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The Client with Limited English Proficiency

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ABSTRACT

This article explores the ethical concerns of working with a client with limited English proficiency. While the "APA *Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations*" advocates referring the client to a practitioner who shares the client's first language, or working with an interpreter if this is not possible, there are a number of situations in which neither of these solutions are feasible. Additionally, the use of an interpreter raises ethical concerns about which practitioners should be aware. The paper explores alternatives to a referral or the use of an interpreter, discussing how the client's use of a second language may impact sessions and suggesting ways to work ethically with the client.

Key Words: Ethics; Language; Interpreter; Self-Disclosure

Twenty percent of the U.S. population speaks a language other than English at home, yet very few mental health practitioners possess adequate language skills to work bilingually (U.S. Census Bureau, 2007; Westermeyer, 1990). Research has explored the impact of bilingualism and interpreters on client self-disclosure and diagnosis; however, authors have not addressed the ethical concerns of working with a client with limited English proficiency. The following article aims to prepare the practitioner with an ethical response for when he/she is approached by a client with limited English proficiency.

The APA (1993) advocates interacting in the language requested by the client, yet recognizes that this is not always possible: "Problems may arise when the linguistic skills of the psychologist do not match the language of the client. In such a case, psychologists refer the client to a mental health professional who is competent to interact in the language of the client" (APA, 1993, 6.a). With 381 languages represented within the U.S., a practitioner proficient in the language of the client may be hard to find, particularly outside of metropolitan areas. The APA (1993) advocates the use of an interpreter if a practitioner cannot be found: "Psychologists offer the client a translator with cultural knowledge and appropriate professional background" (APA, 1993, 6.b.). The use of an interpreter creates many ethical concerns requiring further discussion.

Working with an Interpreter

Multiple Relationships

Due to language barriers, an adolescent interpreted a diagnosis of terminal heart disease to her mother and a 7-year old interpreted the doctor's news that her mother had a miscarriage (Levine, Glajchen, and Cournos, 2004; Paras et al., 2002). While these examples are extreme, it is common for children to serve as language brokers for their parents (Glajchen&Cournos, 2004; Paras et al., 2002). Given the prevalence of health professionals, clinics, and hospitals who rely on a patient's friend or relative, untrained staff, or strangers from the waiting room or street to interpret, a practitioner should be knowledgeable about his/her respective code of ethics and conscious of multiple relationships when locating an interpreter (Flores, 2006; Searight and Searight, 2009).

The APA (2002) requires that the practitioner "take reasonable steps to avoid delegating such work to persons who have a multiple relationship with those being served that would likely lead to exploitation or loss of objectivity" (2.05). The use of a family member or friend to interpret can hinder the therapeutic process; a client might be less willing to disclose sensitive information, such as psychological disorders, domestic violence, substance abuse, or sexually transmitted diseases (Flores, 2005); the interpreter may pursue his/her own agenda by disclosing more or less than the client had intended (British Psychological Society, 2008); and the confidentiality of sessions may be jeopardized (British Psychological Society, 2008).

Competence

The APA Code of Ethics requires that a practitioner "authorize only those responsibilities that such a person can be expected to perform competently on the basis of their education, training, or experience, either independently or with the level of supervision being provided" (APA, 2002, 2.05). While the practitioner has an ethical responsibility to ensure the competence of the interpreter, due to his/her lack of proficiency in the language in question, the monolingual practitioner is not in a position to assess the interpreter's competence (Acevedo, Reyes, Annett, & Lopez, 2003). For the health professional with limited experience with foreign languages, an interpreter who possesses some academic credentials may be viewed as someone with obvious interpretive competency.

Acevado, Reyes, Annett, and Lopez (2003) warn, however, that the two are not synonymous: "Bilingual individuals with advanced academic credentials may have superior knowledge of a language and its literature and may even be an excellent writer, but the subtleties of interpretation and translation may not come easily without formal training" (Acevedo, Reyes, Annett, & Lopez, 2003, p. 196).

A more accurate indicator of interpreter competence is professional certification. A number of professional organizations, such as the American Translators Association (ATA), Certification Commission for Healthcare Interpreters (CCHI), and the National Board of Certification for Medical Interpreters (NBCMI), offer a standardized certification process requiring training, examination, and/or previous experience. These organizations also provide online registries of certified interpreters that are searchable by location and language.

