NCTSN The National Child Traumatic Stress Network

A Socio-Culturally, Linguistically- Responsive, and Trauma-Informed Approach to Mental Health Interpretation

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ACKNOWLEDGMENTS

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PREFACE

Purpose

The National Child Traumatic Stress Network (NCTSN)'s *Socio-Culturally, Linguistically-Responsive, and Trauma-Informed approach to Mental Health Interpretation* (SCLRTI-MHI) Resource is designed as a dyadic training to increase the capacity and partnership of professional interpreters[i] and qualified mental health clinicians[ii] working together in order to improve quality and access of services for children, adolescents and families with no or limited English proficiency (LEP) and who have experienced trauma and are seeking mental health services.

The specific aims are fourfold:

1. To prepare professional interpreters to work with children, adolescents/and families with no or limited English proficiency and who have experienced trauma.

2. To prepare qualified mental health clinicians to work with professional interpreters.

3. To highlight the importance of and encourage developing a working partnership between the two.

4. To offer recommendations of how to provide socio-culturally, linguistically-responsive, and trauma-informed mental health interpretation to children, adolescents, and families with no or limited English proficiency and have experienced trauma.

Providing education for both interpreters and clinicians about collaborative practice to support families with LEP can increase engagement and access in services by those children, adolescents and families with no or LEP who need them. It can also uniquely develop the mental health workforce to be socio-culturally, linguistically-responsive, and trauma-Informed, ultimately contributing to health equity for groups who face mental health disparities.

Background

The act of voluntarily leaving one's country of origin to live permanently in another country is generally referred to as immigration and is a world-wide phenomenon. People from all over the world come to the United States (U.S.) to set up residence; it is known for a being a safe haven to those who flee their countries involuntarily and out of fear of persecution. Individuals who have been forced to leave his/her country because of persecution, war, or violence, and have a well-founded fear of being persecuted or killed are known as refugees[iii]. The U.S. has traditionally been one of the top resettlement countries for refugees.[144] Nearly 59 million immigrants and 3 million refugees have arrived and settled in the U.S. since the 1965

Immigration and Naturalization Act and the Refugee Act of 1980, respectively, were passed.[74,80] This equates to an unprecedented 14% of the current U.S. population.

The U.S. does not have an official language but English serves as the primary language. Many immigrants and refugees come from countries that do not speak English and as a result, a vast number of languages and various levels of English proficiency exist amongst this group and across the U.S. While a majority of the U.S. population speaks English "very well", approximately 8% of the total population of the U.S. (ages 5 and older) is considered limited English proficient.[143] LEP refers to anyone above the age of 5 who reported speaking English less than "very well," as classified by the U.S. Census Bureau.[143] Although most individuals with no or LEP are immigrants, 19% are individuals who were born in the U.S. to immigrant parents.[143]

Youth and families come to the U.S. for numerous reasons including seeking new and better social, political, economic, and/or educational opportunities not available to them in their home countries; however, for many, reasons stem from violence, war, torture, and deprivation of resources (like food, water, shelter, medical care). After having endured unforgiving traumas and/or life in refugee camps, when youth and families relocate to the U.S., they face complex cultural differences and uncertainty around how to navigate systems for resources. This can lead to a lack of connection to others and community and a diminished sense of safety. Furthermore, the inability to speak English may additionally compound the impact of isolation and trauma. These complex factors, lack of familiarity with U.S. customs, and potential lack of access to resources (like food, housing, healthcare) put them at risk for experiencing further trauma.

What youth and families have endured in their countries of origin as well as part of their relocation and resettlement process can have a profound impact on their psychological functioning and overall well-being. Having access to quality socio-culturally, linguistically responsive, and trauma-informed screening, assessment, and psychotherapy services is an integral step to reconnection, healing, and rebuilding. Interpreters serve as a bridge to help non- or limited-English speaking persons access resources and mental health care. In fact, interpreters play a key role in the care that youth and families receive.

Although increasing, to date there remains limited research that examines the use of interpreters in mental health settings with those who have limited language proficiency.[9,142] What is known is that a mental health assessment in an individual's non-primary language may impact the validity of the diagnostic assessment and treatment planning decisions.[9] Both trained and untrained interpreters can make mistakes in interpretation, but untrained interpreters' errors appear to have more of impact on clinical care.[9,81] Other factors such as migration experience, stigma of mental illness and mistrust of authorities can impact diagnostic assessment.[99] Culture for example has been shown to influence how a client conceptualizes his or her mental health,[70,71] how he or she describes symptoms[24,69,72] and

ascribes meaning to them,[99] as well as help-seeking behaviors.[10,99] However, using an interpreter in the mental health setting has been shown to be beneficial.[17,66] More specifically, a review of the literature on use of interpreters with no or LEP patients in the healthcare setting shows that use of an interpreter is related to improved communication (fewer communication errors and better comprehension of diagnosis), increased uptake in referrals provided and an increase in both client and provider satisfaction.[66]

Based on a preliminary literature review, there is limited existing research that examines the use of interpreters in a mental health setting and even less research examining the intersection between mental health clinicians and interpreters with refugees, trauma survivors, and children in particular. Some limited studies have shown that treatment of trauma related to the migration experience utilizing an interpreter is effective in demonstrating improvement across measures of mental distress including posttraumatic stress disorder (PTSD), anxiety, and depression and overall symptom improvement from baseline.[64,27,17] Quantitative measures have also been used to analyze the experience of interpreters in these settings and found simultaneously high levels of secondary traumatic stress and high levels of "compassion satisfaction[120]" or in other words the positive aspect of working with a traumatized group, the feeling that the work being done is valuable and contributes to the greater good of society.[87] There are a small number of studies that qualitatively examine the experience of interpreters, clients, or clinicians in cases that involve refugee trauma.[88,30,34,89] These studies describe the benefits of using interpretation in the mental health setting (e.g., increased communication, improved quality of care, etc.) despite the various challenges (e.g., errors in interpretation, secondary traumatic stress, culture's impact on symptomatology, etc.) posed to the interpreter, the clinician and the client. It also underscores the need for adequate training and support for the interpreter/ mental health clinician dyad in the mental health setting. Hunt and Swartz (2017) further the discussion by suggesting that clinicians along with interpreters require training and support about the complex issues and processes that arise in interpretation-mediated psychotherapy. Taken together, it becomes clear that both interpreters and mental health clinicians as well as the client would benefit from a dyadic training in a socio-culturally, linguistically-responsive, and trauma-informed approach to mental health interpretation and especially when working with youth and families who have no or LEP and have also experienced trauma and are seeking mental health services.

Identified Need

Despite the critical role interpreters have in the provision of child mental health services, they often don't receive specialized training in working with children, individuals or families, especially those with no or LEP, nor do they receive training in how to partner with mental health clinicians. Yakushko (2010) highlights the fact that there are currently no national standards for the provision of mental health services to clients with no or LEP for both interpreters and clinicians as there are in healthcare. To date, several resources for interpreters working with those who have experienced trauma have been identified (see

Appendix E). Most, if not all, of these resources are geared towards interpretation for adult torture survivors and none identified are specifically geared towards working with youth. Despite the importance of interpreters being trained to work with children in a medical setting being established, no specific resources were identified that attend to interpretation in a child mental health setting. Working with an individual adult differs in many ways from working with a child and his/her family: developmental level, adherence to hierarchical family dynamics, level of acculturation, and differences in language acquisition, among others. It is critical that mental health clinicians tasked with working with children, adolescents, and families have some fundamental understanding of child and adolescent development and traditional family structure. Other key areas in the training of interpreters that often go unaddressed are how to work within the family dynamic, the importance of self-care, and the need for supervision. When working with youth and families with no or LEP in particular these may be important to understand and attend to, given the tremendous pull an interpreter may feel to loosen his/her boundaries with a child from his/her same culture/country, repeated exposure to personal narratives filled with tales of violence and conflict, and the potential for secondary traumatic stress (STS) among others.

> **Note to Clinicians:** STS is the emotional hardship that occurs when an individual hears about the traumatic experiences of another (nctsn.org). It is a set of observable reactions that mirrors PTSD symptoms, including re-experiencing, avoidance, hyperarousal symptoms, and negative changes in mood.

It has also been widely observed that interpreters do not feel equipped or fully capable of understanding the mental health system nor competent or comfortable to interpret or emotionally respond to (for themselves or to convey the emotional impact) the extreme, unfamiliar, and horrific traumas experienced. In complementary fashion, clinicians also report not feeling equipped, trained, or culturally competent to work with international populations and/or interpreters in therapy.[17,119,142]

Intended Audience

The target audience for this resource is 1) professional interpreters and 2) qualified mental health clinicians. It is intended for individuals who have completed or are in the process of competing basic interpretation training (spoken language) for community, medical and/or legal settings and for individuals who have completed or are in the process of completing training in mental health service delivery.

This resource is designed to enhance service provision to speakers with no or LEP by providing a review of basic interpretation in the mental health setting, offering a socio-culturally, linguistically-responsive, and trauma-informed approach to mental health interpretation and preparing interpreters and mental health clinicians to work together in partnership. Working

together in partnership will enable and empower interpreters and mental health clinicians to create a mindful, equitable and collaborative approach to trauma-informed clinical care that is culturally and linguistically responsive to no or limited English proficient youth and families.

Overview

This resource has been developed by an expert group inclusive of interpreters, clinicians, researchers, and administrators, both NCTSN members and affiliates as well as non-NCTSN members. Multiple conceptual frameworks/core concepts were identified by this working group through review of existing literature, cultural expertise, as well as clinician and interpreter input. All of these are critical to effective engagement and provision of services to children and families with no or LEP who have been impacted by trauma and are seeking mental health services. The conceptual frameworks/core concepts including socio-cultural and linguistic responsiveness, being trauma-informed, holding a developmentally appropriate lens, and working in a dyadic relationship are considered foundational to the socio-culturally, linguistically-responsive, and trauma-informed approach to mental health interpretation (see *definitions and descriptions of these conceptual frameworks/core concepts are provided in Chapter 1*).

Content and Intended Use

This resource is not intended to be prescriptive in nature. Rather it presents content that is important to the provision of interpretation services to no or limited English proficient speakers in a mental health setting. It presents content that can both be read in its entirety and followed in the order presented or different sections can be read or referenced as needed.

This resource begins with this preface followed by nine chapters, and these nine appendices including:

A. Key Terms/Concepts
B. Interpreter/Translator Comparison Table
C. Overview of Mental Health Systems and Institutions
D. Selected Websites for Code of Ethics for Interpreters and Mental Health Professionals
E. Additional Resources for Interpreters Working in Mental Health Settings
F. Pre- and Post-test Answer Keys
G. Training Resources for Interpreters Who Will Be Working with Trauma
H. Identified Clinical Guidelines for The Use of Interpreters in Mental-Health Settings
I. NCTSN's 12 Core Concepts for Understanding Traumatic Stress Responses in Children and Families

Of note, each chapter contains a pre- and post-test to assess users' knowledge of topics presented throughout this Resource. *It is recommended to take the pre-test before initiating*

each chapter, and then the post-test after completion of each chapter. This helps track progress, ensure understanding, and meet learning goals. A full answer key to all tests can be found in Appendix F.

Each chapter's learning objectives are listed below:

Chapter 1: Frameworks (Interpreter and Clinician)

Learning Objectives:

1. Describe what it means to be socio-culturally and linguistically responsive.
2. Specify how implicit bias impacts provision of services.
3. Understand the concept of cultural humility.
4. Apply trauma-informed practices to care.
5. Explain what it means to hold/implement a developmental perspective/framework in the provision of services.
6. Recognize the importance of the dyadic partnership.
7. Explore the concept of organizational sustainability for interpretation and clinical services.
8. Name the core concepts and/or theoretical frameworks that provide the foundation to this approach to interpretation.

Chapter 2: Roles in the Clinical Setting (Interpreter and Clinician)

Learning Objectives:

1. Define interpreter and distinguish interpreter roles.
2. Identify types of mental health professionals.
3. Understand who the client is.
4. Increase ability to implement a developmental perspective in the mental health context and consequently in the interactions between clinician-interpreter and child/family.
5. Explain the concept of being trauma-informed in this context.

Chapter 3: Mental Health in the US: Basic Concepts (Interpreter)

Learning Objectives:

1. Explain basic mental health concepts.
2. Distinguish between the understanding of mental health in Western and Non-Western cultures.
3. Understand trauma exposure and traumatic stress.
4. Identify different types of mental health documentation.
5. Specify different levels of clinical care.
6. Recognize the value of mental health care as a healing tool.

Chapter 4: The Interpreter/Mental Health Clinician Dyad (Interpreter and Clinician)

Learning Objectives:

1. Recognize the importance of the trauma-informed interpreter-clinician relationship.
2. Explain relationship dynamics in the therapeutic triad.
3. Apply recommendations for building true partnerships before a session.
4. Explain the importance of pre and post-sessions after a session.

Chapter 5: Managing a Session (Interpreter and Clinician)

Learning Objectives:

1. Specify intake/evaluation information.
2. Describe the flow of a session.
3. Explore common issues that arise in the interpretation interaction.
4. Identify opportunities for interpreter intervention.

Chapter 6: Secondary Traumatic Stress (Interpreter and Clinician)

Learning Objectives:

1. Define secondary traumatic stress.
2. Identify self-care practices.
3. Recognize organizational support of providers.

Chapter 7: Supervision (Interpreter and Clinician)

Learning Objectives:

1. Describe reflective supervision in the clinician-interpreter dyad.
2. Understand how reflective supervision aligns with being trauma-informed.
3. Identify linguistic considerations in the provision of reflective supervision for interpreters.

Chapter 8: Interpreter Values and Ethics (Interpreter and Clinician)

Learning Objectives:

1. Understand ones' own values, and the process of values clarification.
2. Recognize the ethical guidelines for confidentiality in a clinical setting.
3. Identify at least two key ethical guidelines for interpreters and clinicians.

Chapter 9: Advocacy (Interpreter and Clinician)

Learning Objectives:

1. Understand advocacy from the interpreter perspective.
2. Identify costs and benefits of an interpreter taking on an advocate role.
3. Distinguish when and how an interpreter should advocate.
4. Understand advocacy from the clinician perspective.
5. Recognize effective communication in advocacy.

