that are no less important. When the practice of interpreting first started being heavily researched after the post-WWII war

trials in both Tokyo and Nuremberg, researchers focused intensively on conference interpreting and applied much of what they learned about it to other areas of interpreting, due to their familiarity with it. After a while, other interpreting fields slowly emerged, but as a result, many interpreting programs that covered other areas (e.g., healthcare and legal) based their curriculum on conference interpreting models which cover basic skills but is problematic due to the inherent differences between conference and community interpreting (Angelelli 2006). Because of these differences (e.g., differences in register, terminology), several pedagogical strategies have been developed in order to address the needs of both educators and learners, including Student Learning Outcomes, Problem-Based Learning, and Task-Based Teaching.

Student Learning Outcomes (SLOs) as defined by Angelelli (2006) are outcomes that serve as indicators of program or course effectiveness, measure student performance, reflect intentions that guide teaching and learning, and can clarify student expectations. There are also curricular benefits that can be associated with SLOs. These can include help with designing curriculum, creating and designing prerequisite and co-requisite courses, and estimating workload for both the educator and the students (*ibid*). This learner-focused approach when looking at interpreting/translation has also been discussed by other researchers and educators. Li (2015) in the context of strategies in teaching business translation, noticed a clear set of differences when shifting the perspective away from seeing the educator as the primary source of knowledge and expert in their respective field of study. Essentially, the educator is a co-constructor of meaning in more learning-centered education, which parallels the already discussed literature on interpreting in mental health sessions (Angelelli 2006; Wadensjö 1998). Some of the

ways in which this learner-centered focus stands out is that learners construct knowledge on their own and through others by means of interaction and experience. Students also take responsibility for their learning, and education focuses more on learning than teaching, as it requires learners to further develop their critical and problem-solving abilities (Li 2015).

In close alignment with the various approaches to coordinating curriculum and general learning structure are the diverse set of teaching methods that have been developed in language-based pedagogy. One such method that has been widely discussed is PBL. This method, or philosophy, has its roots in medical schools of the 1960s as a result of the rejection of more mechanical and traditional methods of education, and views students as invaluable participants in their individual learning opportunities (Dean and Pollard 2009). As the name implies, PBL requires students to collaborate to research the intricacies of a problem that they are given and collaborate in order to brainstorm and apply effective strategies to overcome it (Angelelli 2006). This method is especially relevant to translation/interpretation, as transferring meaning between languages and cultures is a complex activity that often demands a large amount of experience and practice. Angelelli (2006) points out that interpreting pedagogy often seek to develop certain skills and strategies that are relevant to problem solving, and students would benefit from PBL. However, it often entails lengthier courses and not much room for professional development workshops. Therefore, it is imperative that any potential issues are addressed early on in the conceptual phases of program development.

Another form of PBL that has emerged in the field of interpreting pedagogy is that of Observation-Supervision (O-S). In the observation component, students visit

various service settings and observe a doctor and a patient who speak the same language in order to avoid focusing on how the interpreter is performing. This strategy helps them focus on communication goals for both parties and any technical language that may arise (Dean and Pollard 2009). The other component to Observation-Supervision is the Supervision activity. This component is a more interactive experience in which students turn in clinic observation forms to their instructor for feedback, as well as meeting with other students for group supervision sessions to discuss findings and apply theory to their individual experiences (*ibid*). These authors undertook their study of O-S through working with American Sign Language (ASL) and the Deaf community, and ASL is largely considered a unique language in its own right. That fact implies the results of Dean and Pollard's (2009) study can be easily implemented with other languages.

One final approach is task-based learning. The method puts forth the idea that students learn more effectively when they are focused on a task they are trying to complete (academic or otherwise) rather than focusing entirely on route memorization or grammar drills in a foreign language (Li 2015). Task-based learning as applied to translation/interpretation is composed of a number of stages that, to a large extent, are greatly influenced by the work of Willis (1996). In her article, Willis explains that the task-based learning method emerged from the earlier Presentation, Practice, Production (PPP) model in order to address PPP's challenges in being able to adequately prepare students in foreign language communication. Li (2015), working in a different context, however, found that the stages that are applicable to this learning method for translation/interpretation are pre-task, task, reporting, analysis, revision, and reflection (Li 2015). Li (2015) then goes on to group these six stages in three overall bigger stages.

The first big stage is the pre-stage, which introduces the topic and gives instructions, followed by the main stage of the task cycle which composes of task (students complete tasks in groups), planning (preparation of a short written or oral report of the task), and report (written report is presented to the class) (*ibid*). For the author, the overall task for students is that of a major translation project simulation. This project simulates the entire translation process, from negotiating terms and conditions with the client to invoicing and payment and requires students to work as a team and overcome challenges together (*ibid*).