If a certified interpreter is not available, the practitioner may consider using a paraprofessional. In order to ensure the paraprofessional's competence, however, the practitioner should find an external evaluator to conduct an assessment. If a local evaluator is not available, a number of commercial agencies exist, such as Language Testing International, the Center for Applied Linguistics, or the Test of English as Foreign Language (TEFOL) organization (Acevedo, Reyes, Annett, & Lopez, 2003). These agencies offer oral proficiency tests in a multitude of languages that can be conducted over the telephone, allowing the monolingual practitioner and interpreter to seek assessment services, regardless of their geographic location.

Many experienced interpreters have not worked in mental health settings (Westmeyer, 1990), and of those who have, only 20% have had any formal mental health training (Miller, Martell, Pazdirec, Caruth, & Lopez, 2005). An interpreter's skill will impact his/her tendency to omit, add, substitute, and condense what the client says. The unskilled interpreter often cleans up sentences so that they make sense when he/she has a hard time following the thoughts of the client (Bamford, 1991; Marcos, 1979) as is illustrated in the following exchange:

> *Clinician to Spanish-speaking patient*: "Do you feel sad or blue? Do you feel that life is not worthwhile sometimes?"
>
> *Interpreter to patient*: "The doctor wants to know if you feel sad and if you like your life."
>
> *Patient's response:* "No, yes, I know that my children need me, I cannot give up, I prefer not to think about it."
>
> *Interpreter to clinician:* "She says that no, she says that she loves her children and that her children need her." (Marcos, 1979, p.173)

The interpreter clearly reframes both the question and answer, eliminating the significant nuances and implications of both. Flores (2005) found that untrained interpreters omitted or misinterpreted up to 50% of physicians' questions. Searight and Searight (2009) suggest that in addition to basic language skills, interpreters should also be knowledgeable about both the client and the practitioners' cultures and values, psychological terminology, and ethical expectations. The interpreter should be empathetic, caring, respectful, and sensitive, and be capable of facilitating communication between the client and practitioner without interfering.

Practitioners may also have a legal obligation to ensure the competency of those they hire. In the 1980s, a hospital paid $71 million in a malpractice settlement after the misinterpretation of a patient's symptoms resulted in his quadriplegia (Flores, 2006), and Social Services removed two children from their mother's custody after a staff member misinterpreted the mother's explanation of her daughter's injuries (Flores, Milagros, Schwartz, & Hill, 2000).

Cost

In 2000, the Federal Government issued Executive Order 13166, entitled, "Improving Access to Services for Persons with Limited English Proficiency" (U.S. Department of Labor, 2000). Executive Order 13166 requires that health providers receiving federal financial assistance provide the same access to mental health care to individuals with limited English proficiency as they do to native English speakers.

The APA Code of Ethics also encourages practitioners to promote equal access: "Psychologists recognize that fairness and justice entitle all persons to access to and benefit from the contributions of psychology and to equal quality in the processes, procedures, and services being conducted by psychologists" (APA, 2002, Principle D).

The high cost of interpretive services may render mental health inaccessible for individuals with limited English proficiency, individuals who often already have lower incomes and fewer resources available to them (Acevedo, Reyes, Annett & Lopez, 2003). Hourly rates vary with the supply-demand ratio, with some English-Japanese interpreters receiving up to $200 per hour (Searight&Searight, 2009).

External funding for interpretive services is inconsistent, with Medicaid in only 10 states and very few private insurers covering the costs (Searight&Searight, 2009). Without external funding, however, many clinics or hospital settings use untrained staff or a client's family member to interpret (Searight&Searight, 2009), raising the ethical concerns of dual relationships and competency addressed above. If working with a client in need of an interpreter, the practitioner might absorb the interpretive costs into his/her overall costs, or provide pro bono services to the client, or allow those clients who are able (without undue hardship) to cover the costs of the interpreter.