TRAINING

This resource is intended to support an in-person dyadic training of professional interpreters and qualified mental health clinicians in a socio-culturally, linguistically-responsive, and trauma-informed approach to mental health interpretation for youth and families with no or (LEP) who are seeking mental health services. This training can be configured in multiple ways, including:

- Half or 1-day training
- 2-day training
- Several shorter trainings over the course of several months or a year
- Other formats, as needed per organization

Ideally, continuing education credits would be provided for both interpreters and clinicians. For interpreter credits, we would recommend going through the Certification Commission for Healthcare Interpreters (CCHI) to obtain Continuing Education Accreditation Program (CEAP) credits. For clinicians, we would recommend getting approval for continuing education (CEUs) through the professional organizations of the intended audience such as the National Association of Social Workers (NASW) for social workers and the American Psychological Association (APA) for psychologists.

A thorough review of other types of interpretation such as ad hoc and telephone is beyond the scope of this resource. We will, however, provide caveats, note important issues, and make recommendations in these areas based on lived experience as deemed important throughout.

Overall Mission

The overall mission of the *Socio-Culturally, Linguistically-Responsive, and Trauma-Informed Approach to Mental Health Interpretation Resource* is to improve services provided to children, adolescents and families with no or limited English proficiency, who have experienced trauma and are seeking mental health services.

CHAPTER 1 | Frameworks

By the end of this chapter, readers will be able to:

1. Describe what it means to be socio-culturally and linguistically responsive.
2. Specify how implicit bias impacts provision of services.
3. Understand the concept of cultural humility.
4. Apply trauma-informed practices to care.
5. Explain what it means to hold/implement a developmental perspective/framework in the provision of services.
6. Recognize the importance of the dyadic partnership.
7. Explore the concept of organizational sustainability for interpretation and clinical services.
8. Name the core concepts and/or theoretical frameworks that provide the foundation to this approach to interpretation.

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Chapter 1 | Pre-Test

1. Which of the following is **NOT** an aspect of socio-cultural and linguistically responsive interpretation?
   a. The clinician and interpreter should examine the socio-cultural factors that influence their own thoughts, attitudes, beliefs and behaviors.
   b. It is a "one-size fits all" approach.
   c. It involves an awareness of ethnic/religious group differences and the potential for discomfort between client and interpreter if they come from different groups.
   d. It requires flexibility and open-mindedness.

2. _____ is a preference or an aversion towards certain groups of people, unconsciously acquired by a person's exposure to explicit and implicit cultural messages via stereotypes expressed and passed on by family members, media, and other sources of knowledge and information, including major institutions such as basic and higher education.

3. **True or False:** Cultural competence is recognized as the best model for use with diverse populations, because it takes into account intersectionality of diverse factors, like race, ethnicity, gender, and sexual orientation.

4. A _____ approach realizes the impact of trauma and understands potential paths for recovery.

5. Holding a developmental perspective or framework takes which of the following under consideration? **(Choose all that apply):**
   a. Each child is unique in his/her own developmental patterns.
   b. The socio-cultural context in which the child lives is unimportant, as children should be considered as individuals.
   c. Knowing about typical and atypical child development can help assess development and intervention
   d. Children should be met where they are at developmentally.

6. Which of the following is **NOT** a way that organizations can support interpreters and clinicians?
   a. Provide quality training for both clinicians and interpreters
   b. Reduce the time before and after sessions in order to streamline the interpretation process
   c. Provide supervision for clinicians and interpreters
   d. Provide opportunities for personal and professional growth for clinicians and interpreters

7. **True or False:** In the model of a dyadic partnership, the relationship between clinician and interpreter is central, and both members of the team contribute.

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Being Socio-Culturally and Linguistically Responsive

Holding a socio-cultural and linguistically responsive frame for children and families with no or LEP who have been impacted by trauma and are seeking mental health services means understanding the importance of the social, cultural, and language factors to their experience. Providing socio-cultural and linguistically-responsive interpretation in the mental health setting recognizes that a "one-size-fits-all" approach should be avoided, and instead incorporates socio-cultural and historical factors into the process. It requires both the interpreter and mental health clinician to examine the socio-cultural factors that influence their own thoughts, attitudes, beliefs and behaviors (*more about implicit bias below*) as well as understand that the way a person behaves is influenced not only by the social and cultural groups to which he or she is a member/identifies but also the social policies and practices of the systems in which he or she interacts and of society at large. Linguistic responsiveness specifically refers to the recognition that diversity of language exists (e.g., languages have different words for the same concepts, are pronounced in different ways, and have different grammar); there is variation in dialects and meanings within languages (e.g., Spanish). In this resource it also refers to understanding how languages and linguistic varieties function and have purpose in the interpretation process as well as appreciating others' languages and not to assume that speaking the "same" language equals perfect understanding. Socio-cultural and linguistic responsiveness in mental health interpretation entails being open minded, flexible, and being able to identify socio-cultural, historical and linguistically relevant factors (e.g., awareness of multiple languages and dialects spoken by the population of a particular country and issues (e.g., awareness of ethnic/religious group differences and the potential for discomfort between client and interpreter if they come from different groups (e.g., Rohingya) that should be addressed to improve the interpretation process and ultimately facilitate the client's mental health and overall well-being.

Being Trauma-informed

The Substance Abuse and Mental Health Services Administration (SAMHSA)[iv] defines a trauma-informed approach as follows,

"A program, organization, or system that is trauma-informed:

1. Realizes the widespread impact of trauma and understands potential paths for recovery;

2. Recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system;

3. Responds by fully integrating knowledge about trauma into policies, procedures, and practices; and

4. Seeks to actively resist re-traumatization."

In line with this definition, our socio-culturally, linguistically-responsive and trauma-informed approach to mental health interpretation seeks to ensure youth and families with no or LEP who are seeking mental health services are able to receive interpretation services that allow them to feel respected, safe and empowered by the interpreter/ mental health clinician dyad.

Developmental Perspective/Framework

Holding a developmentally appropriate stance or lens when serving children and families impacted by traumatic events means using research about how children develop, learn and function as well as what is effective with children to create and implement therapeutic models and strategies that are attuned to the age and stage of development of the child (and his/her primary caregivers, in the case of very young children) to promote children's return to an optimal developmental pathway. It involves meeting each child (and his/her caregivers/family) where they are at, by stage and development, as a group and as individuals.

This developmental perspective takes into consideration:

1. Each child (and his/her caregivers/family) is unique in his/her/their own developmental patterns.

2. The centrality of relationships and the socio-cultural context in which the child lives.

3. Knowledge of typical and atypical child development is crucial in determining which are best practices and interventions for children.[78,29]

According to Lieberman et al. (2015), "all psychotherapies should consider developmental progress as a process that encompasses the entire lifespan and involves momentum towards healthy grow as well as unmet milestones, distortions, delays and pathological patterns" (p. 20).

The Socio-Cultural Context

As it has been mentioned previously and will be explored in more depth later, it is important to be aware that developmental skills, milestones and stages are shaped by the rules, expectations and experiences of the socio-cultural context in which children and their families/ caregivers live. In westernized societies, for instance, children might be expected to become independent and master self-help skills at an earlier stage when compared with children from different socio-cultural contexts where dependency and close contact with the primary figures is valued and encouraged in children. Although most characteristics of human attachment and developmental skills and stages seem to be biologically-based and therefore universal, the particular expression of children's behavior and competencies and attachment styles (relationship characteristics, ways of relating), may differ depending on the socio-political-

geographical and historical context[4,78,79,111] surrounding the child and his/her family. The socio-cultural context influences all aspects of the child's experience including child rearing practices, developmental expectations, child socialization practices, attachment expressions and ways in which children and their communities express distress and pain, face adversity and recover from it. Therapeutic or developmental interventions heavily based on features of Western developmental theories may not be effective with diverse populations as they may lead to mistakenly perceive children's functioning and family or caregiver practices as inadequate or pathological.

Importance of the Dyad Partnership

The partnership between the mental health clinician and interpreter is essential to supporting the client. In this model, the relationship between clinician and interpreter is central, and both members of the team contribute. Both the clinician and interpreter hear the trauma presented by the client and work together as a team to promote healing. The clinician and interpreter debrief together, assess situations, and consult on possible outcomes. Each member of this partnership brings unique skills to the team. The mental health clinician brings clinical expertise and experience, while the interpreter brings native language skills, and a cultural lens to understand the client's experience. Working in collaboration and within their expertise, the two in partnership can then provide the client with the best possible practice outcomes, as well as the opportunity to heal and move forward. In some cases, the dyad may expand to additional members, if more than one family member is served, and if there are multiple clinicians or interpreters needed in the session. In this case, the clinician(s) and interpreter(s) should follow the same principles of working together and supporting each other and the client.

Implicit Bias

Critical to our approach is the concept of implicit bias. Implicit bias or implicit social cognition is a concept that illustrates the *unconscious cognitive processes* whereas human beings automatically associate groups of people with positive or negative traits. It is a pervasive process present in every person, regardless of his/her socio-cultural background, that happens in an involuntary fashion outside of the conscious awareness of individuals and has direct influence on most human behavior.

Implicit biases can be both a preference or an aversion towards certain groups of people and are unconsciously acquired by a person's exposure to explicit and implicit cultural messages via stereotypes expressed and passed on by family members, media, and other sources of knowledge and information, including major institutions such as basic and higher education. Implicit biases can often be incongruent with an individual's declared social values and even explicit biases, and may often shed light on the gap between a person's intentions and his/her actual behaviors.

Cultural Humility

Basic cultural understanding and a willingness to learn on the part of the mental health clinician and interpreter is imperative in effectively serving culturally diverse populations. Cultural competence, a well-known term in the mental health field, is based on mastering a knowledge base of generalized information about diverse populations in order to improve effectiveness and decrease disparities of health care in these populations. It is often criticized for perpetuating stereotypes and not taking into account an individual's experiences. It also been suggested that it does not take into account the impact of the provider's own history, values beliefs, training and socio-cultural context and of social structures and institutions in shaping the lenses with which the provider "sees" a client. There is such intersectionality of diverse factors, like race, ethnicity, gender, sexual orientation, etc. that the infinite number of combinations of these factors render finding an endpoint or achievement of being culturally competent practically impossible.

Therefore, movement from the idea of a mental health clinician and an interpreter achieving cultural competence to a process of practicing humility and empathy as a learner as well as reaching deeper levels of self-awareness about his/her own location and how this influences his/her work acknowledges the fluidity and subjectivity of culture and the client as especially qualified to understand the unique intersection of race, ethnicity, religion, class, etc. in her or his life. Cultural humility was first coined by Tervalon and Murray-Garcia[125] in 1998 and the process of cultural humility is guided by three factors:

1. A lifelong commitment to self-evaluation and self-critique.

2. A desire to fix power imbalances where none ought to exist.

3. Aspiration to develop partnerships with people and groups who advocate for others.

As such, cultural humility is a process-oriented approach to an increased understanding of intersectionality and the impact of provider implicit biases in service delivery. A process of continual self-reflection and critique as a lifelong learner with a commitment to challenging the power imbalances that exist in clinician-client relationships by using effective interviewing and communication in order to develop clinician-client partnerships with shared power and mutual respect. In this approach, this process of continual self-reflection and critique would extend to the interpreter-clinician-client relationship. Other humility is essential for the mental health

clinician and interpreter to be able to let go of being the "expert" and be open to understanding the client's own culturally bound understanding of his/her illness. The interpreter may also be confronted with challenges if he/she comes from a different ethnic group or class than the client. In these situations, they can use concepts of cultural humility in order to minimize power imbalances and ensure mutual respect (*for further information see Chapter 9, Advocacy*). Utilizing cultural humility takes pressure off the mental health clinician and interpreter to have to "know everything" and assists in building mutually beneficial partnerships where the client is expert and teacher of his/her own experience and culture.

Organizational Sustainability

As a mental health organization explores how they can best serve children and families with interpretation needs (those with no or LEP), it is vital for the organization to plan for how they will sustain the services. Interpreters and mental health clinicians can use the suggestions below for speaking to upper levels of directorship about the importance of language access, and how to support interpretation services.

Importance of Language Access

Quality interpretation services are essential, and provide the following benefits:

- Meet the needs of a larger pool of community members
- Provide higher quality assessment and more accurate diagnosis
- Engage children and families at higher levels
- Experience less attrition in services
- Improve adherence to medication schedules[44]

In addition, legally, interpretation services must be provided:

- "Every hospital or separate unit of a hospital which provides acute psychiatric services shall in connection with the delivery of such services, and if an appropriate bilingual clinician is not available, provide competent interpreter services to every non-English speaker who is a patient.[61]"
- "Agencies that conduct federal business or that receive federal funds are required to develop and implement a system to provide its services so that LEP persons can have meaningful access to them.[60]"

Barriers to Provision of Language Services

It may be important to understand and/or acknowledge that organizations may face barriers to provision of language services, such as:

- Immediacy of language service availability in crisis

- Access to language services in rural and limited resource settings

- Limited time of language service availability for settings such as 24/7 residential services

- Lack of service for non-clinical contacts (e.g., administrative communication, intake, billing, scheduling, informing of events, etc.)

Supporting Interpreters and Clinicians

Organizations can support interpreters and clinicians in the following ways:

- Provide quality training for both clinicians and interpreters

- Support the relationship between clinician and interpreter by allowing time before and after sessions for discussion and debriefing (*discussed further in Chapter 5*)

- Ensure that interpreters and clinicians feel comfortable asking questions, expressing boundaries, and articulating needs

- Invite interpreters and clinicians to utilize and embrace the expertise of the other

- Provide supervision for clinicians and interpreters, to prevent overwork and vicarious trauma, and secondary traumatic stress (*discussed in depth in Chapter 6*)

- Provide opportunities for personal and professional growth and development (*further explored in Chapters 7*)

Developing Capacity for Interpretation Services

In order to develop capacity and sustain services, below are several measures that can be taken within an organization:

- Pursue funding opportunities for interpretation services

- Make interpretation training (for both interpreters and clinicians) an institutional priority

- Develop and maintain systems for supervision of interpreters, and provide means of support within the organization

- Provide systems for monitoring and evaluation of interpretation services[95]

Chapter 1 | Post-Test

1. Which of the following is **NOT** an aspect of socio-cultural and linguistically responsive interpretation?

   a. The clinician and interpreter should examine the socio-cultural factors that influence his/her own thoughts, attitudes, beliefs and behaviors.

   b. It is a "one-size fits all" approach.

   c. It involves an awareness of ethnic/religious group differences and the potential for discomfort between client and interpreter if they come from different groups.

   d. It requires flexibility and open-mindedness.