CHAPTER 4: COURSE/SYLLABUS CREATION

4.1. Introduction

As briefly mentioned in the previous chapter, programs related to both the teaching of healthcare and language interpreting have evolved greatly over the past fifty years or so. Structurally speaking, however, most curricula in interpreting programs have consisted of basic concepts of language and communication, specialized terminology, sociocultural background knowledge, skill training in both simultaneous and consecutive interpreting, and interpreter ethics (Pöchhacker 2016:193-194). The various activities that are performed in order to increase student knowledge in the aforementioned areas vary from legal to healthcare interpreting, for instance, but many common ones have become the norm. These include notetaking, shadowing, paraphrasing, sight translations, and role playing (Pöchhacker 2016:199-202). As such, these activities would be standard in a mental health interpreting add-on component.

In conjunction with the literature that has shown a more learner-centered method of education to be helpful to students, it follows that the creation of curricula in this mental health component proposal should be heavily influenced from student opinion. Li (2013) has several suggestions as to how an educator can gather data in order to more effectively make courses more student-oriented. The example that the author gives involves an instructor who had pitched the idea for the proposed course to students. As a result, a lot of discussion was held with regard to content, assessment methods, quizzes, and potential readings (*ibid*). Because course content will largely depend on student needs and other factors, implementation may look different from program to program, but it will focus on a number of objectives across the board. Objectives such as interpreting knowledge and

theory, interpreting skills, practicing professional standards, and maintaining ethics are a given (*ibid*). Knowledge of mental health and psychotherapy in alignment with the mental health interpreting courses is also crucial. Numerous opportunities for interpreting practice are also important in curriculum development but must be carefully woven with other activities, including vocabulary exercises, written assignments, and the on-site service-learning requirement of mental health interpreting students. The requirement of students to keep a journal detailing their experiences at mental health facilities is also highly encouraged, as it gives them the chance to reflect on the work they have completed. It also gives the instructor the opportunity to see what aspects of the program work, or what could be changed. Li (2015) suggests a similar idea and calls it a "learning journal" and had students turn in the journal every other week to be graded and to eventually count for 15% of the student's final grade in the course. This journal—along with interpreting practice, attendance, homework, service setting observation/practice and quizzes—are formative assessments that will be used in the mental health interpreting courses and will make up the largest portion of the student's grade, with a smaller portion dedicated to summative assessments (e.g., final paper/final exam) (*ibid*).

Before actually designing the various modules and activities in a given course, it is necessary first to understand why the course was created and what its intended outcomes are. Kelly (2014:65-66) has some ideas as to how the outcomes should be focused and divides them into a number of areas, including social needs, professional standards, industry need and views, institutional policy and constraints, disciplinary considerations, and student profiles. Social needs in the context of the present paper refer to designing curriculum with a large focus on the Latino/a population and current economic

opportunities in that area. Professional standards as they relate to the field of interpreting are impartiality, fidelity, accountability, professionalism, and confidentiality. Industry needs will vary from region to region, and as mental health is still highly stigmatized, especially in the Latino/a community, students will specifically need to understand how to navigate these issues. With regard to institutional constraints, again, funding and feasibility of obtaining access to necessary course components (e.g., service users and partnership with local mental health clinics) will depend on an institution's specific funding accessibility. Disciplinary considerations refer to existing literature and programs that exist in the field of mental health interpreting, or MHI for short. MHI as a field of research has been well established, relating to its uniqueness and challenges, such as turn-taking, placement, and briefing/debriefing, and there have been some programs in the United States that have at least incorporated some mental health training to general healthcare curricula (i.e., the University of Texas at Austin). These intended outcomes as they relate to academia are also called Student Learning Outcomes.

Student Learning Outcomes, as mentioned in the previous chapter, help to hone in on the purpose and goals of a given course. For the mental health interpreting add-on, Mental Health Interpreting: Theory and Method and Mental Health Interpreting: Practice and Research are the two courses that are proposed. In these courses, the content will vary depending on setting and instructor, but a number of important areas in each course should be covered.

In both interpreting courses, students should first and foremost be able to obtain a basic understanding of the psychotherapeutic process between patient and provider. They should be aware of the various factors that influence this relationship, including

considering race and ethnicity (mostly Latino/a) and the requirement of the same interpreter to be present for each counseling session. This desire to have the same interpreter for each counseling session, again, is important because it establishes consistency for the patient and counselor. Through these factors, students will be able to more easily grasp the complexities of mental health sessions and how the interpreter contributes to the conversation. Students should also be aware of the ways in which interpreting in a mental health setting can differ from other healthcare settings. These differences cover a range of topics related to both the interpreter (e.g., including roles, vicarious trauma, and ethics) to procedure (e.g., turn-taking, briefing/debriefing, and placement).

Student communication skills are also important to include in course outcomes and encompass both active and passive skills of textuality and discourse (Kelly 2014:83). Students who enroll in the Theory and Method course should be able to have a better understanding of communication skills between English and Spanish as well as improve their own Spanish language abilities (vocabulary, writing, speaking, and listening). Cultural and intercultural competence will also be of vital importance, which will range from Latino cultural values, beliefs, and relation to mental health. Kelly (2014:84) then goes on to highlight subject area competence for translator's ability to work with a variety of source texts; in the case of this course, the student's ability to understand documents in mental health settings and areas of mental health interpreting that make it unique. In order to fully prepare students for a career working in these settings, goals of communicating professional standards for mental health interpreters (e.g., ethics and role) as well as interpersonal skills (e.g., student's ability to work well with others to solve

problems) must be incorporated (*ibid*). Lastly, strategic competence is a suggested learning outcome that would expect students to be able to present planning and organizational skills as well as problem identification and problem solving, and self-assessment (*ibid*) in counseling sessions with an interpreter present.