Impact on Sessions

Kline, Acosta, Austin, and Johnson (1980) examined the impact of using an interpreter in counseling sessions. Whereas therapists responded negatively to working with an interpreter, expressing discomfort with the client and underestimating both how much they had helped the client and the client's willingness to return for a second appointment, clients responded positively, being more satisfied than those working without an interpreter. Many indicated being helped by the initial interview. Those who continued sessions with an interpreter showed therapeutic progress. Given

the inaccuracy of the practitioner's perceptions, a practitioner should regularly ask for the client's perception of the therapeutic progress when working with an interpreter.

Working in the Client's Second Language

Finding an interpreter to work in the client's first language may be impossible. In the U.S. alone, 381 languages other than English were spoken in homes, from rare languages such as Hmong (0.8% of the U.S. population) to well-represented languages such as Spanish (15.3% of the population) (U.S. Census Bureau, 2007). Unless the client's first language is well-represented in the region (i.e. Tagalog in Alaska) or common throughout the U.S. (i.e. Spanish), a practitioner is unlikely to find a qualified interpreter to work in the client's native tongue. Should the practitioner attempt to provide services without an interpreter?

Competence

The APA addresses the provision of services when no others are available, declaring that "psychologists with closely related prior training or experience may provide such services in order to ensure that services are not denied if they make a reasonable effort to obtain the competence required by using relevant research, training, consultation, or study" (APA, 2002, 2.01d). Whether this code applies to language competency is unclear, given that psychological services rely predominantly on verbal communication (Price & Cuellar, 1981).

Programs that train practitioners in the competent delivery of mental health services in languages other than English are most effective when the practitioner has some proficiency in the language (Biever, Gomez, Gonzalez, &Patrizio, 2011). Without extensive language training, a monolingual practitioner is unlikely to develop adequate language skills to work with a client, especially given that language acquisition during adulthood yields lower levels of proficiency than during childhood (Krashen, Long, Scarcella, 1979).

Provision of Services

Given that the practitioner is unlikely to become proficient in the client's language, provision of services should depend upon the client's proficiency in the practitioner's language. Of the 55.4 million individuals in the US speaking a language other than English at home, 19.8% reported that they spoke English "not very well" and 8.1% "not at all" (U.S. Census Bureau, 2007). The remaining 72%, however reported that they speak English well (19.8%) or very well (55.9%) (U.S. Census Bureau, 2007). The client's proficiency will likely become evident during the first encounter, allowing the practitioner to make an informed, ethical decision about whether to provide services.

Because of the role of verbal communication in assessment, diagnosis, and treatment, the practitioner should only provide services to a client with an adequate level of proficiency (Price & Cuellar, 1981). Practitioners might suggest that clients with a very limited level of proficiency seek internet or phone counseling with a licensed professional who speaks the client's first language.

Informed Consent

The remainder of this article refers to the provision of services to subordinate bilinguals – a term Weinriech (1974) uses for individuals who speak their first language like a native, but who exhibit deficiencies in their second language.

Although the complications of informed consent are typically discussed in reference to work with children, individuals with limited intellectual capability, and other vulnerable populations, the discussion is also pertinent to individuals with limited English proficiency. The APA requires that informed consent be obtained "using a language that is reasonably understandable to that person" (APA, 2002, 3.10a). Privacy, confidentiality, and privilege, and the related laws and regulations should be thoroughly discussed with the client, especially given that these concepts may be unfamiliar to the client or in conflict with the client's cultural norms (Koocher& Keith-Spiegel, 2008). The practitioner also has an ethical obligation to explain the nature, goals, expectations, procedures, and potential risks of therapy, allowing the client to make an informed choice about seeking services.

The APA (1993) advocates providing written informed consent in a language understandable to the client. Given that reading ability often differs from speaking ability in a second language (Devine, 1988), the practitioner may choose to have the informed consent document professionally translated into the client's first language. The ATA provides an online directory of translation companies that is searchable by language and location, allowing the practitioner to easily find a reputable translator. Whether or not using a translated document, it is the practitioner's responsibility to ascertain that the client fully understands the terms to which they are agreeing.

Effectiveness of Therapy

Even if the client is relatively proficient in his/her second language, language barriers may impact the effectiveness of therapy. Research has shown that the client's use of a second language impacts both self-disclosure and emotional depth in sessions.

