Interpreters' Self-Perceptions of Their Use of Self When Interpreting in Health and Behavioral Health Settings

Abstract

This study examines interpreters' self-perception of their use of self when interpreting in health and behavioral healthcare settings.

Constant comparative analysis was used to analyze the individual, semi-structured interviews of 36 interpreters.

Interpreters identified specific skills and techniques, that they developed on their own, to (a) create a safe environment for both the provider and the client, and (b) to increase the effectiveness of the intervention.

Interpreters are vital members of care teams. Interpreters might be under-utilized if only seen as a language conduit. Embracing interpreters as members of the interprofessional team may hold great promise for addressing challenges in providing culturally effective services.

Keywords: use of self, interpreter, healthcare interpreting, integrated interprofessional, Affordable Care Act

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When there is not a shared language, interpreters are needed. Meeting the healthcare needs of newly arrived immigrants and refugees requires competent language services as these populations are less likely to have economic, language, and cultural resources to help them navigate through systems of care. The United States has one of the largest foreign born populations, with many of these foreign born arriving with little prior experience with the language or culture. In the United States, 70,000-80,000 refugees arrive each year (Immigration Policy Center, 2014).

Studies have examined the effectiveness of interpreters in healthcare settings when the interpreter has been a family member, a staff worker who is asked to leave her/his job station to interpret, and when the interpreter has been professionally trained (Amodeo, Grigg-Saito, & Robb, 1997; Armstrong, 2010; Bischoff & Hudelson, 2010; Butow et al., 2011; Karliner, Jacobs, Chen, & Mutha, 2007). Karliner and colleagues (2007) found that clients who worked with professional interpreters received better clinical care. But having a professional interpreter present

does not ensure better care is received. Providers who work with interpreters respond fewer times to non-verbal cues and are less responsive to clients' emotional state (Butow et al., 2011). This speaks to the need for better training of providers in working with interpreters, and better training of professional interpreters on interpreting communication that is not verbal. There are a number of hurdles that prevent providers from working with professional interpreters. Bischoff and Hudelson (2010) found that professional interpreters are used less frequently than a client's relative or a bilingual staff member, both of which are perceived to be logistically easier and less expensive to access. Other studies have examined additional factors that impede the effective use of interpreters (Hadziabdic, Heikkilä, Albin, & Hjelm, 2011), including factors such as the availability of interpreting services and difficulty scheduling the interpreter and the client together.

In addition to challenges in working with interpreters, there are challenges between the provider and the interpreter (Hsieh, 2006; Hsieh, 2008, 2010; Hsieh, Ju, & Kong, 2010). Hsieh has examined the dynamics between provider and interpreter in a number of studies. Her work demonstrated the complexity of this relationship and the importance of developing trust and clear roles between the provider and interpreter. Her work also makes a compelling case for deliberately using the interpreter's many possible roles within the visit to the benefit of the client and provider relationship. An interpreter can act as a language conduit, a cultural broker, an advocate, and a support for the client. Some providers are comfortable having the interpreter use a number of roles within the visit (Hsieh & Kramer). There are a number of studies that examine the provider's experiences working with interpreters (Brämberg & Sandman, 2013; Brisset, Leanza, & Laforest, 2013; Hsieh, 2010; Hsieh, 2014; Hsieh, et al., 2010; Mirdal, Ryding, &

Essendrop Sondej, 2012; Rousseau & Foxen, 2010). There are few studies on the client's experience of interpretation services (Hadziabdic & Hjelm, 2014); and, a small but growing body of literature on the experiences of interpreters (Green, Sperlinger, & Carswell, 2012; Hsieh, 2008).