Grading students on their performance in a course, much like objectives and funding, will vary from school to school; however, a simple 10 point scale will work for the sake of this proposal, with a 70 or above being classified as a passing grade. Making up the student's overall grade will be several categories, including attendance/participation, quizzes, homework, tests, and a final exam. The exact percentage that each of these areas will count toward the student's final grade will depend on the individual professor, but one way in which they can be calculated is as follows: attendance/participation: 15%; homework: 10%; tests: 25%; a research paper: 20%; and a final exam: 30%. A brief breakdown of each individual category will be presented in the next section.

In order to effectively learn and be engaged with the material, students will need to come to class. This consists of not only being physically present, but also mentally present. In other words, coming to class prepared (i.e., having done the homework assigned the previous class), being an active participant in-class discussions, working well with other classmates during games and in-class presentations, and developing strategies to successfully interpret in a mental health session are all important factors in attendance and participation. In keeping a good attendance record and participation score, the students show genuine interest in the course material and takes an active role in their education.

None of the students who decide to take these suggested mental health interpreting courses will be professional interpreters. Likewise, a great many will have probably never interpreted in their lives thus far. As opposed to pushing students head-first into interpreting practice, several activities can be planned to give them a leg up. To test students' analysis and comprehension levels, an instructor could play a text read aloud in a foreign language in the classroom and have them simultaneously write information about what they are hearing (Pöchhacker 2016: 200). This process of training the mind to do two different things at once is generally referred to as *dual-task* and has long been present in interpreting training. Other pre-interpreting strategies include paraphrasing and shadowing. Paraphrasing, in essence, is an activity in which the meaning of a message is represented using different lexical and syntactical resources, which helps the student develop the knowledge to convey the message without being constrained by its original form (*ibid*). As paraphrasing can be used for any language, it is also a helpful way to help students to increase their vocabulary in their target language. The other aforementioned activity, shadowing, is similar in that it increases foreign language proficiency, but also different in that no changes to the source material are made. The student listens to speech in a language and simply repeats back what they hear, helping him or her to become aware of patterns and rhythm in spoken language.

During the time that students are enrolled in the Theory and Method course, they should be expected to complete outside work related to what is being discussed in class. This will primarily take the form of homework assignments, which will be mostly made up of readings and vocabulary assignments. For the Theory and Method class, readings would come from *An English-Spanish Manual for Mental Health Professionals*, and *The*

Bilingual Counselor's Guide to Spanish as well as any academic articles or online readings that the instructor thinks would be beneficial to the class. *An English-Spanish Manual for Mental Health Professionals* is a fairly short volume that has 10 lessons. Students should be expected to complete the lessons assigned in this book, which covers both reading and vocabulary/translation practice. *Latino Families in Therapy* is a denser volume in terms of content, so the various topics covered (e.g., disparities, migration, and spirituality) should also form a large part of classroom lectures and discussions. Besides these discussions and lectures on mental health interpreting and demographic information on Latino/as, role playing and practice interpreting scripts must be integrated in class meetings in order for students to practice working in mental health settings. The third book that will be used in the mental health interpreting add-on is *The Bilingual Counselor's Guide to Spanish: Basic Vocabulary and Interventions for the Non-Spanish Speaker*, which is similar to *An English-Spanish Manual for Mental Health Professionals*, but more comprehensive in covering the interpreter's role in therapeutic encounters. Homework in the Practice and Research course will mostly require observation by the students in mental health settings as well as a graded journal and a research paper in a topic related to mental health interpreting.

Tests will make up a significant part of the student's grade in Mental Health Interpreting: Research and Practice and will contain the various topics and vocabulary covered in class and readings at certain points during the semester. The specific test format is flexible to the individual instructor but can take on a number of arrangements, including fill in the blank, matching, short answer, and essay questions. Essay questions should be short and clear-focused, asking students to make connections to the material

they have learned in a few detailed paragraphs. For example, a sample essay question that could appear on an exam could say something like: “How does sexuality compound the issue of being a Latino/a individual who is struggling with a mental illness?”

A research paper, besides showing the instructor the student’s writing skills, also shows his or her ability to formulate ideas, argue opinions, and organize thoughts in a coherent and organized manner. In Theory and Method, students should be given the task to do some research in the field of mental health and/or interpreting in mental health settings by compiling a literature review. Reviewing the literature provides a chance for them to look at a particular topic and to take a closer look at how academics have contributed to overall understanding of their researched area. Length requirements will most likely vary based on the individual instructor’s preferences, but a good suggestion is around 2000-2500 words double-spaced in order to allow the student to fully examine their particular topic of interest. From this literature review, students will then be prompted to create a research paper based on a gap or gaps in the literature that they discovered. This assignment will be given in Practice and Research, and the paper should be around the same length as the literature review, or slightly longer in order to demonstrate that the student has put forth the effort to increase their understanding of mental health interpreting as a discipline.