2. _____ is a preference or an aversion towards certain groups of people, unconsciously acquired by a person's exposure to explicit and implicit cultural messages via stereotypes expressed and passed on by family members, media, and other sources of knowledge and information, including major institutions such as basic and higher education.

3. **True or False:** Cultural competence is recognized as the best model for use with diverse populations, because it takes into account intersectionality of diverse factors, like race, ethnicity, gender, and sexual orientation.

4. A _____ approach realizes the impact of trauma and understands potential paths for recovery.

5. Holding a developmental perspective or framework takes which of the following under consideration? **(Choose all that apply):**

   a. Each child is unique in his/her own developmental patterns.

   b. The socio-cultural context in which the child lives is unimportant, as children should be considered as individuals.

   c. Knowing about typical and atypical child development can help assess development and intervention.

   d. Children should be met where they are at developmentally.

6. Which of the following is **NOT** a way that organizations can support interpreters and clinicians?

   a. Provide quality training for both clinicians and interpreters.

   b. Reduce the time before and after sessions in order to streamline the interpretation process.

   c. Provide supervision for clinicians and interpreters.

   d. Provide opportunities for personal and professional growth for clinicians and interpreters.

7. **True or False:** In the model of a dyadic partnership, the relationship between clinician and interpreter is central, and both members of the team contribute.

(Answer key is available in Appendix F)

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CHAPTER 2 | Roles in the Clinical Setting

By the end of this chapter, readers will be able to:

1. Define interpreter and distinguish interpreter roles.
2. Identify types of mental health professionals.
3. Understand who the client is.
4. Increase ability to implement a developmental perspective in the mental health context and consequently in the interactions between clinician-interpreter and child/family.
5. Explain the concept of being trauma-informed in this context.

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Chapter 2 | Pre-Test

1. Select the roles that are appropriate for an interpreter to take on **(Choose all that apply)**:
   a. Clarifier
   b. Social worker
   c. Conduit
   d. Advisor
   e. Advocate

2. **True or False:** Ad hoc interpreting by family members is recommended, as family members have a wealth of information about the client and can provide appropriate cultural and familial context.

3. Match each term to its definition:

Psychiatrists _____

a. Those who have either a Doctor of Philosophy (PhD) or Doctor of Psychology (PsyD) and are not medical doctors.

Psychologists _____

b. Those trained to provide therapy that is not limited to a clinician-client dialogue, including the use of objects, art forms, and other recreational activities.

Case Managers _____

c. Medical doctors who have specialized in mental health treatment.

Occupational, Music, Dance, Art, and Activity Therapists _____

d. Generally serve as the primary coordinator for client services; usually have a Bachelor of Arts or Bachelor of Science degree in human service-related field.

4. Match each term to its definition:

Unaccompanied minor _____

a. Someone who voluntarily leaves his/her home country for better economic, educational, or other opportunities.

Immigrant _____

b. Someone who has been forced to flee his or her country because of persecution, war, or violence, for reasons of race, religion, nationality, political opinion or membership in a particular social group.

Asylum Seeker _____

c. Someone whose request for sanctuary has yet to be processed.

Refugee _____

d. A person who is under the age of eighteen, who is separated from both parents and is not being cared for by an adult who by law or custom has responsibility to do so.

5. **True or False:** Child development is a transactional (interconnected, not linear) process.

6. Which is **NOT** a principle of being trauma-informed?
    a. Trustworthiness and Transparency
    b. Timeliness and swift diagnosis
    c. Safety
    d. Empowerment, voice and choice

What is an Interpreter?

Interpreters serve as verbal connections between people who need to communicate but do not speak the same language. An interpreter's job is to relay what is said in a conversation by interpreting each speaker's message for the other speaker. Typically, the interpreter will simply take the words from one language and interpret them into the other language.

The two fundamental aspects of interpreting are as follows:

- Facilitate communication. The main function of a professional interpreter is to facilitate understanding in communication between people who are speaking different languages. The interpreter serves as a bridge between the speakers to make communication possible. In acting as this connector, the interpreter allows health care access to a person who may not have access to it otherwise.

- Represent information accurately. The interpreter must convey information accurately. This is particularly important in a mental health setting because miscommunication can lead to misdiagnosis.

While the term "interpreter" is often interchanged with the term "translator," in fact interpreting and translating skills are quite different from each other. Interpreters render speech from one language into another verbally, while translators render written messages from one language into another (*see Appendix B for Table comparing interpreter and translators*).

What is a Trauma-informed Interpreter?

A trauma-informed interpreter has received specialized training in trauma and the provision of services to those who have experienced trauma. He or she gives traumatized children and their families a voice, and provide socio-cultural, linguistically responsive services that do not re-traumatize the children and their families, but rather allow them to feel respected, safe and empowered. The trauma-informed interpreter plays a critical role from the moment the client first seeks help to the last stages of finding healing. At each stage, the interpreter is needed to help ensure that everything the survivor wishes to say is clearly communicated to the mental health clinician.

Trauma-Informed interpreters:

- Understand trauma
- Support survivor's safety, choice and empowerment
- Are aware of the impact of and prevent vicarious trauma

Interpreting for children exposed to trauma and their families often is more intense and complex than general interpreting. It poses a number of specific challenges, such as not

allowing one's feelings to become visible, and developing strategies to avoid activating past trauma during situations that develop.

(Appendix G provides a list of training resources, to date, for interpreters who will be working with those who have experienced trauma whereas Appendix H identifies clinical guidelines, to date, for the use of interpreters in mental-health settings.)

MEMORY SKILLS

Memory skills are very important when interpreting. Expanding short-term memory capacity requires consistent, repeated exercises practiced habitually. Below are several techniques interpreters can practice or use within the context of a session:

Concentrate: Focus on the words being *communicated*. In the course of a session, interpreters can close their eyes or focus on a point on the wall in an effort to shut out all distractions and concentrate better.

Visualize: Picture the events being communicated as a way to remember a sequence of events. Visualizing a scenario as it is being spoken can help an interpreter to recall the events efficiently when they interpret them for the other party.

For example, a client might say: "I feel my anxiety increase every time I am expecting an important phone call. Yesterday, I was expecting a conference call from my client at 4:00 p.m. I started to lose my concentration at 12:30 p.m. and I couldn't finish my report. By 2:15 p.m., I began to perspire more and my palms were sweaty. About 3:00 p.m., I had to use the washroom every 15 minutes."

In this instance, an interpreter might picture the client watching the clock, sweating, and going into the bathroom multiple times with 4pm written in large letters on a calendar on the wall. Visualizing just the concepts can make the interpretation much easier.

Echo: When hearing key phrases in a client's message, an interpreter might echo them in their head as a way to remember them. In the following paragraph, the words in boldface are those that an interpreter might want to echo in her head while listening.

"Well, Doctor, **I don't know** how it **started**. I used to **never get headaches**, but over the **past several months**, I have been **having them frequently**. They give me **throbbing pain**, and some **last for hours**."

Of course, an interpreter will pass on everything that is said, but, by echoing those key words in their mind, the interpreter will create neural pathways that make it easier to "find" those keywords again.

Count: When a client states a few items to be interpreted, an interpreter can create a numbered list in her head. For example, the mental health clinician may ask, "Is there any history of depression, bipolar disorder, or schizophrenia in your family?" If the interpreter visually attaches a number to each disorder and creates a list in her head, it will be easier to remember everything that was mentioned.

Take notes: Interpreters are permitted to write notes while interpreting to remember key phrases, names, numbers, dates, and the like. As a matter of practice and to increase transparency, however, ask clients if they mind note taking before a session starts. Assure them that all notes taken for use during the session will be disposed of immediately after the session to ensure confidentiality.

Note taking during interpreting sessions can be made easier if interpreters develop shorthand for themselves. Using shorthand enables speakers to talk for longer periods without interrupting the message's flow for interpretation. Avoid making up symbols on the spot. Instead, take time outside of sessions to develop a personal shorthand of terms that come up frequently in interpreting sessions. Using shorthand requires a good deal of practice so that it becomes automatic. After some practice, taking notes will not impede the interpreter's ability to listen to what is said.

Note to Clinicians and Interpreters: For a variety of reasons, including but not limited to a legacy of abuses by authorities and differences in literacy, it is important to be as transparent as possible when taking notes with clients with no or LEP and openly explaining what is being written and why. Explicitly stating, "What you are telling me today is very important and I want to make sure I don't forget anything" can be helpful for building rapport and trust. The act of note taking can be off putting and may create distance between interpreter and client if not fully explained. It is always good practice to write notes in a way that if the client were to read them, he or she would feel respected and heard

Modes of Interpreting

Interpreters employ four different modes of interpreting to fit specific circumstances. The four modes are consecutive interpreting, simultaneous interpreting, sight translation, and summarization.

Consecutive Interpreting

Consecutive interpreting is the most common method of interpreting. In this situation, an interpreter remains silent and listens to the first speaker relay his/her entire message. Then the interpreter relays the message to the second speaker in the appropriate language. This action is repeated back and forth throughout the interpreting session.

Simultaneous Interpreting

During simultaneous interpretation, the interpreter relays the speaker's message while the speaker is speaking, following only a few words behind. This mode is most often used when interpreting for one or more persons in a group. Simultaneous interpreting might be used when two clinicians are discussing a client's situation and not directly addressing the client. It might also be used in the case of a medical emergency, when time is short and the need to transmit information quickly is essential. In a mental health setting, it is not uncommon for clients to have highly charged emotions. Simultaneous interpreting can work well in these situations because the speakers do not have to interrupt their conversation to wait for the interpreter. This is a very fast-paced type of interpreting that requires great skill on the part of the interpreter. However, this mode has the potential to be confusing as sentence structure varies from language to language.

Sight Translation

Sight translation requires that an interpreter read a document written in one language and then read it aloud in another. Sight translation is often used for prescriptions, consent forms, discharge directions, and other written documents.

TIPS FOR SIGHT TRANSLATING

Before translating, interpreters should read the entire document to ensure their complete understanding of what it says. If words or concepts are confusing or new to the interpreter, they should ask for clarification.

- Translate at a steady, moderate pace. The goal is to read as if reading in the language of the client. If several lines are read quickly and then there is a pause for several seconds, the client might find it difficult to understand and retain what is read.

- Translate exactly what is written. Do not add to, omit, or change anything in the text. Keep in mind that some forms are legal documents; it is crucial that they are translated exactly as they are. If the document is written in complex language, the interpreter may ask the clinician to summarize the important points in the document, which the interpreter will then interpret for the client. This way, the clinician is responsible for any editing of the document.

There are some occasions when it may be inappropriate to do a sight translation. For instance, a mental health clinician might ask an interpreter to sight translate technical instructions or client information pamphlets while he/she does something else or leaves the room. This is not a function of an interpreter, as interpreters are not qualified to answer technical questions or determine what should be summarized in a document. As a general rule, all documents that require sight translation should be translated in the presence of the clinician. If a document is too long to translate in the normal duration of a session, the clinician should give a summary

and an explanation for the interpreter. By doing so, the clinician is then responsible for the editing and summarizing that must be done.

Summarization

With a speaker's agreement, an interpreter might use summarization when a person speaks for a lengthy time. The interpreter summarizes the important points of the message once a speaker is finished. When this method is used, it is important to take careful notes while a person is speaking. Summarization is effective when a provider summarizes a lengthy and/or complex document. This mode is **not recommended** in a mental health setting because the potential for leaving out crucial details is increased.

Roles of the Interpreter

There are a multitude of situations one might be asked to interpret in, and interpreters soon learn that there are four basic roles that they will fall into as a function of their jobs.

CONDUIT	As a conduit, interpreters translate exactly what is said in one language into another. This is the role most frequently taken by interpreters. To this end, words spoken should never be omitted, edited, or polished; instead, interpreters should simply relay the message presented by the client or clinician. If a client talks for a very long time or gives information that does not seem relevant, it is not the responsibility of the interpreter to cut the client off or redirect the conversation; this is what clinicians should do if they feel they are not getting the information that they require.
CLARIFIER	As a clarifier, interpreters ensure understanding between parties. Interpreters should only switch to this role if a misunderstanding is detected. If one of the parties involved in the session does not understand a message once interpreted, interpreters can add "word pictures" or description of the words to clarify unfamiliar concepts.
CULTURAL BROKER*	When acting as a cultural broker, interpreters give clinicians a framework in which to understand a client's cultural perspective. For example, "mal de ojo" and "susto" are two illnesses commonly noted in Latino culture. "Mal de ojo" translates to "evil eye" and refers to a disease that arises from certain social relations. "Susto," or "soul loss," is an affliction that comes from a frightening experience in which spirits capture a person's soul. Clinicians unfamiliar with these concepts might not be able to address client needs accurately. Sensitive topics such as sexual intimacy and substance abuse may need to be clarified and discussed, with interpreters acting as cultural brokers between the clinician and client. By explaining culture-specific aspects of home remedies, attitudes, and issues, interpreters can give a clinician the chance to understand and respond to immediate needs effectively. *See additional note about cultural brokering in insert box in Chapter 5*

Understanding each of the roles an interpreter might take on is just the start. In order to be a good interpreter, one must be able to switch from role to role with ease. Many sessions require interpreters to serve solely as conduits. Alternately, there are times when an interpreter might jump from role to role within a single session. For example, an interpreter might start a session as a conduit, and then move into the clarifier role to explain a medical condition, only to slip into the advocate role in order to help a client secure the care he/she is eligible for. Obviously, interpreting is more than just translating words from one language into another. Good interpreters pay attention to the whole conversation and promote understanding that contributes to the quality of client care.

IMPORTANT TO NOTE: AD HOC INTERPRETATION

Ad hoc interpreting refers to interpreting that is done by a person who is not trained as an interpreter but happens to speak the two languages needed for a specific interaction. For example, a bilingual receptionist, nurse, or family member may be asked to interpret if a trained interpreter is not available.