As more remote methods of interpreting (telephonic, video) are becoming more common, studies have sought to evaluate the effectiveness of each of these methods (Crossman, 2010; Locatis et al., 2010; Wofford, Campos, Johnson, & Brown, 2012). In-person interpreting is preferred by providers and interpreters more than a remote method, while video is preferred over telephonic (Locatis et al., 2010). The findings reflect the perception that "much was lost" when not in-person. This suggests that the physical presence of the interpreter with the client and provider is important. Studies have demonstrated that interpreters understand that they are more "than a robot" (Hsieh, 2008), and that providers feel both burdened and enriched by the quality of the interpretation service (Hadziabdic, Heikkilä, Albin, & Hjelm, 2011; Hsieh, 2010). Few studies, though, have examined the interpreter's physical presence as part of the interpreting service. In particular, this study seeks to understand how, if at all, interpreters use themselves as a tool to enhance the interpretation services. The use of one's self to enhance service delivery and client trust is most often associated with psychotherapy. The use of self is defined within social work and counseling literature as the "use of personality; use of belief system; use of relational dynamics; use of anxiety; and use of self-disclosure" (Dewane, 2006). For social workers and counselors, the use of self is an important skill in working with clients. In using one's self with a client, a therapist consciously uses aspects of her personality, her personal experiences, and dynamics within the relationship to create a safe and authentic exchange with

the client. The intent of using parts of one's self within the helping relationship is always to enhance the intervention, and deepen the trust with the client (Arnd-Caddigan & Pozzuto, 2008; Maclaren, 2008).

Studies have looked at ways interpreters struggle with the complex dynamics inherent within interpreting sessions (Doherty, MacIntyre, & Wyne, 2010; Dubslaff & Martinsen, 2005; Green, et al., 2012; Hsieh, 2010; Kosny, MacEachen, Lifshen, & Smith, 2014; Rousseau & Foxen, 2010). While these studies identify challenges and limitations of interpretation services, they do not explore the interpreter's conscious and deliberate use of self to enhance the service. This study seeks to understand, through the interpreter's perspective, the interpreter's use of self when interpreting in health and behavioral healthcare settings. Behavioral healthcare in the United States are services that address mental health issues, such as counseling and medication.

Method

The Institutional Review Board of the author's institution has approved all components of this study. To better understand the subjective experiences of the participants, semi-structured interviews were conducted with 36 interpreters.

Participants and Procedure

Thirty-six interpreters participated in this study. The data was collected from July 2013- July 2014. Recruitment was through interpreting agencies. Supervisors from the agencies informed interpreters of the study and were directed to contact the primary investigator of their interest. Because the purpose of the study is to explore the interpreter's use of self, it was important to have interpreters who have had both in-person and telephonic interpreting experience to tease out the importance of physical presence versus other means of

using one's self (voice, tone, silences). Participants who have interpreter both in-person and telephonically were included in the study. It was important to have an equal sample of men and women in the study to see if any gender difference would occur in the findings. Once an equal size of men and women participants had been achieved, recruitment ended. Final sample contained 36 interpreters. Participants were paid for their time at the same rate they are paid for interpreting. For most participants, this ranged from $25 - $60 per hour. Written informed consent was obtained. Confidentiality and anonymity of their responses were described. All interviews were individual, face to face, lasted 45 minutes to an hour, and were audio-taped, with consent, for later transcription.

In addition to demographic questions (length of time as interpreter, languages spoken, age, sex), interviews were guided by the following questions: Describe the process when you interpret in-person. Describe the process when you interpret telephonically. What are the differences in interpreting in-person versus telephonically? What are the challenges and strengths of each method? What do you see as your role with the provider? The client? With both? How does the trust of the client affect your ability to effectively interpret? Are there ways that you try to develop trust with the client? With the provider? Does this vary if in-person versus telephonically? Are there ways that your personality affects your work? Do your own beliefs and experiences affect your work? Are there dynamics with three in the room that affect the process? How do you know if you are effective in your role?

Each interview was conducted in English at a private location of the participant's choosing. To maintain confidentiality of the participants, the audiotapes and transcripts were

anonymized and coded by number. All data was stored in locked file cabinets and password protected drives that could only be accessed by the principal investigator.