At the end of both Theory and Method and Practice and Research, there should be some type of final assessment, or final exam in order to demonstrate what the student has learned over the course of the semester. Much like with the format of the tests, students should be tested on mental health vocabulary learned in the class, as well as be able to answer short essay questions based on material. Instructors should also incorporate a final

assessment of student interpreting abilities in the final exam. While it would be ideal if the instructor could arrange for multiple teams of three students to role play, this could prove to be time-consuming and impractical. An alternative, therefore, would be to assess the students electronically. In this scenario, students could be assigned to take on the role of the interpreter for a section of a role-play script that they have seen before in the class, and then upload their interpretations on the institution's learning management system of preference (i.e., Canvas). Of course, this alternative does not quite give the instructor the full gist of the student's ability as a novice mental health interpreter, but it does provide a way to see how far he or she has progressed from the start to the end of the course.

4.2. Mental Health Interpreting: Theory and Method

For the introduction class to the add-on component, a range of Student Learning Outcomes should be communicated. Students should be able to explain what mental health interpreting is as well as identify the different modes of interpreting, be aware of culturally-bound illnesses, and understand the role stigmatization has on mental health in Latino/a populations. Students who enroll in these classes should also demonstrate rudimentary sight translation and consecutive interpretation skills and be informed about the many stages in mental health treatment that start with initial contact and end with termination of treatment. Students will be graded on a number of different items throughout the class that will make up their final grade. These items include attendance/participation, homework, three quizzes, a final exam, and the literature review. As stated earlier, attendance/participation requires students to come to class and to participate in the activities planned for each face-to-face meeting. Lectures will be a vital component of the course but will also be complimented by in-class discussions,

sight translation exercises, scripted dialogues to practice consecutive interpreting, and time dedicated to look over and practice vocabulary from readings. Besides the readings, there will be a few additional homework assignments that will be planned throughout the semester. These assignments will mostly be made up of shadowing and consecutive interpreting practice to be submitted online as well as online discussion posts and responses to other students. The remaining parts of a student's grade will be three quizzes (based on vocabulary and readings), the final exam, and the literature review.

4.3. Mental Health Interpreting: Practice and Research

For the second course to the add-on component, students should be able to demonstrate some of the same learning outcomes as the Theory and Method course, such as having basic consecutive interpreting skills and demonstrating skills exclusive to Practice and Research. Students should not only be able to communicate basic information on Latino/a populations, but also have a more pinpointed understanding of the complexities of Latino/a life and culture. These aspects include family life, effects of migration, childrearing, and marriage/divorce. Students should also be able to show an improved ability in both sight translation and consecutive interpretation as well as have a more fine-tuned understanding about the psychotherapeutic process through the hours that they will spend during observation sessions.

As the course name indicates, a large part of this class will be made up of a final research paper. This paper will help to further develop students' professional skills as writers and researchers and aid in their comprehension of mental health interpreting research. A research paper is also helpful because it helps students to find interests in the field of mental health and to help them in their pursuit of future career goals. Attendance

will follow a similar path as in Theory and Method, but participation will have one unique component in the group discussion of journal entries and experiences with their practicum hours.

Journal length will vary according to the instructor's preference, but students should at least write enough to be able to remember what they experienced during observation hours, as well as some of the ideas that came to mind that they may want to further explore. One of the easiest and quickest ways to record important information is through a handwritten medium (i.e., pen and paper). This method also facilitates the ability for students to share their observations with their classmates in group discussions. Toward the end of the semester, the instructor may decide to take up and return individual journals to the corresponding student or simply ask them to transcribe and electronically turn entries in. If the latter is decided, it may be easier to ask students to instead take notes during sessions and then go back and write more detailed journal entries through an electronic format when they have the time. During group journal discussions, students should be expected to talk with their peers regarding their understanding of psychotherapy. While this dialogue is occurring, it is the instructor's job to both supervise student interaction and to guide communication toward student learning outcomes of the class and topics that have been explored in class lectures. Instructors can also decide to make the journals count as the biggest part of a student's final homework grade in the class or to simply have them count together as another individual test grade.

Tests themselves will largely follow the format of the quizzes in Theory and Method. In other words, the content that students would be tested on should be based on the readings and discussions that are held in class and can vary in the way they are

structured (e.g., essay, true/false, fill in the blank). Instructors should also consider incorporating formal assessments of student interpreting ability throughout the semester to make sure that they are retaining what they have learned.

Near the beginning of this chapter, it was mentioned that a final paper based on the literature review that students completed in Theory and Method will be assigned in Practice and Research. This assignment should make up a significant part of a student's final grade in the course and serve to help them to begin working in the research field and to advance understanding of mental health interpreting topics in a field that is still relatively new. While it may be true that students in their future career may not be writing and publishing academic books or articles, interpreting and counseling still require advanced writing skills in the necessity to take notes, perform translation work, and communicate to other professionals in similar and differing fields.