Legal Aspects of Ad Hoc Interpretation

According to Title VI:

- All organizations that receive federal funding are obligated to provide interpretation services.
- Patients can refuse those services, but it must be documented.
- The organization can choose to have an interpreter present to oversee the communication.
- Children may only interpret in cases of emergency when there are no other resources available (i.e., in cases of rarely used languages when an adult is critically ill in the emergency room and there are no interpreters available in person or by phone).

Issues with Use of Ad Hoc Interpretation

- Although a person might have a grasp on one or both languages on a conversational level, an ad hoc interpreter who is not fully fluent in both languages will not be effective.

- Ad hoc interpreters who try to interpret in settings with complex terminology, such as mental health settings, are putting themselves and those with whom they work in non-optimal situations as it has been shown that using family members as interpreters are more likely to make errors, violate confidentiality, and increase the risk of poor outcomes such as misdiagnoses.[81,48]

- It is necessary to have a grasp on ethical and legal guidelines on interpreting.

- While family members often serve as interpreters in a pinch, using them is unwise because of the difficulty they might have in remaining neutral. Although a family member may have the best of intentions, upsetting or embarrassing information shared in a serious mental health or medical setting can make it difficult for family members to serve as an interpreter. Emotions can easily cloud thinking, and this does not make for accurate or useful interpreting. Children and teens are sometimes asked by their parent to translate. This is suboptimal for a variety of reasons, including that children may be exposed to adult matters (e.g., family financial hardship, parental conflict) that might cause them distress and from which adults ordinarily would shelter them. Additionally, putting children/teens in the powerful position of gatekeeping the information they share with or express on their parents' behalf often undermines the parents' authority.

For these and other reasons, ad hoc interpretation is not recommended for use in professional settings or at least should be kept to a minimum.

If the family is reluctant to use a professional interpreter, here are potential scripts for the clinician to utilize:

Script for Clinician to use when family suggests using an adult family member:
"It is your right to refuse the services provided. Nevertheless, at [insert name of organization] we offer the services of trained interpreters so that your [uncle, sister, friend] can fully support you in his/her role. We are here to help you. Often family members find that their emotional attachment can cloud their ability to remain neutral and can cause them to make errors. You are welcome to have your family member interpret for you if you feel more comfortable, but in order to ensure that everything that you and I say is being accurately interpreted, I would like to have our interpreter present for our meeting. Please know that professionally trained interpreters have to abide by the same rules of confidentiality that medical professionals do."

Script for Clinician to use when family suggests using the child to interpret:
"I understand that you would prefer that your child interprets for you. However, we don't expect children to have vocabulary or maturity to accurately interpret medical terminology. We also may discuss topics during the evaluation/therapy that are mature in nature, things we don't usually discuss with children, that might cause the child unnecessary distress. We provide interpretation services at no cost so our patients and families can focus on their concerns and well-being. For these reasons, at [insert name of organization] our policy states we cannot use minors to interpret. We offer professionally trained interpreters who abide by the same rules of confidentiality that medical professionals do."

Roles to Avoid While Interpreting

It is important to understand the roles that should be avoided in professional interpreting relationships. Examples of roles to avoid include:

ROLE TO AVOID	RATIONALE
A mental health services provider	To be a mental health service provider, you must have proper training and licensing.
The client's close friend/ co-parent/elder/ advisor or main source of emotional support	An interpreter should not be friends with clients. He or she should not provide emotional support for a client because the client's family and friends fulfill that role. However, it is nonetheless important for the interpreter to take a non-rejecting, non-invalidating stance towards the client. In addition, it is important not to ally with either the child/teen or the parent, as the interpreter needs to remain neutral. This may be culturally dissonant for interpreters who come from a background where respect for elders is paramount. If a child disagrees with an elder, this could be frowned upon by the family, nonetheless the interpreter would need to remain neutral. The temptation to comfort children and overstep professional boundaries may be huge. However, such "helpful" behaviors from the interpreter can damage or delay the survivor's recovery.
Guarantor of a positive treatment outcome, or of the clinician's and client's satisfaction	It is impossible for an interpreter to guarantee a positive mental health outcome for the client or to ensure that the client's relationship with the clinician will be a good one. Realizing this will greatly reduce interpreter frustration and increase his/her ability to focus on the main goal of interpretation.

Types of Mental Health Professionals

There are many kinds of mental health professionals. Some have training in specialties that focus on children and adolescents, adults, and/or the elderly. Knowing about these different types of professionals, their special areas of expertise, their roles, and their functions will help an interpreter be prepared to work with them. This knowledge will improve the speed, comfort, and quality of interpretation by having an understanding of what is said and of the goals and purposes of the various types of practices during each session.

Administrative Professionals

Administrative professionals are those who are trained in the administrative aspects of mental health care. This may include scheduling, billing, or other administrative tasks to support the provision of mental health services.

Case Managers

Case managers generally serve as the primary coordinator for client services. They might assist clients in ways similar to social workers and counselors. Case managers usually have a Bachelor of Arts or Bachelor of Science degree in a human service-related field; they might also have higher degrees. Case managers often have supervisory responsibilities. They may be in charge of all client documentation and communication between all professionals providing treatment to the client. They also ensure that the treatment plan is being followed and work with the client on the discharge plan and arrangement for outpatient services.

Direct Care Service Providers

Direct Care Service Providers are individuals who are trained to provide support and care for clients, such as aiding them with medications, feeding, or other activities.

Para-Professionals

Para-professionals are individuals who work in the mental health care field but do not have professional licenses. They are trained to assist those who have professional licenses, such as psychiatrists.

Occupational (OT), Music, Dance, Art, and Activity Therapists

These professionals are usually trained at the BA and MA levels, although there are a few at the PhD level, to provide therapy that is not limited to a clinician-client dialogue. Therapies include the use of objects, art forms, and other recreational activities as the primary media of communication and treatment.

Peer Supports

Peer supports are those who share the same mental health condition and/or life experiences as the client and are able to provide support & connection to resources. Their role in the mental health setting may include "peer mentoring or coaching, resource connecting, recovery group facilitation, and building community."[104]

Psychiatrists

Psychiatrists are medical doctors who have specialized in mental health treatment. Their training consists of four years of residency in psychiatry after completing medical school. Therefore, psychiatrists are physicians (Doctors of Medicine-MD or of Osteopathic Medicine-DO), which is why they can prescribe medications. Some psychiatrists work with all age groups, and others treat only special populations like children, trauma victims, developmentally disabled adults, or mentally ill substance abusers.

Psychiatrists often spend most of their time dealing with serious mental illness and medicine. In most settings, psychiatrists are responsible for a large number of clients since they are seen less often and for a shorter period than other mental health professionals. Interpretation for psychiatrists will mainly focus on medical and medicine-related topics, description of symptoms, explanation of side effects caused by drugs, etc.

In a hospital setting, psychiatrists have the most authority. They are responsible for admissions and discharge. Sessions with psychiatrists are usually brief. Expect psychiatrists to look for specific information and make rapid decisions.

Psychiatric Nurses

Psychiatric nurses are specialized in psychiatric or mental health care. They are highly trained and independent. Some nurses obtain advanced education and training and are called nurse practitioners. They can perform some functions of medical doctors, such as medication evaluations and medication management, giving injections, doing health checkups, and administering medical tests under the supervision of a doctor. Psychiatric nurses are usually present in inpatient settings. They are often in charge of the day-to-day workings of the inpatient unit. Others may offer counseling, psychotherapy, and treatment planning in outpatient settings.

Psychologists

Psychologists are not medical doctors; in most states, they cannot write prescriptions. They are called doctors because of their doctoral degree, either a Doctor of Philosophy (PhD) or Doctor of Psychology (PsyD). There are many types of psychologists, including clinical psychologists, counseling psychologists, educational psychologists, industrial psychologists, social psychologists, researchers, trainers, consultants, etc. Training for clinical and counseling

psychologists consists of approximately 5 years of graduate training, multiple part-time clinical practica, one year full-time clinical internship, and at least one year of postdoctoral fellowship.

In terms of client service, psychologists are more likely than psychiatrists to provide psychotherapy and directly evaluate clients. Psychologists are authorized to conduct psychological testing to determine cognitive ability and learning disabilities. Neuropsychologists conduct testing to look more in depth at cognitive strengths and difficulties, usually in more diagnostically or medically complex patients. Psychologists may hold a position of authority, such as being in charge of a mental health program, or being a trainer, principal investigator, supervisor, or consultant.

Social Workers and Counselors

Social workers and counselors may fill different roles, including administration, advocacy, and/or direct client care. They provide therapy, counseling, or other direct treatment services to clients in public mental health or large social services settings. Social workers and counselors also help clients gain access to community resources, such as housing, healthcare, food, employment, after-care planning and placement, financial assistance, or other public services. In hospitals, they make sure that clients treatment continues even after they are discharged, or on an "outpatient" basis. Because of these services, social workers in hospital settings tend to spend the bulk of their time contacting different resources and doing paperwork for their clients to ensure continuity of care.

Social workers who have earned a Bachelor of Social Work (BSW) are prepared for general social work practice like case management and connect individuals with resources in their community, while social workers with a Master of Social Work (MSW) are prepared for advanced practice in the areas of direct case and clinical work, community organization and development, and administration. Doctoral programs emphasize preparation for academic and research careers. In many states, Licensed Clinical Social Workers (LCSW) are required to have at least an MSW and two years of supervised practice in the areas of individual, group, and family therapies. Social Workers are trained to work with the people in communities, while counselors focus more on the individual client. Counselors with a Master of Science (MS) or Master of Arts (MA) level training and relevant experience and supervision can be Licensed Clinical Professional Counselors (LCPC). Counselors fill many different roles in the mental health and substance abuse fields that often overlap with the roles of the social workers and psychologists in various settings.

Students, Interns, and Residents

In some mental health settings (*see Appendix C for an Overview of Mental Health Systems and Institutions*), there are clinicians who are in training to become one of the professionals described above. They have direct client care responsibilities under supervision of experienced professionals. Examples include residents, interns, postdoctoral fellows, externs, etc. They

have less experience in direct service work and may have no experience working with interpreters. Trainees may seek guidance from interpreters. Interpreters must be cautious about providing help and advice when it is not directly related to their role as communication facilitators.

Mental health workers, recreational therapists, family therapists, and group therapists are other titles ascribed to various clinicians. In some inpatient units, there are people who serve as client care technicians, psychiatric technicians, or therapeutic assistants. These workers may help clients take care of their physical needs, such as hygiene or health care. They provide support and assistance to clients, explain the treatment program, and spend a lot of time directly with clients.

What is a trauma-informed mental health clinician?

Just like the trauma-informed interpreter, a trauma-informed mental health clinician has received specialized training in trauma and the provision of services to those who have experienced trauma. He or she uses a trauma-informed approach (*defined above*) to clinical services that do not re-traumatize the children and their families, but rather allow them to feel respected, safe and empowered. When indicated, trauma-informed mental health clinicians use trauma-specific interventions or treatments that are designed specifically to address the consequences of trauma and to facilitate healing.

The trauma-informed mental health clinician adheres to the six key principles of trauma-informed care rather than a prescribed set of practices or procedures.[129] These key principles are:

1. Safety
2. Trustworthiness and transparency
3. Peer support
4. Collaboration and mutuality
5. Empowerment, voice and choice
6. Cultural, historical, and gender Issues

Trauma-informed mental health clinicians promote recovery and resilience in youth and families impacted by trauma through providing and linking them to trauma-informed services and supports that are evidence based, and having a focus on youth and family engagement, empowerment and collaboration.

IN PRACTICE: CASE ILLUSTRATIONS REGARDING THE USE AND IMPORTANCE OF A CLINICAL INTERPRETER

Case #1: Manuel, an 8-year-old male from Guatemala, attended an after-school program associated with a local state university. This site provided trauma-informed therapy for the Latino/Hispanic community. Manuel, after displaying behaviors that were of concern to the staff of the after-school program, was referred for an assessment and therapy. His mother was provided with the information, and she agreed to treatment.

Manuel's mother was the mother of four children, ages 12, 8, 4, and an infant. She had no education and could not read or write Spanish but spoke an indigenous form of Spanish from her area of Guatemala. The concept of mental health, especially for a child, was very difficult for her to understand, but she did want help her son stop his violent outbursts. Even though the child was the identified client, this mother was also a client of sorts, as she also had experienced complex trauma, and had fled her country to come to the US. She did not have formal refugee status and was in the US without sufficient documentation to legally do so (an undocumented immigrant) who had little knowledge about how to make life work for her and her children.

Manuel had a complex history of sexual and physical abuse. It was very difficult for his mother to understand therapy and treatment, or how medication could be used to help with behaviors.

The clinical interpreter provided not only language interpretation, which was a challenge due the mother's level of comprehension, but also psycho-education about treatment and medication at a level that the mother could understand. For example, when accompanying the mother and client to an appointment with the psychiatrist, the psychiatrist was trying to find out if the medication had helped lower her son's anxiety, but his mother could not understand the term "anxiety," and started talking about how she was considering sending her son back to her country so that he could run around outside in the field to free his energy. It took the clinical interpreter several efforts to convey what the psychiatrist was asking and wanted the mother to assist in measuring. Despite the initial confusion, the relational trust of the clinician and the clinical interpreter allowed her to feel safe enough to continue with medication for her son and bring him to his sessions. After a few months, she began to confide in the psychiatrist about her own depression and her willingness to start medication to support her own mental health.

Who is the Client?

The client is an individual with no or LEP who may fall under one of the following categories.

ASYLUM-SEEKER: An asylum-seeker is someone whose request for sanctuary has yet to be processed.[6]

ENGLISH SPEAKER: In some cases, English speakers may have difficulty speaking with other English speakers, due to dialect, area of origin, or other reasons.

IMMIGRANT: An individual who voluntarily leaves his or her home country and permanently settles in a new country in order to pursue better economic, educational, or other opportunities like to join family members who have settled in another country or have married someone who is a citizen of another country.