Self-Disclosure. Price and Cuellar (1981) found that bilingual clients disclosed significantly more during interviews conducted in their first language than those conducted in their second language. Marcose, Urcuyo, Kesselman, and Alpert (1973) found that bilingual schizophrenic clients spoke less and exhibited obvious translation difficulties in their second language. The practitioner should thus be aware that he or she may be hearing very little of what is actually happening.

Emotional Depth. Marcos, Alpert, and Kesselman (1973) found that schizophrenic clients were significantly more emotionally withdrawn and had a weaker emotional connection with the therapist when using their second language than when using their first language. Marcos (1997) analyzed the kinetic behavior of bilinguals during therapy and found that there was a significant relationship between the use of a second language and speech-related hand movements (associated with active encoding) and between the use of a first language and continuous body-focused movements (associated with emotional states, including tension and distress).

Marcos (1976) illustrates why the use of a second language interferes with a client's emotional expression with a schema depicting the encoding process:

FIRST LANGUAGE

IMAGE → Word Selection → Grammatical ordering → Articulation → WORD

SECOND LANGUAGE

IMAGE → 1st Language word selection → 1st Language grammatical ordering → 2nd Language translation equivalent → 2nd Language grammatical ordering → 2nd Language articulation → WORD

Use of a second language complicates the encoding process, requiring more cognitive work by the client. Marcos (1976) notes that this extra work impacts on the client's emotional expression: "Since the extra cognitive and attentional demands placed upon the subordinate bilingual determine the displacement and concentration of affective energy, the patient invests the affect in how he says things and not in what he is saying" (p.554).

Practitioners working with bilingual clients should monitor whether the language barrier is significantly hindering emotional expression during therapy and, given their ethical obligation to terminate when the client is not benefiting or is being harmed by therapy, make appropriate referrals or terminate with the client if necessary. Marcos (1973) warns that the lack of emotional depth may hinder therapeutic progress: "Affects may also be blocked, and the patient may have significant difficulty in benefiting from therapeutic processes such as catharsis and abreaction. Verbalization of feelings may, then, turn out to be a mere intellectual task, arduous as it may be, which brings little relief to the patient" (p.557).

Diagnosis

The impact of culture on diagnosis is recognized. The American Psychiatric Association (2000) dedicates an appendix to culture-bound symptoms in the DSM-IV-TR and the APA (1993) recommends that "psychologists consider not only differential diagnosis issues but also cultural beliefs and values of the clients and his/her community in providing intervention" (3.e). Linguistic differences and bilingualism may also impact on the diagnostic process.

A number of studies have shown how the use of the first or second language may impact a bilingual client's reporting of psychotic symptoms. Del Castillo (1970) found that clients reported psychopathology when using their first language but not when using their second language. Price and Cuellar (1981) also found that bilinguals reported more symptoms indicative of psychopathology when using their first language than when using their second language. Malgady and Constantino (1998) found that clinicians rated symptoms in clients with schizophrenia, depression, and anxiety as more severe when two languages were used during sessions and less severe when the second language was used. In contrast, however, Marcos, Alpert, Urcuyo and Kesselman (1973) found that clients demonstrated more pathology when using their second language. Marcos and Urcuyo (1979) note that a practitioner may easily mistake a bilingual client's lack of self-disclosure for depressive symptomatology, emotional withdrawal, or a lack of motivation.

Although the research is not conclusive about how the use of a second language impacts on the reporting of symptoms, it does suggest that the use of a second language will impact what is reported in session. Practitioners should, thus, make diagnoses with reservation.

Conclusion

While the APA (1993) provides some guidelines as to how a monolingual practitioner should respond to a client with limited English proficiency, advocating the referral of the client elsewhere, or the use of an interpreter, it does not address how to respond when no interpreters are available, leaving the practitioner in an ethically risky position. Would the practitioner be justified in attempting to provide services because no other services are available? When making this decision, the practitioner should act with integrity and in the best interest of the client rather than his or her own need for business. The practitioner should consider how the client's use of a second language limits self-disclosure and emotional depth, and affects the diagnostic process.

Other alternatives that merit further attention include the use of telehealth. A number of ethical concerns arise with international or intra-national phone or internet counseling that should be thoroughly considered; however these new technologies might allow clients to seek and receive counseling in their first language when they might otherwise not be able to do so.

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