CHAPTER 5: CONCLUSION

The United States is in the middle of a great shift in demographics, with the percentage of persons speaking Spanish at home rising across the board since the 2000 census (Castaño et al. 2007). To prepare for this continuous change in racial, ethnic, and linguistic makeup, all aspects of society must build a better network of language services for those who may not feel comfortable or able to speak English at a determined level. This is especially true in sectors relating to government services, as language-related disparities in healthcare cost significant sums of money (CLAS Standards) in care that could prevent ailments and disease. From a purely monetary standpoint, great losses in money are an obvious problem affecting the quality of current healthcare services.

This paper has demonstrated that there is a significant correlation between physical and mental health. People who have depressive disorders often show changes in weight, insomnia, or lethargy as a result of a mental health disorder. Humans may not be able to view exactly what is going on in the head of their fellow person, but physical symptoms from mental illnesses are often key indicators that something may be affecting their mental stability. Therefore, healthcare services must be able to accommodate patients with Limited English Proficiency in order to address their healthcare needs.

In the area of mental health, there are a number of barriers that have prevent comprehensive services from being available to the Latino/a population. The most obvious of these is the sheer level of stigma that Latino/as with mental illness may face from members within their own communities. It is certainly the case that mental health in general is mostly stigmatized across various cultures, but it is especially so in

communities of color. This issue is only further compounded by the often close-knit family ties.

Related closely to stigmas are financial barriers. In the United States millions have no health insurance coverage, and many of those without insurance are people of color. As a result, expensive mental health services are oftentimes out of the question for families who struggle to make ends meet. In fact, only around 19% or so of uninsured Latino/as use any type of mental health service (Alegría et al. 2007). For those who are able to get a public health option like Medicaid, service usage is better, but still low. According to Alegría et al. (2007), still only around half of Latino/as with Medicaid used mental health services, which reaffirms both the presence of stigma in the pursuit of treatment for mental health issues, and an unawareness in the need to take off work to address these issues.

Latino/as who do decide to pursue treatment may find therapy sessions to be difficult for many reasons in addition to the obvious linguistic and cultural barriers between themselves and their therapist. One of these challenges is the sheer presence of the interpreter, which may intimidate or bewilder a patient who is not familiar with mental health interpreting proceedings. This triadic relationship between patient, provider/therapist, and interpreter is also challenging for the interpreter personally. This is due to the uniqueness of mental health interpreting, which presents a number of challenges not necessarily encountered in other areas of interpreting, ranging from the need to create a therapeutic reality and the need to brief/debrief, to the number of roles that a mental health interpreter might take on in their job.

In a perfect world, mental health interpreting training would be standardized and widely available across the U.S., but this unfortunately is not the case today. As many interpreters do not have access to training opportunities, they often go into a counseling session for the first time feeling overwhelmed and underprepared. While there are medical certifications in the U.S. (e.g., CCHI or CMI at the national level or the University of Texas at Austin at the local level) these programs do not adequately devote time to training interpreters to be fully aware of the nuances that exist in mental health interpreting.

Therefore, due to the current lack of training opportunities for interpreters who work in mental health, the two-course add-on component to existing healthcare interpreting programs proposed in this paper is suggested as a way to move forward. The overall goal of this proposal has been to not only raise awareness of existing literature and programs in the U.S. relating to healthcare interpreting, as well as lay out syllabi that can be used in mental health interpreting, but to also lay out the importance of mental health as a crucial component to an individual's overall health. Without providing the necessary training resources for interpreters who work in mental health settings, service providers are doing a great disservice to interpreters who genuinely want to focus on mental health, but currently have very limited options in terms of gaining the necessary expertise. The hope of this proposal is to try to recommend a model for addressing this gap in training.

In this thesis, many different activities and teaching strategies have been outlined for the purpose of training interpreters in mental health settings. Methods have ranged from Observation-Supervision and Problem-Based Learning to using relevant forms for

sight translation practice and playing the role of the interpreter in scripted dialogues in class. These suggestions by no means represent an exhaustive list but are just a few teaching strategies that researchers have found to be effective in their instruction of interpreting. This proposal, however, cannot move forward without partnership from outside the field of interpreting itself. Partnership from many different units within a university, of course, is essential and a great way to grow a program. At the University of North Carolina at Charlotte, for instance, there are a great many certificate programs and majors that all tie into the proposed mental health interpreting add-on, including certificates in Early Childhood Mental Health, Addiction Counseling, and School Counseling. Some related majors that can strengthen the add-on component include Health Administration, Nursing, Social Work, and Psychology. In terms of outside the university, local clinics, counseling centers, hospitals, and schools should all be aware and have an influence in the mental health interpreting program and assist in decreasing disparities for Latino/as in mental healthcare with regard to language barriers and financial obstacles.