INDIVIDUALS WHO HAVE LIMITED ENGLISH PROFICIENCY (LEP) BORN IN U.S.: Individuals who were born in the US, do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English.[39]

MIGRANT/MIGRANT WORKER: An individual who often tends to return or travel back and forth to his/her country of origin to a country where he or she was not born, and typically acquires some significant social ties to this country.[136]

REFUGEE: A refugee is "someone who has been forced to flee his or her country[v] because of persecution, war, or violence. A refugee has a well-founded fear of persecution for reasons of race, religion, nationality, political opinion or membership in a particular social group. Most likely, they cannot return home or are afraid to do so. War and ethnic, tribal and religious violence are leading causes of refugees fleeing their countries."[6]

UNACCOMPANIED MINOR: An unaccompanied minor is a person who is under the age of eighteen, who is separated from both parents and is not being cared for by an adult who by law or custom has responsibility to do so.[48]

As discussed in the Preface, clients with no or LEP who have come to the U.S. from another country may share in the types of trauma exposed, pre-flight and during migration experiences as well as experience specific types of overlapping stressors that impact their post migration experience[vi] including:

REFUGEE TRAUMA: Refugee trauma refers to the events that refugees have experienced related to war or persecution that may affect their mental and physical health long after the events have occurred. These traumatic events may occur while the refugees are in their country of origin, during displacement from their country of origin, or in the resettlement process here in the U.S.

RESETTLEMENT STRESSORS: Resettlement stressors refer to stressors experiences in the process of making and settling into a new life in a new country. These include but are not limited to learning a new language, financial stress, difficulties in finding adequate housing and employment, lack of access to healthcare, lack of awareness of services and systems, and transportation difficulties.

ACCULTURATIVE STRESSORS: Acculturative stressors refer to stressors experienced when navigating between a new culture and culture of origin. These include but are not limited to socio-cultural changes (e.g., adjusting to a new language, making U.S. born friends, considering oneself as an American), differences in rates of acculturation between children and parents (e.g., children learning the new culture and language more quickly), parent-child conflict (e.g., conflict around topics like autonomy, dating, and cultural identity), and parenting in a new context among others.

ISOLATION STRESSORS: Isolation stressors refer to stressors that experienced as minorities in a new country. These include but are not limited to feelings of loneliness and loss of social support network, loss of social status among others, survivor's guilt, discrimination, bullying, and experiences of harassment from peers, adults, or law enforcement.

TRAUMATIC STRESS: Traumatic stress occurs when an individual experience an intense event or ongoing situation that threatens or causes harm to his or her emotional and physical well-being. Individuals can experience traumatic stress in relation to a variety of events including but not limited to war and persecution, poverty, interpersonal violence, discrimination, racism, and community violence among others.

Putting a Developmental Framework in Practice: Considerations for Mental Health Service Delivery

Developmental Perspective

In Chapter 1, the centrality of holding a developmental framework in mental health service delivery to children exposed to trauma was highlighted. Best practices in serving the mental health needs of children (and particularly young children) require an understanding of how children process information, relate to the world and others, develop internal representations about themselves and others, and regulate emotions and how the social-cultural context shapes children's developmental functioning. This section provides a brief overview on child development, developmental stages and skills.

Child Development and Developmental Stages or Milestones

Child development is defined as the typical gradual advancement by which children (from birth to age 18) change as they grow older by obtaining and refining abilities, knowledge and behaviors. Development is different than growth. Growth refers to physical changes to the child's size, weight and height while development refers to the continuous progression that allows children to gain more complex knowledge and skills.[16,22]

Child development is a transactional (interconnected, not linear) process[112] that results of the evolving exchange between the child (what the child brings in terms of his/her endowment like physical capacities and capacities for organizing experience and interacting with the environment), his primary figures or caregiving context (what experiences, abilities, expectations the individuals and/ or community in charge of the child's physical and emotional wellbeing bring to the process) and the environment (physical, social, economic determinants) surrounding the child and his/her caregivers/family. When trying to influence developmental progression in children it is critical to consider each player in this dynamic; affecting positive change with one part of it can impact the entire developmental process for a child and his/her caregivers. This transactional process cannot be understood without recognition of the power and role of the relational and socio-political-cultural context of the child and his/her family. Child development undoubtedly happens in the context of relationships and this is particularly true for very young children.

Developmental Domains and Stages

When looking at child development there are generally five areas that are observed or assessed.

MOTOR/PHYSICAL DEVELOPMENT: Involves gross motor and fine motor development. Gross motor skills involve the ability to use large groups of muscles to sit, stand, walk, and run keeping balance and changing position. Fine motor development relates to the use of fingers and hands to eat, draw, dress and play.

COMMUNICATION/LANGUAGE DEVELOPMENT: Involves perceiving, understanding communication and language. This, as with other abilities, varies with age ranging from crying in babies to eventually being able to communicate with words.

COGNITIVE DEVELOPMENT: Refers to intellectual or mental abilities like learning, understanding, reasoning, remembering and problem-solving. It involves interaction between the child and his/her environment or events in the environment.

SOCIAL-EMOTIONAL DEVELOPMENT: Involves feelings and emotions, relationships with others, cooperating and responding to the feelings of others, self-esteem, temperament and independence-dependence.

SELF-HELP/ADAPTIVE DEVELOPMENT: Refers to the ability to adapt to the environment and to do things for oneself including feeding, dressing, toileting and drinking independently.[100]

These domains are ways of understanding the child's skills and competencies and it is important not to look at the child through the domain but to look at the child as a whole.

A child's developmental progression through these different domains is considered in light of developmental milestones. These are sets of age-specific tasks that most children can do at a certain age range; children reach milestones in how they learn, relate, move, learn, speak, behave and play. Children build new skills on the skills of a prior stage; each stage is cumulative. Usually milestones can help indicate children's movement between and inside developmental stages (e.g. walking for the first time) and although a child's stage of development happens at a certain age, age is actually only an indicator of the child's stage of development; it does not determine it. Children develop at their own pace and each child is unique, hence there is great variability as to what age typically developing children reach milestones (e.g. children might learn to walk between 8-12 months). Therefore, children of the same age can be expected to be at different developmental stages.[100,65]

What do we mean by developmental stage?

Childhood development is divided into stages. During each developmental stage, as mentioned previously, children acquire functional skills that the majority of children can do at a certain

age range. The definition of each stage is organized around these main tasks of development at each stage, although the boundaries between stages are flexible. The three broad stages of development from birth to age 18 are: Early Childhood (which encompasses infants, toddlers and preschoolers), middle childhood, and adolescence.

STAGE	AGE
Early Childhood	Birth to 5 years
• Infancy	Birth to 12 months
• Toddlerhood	12-36 months
• Preschool	36 months- 5 years
Middle Childhood	5-12 years
Adolescence	12-18 years

Developmental Consideration and the Provision of Interpreters Services in Child Mental Health Settings

Infants, Toddlers and Preschoolers (Early Childhood)

Early childhood is a key period in human life as it is the most and rapid period of development for children. It is a critical period to the healthy cognitive, emotional and physical development of children.[37,31] Early childhood experiences have significant impact on brain development, the development of trust and a sense of security with primary caregivers, the development of exploration and mastery and of identity formation.

Young children are born ready to learn, relate and communicate. The first year involves the development of the basics of language the establishment of attachment relationships and the acquisition of regulatory capacity through the care provided by the primary caregivers. Infants' cognitive development is emerging, and they learn through their senses. The second year of life typically involves two significant accomplishments: (1) language and symbolic play and thought (they can hold a representation of an object and therefore, they know who their caregivers are and may experience fear related to being separated from them), and (2) mobility. Their increased ability to move allows children to explore the environment, develop cognitively and separate momentarily from the caregiver and potentially become more independent. Between the third and fourth year children have mastered a number of skills including sitting, walking, scribbling, toilet training, they develop interest in other children and start to play with them and have started to consolidate a sense of self in relation to others and of the world around them. Between the fourth and fifth year of life children evidence good control of pencils, crayons,

scissors, can skip and balance in one foot and use language to express thinking and complex sentences when speaking to others. They are able to express their feelings and begin to realize that they have feelings and opinions different than others. They learn from interacting with others, are more cooperative, they are able to remember the strategies that they learn from experience and have longer attention spans.[82,23] Preschoolers still need a secure base of attachment (usually the parent or primary caregiver) to understand the world and regulate their affect and behavior in a wider social network. They struggle against forbidden impulses and keeping control of bodily functions and new coping skills.[79] Cognitively, they have a basic awareness of cause-effect; their thinking is concrete, present-focused, and dominated by the use absolutes. Preschoolers' perception of the world is animistic, egocentric, magical and their reasoning transductive.[107] This can lead them to misunderstandings of events, in which they assume that they are to blame when things go wrong.[45]

As mentioned before, development does not occur in isolation but in the context of relationships. Babies are born with many competencies like the capacity to express and regulate emotion, develop relationships/attachments, self-comfort and develop an independent sense of self; however, for these capacities to develop children need the relationship with primary caregivers. Currently it is widely accepted that the quality of these early relationships is going to shape the developmental outcomes for children and their strengths and vulnerabilities. The family has a central impact in facilitating the child's development in the early years; however, the family also exists in an environmental, relational and cultural context that can either undermine it or support it in this function. Traumatic events in the early years affect not only the child but the caregivers/ family and the child-parent relationships. There is evidence that early stress impacts brain development and consequently all developmental domains.[82,79]

Early childhood developmental, behavioral, developmental, and emotional problems (including the impact of traumatic events) need to be address by a relational approach; not only because young children are dependent on their caregiver context but also because their competencies may vary in different relationships. In addition, there is evidence[82,78,79] that the most parsimonious avenue to help children return to a typical developmental pathway is through the restoration and enhancement of the attachment with their primary figures.[78,79] In the context of trauma-informed relationship-based interventions the mental health clinician will be most likely working with the child and the caregiver/s (dyads or triads) with the goal of helping the child and caregivers make meaning of each other's behaviors and emotions, reach co-regulation, obtain safety in relationships, and make sense through play, and verbalize traumatic events. Since young children lack the verbal and cognitive abilities to express their thoughts, memories, and feelings, they communicate through play or behavior. The mental health clinician would therefore engage the child and the caregiver in the therapeutic work through play or other activities identified by the caregiver as familiar, favorite or appealing to the child and the caregiver. The mental health clinician might ask the caregiver for his/her thoughts and feelings about the child's play and/or behavior and/or might encourage the caregiver to

interact with the child in a particular way. In work with very young children, the mental health clinician forms an alliance with the caregiver in order to have access to the child and holds a stance of observing, waiting and wondering,[127] while the child and the caregiver interact. In this context, the role of the interpreter would be to facilitate the connection and interaction between the caregiver and the mental health clinician, the interpreter cannot take the role of the caregiver in interacting with the child as one of the goal of the intervention is to restore caregivers in their role as protectors, as reliable and safe figures for their children.[78] Nor can the interpreter take the role of the mental health clinician in interacting with the child through play or other therapeutic activities as these involve clinical skills and it is important to keep in mind young children's vulnerabilities. This does not mean that the interpreter should not be ready to interact with the child if the child offers him/her a toy, approaches him/her or engages with him/her in any way.

Middle Childhood to Adolescence

Children should not be utilized as interpreters for the family. Oftentimes, children will develop proficiency in a second language faster than their parents, while their own knowledge of their primary language can decrease. In turn, this can create strain within the hierarchy of the family and foster shame within therapy sessions. The interpreter should work to decrease the power differential by interpreting both the statements of the mental health clinician as well as the statements of the child to the native language.[117]

Children often engage in a wide range of behaviors that may be viewed as disrespectful by the interpreter. These can include fidgeting, playing with toys, inattention, talking back, and other behaviors. These behaviors are permitted within the therapeutic environment, and children are often encouraged to freely share their thoughts and feelings without experiencing judgment. It is important that the interpreter allow a child to engage in these behaviors and does not attempt to discipline or reprimand the child.[117]

The interpreter should be prepared to engage with the child in an age-appropriate manner rather than in a role of authority.[110] The interpreter should also provide opportunities for the child to engage with his/her parents in their native language without involvement of the interpreter to allow for assessment of current language. The interpreter should then provide feedback to the mental health clinician after the session surrounding the current appropriateness of the child's language.

When working with the young child (toddler to preschool age), it is important for the interpreter as mentioned above to be open to engage in play activities with the child but should not out-parent the parent or take the role of the clinician. The mental health clinician's speech should be interpreted both in content, which is often silly and childlike, as well as in voice tone, which may be a more sing-song or animated rhythm. Engaging with a child at this age level often requires interaction on the floor and may involve imitation of sounds and actions rather than

conversational communication. It may be more beneficial during this play-based interaction for the interpreter to engage in simultaneous interpretation. It is also normal for children this age to lack the ability to discern that the interpreter is interpreting for the mental health clinician, and they are more likely to engage in play with the interpreter.[110]

Elementary school aged children are often encouraged to express their emotions and opinions about the activities occurring in the therapeutic environment, as well as activities occurring at home. It is important that the interpreter assist in explaining this potential difference to the family. Additionally, the mental health clinician will often use playful terminology, silliness, and metaphors to enhance the child's willingness to engage in therapy. The mental health clinician may need the interpreter to assist in determining more culturally relevant metaphors. The interpreter should work to match the mental health clinician's tone of voice, nonverbal expressions, and mannerisms to create a similar perception of the communicated information for the child.[117]

Adolescents or teenagers are often encouraged to meet with the mental health clinician independent of their caregivers. The interpreter may have to assist in bridging this cultural difference, as parents may be used to answering questions for the teenager. Roles of confidentiality may also be different depending on the age of the teenager, and these differences should be explained to the teen.[117]

Empathy can be difficult at times to convey through interpretation. It is important to maintain consistent tone of voice and other nonverbal communication to more effectively convey empathy when interpreting for the mental health clinician. Also, it is important to engage in conversation about the client's nonverbal communication with the mental health clinician as this is often experienced incongruently with the interpretation.[108]

Working with Hard of Hearing and Deaf Individuals

Though deaf children experience higher levels of certain types of trauma than hearing children, such as abuse[56,76] and childhood maltreatment,[33,114] providers are often unprepared to work with deaf clients, and interpreters unprepared to work in the mental health setting.[92]

This section aims to give a brief overview of working with deaf clients, including acceptability of terminology, cultural considerations, and implications of identity. It also offers tips for working with deaf clients and managing the interpretation session. Specifically, we aim to highlight considerations for care for deaf children in non- or limited English speaking families.

Terms

The following terms are defined as:[124]

HARD OF HEARING: "Typically, an individual who identifies as *hard of hearing* has some degree of reduced hearing yet can still access sound and spoken language."

DEAF: "When a person's auditory input is minimal such that there is limited functional access to spoken language, the term *deaf* may be used."

