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

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

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## Abstract

*This study examines interpreters' self-perception of their use of self when interpreting in health and behavioural health-care settings. Constant comparative analysis was used to analyze the individual, semi-structured interviews of thirty-six interpreters. Interpreters identified specific skills and techniques, that they developed on their own, (1) to create a safe environment for provider and client, and (2) 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 inter-professional team may hold great promise for addressing challenges in providing culturally effective services.*

## Résumé

*Cette étude se penche sur l'auto-perception des interprètes de leur recours au soi dans l'interprétation en milieux de services de santé et de santé comportementale. Une méthode comparative constante avait été employée pour analyser les 36 entrevues individuelles semi-structurées des interprètes.*

*Les interprètes ont identifié des aptitudes et des méthodes spécifiques qu'ils avaient indépendamment développées afin de (a) créer un environnement rassurant pour le fournisseur ainsi que le client, et (b) accroître l'efficacité de l'intervention. Les interprètes constituent des membres essentiels d'équipes de soins. Ils risquent toutefois d'être sous-utilisés s'ils sont considérés uniquement comme des*

*intermédiaires de langue. Intégrer pleinement les interprètes en tant que membres de l'équipe interprofessionnelle est très prometteur pour aborder les défis reliés à la prestation de services adaptés aux particularités culturelles.*

When there is not a shared language, interpreters are needed. Meeting the health-care 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. The American Immigration Council<sup>1</sup> reports that in the United States, 70,000–80,000 refugees arrive each year.

Studies have examined the effectiveness of interpreters in health-care settings when the interpreter has been a family member, a staff worker who is asked to leave her or his job station to interpret, and when the interpreter has been professionally trained. Karliner and colleagues<sup>2</sup> 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. Butow and colleagues<sup>3</sup> found that providers who work with interpreters respond fewer times to non-verbal cues and are less responsive to clients' emotional state. This speaks to the need for better training of providers in working with interpreters, and better training of professional interpreters on interpreting non-verbal communication. A number of hurdles prevent providers from working with professional interpreters.

Bischoff and Hudelson<sup>4</sup> 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, 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 hurdles between provider and interpreter. Hsieh<sup>5</sup> 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 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-provider relationship. An interpreter can act as a language conduit, a cultural broker, an advocate, and a support for the client. Brisset, Leanza, and Laforest<sup>6</sup> found in their meta-analysis of the literature that some providers are comfortable having the interpreter use a number of roles within the visit. Several studies such as Kosny et al.<sup>7</sup> examine the provider's experiences working with interpreters. There are few studies, like Hadziabdic and Hjelm<sup>8</sup> that focus on the client's experience of interpretation services, and a small but growing body of literature on the experiences of interpreters. Green, Sperlinger, and Carswell<sup>9</sup> looked at refugees experiences when they worked as interpreters for fellow refugees.

As more remote methods of interpreting (telephonic, video) become more common, studies have sought to evaluate the effectiveness of each of these methods. Studies such as Locatis<sup>10</sup> show that in-person interpreting is preferred by providers and interpreters more than a remote method, while video is preferred over telephonic. 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, as Hsieh<sup>11</sup> stated, that they are more "than a robot," and in a different study by Hadziabdic<sup>12</sup> and colleagues, they found that providers feel both burdened and enriched by the quality of the interpretation service. 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. As Dewane<sup>13</sup> describes, the use of oneself to enhance service delivery and client trust is most often associated with psychotherapy. The use of self is defined within social work and counselling literature as the "use of personality; use of belief system; use of relational dynamics;

use of anxiety; and use of self-disclosure."<sup>14</sup> For social workers and counsellors, the use of self is an important skill in working with clients. Maclaren<sup>15</sup> and others describe the purpose of using oneself as a method where the therapist consciously uses aspects of her personality, personal experiences, and dynamics within the relationship to create a safe and authentic exchange with the client. As Arnd-Caddigan and Pozzuto discuss,<sup>16</sup> the intent of using parts of oneself within the helping relationship is always to enhance the intervention and deepen the trust with the client.

Studies, such as Doherty, MacIntyre, and Wyne<sup>17</sup> have looked at ways interpreters struggle with the complex dynamics inherent within interpreting sessions. 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 behavioural health-care settings. Behavioural health-care in the United States is a service that addresses mental health issues, such as counselling 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 thirty-six interpreters.

## Participants and Procedure

Thirty-six interpreters participated in this study. The data were collected from July 2013 to 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 oneself (voice, tone, silences). Participants who have interpreted 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 number of men and women participants had been achieved, recruitment ended. Final sample contained thirty-six interpreters. Participants were paid for their time at the same rate they are paid for interpreting. For most participants, this ranged from \$25 to \$60 per hour. Written informed consent was obtained. Confidentiality and anonymity of their responses were described. All interviews were individual, face to face,

lasted forty-five 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 were stored in locked file cabinets and password-protected drives that could be accessed only by the principal investigator.

### *Data Analysis*

The qualitative software program Dedoose was used to manage the data. The data were analyzed using grounded theory constant comparative analysis. This process entails four coding phases as described by Charmaz,<sup>18</sup> Glaser<sup>19</sup> in his work, and by Kamya and Poindexter.<sup>20</sup> 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 and 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 rereading of the transcripts, reviewing the codes, and 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 subcategories 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, and 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 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, one 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 ok because this interpreter understands me ... where I come from."

Another 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 [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 herself or 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 assuring the client). They also used their personality to balance the dynamics in the room and to help the client feel safer, as evident by another 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 [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 herself or himself in the sessions. If an interpreter had worked with a provider before, she or 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 each felt treated by the provider: "I think he thinks I am a machine just spitting out words. Just use the god-dam 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. One 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 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:

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 client's culture 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, as recollected by one interpreter (female, #31):

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.

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 term *self* is often used in psychotherapeutic settings to describe how a therapist consciously uses aspects of his or her personality, personal experiences, and dynamics within the relationship to enhance the intervention and deepen the trust with the client. The presence of a third person in the room affects interpersonal dynamics, particularly within a helping relationship. The provider and interpreter are

an inter-professional team present in the room to help 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 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. Perhaps interpreters should be considered as a member of the inter-professional team in health-care settings. This is a timely redefining of the interpreter's role in health-care settings in the United States. Since the implementation of the Affordable Care Act in the United States in 2014, the health-care industry has been encouraged to develop inter-professional teams in health-care delivery as a means to improve health-care outcomes and decrease health-care costs. 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, 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 health care where the provider and interpreter work together in the best interests of the client. It may be warranted to draw out the roles of the interpreter, make those roles more pronounced and deliberate, and train interpreters to consciously and skilfully 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 health-care setting, their

presence affects the dynamics in the room with the client. In the United States, as it moves toward inter-professional team approaches in health care, 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 health-care 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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