It is also very important that these settings (e.g., hospitals, mental health clinics) maintain this relationship with the mental health interpreting program for professional reasons. In mental health clinics especially, rigorous language skills competence tests (Acevedo et al. 2003), providers who are well-versed in CLAS Standards, and training workshops in working with an interpreter are components that are necessary in order for Latino/a patients who have Limited English Proficiency to receive the same care and treatment as non-LEP patients in the U.S. In addition, it is a goal that therapists and staff at mental health settings would also form a positive and ongoing dialogue with the

interpreting student or students that they work with throughout the semester and that in turn will expose them to some of the fundamentals and etiquette related to mental health interpreting. Perhaps it could be advantageous for clinics to even work with the university to establish interpreting internships in preparation for a full-time career as a mental health interpreter at their specific setting, contingent upon the overall success and popularity of the mental health interpreting add-on.

As Angelelli (2006) and others have stressed, therapy is a conversation where each member of the team contributes to a therapeutic reality. This is especially true for the interpreter, who often helps to act as a co-diagnostician for the patient. In creating this add-on, the drive to improve the interpreter's power (knowledge and influence) was noted. This newfound knowledge and expertise would then be used to facilitate meaningful conversations in counseling and allow the interpreter to have a more professionally-informed role in the patient's healing process. As author J.K. Rowling says: "Words are, in my not-so-humble opinion, our most inexhaustible source of magic. Capable of both inflicting injury and remedying it." Therefore, it should be the task of both researchers and professionals alike to make sure an interpreter has every ability to render the patient's language efficiently and in turn ensure successful treatments.

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APPENDIX A: MENTAL HEALTH INTERPRETING: THEORY AND METHOD

Week 1
January 6 and 8, 2020

In class	**Homework**
Course Introduction What is mental health interpreting? Modes of interpreting Who are the Latino/as? Mental health perceptions Initial contact with a Latino patient	Homework 1. Study and memorize vocabulary in the readings! Readings 1. *An English-Spanish Manual for Mental Health Professionals*: Pg. 6-17 2. *The Bilingual Counselor's Guide to Spanish*: Ch. 1 & 2 3. Gray, Mendelsohn, and Omoto 2015 4. Rastogi, Massey-Hastings, and Wieling 2012

Week 2
January 13 and 15

In class	**Homework**
Familismo Culturally-bound illnesses Overview of acceptance of LGBTQ people in Latin America LGBTQ acceptance in U.S. Being LGBTQ, Latino/a, and having problems with mental health	Homework 1. Study vocab Readings 1. Elkington et al. 2012 2. Fripp and Carlson 2017

Week 3
January 20 and 22, NO CLASS MON

In class	Homework
What is stigma? Watch Emma Harrison TED Talk on YouTube Class discussion after video How do we deal with stigma in a healthy way? Being Latino/a and stigma with mental health What stigmas exist toward Latino/a people?	Homework 1. Study vocab/readings for Quiz 1 Readings 1. *An English-Spanish Manual for Mental Health Professionals*: Lesson 2 2. AUSIT Guidelines for Health Professionals Working with Interpreters 3. Bot 2006 4. Baylav 2003

Week 4
January 27 and 29

In class	Homework
What roles does a mental health interpreter take on? Advocate/Link-worker/Language interpreter Models of interpreting (linguistic, service provider team model, service user centered) Co-construction of meaning Advocate/Ally and ethical challenges **QUIZ 1- JAN 29**	Readings 1. Hwa-Froelich and Westby 2013

Week 5
February 3 and 5

In class	Homework
Interpreting ethics and standards Initial contact/forms What is sight translation? Intake form sight translation activity Culturally-bound illnesses Overview of vocab from readings	Homework 1. Continue to study and memorize vocabulary. Readings 1. *An English-Spanish Manual for Mental Health Professionals*: Lessons 3 & 4 2. *The Bilingual Counselor's Guide to Spanish*: Ch.4

Week 6
February 10 and 12

In class	Homework
Who works in mental health settings? Introduction to Simul and Consecutive Vocab overview Group role play- mental health intake interview Sight translation practice- mental health evaluation form What is shadowing? What is paraphrasing?	Homework 1. Shadowing practice (upload online) 2. Continue studying vocab Readings 1. Tribe and Morrissey 2004 2. *An English-Spanish Manual for Mental Health Professionals*: Lesson 5 3. Hwa-Froelich and Westby 2003

Week 7 **February 17 and 19**	
In class	**Homework**
Interpreter qualifications/skills Interpreter ethics/expectations Breaking the flow: what if the patient has an outburst? Mental Health examinations Examination role play in groups	Homework 1. Study vocab for Quiz #2 Readings 1. Doherty, Macintyre, and Wyne 2010 2. Crezee, Jülich, and Hayward 2011

Week 8 **February 24 and 26**	
In class	**Homework**
Why mental health interpreting? Self-care strategies for interpreters What is briefing? debriefing? What is Vicarious Trauma? Ways in which clinics can be prepared to handle refugees with little to no English language ability **QUIZ 2- FEBRUARY 26**	Homework 1. Online Discussion Board post and responses about VT due **FEB 24** Readings 1. *The Bilingual Counselor's Guide to Spanish*: Lesson 5 2. Magaña et al. 2013