DEAF: "When an individual has significantly reduced hearing sensitivity, they may identify as Deaf and belong to the Deaf community, and share a sense of linguistic and cultural belongingness. For those who self-identify as members of the Deaf community, the use of a uniform signed language and the incorporation of Deaf cultural norms are common. For "capital D (Deaf)" individuals, reduced hearing sensitivity is not perceived as a loss but rather as Deaf gain, the recognition by members of the Deaf community that being Deaf has added numerous benefits to their lives."

HEARING IMPAIRMENT: "This a term that has historically been applied to individuals with reduced hearing. However, this term is not accepted by members of the Deaf community and is perceived as disrespectful."

DEAF CULTURE: The medical perspective's view of deafness as a 'problem' with medical solutions may be in conflict with the cultural perspective on deafness.[124] Many individuals consider themselves part of the Deaf community, which has its own cultural norms and values, and does not view deafness as a disability.[92] Clinicians and interpreters should consider these varying perspectives when working with deaf clients, and how this may impact the session. For resources on supporting cultural perspectives in the clinical setting, (see *Additional Resources for Interpreters Working in Mental Health Settings in Appendix E*).

Working with Hard of Hearing and Deaf Children in Non- to Limited English-Speaking Families in the Clinical Setting: For Both the Clinician and Interpreter

Seek understanding of the child's/family's cultural perception toward being deaf or hard of hearing. Some clients may identify as part of the Deaf community, while others may not. It is important for both the clinician and the interpreter to understand how the client perceives his/her reduced hearing in order to facilitate trust and respect.[124] It is also be important to have an understanding of how the youth's family perceives the child's reduced hearing as well as cultural norms around being deaf (e.g., stigma, prejudice, status, etc.).

Understand challenges that the client may face in the healthcare setting:

- **Limited health literacy:** Deaf clients may experience limited health literacy due to lack of access to health information, and barriers to health care.[75]
- **Discrimination:** Deaf individuals experience oppression in many areas of society. Be aware that clients may have experienced discrimination within the healthcare setting. Additionally,

clinicians and interpreters may have implicit biases that impact provision of services (*see Implicit Bias section in Chapter 1 for more information on working to confront implicit biases.*)

- **Reduced Engagement**: Health care providers' reduced expectations of deaf individuals' ability to understand health-related information, coupled with the lived experience of having reduced access can result in sub-optimal engagement in treatment and follow through with medical recommendations.

Attend to differential diagnoses. It is important to distinguish behavioral challenges and risk for socio/emotional issues in youth. As such, distinguishing between implications of hearing versus attentional versus other issues is warranted. It should be noted that psychological issues are not caused by hearing loss but may be a consequence of a youth's context. In addition, a youth may have interrupted or limited educational experiences, which may have an impact on his/her language foundation.[83]

Be aware that written language may not be appropriate. An assumption is often made that written language would be preferred for those who cannot speak. However, many clients with reduced hearing may not prefer this. Care should be taken by to ensure that health care providers understand that written language may be a second language for deaf individuals who communicate in a signed language; their written abilities should not be assumed to reflect their cognitive abilities.[124] These preferences may also differ between a youth and his/her caregivers.

Ensure access to communication and information. The Americans with Disabilities Act (ADA) requires that healthcare providers use interpreter services (ADA, 2005). All clients should be provided health care information that they are able to access and understand.

Managing the Interpretation Session with Deaf and Hard of Hearing Children in Non- to Limited English-Speaking Families

Interpretation with Deaf and Hard of Hearing children and adolescents in non- or limited English speaking families may take several forms. In some cases, this will involve three individuals: the interpreter, the youth, and the clinician. In other cases, there may be multiple interpreters present. Multiple interpreters are necessary when one interpreter is needed for communication with the client, while an additional interpreter is needed for communication with a hearing family member who speaks a different spoken language than the clinician. Even with clinicians who can sign (such as those who utilize American Sign Language (ASL) in the United States), may encounter deaf patients from other countries who utilize a difference signed language. In such cases, a Certified Deaf Interpreter (CDI) is often brought in to translate ASL to a more gestural communication that can be widely understood by people from various backgrounds.

Tips for Clinicians:

1. Recognize the cultural affiliation and identities of the youth and his/her family members. Note that these may be different.

2. Ensure that the appropriate interpreter(s) are present for the language(s) needed by both the client and family members present.

3. As with hearing clients, *face the client* and not the interpreter.

4. If there are multiple interpreters present, have *both interpreters sit next to you*, facing the client and family member(s).

5. Reduce visual distractions. For example, to avoid glare, try not to place the client facing a window, as visual input may be important for the client to access.

6. Provide visual aids (notes, diagrams, visual displays) with prioritizing visual access to the child. Even among deaf and hard of hearing patients who communicate orally, visual access to information is generally quite helpful.

7. Check in to ensure comprehension and consistency in messages to client and his/her family.

8. Recognize and account for the additional time needed for clarification, attention getting and transitions (i.e., leave taking, the "long goodbye").

(NCTSN, 2006; Meder, 2015; NCDHHS, 2015)

Tips for Sign Language Interpreters:

1. Ask the client about his/her preferred method of communication: Some clients may prefer American Sign Language (ASL), while others may prefer lip reading along with ASL, finger spelling, or other methods of communication (for an explanation of additional communication methods, see: http://www.nctsnet.org/nctsn_assets/pdfs/edu_materials/Trauma_Deaf_Hard-of-Hearing_Children.pdf).

2. Be aware that there may be an additional interpreter present, if a family member prefers a different language than the child. Be prepared to work alongside this additional interpreter in the session and include him/her in pre and post-sessions with the clinician.

3. Ensure that the client has visual access to you, and that this is not impeded by distractions, such as glare.

4. As with other cultural groups, the interpreter may take on the role of explaining certain elements of Deaf culture to the clinician to facilitate understanding and trust.

(NCTSN, 2006; NCDHHS, 2015)

Chapter 2 | Pre-Test

3. Select the roles that are appropriate for an interpreter to take on (Choose all that apply):
    f. Clarifier
    g. Social worker
    h. Conduit
    i. Advisor
    j. Advocate

4. **True or False:** Ad hoc interpreting by family members is recommended, as family members have a wealth of information about the client and can provide appropriate cultural and familial context.

3. Match each term to its definition:

Psychiatrists ____

a. Those who have either a Doctor of Philosophy (PhD) or Doctor of Psychology (PsyD) and are not medical doctors.

Psychologists ____

b. Those trained to provide therapy that is not limited to a clinician-client dialogue, including the use of objects, art forms, and other recreational activities.

Case Managers ____

c. Medical doctors who have specialized in mental health treatment.

Occupational, Music, Dance, Art, and Activity Therapists ____

d. Generally serve as the primary coordinator for client services; usually have a Bachelor of Arts or Bachelor of Science degree in human service-related field.

4. Match each term to its definition:

Unaccompanied minor ____

a. Someone who voluntarily leaves his/her home country for better economic, educational, or other opportunities.

Immigrant ____

b. Someone who has been forced to flee his or her country because of persecution, war, or violence, for reasons of race, religion, nationality, political opinion or membership in a particular social group.

Asylum Seeker ____

c. Someone whose request for sanctuary has yet to be processed.

Refugee ____

d. A person who is under the age of eighteen, who is separated from both parents and is not being cared for by an adult who by law or custom has responsibility to do so.

5. **True or False:** Child development is a transactional (interconnected, not linear) process.

6. Which is **NOT** a principle of being trauma-informed?
   e. Trustworthiness and Transparency
   f. Timeliness and swift diagnosis
   g. Safety
   h. Empowerment, voice and choice

(Answer key is available in Appendix F)

CHAPTER 3 | Mental Health in the U.S.: Basic Concepts

By the end of this chapter, readers will be able to:

1. Explain basic mental health concepts.
2. Become aware of differences of understanding of mental health among diverse U.S. cultures.
3. Understand trauma exposure and traumatic stress.
4. Identify different types of mental health documentation.
5. Specify different levels of clinical care
6. Recognize the value of mental health care as a healing tool.

Intentionally Left Blank

Chapter 3 | Pre-Test

1. Match each term to its definition:

    Mood Disorders _____

    Anxiety Disorders _____

    Disruptive Behavior Disorders _____

    Psychotic Disorders _____

    a. A group of behavioral disorders defined by ongoing patterns of hostile and defiant behaviors that children and adolescents direct towards any type of authority figure.

    b. Emotional and/or behavioral difficulties that are characterized by the elevation or lowering of a person's mood, which can impact many areas of a person's life.

    c. These disorders are generally characterized by feelings of uneasiness, worry, fear, and avoidance that is more often than is reasonable or appropriate to the situation.

    d. These types of disorders are characterized by symptoms that include delusions (a belief, thought, or impression that is not consistent with reality) hallucinations (seeing, hearing, or feeling something that is not real or present in the environment), and/or a general inability to organize speech and behavior.

2. **True or False:** U.S. mainstream culture is primarily defined as White, English-speaking, middle-class, Christian, cisgender and heterosexual.

3. _____ and its overlay with immigration status and linguistic issues, contributes to the mental health problems among newcomer people of color.

4. **True or False:** Even when language translation services are provided, lack of diversity in the mental health workforce breeds cultural insensitivities that lead to negative health outcomes.

5. When using an interpreter, more work is needed to build _____ because having a different language and culture creates barriers when showing _____.

6. **True or False:** Those who experience traumatic stress always develop Post-Traumatic Stress Disorder (PTSD).

7. In _____ therapy, the client is encouraged to abandon avoidance behaviors and process in great detail the traumatic event(s) that is causing distress.

8. Please match the signs and symptoms of traumatic stress to the age group that is most accurate:

Signs and Symptoms of Traumatic Stress	Age Group
Recreate the trauma through play ____	a. Middle and High School Age
Become clingy with a teacher or parent ____	b. Preschool Age
Develop self-harming behaviors ____	c. Elementary School Age

9. Fill in the blanks:

a. A _____ includes information regarding the course of treatment as agreed upon by the mental health clinician and the client.
b. A _____ includes information added to the client file each time the clinician encounters the client.
c. A _____ includes information related to the course and progress made throughout treatment collected when treatment is terminated.

10. Match each term to its definition:

Outpatient Care (OP) ____

Inpatient (IP) ____

Partial Hospitalization (PHP) ____

Intensive Outpatient (IOP) ____

a. A time-limited, intensive treatment that allows the opportunity to provide varying hours per day throughout a week to individuals whose symptoms and behaviors do not require more clinical support and/or interventions in the evening or night.

b. The lowest level of clinical care provided to an individual and is offered once a week on average and typically based in a community, school or mental health agency setting.

c. The highest level of care provided to an individual and utilizes 24-hour monitoring and skilled clinical care in order to ensure the safety of the individual.

d. Requires individuals to participate in multiple hours of clinical intervention per week inclusive of both individual and group therapy.

Cultural Considerations in Mental Health Among Foreign-Born Clients

In a mental health setting, cultural frameworks play a large role. For instance, a Cambodian client claiming to have heard the voices of his ancestors could lead a Western provider to believe that the client was hallucinating. In actuality, describing "waking dreams" and visits from ancestors is a common way for traditional Cambodians to communicate unresolved emotional problems.

In the United States, mental health services may be generally defined as assessment, diagnosis, counseling/therapy, or medication treatment that focuses on supporting an individual or group's emotional health and behavior well-being. Mental health services are provided by a professional with the intention of alleviating one's distress. Services may focus on a specific problem like anger management or public speaking or it may be more broad like depression, grieving the loss of a loved one, or coping with stress or an experience of physical or sexual abuse. There are many different types of non-clinical self-care activities that can help alleviate distress like yoga, meditation, or working out, but the focus of this chapter is to describe traditional Westernized mental health services, basic concepts, and types of practice to address clinical levels of distress.

Generally, U.S. behavioral health practice characterizes persons as mentally healthy when one is emotionally, psychologically, and socially in a place of being or feeling comfortable, happy, and connected. Often, this is associated with having being able to articulate one's emotional experience, have strategies to be able to manage periods of stress, and possess confidence in one's ability to implement such strategies. Sustaining mental wellness also requires resilience that enables one to rebound after a crisis and to successfully sustain productivity even while experiencing prolonged periods of stress.

Communication occurs within a cultural framework, so it is necessary for interpreters to explain cultural differences or practices to mental health clinicians and clients, when appropriate. For example, an interpreter should explain when a Somali woman refuses to shake hands with her male doctor, she is doing so because to shake his hand would go against her cultural norm. (*Appendix H identifies clinical guidelines, to date, for the use of interpreters in mental-health settings*).

Based on this definition, a person's mental health must be assessed in terms of one's feelings about oneself, one's own life, and how one responds to periods of stress. One's abilities to engage in relationships with friends and family and with school/work are indicators of mental well-being.

It's important to acknowledge diverse U.S. cultures in conceptualizing effective mental health practices and interventions. The history and continuing legacy of racial stratification in the U.S. has defined mainstream U.S. culture primarily as White, English-speaking, middle-class,

Christian, cisgender and heterosexual. However, the U.S. is home to many cultures whose values typically deviate from the White mainstream, among them: American Indians, Asian Americans, African Americans, Latinxs, and Pacific Islanders. Different streams of U.S. cultures have varying experiences with oppression and social injustice.

Among foreign-born groups, there are stark differences based on mode and immigration status that impact socioeconomic status, educational attainment, proximity and exposure to White mainstream culture, among other considerations. African immigrants may share Blackness in common with African Americans, however, they may share similar experiences with other newcomer groups related to navigating complexity of linguistic, ethnic and/or religious differences. In terms of immigration concerns, an undocumented immigrant may be in constant fear of interactions with police and immigration enforcement. On the other hand, a newcomer with educational privilege and stable financial resources may have a different set of concerns. Poverty, and its overlay with immigration status and linguistic issues, contributes to the mental health problems among newcomer people of color. Undoubtedly, social class determines the type and quality of treatment that a foreign-born client is likely to receive. More notably, increase of discrimination and prejudice against foreign-born Americans has accelerated.