Data Analysis

The qualitative software program Dedoose was used to manage the data. The data was analyzed using grounded theory constant comparative analysis. This process entails four coding phases (Charmaz, 2004; Glaser, 1967; Kamya & Poindexter, 2009). A second coder (a graduate student experienced in coding) was hired in addition to the principal investigator to independently analyze the data, and to generate memos and codes. The initial coding phase involved each rater independently reading the transcripts line by line and generating codes from excerpts of the transcripts. The principal investigator and graduate student compared the excerpts and the code names. If the excerpts and codes varied, the two discussed the rationale, looked for more evidence to substantiate the code or to reject the code. This process continued until an agreed list of codes were identified. This list contained codes such as: "interpreter using body language to develop trust with client", "provider looks only at client", "perceived anxiety in client". In the second phase the raters performed selective coding, a process that creates conceptual categories from the codes through a re-reading of the transcripts, reviewing the codes, combining and reorganizing codes when doing so strengthened the theme of the codes. This resulted in fewer codes, but the remaining codes seem to better capture the information, for example: self-taught techniques for developing trust, self-perception of interpreter as a bridge. In axial coding, the third phase, categories and sub-categories were developed to show causal relationships, if any. In the final phase major themes or stories emerged from the categories. The two raters then reviewed the coding process to ensure the

validity of the findings. These findings and the coding process were critically peer reviewed by researchers not affiliated with the study to further ensure the findings' validity.

Findings

The findings presented in this section are of the stories that emerged from the interpreters. The interpreters described their roles as complex. They saw themselves as interpreters, advocates, cultural brokers, support for the client, cultural navigators, and teachers. They believed the different roles were inevitable in ensuring the effectiveness of the service. They felt rewarded and valued, but also invisible and devalued, and that their satisfaction in the work was determined often by how the provider treated them. Throughout their narratives was the story of interpreters using themselves to enhance the services received by the clients and the effectiveness of the providers.

The interpreters' didn't use the term "use of self" but did describe the components that make up the concept, such as consciously using aspects of their personality, awareness of their belief system and its possible impact on the client; use of relational dynamics among the three in the room (client, interpreter, and provider). The interpreters used these components of "use of self" to develop the trust with the client and provider, and to enhance the effectiveness of the services provided. In addition to these components they used their body language, voice, and eye contact to develop trust with the client. For example, this interpreter (female #30) stated,

> For me, it starts with when I fetch her in the waiting room. I make sure to talk softly to the client and look at them. I usually sit down next to them and tell them who I am. Then when we get in the room, I set up the chairs for her and me to sit. The whole time I am trying to help her feel safe. I watch for signs of whether she does or doesn't.

And another (male #24) stated,

> I make sure I use a familiar greeting. Sometimes it is easy,' cause they are the usual ones. But sometimes you find out they are from a region and I then try to use that region's greeting. I love when I can do that. It's rare, but fun. I see them feel more relaxed. Like, 'it's going to be okay because this interpreter understands me…where I come from'.

This interpreter (female #11) described developing trust with the client when the provider is present,

> Voice is really important. If the provider is stern, and I don't think the client will understand being talked to like that, I soften my voice. Sometimes I reach out and touch the client on the shoulder or arm to let them know I am here with them. With some providers you have to do the little extra to help the client feel comfortable. Some providers are too quick and brisk. They can come off as angry. The client doesn't need that. So I soften it. I also keep my body open, like this (she positions her arms along her sides). I want the client to know I am safe to trust.