Week 9
February 24 and 26

In class	Homework
Theoretical orientations in psychology Challenges to traditional methods from a Latino/a standpoint Vocab overview Mental health counseling in schools First look at a guidance counselor letter setting up meeting with parents Group work: sight translation of letter, outside collaboration of teams to create script for hypothetical encounter	Homework 1. Look up vocab/work on script for school counseling meeting with parents 2. Study vocab Readings 1. *An English-Spanish Manual for Mental Health Professionals*: Lesson 6 2. Chapman and Stein 2014

Week 10
March 2 and 4, NO CLASSES

In class	Homework
	Homework 1. Continue working on scripts/readings

Week 11 **March 9 and 11**	
In class	**Homework**
Continued discussion on Latino parents and stigma in children Break into groups to practice completed scripts Vocab overview Mental health diagnosis What is the clinician/parent/interpreter's role in the diagnosis process? Ethical considerations	Homework 1. Study vocab Readings 1. *An English-Spanish Manual for Mental Health Professionals*: Lesson 7 2. Lor, Bowers, and Jacobs 2018

Week 11 **March 16 and 18**	
In class	**Homework**
Theoretical orientations in psychology Discussion of Lor, Bowers and Jacobs 2018 article Vocab overview Similarities/differences with AUSIT Guidelines Placement/Turn-taking Review of briefing/debriefing	Readings 1. Searight and Searight 2009 2. *An English-Spanish Manual for Mental Health Professionals*: Lesson 8 3. *The Bilingual Counselor's Guide to Spanish*: Lesson 6

Week 12 March 16 and 18	
In class	**Homework**
Article discussion The therapeutic process Vocab overview Counseling for substance abuse/hand out scripts What is a Lit Review?	Homework 1. Study script/look up useful vocab 2. Study vocab for Quiz 3 3. Come up with a Lit Review topic

Week 13 March 23 and 25	
In class	**Homework**
Therapeutic process continuation Vocab overview Break into groups to practice scripts Answer questions/clarify expectations for Lit Review **QUIZ #3- MARCH 25**	Homework 1. Study vocab 2. Start researching for Lit Review Readings 1. *An English-Spanish Manual for Mental Health Professionals*: Lesson 9 2. *The Bilingual Counselor's Guide to Spanish*: Lesson 7

Week 14 **March 30 and April 1**	
In class	**Homework**
Treatment planning Vocab overview How do cultural differences affect the treatment process? Developing bilingual materials/techniques for working with an interpreter Consent of treatment form sight translation/breakdown	Homework 1. Continue researching/writing for Lit Review 2. Study vocab and readings Readings 1. *An English-Spanish Manual for Mental Health Professionals*: Lesson 10, look over Letter before Closing Case 2. Echuari Galván 2014 3. "Terminating the Treatment Relationship" https://bit.ly/2tNhRQe

Week 15 **April 6 and 8**	
In class	**Homework**
Vocab overview Termination of treatment Article discussion Why is it hard to continue with treatment? Importance of pragmalinguistics throughout treatment process Need for all parties to understand why termination was decided upon	Homework 1. Study vocab 2. Discussion Board post and responses about treatment termination due **APRIL 15**

Week 16 April 13 and 15	
In class	**Homework**
Current certification options CCHI, DSHS Washington, National Board for the Certification of Healthcare Interpreters Requirements & Contents of each Guest speaker from a local mental health clinic or counseling center?	Homework 1. Bring in any questions you may have about the final exam 2. Keep working on Lit Review

Week 17 April 20 and 22	
In class	**Homework**
Review for Final Exam What did you like/dislike about the course? What would you change/keep? Lit Review topic discussions	Homework 1. Study for Final Exam on 4/27 2. Finish working on Lit Review

Week 18 April 27	
In class	**Homework**
FINAL EXAM APRIL 27	Homework 1. Finish and turn in Lit Review, due on **MAY 6**

APPENDIX B: MENTAL HEALTH INTERPRETING: PRACTICE AND RESEARCH

Week 1
August 24 and 26

In class	**Homework**
Class introduction Goals/learning outcomes Assignments/expectations Intro to book/author's approach (MECA) Brainstorm: who are Latino/as and what issues face their community?	Homework 1. Complete online Intro Survey by class time on TUES, Aug. 24th Reading 1. *Latino Families in Therapy*: Chs.1 &2

Week 2
August 31 and September 2

In class	**Homework**
Where do Latino/as come from? Migration Migration and age differences/cultural differences/sense of belonging Why might a Latino/a seek therapy? Stressors: education level, sexual orientation/gender identity, class, religion, ethnicity, language Families: size, single parent or cohabitation, abortion, same-sex marriage/unions Documented vs. Undocumented	Homework 1. Research a mental health setting to complete observation hours Readings 1. *Latino Families in Therapy*: Ch.3

Week 3 **September 7 and 9**	
In class	**Homework**
NO CLASS MON Why is being an immigrant hard? Physical/social uprootings Finding social capital Different language/cultural values Clinical symptoms of migration (palpitations, dizziness, anxiety, panic attacks) Interpreter and clinician roles of being a cultural observer, social intermediary, and family intermediary Being careful to avoid biases	Homework 1. Study for Test #1 Readings 1. *Latino Families in Therapy*: Ch. 4