Values and norms in mainstream U.S. culture are based on individualism (the concept of being self-reliant and independent), egalitarianism (concept that all people are equal), and self-determination (free to make own choices). The opposite of not having achieved these values may, particularly if not using a socio-cultural, linguistically responsive, trauma-informed approach, be identified as having psychological symptoms or when certain types of symptoms group together it may be a mental health disorder or mental illness. Mental health services in the U.S. are likely to reflect or focus on achieving success or outcomes based on diminishing these symptoms of mental illness in order to achieve the Western conceptualization of mental health and consistent with U.S. mainstream values or standards. A critical task faced by mental health clinicians is to differentiate between a client not meeting societal norms and presence of an actual mental illness. Taking a socio-culturally, linguistically responsive, trauma-informed approach in conjunction with an interpreter will assist the mental health clinician in being successful in this task.

In contrast, newcomers to the United States may define mental health differently. Some cultures believe that mental health relates to the absence of symptoms of physical illness, other cultures believe a healthy person would maintain a balance between mind and body, or that a person is in good mental health when a person works hard for the family and sacrifices personal interests for the family or for the community's interests. Recent immigrants are more likely to hold stronger traditional values and beliefs. Mental health and mental illness may not be familiar concepts; there may not be existing terminology in the client's native language to correspond with the mental health lexicon.

In addition to different worldviews about health and healing, acknowledging the dynamics of institutional power and privilege is another important consideration. In the U.S., people who belong to marginalized social groups that are outside normative and mainstream cultural frameworks face many disadvantages in the behavioral healthcare system. Research shows that people of color are generally less satisfied with the quality of care they receive since they feel that providers simply do not understand their needs.[123] Other studies have shown that, even when language translation services are provided, lack of diversity in the mental health workforce breeds cultural insensitivities that lead to negative health outcomes, such as higher treatment dropout rates.[98]

Sue & Sue (2016) discuss cultural, class, linguistic, and even political issues in multicultural counseling. Use of Standard English unfairly discriminates against newcomers of color with limited English proficiency or lower socioeconomic background.[109,139] If clients do not use their native tongue in therapy, "many aspects of their emotional experience may not be available for treatment; they may be unable to use the wide complexity of language to describe their particular thoughts, feelings and unique situations."[123] Even with the help of a skilled interpreter, mental health concepts in English do not translate to equivalent language, for example, in Spanish.

Essentially, a language barrier is only one component of various elements of cultural considerations in serving diverse communities. Mental health interpreters are in a unique position to identify and address health inequities in counseling and treatment. Being cognizant of how U.S. White mainstream culture is normalized in counseling and therapy is a solid first step toward supporting diverse culturally-driven conflict and communication styles of foreign-born clients who require interpreter services. When using an interpreter, more work is needed to build rapport because having a different language and culture creates barriers when showing empathy.

COMPONENTS OF U.S. MAINSTREAM WHITE CULTURE: VALUES AND BELIEFS	
Rugged Individualism • Individual is primary unit • Individual has primary responsibility • Independence and autonomy highly valued and rewarded • Individual can control environment	**Emphasis on Scientific Method** • Objective, rational, linear thinking • Cause-and-effect relationships • Quantitative emphasis
Competition • Winning is everything • Win/lose dichotomy	**Protestant Work Ethic** • Working hard brings success
Action Orientation • Must master and control nature • Must always do something about a situation • Pragmatic/utilitarian view of life	**Progress and Future Orientation** • Plan for future • Delay gratification • Value continual improvement and progress
Communication • Standard English • Written tradition • Direct eye contact • Limited physical contact • Control of emotions	**Status and Power** • Measured by economic possessions • Credentials, title and positions • Believe "own" system • Believe better than other systems • Owning goods, space, property
Time • Adherence to rigid time • Time is viewed as a commodity	**Family Structure** • Nuclear Family is ideal social unit • Male is breadwinner and head of household • Female is homemaker and subordinate to husband • Patriarchal structure
Holidays • Based on Christian religion • Based on White history and male leaders	**Aesthetics** • Music and art based on European cultures • Women's beauty based on blonde, blue-eyed, thin, young • Men's attractiveness based on athletic ability, power, economic status
History • Based on European immigrants' experience in U.S. • Romanticize war	**Religion** • Belief in Christianity • No tolerance for deviation from single god concept

Source: From The Counseling Psychologist (p. 618) by J. Katz, 1985, Beverly Hills, CA Sage. Copyright 1985 by Sage Publications. Reprinted by Permission.

Culture impacts not only the way an individual conceptualizes his or her illness and well-being but also how symptoms manifest as well as expectation of treatment and outcomes and help seeking behaviors. It is important to gain understanding of the many different dimensions[vii] and styles[viii] in which cultures can differ.

DIMENSION[VIIII]	DESCRIPTION
Viewpoint of the importance and worth of persons	**Individualism vs. Collectivism** Relates to whose interest –the individual's or the group's – prevails over the other. In more individualistic cultures, individual interests tend to be valued over the groups whereas in collectivistic cultures, group interests are often valued over individual interests.
Time	**Monochronic vs. Polychronic Time** Refers to how time is understood and valued. Monochronic time emphasizes schedules and promptness whereas polychronic time emphasizes engagement with people and views appointments as flexible.
Gender roles	**Gender Roles** Refers to the continuum on which gender roles can be placed, from traditional to nontraditional. Gender roles carry expectations about emotional expression, personality characteristics (e.g., submissive, aggressive), appearance, power, relationships, employment, caretaking, etc.
Verbal and non-Verbal Language	**High-context vs. Low-context Language** This refers to how much or how little information is shared verbally within an interaction. Cultures with high context language rely heavily on nonverbal cues and shared cultural meanings to communicate information, whereas cultures with low context language rely heavily on information being verbalized and specific.

STYLE[x]	DESCRIPTION
Communication	Communication style refers to how language and phrases are used, how much importance is given to non-verbal communication (e.g., facial expressions, gestures, personal space, etc.), and how much assertiveness is appropriate.
Decision-Making	Decision Making style refers to how decisions are made (e.g., delegated or personal responsibility, by consensus, by majority, etc.).
Attitudes toward Conflict	Attitudes toward Conflict refers to how people from different cultures and societies may perceive conflict and deal with it. Depending on the culture in which you are socialized, conflict may be dealt with directly and openly or more indirectly and discreetly. In U.S. society, it is common to confront conflict directly and openly. Doing so is usually considered a positive and healthy way of moving forward.

Common Mental Health Disorders of Childhood and Adolescence

Below are general descriptions of common disorders in the Western mental health field. This is not an exhaustive list of mental health disorders, but rather a snapshot of common reasons for referral to mental health services. Therefore, these may be disorders to which interpreters may most frequently be exposed. All interpreters in a mental health setting are encouraged to speak with the mental health clinician and/or do additional research when they come into contact with disorders or terms that are unfamiliar to them.

Mood Disorders

Emotional and/or behavioral difficulties are characterized by the elevation or lowering of a person's mood, which can impact many areas of a person's life. One more common mood disorder is Major Depression. For children, this may look like sadness, low energy, concentration problems, irritability, sleep difficulties, and even suicidal thoughts. Another mood disorder is Bipolar Disorder (also known as Manic Depression). This is a mental illness in which a child might experience periods of time where they feel overly happy, energized that is followed by periods of sadness/depression.

Anxiety Disorders

These disorders are generally characterized by feelings of uneasiness, worry, fear, and avoidance that is more often than is reasonable or appropriate to the situation. These feelings can result in physical symptoms like muscle tension, racing heart, or sweating, or it can lead to sleep problems and/or irritability. One common anxiety disorder for children is Generalized Anxiety Disorder. This might look like a child having fears or worries that they find difficult to control about almost anything like school, sports, peers, or natural disasters. Another common disorder is Separation Anxiety. This is when a child has intense worry about being away from home or a caregiver and it impact his/her ability to function appropriate socially or in school.

Stress Related Disorders

Stress-related disorders are characterized as reactions to traumatic events. One common stress-related disorder is Post Traumatic Stress Disorder (PTSD). PTSD is a diagnosis that refers to an individual's emotional and behavioral responses following a traumatic experience, such as sexual assault, torture, natural disaster or war trauma. Chronic or multiple exposures to events/experiences like domestic violence or witnessing violence crime in a neighborhood, can also lead to PTSD. PTSD may manifest up to six months after the trauma and lasts for more than one month Posttraumatic stress reactions generally fall into 4 categories which include intrusion symptoms, avoidance, negative changes in thoughts and mood, and alterations in arousal or reactivity (*see under Trauma and Traumatic Stress for more information*). Another common disorder is Acute Stress Disorder (ASD). ASD shares the same categories of symptoms as PTSD but typically begins immediately after a trauma and lasts anywhere from 3 days to 1 month.

Disruptive Behavior Disorders

Disruptive behavior disorders (DBD) are a group of behavioral disorders defined by ongoing patterns of hostile and defiant behaviors that children and adolescents direct towards any type of authority figure. While all children go through periods of testing limits by acting out in negative behaviors, children with DBD engage in these behaviors to such an extent that it impacts their daily lives, as well as the lives of those around them. Two of the more common DBD are oppositional defiant disorder and conduct disorder.

Psychotic Disorders

These types of disorders are characterized by symptoms that include delusions (a belief, thought, or impression that is not consistent with reality) hallucinations (seeing, hearing, or feeling something that is not real or present in the environment), and/or a general inability to organize speech and behavior. For example, someone who is delusional may believe that he is a god or that he controls the thoughts of others. Someone who is hallucinating might talk or hear a voice or have a vision that is not actually present. Disorganized speech may look like a

person who unable to use words or actions to communicate with another person in a coherent, logical, or meaningful way. Someone who has disorganized behavior might not be able to perform simple activities of daily living, including cooking food or showering. One example of a psychotic disorder is schizophrenia. People with schizophrenia may perceive distracting or frightening distortions in the world around them and respond based on those misperceptions.

Neurodevelopmental Disorders

Neurodevelopmental disorders are a group of disorders in which there are impairments in growth or development of the brain or central nervous system. These impairments often occur at an early age and the deficits result in impairments in emotions, socialization, self-control, memory, learning ability, language and/or non-verbal communication. The deficits can be very specific, like having difficulties reading, or they can be more global and can affect intelligence and social skills more broadly.

The disorders included in this category include Attention Deficit Hyperactivity Disorder (ADHD), Autism Spectrum Disorder (ADS), Communication Disorders, Motor Disorders, and Specific Learning Disorders.

Due to each of the unique presentations of the different neurodevelopmental disorders and how the symptoms present together to create an effect on a child and his/her functioning, is it important to have a full and accurate understanding of them. These types of disorders are sets of very specific symptoms that go together in very specific ways and have very specific outcomes. It is important to be aware that even with the presentation of some symptoms, it does not always mean a full neurodevelopmental diagnosis.

Attention Deficit Hyperactivity Disorder (ADHD)

ADHD is a disorder that makes is difficult for a person to pay attention and control impulsive behaviors. Specifically, it is characterized by problems paying attention, excessive activity, or difficulties being able to control behavior that is not appropriate for a person's age. The difficulties must interfere with a child's functioning and occur in at least two or more settings, such as home and school. There are three types of presentations for this diagnosis. One primarily manifests as inattention, the second presents as problems with hyperactivity and impulsivity, and the third is a combination of both of the sets of difficulties.

Autism Spectrum Disorders (ASD)

ASD is a disorder that is characterized by deficits in communication and interactions with others in which there are failures in social-emotional reciprocity, deficits in non-verbal communication such as abnormalities with eye contact and lack of facial expressions, and problems with developing and maintaining relationships. Individuals diagnosed with ASD also exhibit restricted or repetitive patterns of movements, show inflexibility to routine, may become

fixated or preoccupied with unusual objects, and/or may be overly or underlie sensitive to sensory experiences, all of which cause significant impairments in social or occupational functioning.

Developmental Delay

Global Developmental delay is a condition in which a child is less mentally or physically developed than what is normal for the child's age. Often it refers to an important developmental milestone that was not met at an expected age in regard to motor, speech, language, cognition, social functioning, or activities of daily living. A developmental delay can be temporary or permanent. Some children can eventually catch up and no longer have developmental difficulties. Persistent developmental delays are called developmental disabilities.

Communication Disorders

Communication disorders are disorders that affect an individual's ability to send, receive, process, and comprehend verbal or nonverbal language. This results in not being able to effectively engage with another person. These disorders can range from a person making simple repetitive sounds like what is observed with stuttering, to occasional misarticulation of words, to having complete problems with not being able to use speech and language for communication. Some examples of communication disorders include Speech sound disorder, fluency disorder, receptive language disorder, and expressive language disorder.

Motor Disorders

Motor disorders are deficits in the nervous system that cause abnormal and involuntary movement of the body. They can cause reduced or slowed movement. Some examples of motor disorders include tic or Tourette syndrome, Parkinson's, or Ataxia.

Specific Learning Disorder

Specific learning disorders are diagnosed when the basic psychological processes involved in understanding or using language, spoken or written word result in an inability to listen, speak, read, write, spell, or do math calculations.

Mental Disorder and Substance Abuse

Substance abuse is another type of mental health disorder. Substance abuse occurs when the recurrent use of alcohol and/or drugs causes functional impairment in health or with other major responsibilities at school, work, home, or in relationships with others. Substance abuse can present on its own or in conjunction with another mental health diagnosis. When the latter situation occurs, it is referred to as having a dual diagnosis. The combination of having

substance abuse and other mental health disorders is more serious because each diagnosis has the potential to exacerbate or make the symptoms of each diagnosis more significant.

Substance use may be one way in which an individual copes with psychological symptoms. Substance use can numb or temporarily help a person experience less distress when using alcohol or drugs.

Understanding Trauma and Traumatic Stress

Traumatic Event

A traumatic event is a scary, dangerous, or violent discrete event or chronic circumstances. An event can be traumatic when we face or witness an immediate threat to ourselves or to a loved one, and it is often followed by serious injury or harm. When this happens, it can cause emotions such as fear, loss, or distress. Sometimes people experience these types of strong negative emotions in reaction to the experience or because the person may not have the ability to protect or stop the event from happening. Reactions to a traumatic event can also have lasting effects on the individual's daily functioning including possible changes in a child's mental, physical, social, emotional, and/or spiritual health. A person also may experience multiple types of different traumas.

Some examples of traumatic events include physical abuse, sexual abuse, domestic violence, witnessing criminal behavior like robberies or gun violence, neglect, and/or homelessness.