Interpreters often balanced themselves in relation to the provider. If the provider seemed "gruff" then the interpreter softened; if the provider made eye contact and was attentive to the client, the interpreter involved her/himself less (the interpreter matched the provider's tone, assumed the provider would notice when the client appeared anxious and would address it without the interpreter providing assurance to the client). They also used their personality to balance the dynamics in the room and to help the client feel safer, as evident by this interpreter (female #17),

> I am really a shy person, an introvert. I think many times this works to my advantage in this work. I think most of the patients are quite like me. Maybe it's a cultural thing. I

> don't know. But I know they feel safe with me. I'm not going to be loud or small talk when we are waiting for the doctor. We just sit. Sometimes I get someone who seems to need to talk, like they are nervous. I have gotten better at talking with them. I think I can talk enough to help them relax. When I first started (interpreting) I wasn't good at this. But now, well, I'm still quiet, but I can talk to them when they need me to.

An interpreter who described himself (male, #4) as an extrovert said,

> I start talking the first I see them. I usually go get them in the waiting room. I start talking, weather, then their home country. Sometimes we have seen each other around town and we talk about restaurants. But the point is, I let them know that I am friendly. That I won't be judging them. There are times where I just get a feeling that my talking might be too much for them. Then I hold myself back. (He laughs) Not that easy. But it's for them, right? It's got to be what is best for them.

The provider's approach in working with a client and an interpreter played an important role in how the interpreter used themselves in the sessions. If an interpreter had worked with a provider before, s/he knew what to expect and worked with the client in specific ways. For example (female #22),

> I work with this one doctor. I already know that I need to do more in the sessions than interpret when I work with him. I don't mind. I actually like doing more. I wish the doctor didn't seem so dismissive of me though. But, anyway, I know this doctor won't look at either of us much in the room. He stares mainly at the computer when he talks. So make sure I look at the patient. I smile. I sit closer. I'll ask the patient if they understand

> what the doctor means because I don't think he explains himself well. I think I am the human element in the room.

This interpreter's reference to being "the human element in the room" came up in a number of interviews, but usually as how they felt treated by the provider, "I think he thinks I am a machine just spitting out words. Just use the god damn internet if that is all I am" (male, 12). When a provider worked closer with the interpreter, the interpreter worked differently. For example (female 7),

> I definitely change who I am based on who's in the room. I work with this one therapist and she is asking me how best to phrase something, or asks about the client's culture, stuff like that. We often have a three way conversation about something from our country that the therapist doesn't understand. In these sessions I get to be more myself. But other times, I am quiet and try to be invisible…like a voice for both of them. Those sessions actually make me really tired.

Interpreters, in addition to using different aspects of their personality when interpreting, also understood that their beliefs play a role in the work. This male (#20) described it this way,

> You see, we have a different culture than the U.S. Like we don't talk about sex much. But the doctors here talk about sex a lot. I feel uncomfortable. I know that if I am uncomfortable then the patient will be. So I have had to learn to not be uncomfortable when sex is talked about. Other times, a patient might talk about something back home (in country of origin) and I will have an opinion. I don't say my opinion of course. But I know it affects me. Sometimes I can feel myself get angry and I don't look at them. I hate that. I don't want it to affect my work, but I think it does. I think it is noticed.

The interpreter from the above quote had strong feelings about the political struggles in his country of origin. At times he had to self-monitor his anger when a client talked about the struggles. Other interpreters felt that their beliefs helped them to interpret better. They described using shared cultural experiences as a way to develop trust with the patient, as well as being able to help the provider understand the client.

> Oh, yeah, I mean I tell the doc that we don't think like that in our country. Or I will tell the doc about a home remedy we use. I bring in what I know about the culture when I think it will help them (the provider and patient) (male, #12).

The interpreters were aware that their knowledge of the culture of the client was helpful to the provider and the client, and they tried to use it carefully. Sometimes, they questioned if every interpreter was able to use their culture well. Some wondered if interpreters projected their own beliefs onto a client. They understood that having the same culture as the client could be helpful but also could complicate the interpreter's role. This seemed to be a nuanced skill that more seasoned interpreters developed over time.