Week 4 **September 14 and 16**	
In class	**Homework**
Family separations Cultures of migration Transnational therapies Repairing bonds Restoring Role clarity **TEST #1- SEPT 16**	Homework 1. Try to start working toward hours for the practicum requirement (10 hrs) 2. Start journaling once you have started the practicum hours Readings 1. *Latino Families in Therapy*: Ch.5

Week 5 **September 21 and 23**	
In class	**Homework**
Second generation struggles Family loyalty Acculturation/Assimilation Models Biculturalism Talk with service user (WED), Q&A session/class discussion	Homework 1. Prepare journal/bring to class for discussions on MON, Sept. 28 2. Look back over Lit Review from Theory and Method to brainstorm topic for paper

Week 6 **September 28 and 30**	
In class	**Homework**
Share/discuss journal in class Challenges? Benefits? Class discussion on final paper Topic sharing?	Homework 1. Online discussion board post/responses relating to journaling/final paper topic 2. Continue practicum hours 3. Continue work on final paper Readings 1. *Latino Families in Therapy*: Ch. 6

Week 7
October 5 and 7

In class	Homework
Mental Health Disparities: Discrimination Acculturation/cultural retention Barriers to receiving care: Money, language, culture, refusal to take medication Strategies to overcome disparities: cultural competence, flexibility, trust-building, indigenous healers, community services Practice script in class- Patient with *mal de ojo*	Homework 1. Study readings for **TEST #2** on October 19 2. Continue with practicum hours 3. Continue work on final paper Readings 1. *Latino Families in Therapy*: Ch. 7

Week 8
October 12 and 14

In class	Homework
	Homework 1. Continue working on practicum hours 2. Continue working on final paper 3. Study for **TEST #2**

Week 9
October 19 and 21

In class	Homework
TEST #2 on MON Class journal discussions	Homework

Religion/folk medicine Implications of folk religion/medicine for clinical practice Clients who may have a family history of mental distress/illness Family interventions	1. Continue working on practicum hours 2. Continue working on final paper Readings 1. *Latino Families in Therapy*: Ch.8

Week 10
October 26 and 28

In class	**Homework**
Culture, class, and race/ethnicity Names as triggers of discrimination Internalizing discrimination Racism/colorism and self-esteem Racism as a cultural mask Awareness of racially-charged language MECA and self-reflection regarding race/ethnicity	Homework 1. Continue working on practicum hours 2. Continue working on final paper Readings 1. *Latino Families in Therapy*: Ch. 9

Week 11
November 2 and 4

In class	**Homework**
School + work challenges Immigrants who have children in school School difficulties: poverty, linguistic barriers, learning styles, family separation	Homework 1. Continue working on practicum hours 2. Continue working on final paper

What is education? Uneasy feelings between parents and school personnel Respect and dignity at work Practice script in class: 16-year-old who wants to drop out of school and work	Readings 1. *Latino Families in Therapy*: Ch. 10

Week 12
November 9 and 11

In class	**Homework**
Family organization *Familismo* and familial self Family rituals Extended family Authority of parents Status of mothers/meaning of fatherhood Communication styles	Homework 1. Study for **TEST #3** on **NOV 18** 2. Continue working on practicum hours 3. Continue working on final paper Readings 1. *Latino Families in Therapy*: Ch. 11 &12

Week 13
November 16 and 18

In class	**Homework**
Journal discussions Latino/a couples: what brings them to therapy? Machismo, divorce, gay couples, intermarriage Raising children: newborns, rituals, etc.	Homework 1. Continue working on practicum hours 2. Continue working on final paper Readings

Childrearing practices: punishment Intervention by other family members **TEST #3- NOV 18**	1. *Latino Families in Therapy*: Ch. 13

Week 14
November 23 and 25

In class	**Homework**
Adolescents: generational tensions, ethnic identity, discrimination Cultural conflicts: gang involvement, teen pregnancy, sexual orientation, suicide Rituals as a therapeutic resource In class script: Attempted suicide in an LGBT teen	Homework 1. Continue working on practicum hours 2. Continue working on research paper Readings 1. *Latino Families in Therapy*: Ch.14

Week 15
November 30 and December 2

In class	**Homework**
Journal discussions Adulthood: staying home, courtship & marriage, parenthood Middle aged Latino/as: exits and entrances, grandparenthood Latino/a elderly: transnational arrangements, multiple jeopardy Dying and grieving Funerals and social networks	Homework 1. Continue working on practicum hours 2. Continue working on final paper 3. Bring questions to exam review on Dec 7

Week 16 **December 7 and 9**	
In class	**Homework**
Exam review on Monday Positives/negatives about the class Changes? Takeaways? **FINAL EXAM** on **DEC 9**	Homework 1. Finish practicum hours/journals (**Due DEC 14**) 2. Finish final paper (**Due DEC 14)**

Week 17 **December 14**	
In class	**Homework**
ALL practicum hours/journals as well as the final paper are DUE on DEC 14	