> I remember when I first started out. I thought I knew what the patient felt because I used to live there too. Over time I realized that not everyone has the same experience as me. So I have to keep an open mind even if we come from the same place. I can't know their experiences. I can make a better guess maybe, but I can't know. (female, # 31)

The interpreters' ability to use aspects of themselves occurred both telephonically and in-person. While it was difficult for them to convey body language over the phone, they deliberately used their voice, pauses, and culturally familiar phrases to aid in the development of trust.

The interpreters described in many ways that they used parts of their personality to aid in the interpreting, as well as their shared culture, body language, voice tones and culturally familiar phrases. They discussed the providers' personalities and style in working with an interpreter as contributing to and hindering their ability to develop trust with the client. Developing trust with the provider appeared to be based on interpretation accuracy and the interpreter's ability to adapt to the provider's expectation of the interpreter's role.

Discussion

The use of self is a term most often used in psychotherapeutic settings to describe how a therapist consciously uses aspects of his/her personality, his/her personal experiences, and dynamics within the relationship to enhance the intervention and deepen the trust with the client (Arnd-Caddigan & Pozzuto, 2008; Maclaren, 2008). The presence of a third person in the room affects inter-personal dynamics. This is particularly true within a helping relationship. The provider and interpreter are an inter-professional team present in the room for the purpose of helping the client. Therefore, the interpreter's presence (whether via a telephone or in-person) is part of that helping intervention, beyond the interpreting services provided. The interpreter can enhance or impede the provider's work with the client, and with the client's trust and engagement in the sessions. The interpreters in this study understood many of the ways that they use themselves to enhance the sessions. They consciously used parts of themselves to deepen trust, enhance understanding, and to make interventions effective. Interestingly, this was true whether the interpreter was in the room or via the telephone. The findings from this study are important because they suggest that interpreters might be under-utilized when used only as a language conduit (Watermeyer, 2011). Perhaps, interpreters should be considered as a member

of the interprofessional team in healthcare settings. This is a timely redefining of the interpreter's role in healthcare settings in the United States. Since the implementation of the Affordable Care Act in the United States in 2014, the healthcare industry has been encouraged to develop interprofessional teams in healthcare delivery as a means to improve healthcare outcomes and decrease healthcare costs (Kuramoto, 2014). As the narratives within this study reveal, interpreters provide valuable interventions in addition to language interpretation. While studies have examined the many roles interpreters can have (Amodeo, et al., 1997; Berthold & Fischman, 2014; Bischoff, Kurth, & Henley, 2012; Brämberg & Sandman, 2013; Hsieh, 2010), this study highlights their importance in the helping relationship. The many roles, and the methods these interpreters have found to execute these roles, are essential components within a team approach to healthcare where the provider and interpreter work together in the best interest of the client. It may be warranted to draw out the roles of the interpreter, make those roles more pronounced and deliberate, and to train interpreters to consciously and skillfully use these roles. In addition, providers could be trained to work with interpreters as team members in the provision of care to clients.

This study examined the experiences of interpreters. The sample was diverse with a wide range of languages spoken. The gender was equally distributed, and interpreters were asked about their in-person interpretation experiences as well as their telephonic experiences. However, the study is just one examination of a topic that is complex and difficult to measure. Would a quantitative study that examined patient outcomes reveal the effectiveness of interpreters consciously using parts of themselves to enhance services? It is possible that a study that

examined team approaches versus the use of interpreters as language conduits would yield results that can assess the effectiveness of one approach over another.

Interpreters work throughout the world interpreting in various settings. Especially in the healthcare setting, their presence affects the dynamics in the room with the client (Hsieh, 2010). In the United States, as it moves toward interprofessional team approaches in healthcare, viewing the interpreter as part of the team has important implications for how interpreters are trained and valued. As the United States in embarking on new models for healthcare delivery, it is a critical time for interpreters' roles to be re-evaluated, and their value as team members be acknowledged.

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