Child Trauma

Child trauma refers to a scary, dangerous, violent, or life-threatening event(s) that happens to a child (0-18 years of age). This type of event may also happen to someone your child knows and your child is impacted as a result of seeing or hearing about the other person being hurt or injured. When these types of experiences happen, your child may become very overwhelmed, upset, and/or feel helpless. These types of experiences can happen to anyone at any time and at any age; however, not all stressful events have a traumatic impact, depending on a child's repertoire of coping skills, health of attachment relationship, presence/absence of pre-existing mental health concerns, and other strengths. In fact, different individuals may have different responses to the same stressor, such that one child may demonstrate symptoms of traumatic stress, while the other demonstrates remarkable resilience and wellbeing despite his/her exposure.

The signs and symptoms of traumatic stress look different in each child and at different ages. Below is a table which can help family members understand traumatic stress symptoms by age. It highlights some of the signs of distress as a result of exposure to traumatic events.

PRESCHOOL CHILDREN	ELEMENTARY SCHOOL CHILDREN	MIDDLE AND HIGH SCHOOL-AGED YOUTH
• Bed wetting • Thumb sucking • Acting younger than their age • Trouble separating from their parents • Temper tantrums • Aggressive behavior like hitting, kicking, throwing things, or biting • Not playing with other kids their age • Repetitive playing out of events related to trauma exposure	• Changes in their behavior such as aggression, anger, irritability, withdrawal from others, and sadness • Trouble at school • Trouble with peers • Fear of separation from parents • Fear of something bad happening	• A sense of responsibility or guilt for the bad things that have happened • Feelings of shame or embarrassment • Feelings of helplessness • Changes in how they think about the world • Loss of faith • Problems in relationships including peers, family, and teachers • Conduct problems

Adapted from: National Child Traumatic Stress Network. (2010). Age-related reactions to a traumatic event. Los Angeles, CA, and Durham, NC: National Center for Child Traumatic Stress.

Traumatic Stress

Reactions that occur in response to a child's experience of a traumatic event and have an impact on her/his daily life may be referred to as traumatic stress. These reactions may show up in different ways, such as changes in a child's behavior (such as more being irritable, withdrawn, or acting younger than his/her age), difficulties in interactions with others, problems or changes in sleeping or eating patterns, or school performance. The NCTSN states,

"Child traumatic stress occurs when children and adolescents are exposed to traumatic events or traumatic situations that overwhelm their ability to cope."

When these stress symptoms develop, they happen automatically (i.e., are not in a child's conscious control) as a child attempts to manage negative emotions (like fear) that emerges in response to memories of the event. When a child experiences traumatic stress, he or she may act in an uncharacteristic or not typical way for him or her. These reactions may continue for days, weeks, or months after the traumatic experience. They can present immediately, but also

could emerge weeks or months after the event took place. These are normal reactions to a child having survived overwhelming life experiences.

When mental health clinicians discuss symptoms, they might refer to them as being "chronic" or "acute." Chronic symptoms are ones that have persisted for a long time whereas acute symptoms have emerged more recently and have may have been present for a shorter period of time.

When a certain combination of emotional and behavioral reactions occurs in response to a traumatic event(s), they may be grouped or categorized into a diagnosis called Posttraumatic Stress Disorder (*see under Anxiety Disorders more information*).

The NCTSN has also developed a core curriculum on childhood trauma (*see Appendix I for information about the NCTSN's 12 Core Concepts for Understanding Traumatic Stress Responses in Children and Families*).

Understanding Mental Health Documentation

After mental health clinicians assess and diagnose clients, they record their findings and treatment decisions on different documents. Documents within the client record include treatment plans, progress notes, and discharge summaries. When a client self-identifies as having no or LEP, best practices state that the use of interpretation in the mental health context should be indicated (e.g., yes, no, refused) and described (e.g., name of interpreter, language used to interpret, etc.).

DOCUMENT	TREATMENT PLAN	PROGRESS NOTE	DISCHARGE SUMMARY
DESCRIPTION	Information regarding the course of treatment as agreed upon by the mental health clinician and the client	Information added to the client file each time the clinician encounters the client	Information related to the course and progress made throughout treatment collected when treatment is terminated

INFORMATION INCLUDED	Immediate, short-term and long-term treatment goals; how outcomes with be measured; types of interventions to be used; frequency / duration of interventions; list of clinical and other service professionals involved in treatment of client including interpreters	Date, time, and duration of intervention or appointment; type of encounter; location; persons present; what was said by clinician and client; interpretation provided, treatment goal progress and issues; plan for future interventions	Results of therapy as related to treatment goals; overall duration of treatment; information about individual interventions, description of interpretation used as well as clinicians and interpreters involved; diagnosis at the time of closing; plans for continued treatment, if necessary

Understanding different levels of clinical care

There are different levels of clinical care that can be provided to clients. The appropriate level of care based on an individual's current functioning and threat to self/others is established by a mental health clinician during the initial assessment and again throughout treatment as there may come a time where a higher level of care is needed. Determining the most accurate level of care can help the individual gain the best treatment available while preventing any potential serious complications such as harm to self or others. There are five different levels of care, ordered from least to most intensive, identified and described in the table below.

LEVEL OF CLINICAL CARE	DESCRIPTION
Outpatient care (OP)	OP is the lowest level of clinical care provided to an individual and is offered once a week on average and typically based in a community, school or mental health agency setting.
Intensive outpatient (IOP)	IOP typically requires individuals to participate in multiple hours of clinical intervention per week inclusive of both individual and group therapy.
Partial hospitalization (PHP)	PHP, sometimes called day treatment, is a time-limited, intensive treatment. PHP allows the opportunity to provide varying hours per day throughout a week to individuals whose symptoms and behaviors do not require more clinical support and/or interventions in the evening or night.

Residential treatment care (RTC)	RTC is a step down from inpatient and allows for the opportunity to provide 24-hour monitoring and clinical services to individuals who are experiencing severe symptoms that significantly impair their day to day functioning.
Inpatient (IP)	Inpatient treatment is the highest level of care provided to an individual and utilizes 24-hour monitoring and skilled clinical care in order to ensure the safety of the individual.

Note: Community-based services may vary by levels of intensity, from crisis to ongoing, from several times per week to once per month, from 24-hour availability to business hours.

The value of mental health care as a healing tool

Psychotherapy as a healing intervention is widely used in Western cultures and becoming more accepted in non-Western cultures as well. Therapy is for children or adults who have, or may have mental health difficulties, trauma experiences, or life experiences that disrupt their thinking, mood, feelings, or ability to relate to others. A person may also seek out therapy because they want a neutral and safe place to talk about difficult life experiences. Many people seek out therapy: adults, youth, teens, even mental health clinicians themselves. Everyone needs somewhere they feel safe and supported. The role of the mental health clinician is to help the person understand his/her situation, teach strategies to express him/herself, and cope with potentially stressful situations. The mental health clinician can also offer the individual or family tools to help them manage difficult feelings, and/or negative thoughts and behaviors.

Psychotherapy may also be used in conjunction with psychotropic medications. Psychotropic medications are medicines that are capable of affecting/altering chemicals in the brain that impact mind, emotions, and behaviors. They may be used to reduce emotional or behavioral problems that impact a child's everyday functioning. Use of medication may allow your child to better engage in school, the community and in after-school activities. But medications do have side effects and there are not a lot of long-term studies on the impact of medications on children and adolescents, so it is important the family speak with the licensed prescriber about the purpose, functioning, and impact of the use of any medication.

Trauma-Focused Therapy is a specific approach to therapy that recognizes and emphasizes understanding how the traumatic experience impacts a child's mental, behavioral, emotional, physical, and spiritual well-being. This type of therapy is rooted in understanding the connection between the trauma experience and the child's emotional and behavioral responses. The purpose of trauma-focused therapy is to offer skills and strategies to assist your child in better understanding, coping with, processing emotions and memories tied to traumatic experiences, with the end goal of enabling a child to create a healthier and more adaptive meaning of the experience that took place in his/her life. Trauma-focused therapy often involves and "exposure" component in which the client is encouraged to abandon

avoidance behaviors and process in great detail the traumatic event(s) that is causing distress. This is a challenging concept to embrace since most traumatized clients want to avoid remembering the traumatic events. However, this avoidance behavior is often what perpetuates the distress. Through a repeated process of "facing fears" or processing the memory, the client can experience "habituation" (i.e., a decrease in distress and more mastery).

Therapy and the Refugee and Immigrant Experience

Many refugee/immigrant children and their families have survived traumatic events that understandably impact their ability to function in a psychologically healthy way. Posttraumatic stress disorder (PTSD) and other types of posttraumatic stress reactions are common among refugee and some immigrant children. Psychotherapy with a mental health clinician and an interpreter can provide a safe haven for refugee/immigrant children and their families to talk about their experiences, feelings, disappointments, fears, hopes, and dreams. The opportunity to talk with a representative from their host country in which the child is currently living (the mental health clinician) and an individual who speaks their primary language (the interpreter), when such a match is possible to arrange, can create an environment where refugee/ immigrant clients can feel secure in being understood. This therapeutic arena can be created when there is a collaborative and mutually respectful dyadic relationship between the mental health clinician and the interpreter. This relationship begins with the interpreter and clinician together understanding and communicating the value of therapy to the client through his attitude and behavior.

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Chapter 3 | Post-Test

1. Match each term to its definition:

   Mood Disorders ____

   Anxiety Disorders ____

   Disruptive Behavior Disorders ____

   Psychotic Disorders ____

   a. A group of behavioral disorders defined by ongoing patterns of hostile and defiant behaviors that children and adolescents direct towards any type of authority figure.

   b. Emotional and/or behavioral difficulties that are characterized by the elevation or lowering of a person's mood, which can impact many areas of a person's life.

   c. These disorders are generally characterized by feelings of uneasiness, worry, fear, and avoidance that is more often than is reasonable or appropriate to the situation.

   d. These types of disorders are characterized by symptoms that include delusions (a belief, thought, or impression that is not consistent with reality) hallucinations (seeing, hearing, or feeling something that is not real or present in the environment), and/or a general inability to organize speech and behavior.

2. **True or False:** U.S. mainstream culture is primarily defined as White, English-speaking, middle-class, Christian, cisgender and heterosexual.

3. _____ and its overlay with immigration status and linguistic issues, contributes to the mental health problems among newcomer people of color.

4. **True or False:** Even when language translation services are provided, lack of diversity in the mental health workforce breeds cultural insensitivities that lead to negative health outcomes.

5. When using an interpreter, more work is needed to build ____ because having a different language and culture creates barriers when showing ____.

6. **True or False:** Those who experience traumatic stress always develop Post-Traumatic Stress Disorder (PTSD).

7. In _____ therapy, the client is encouraged to abandon avoidance behaviors and process in great detail the traumatic event(s) that is causing distress.

Please match the signs and symptoms of traumatic stress to the age group that is most accurate:

Signs and Symptoms of Traumatic Stress	Age Group
Recreate the trauma through play _____	a. Middle and High School Age
Become clingy with a teacher or parent _____	b. Preschool Age
Develop self-harming behaviors _____	c. Elementary School Age

9. Fill in the blanks:

   a. A _____ includes information regarding the course of treatment as agreed upon by the mental health clinician and the client.

   b. A _____ includes information added to the client file each time the clinician encounters the client.

   c. A _____ includes information related to the course and progress made throughout treatment collected when treatment is terminated.

10. Match each term to its definition:

Outpatient Care (OP) _____

Inpatient (IP) _____

Partial Hospitalization (PHP) _____

Intensive Outpatient (IOP) _____

a. A time-limited, intensive treatment that allows the opportunity to provide varying hours per day throughout a week to individuals whose symptoms and behaviors do not require more clinical support and/or interventions in the evening or night.

b. The lowest level of clinical care provided to an individual and is offered once a week on average and typically based in a community, school or mental health agency setting.

c. The highest level of care provided to an individual and utilizes 24-hour monitoring and skilled clinical care in order to ensure the safety of the individual.

d. Requires individuals to participate in multiple hours of clinical intervention per week inclusive of both individual and group therapy.

(Answer key is available in Appendix F)

Chapter 4 | The Interpreter and Mental Health Clinician Dyad

By the end of this chapter, readers will be able to:

1. Recognize the importance of the trauma-informed interpreter-clinician relationship.
2. Explain relationship dynamics in the therapeutic triad.
3. Apply recommendations for building true partnerships before a session.
4. Understand the importance of pre and post-sessions.

Chapter 4 | Pre-Test

1. Which of the following is part of the Trauma-Informed Interpreter-Clinician Relationship?

    a. Maintain strict power differentials

    b. Enhance transparency

    c. Disregard culture

    d. Do not discuss the client outside the session

2. In the therapeutic triad...

    a. The_____ provides expertise on the psychological consequences of severe trauma and strategies for recovery.

    b. The _____acts as a conduit for communication, an expert in languages spoken by the clinician and client.

    c. The _____ acts as an expert on what trauma occurred and its expression within his/her cultural, linguistic, and political context.

3. The clinician should look directly at, and speak directly to, the _____ during the session.

4. **True or False:** The interpreter should encourage the client to introduce themselves and share any personal medical information before the clinician enters the room, so that they are familiar with the case beforehand.

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The Trauma-Informed Interpreter-Clinician Relationship

The relationship between the interpreter and mental health clinician is of great importance to the client and is the foundation from which the healing starts and proceeds. The potential healing process of a client can be enhanced when a client is provided with the same interpreter/mental health clinician dyad for each session. The dyadic partnership approach serves all partners involved. The client is provided with support from the clinical interpreter, who is familiar with the language and culture. The clinician guides the treatment and continues to assess treatment and progress. The clinician and clinical interpreter together absorb, balance, and move forward with the client in an environment that promotes healing as much as the modality of treatment.

The interpreter is part of the team of professionals and brings a valued and unique piece to the table. Just as the interpreter takes "self" out and acts like a conduit for the transfer of information, the clinician takes "self/ego" out as being the only expert in the room regarding client's situation and prognosis. The dynamic of this situation is that it is the opportunity for trust between the clinician and the interpreter where the client benefits from that professional collaboration. When working with clients with no or LEP, it is recommended that ultimately the mental health clinician and the interpreter both do what they can to equalize power differentials, enhance transparency, demonstrate cultural humility, and model self-advocacy.

The clinical interpreter is the connection between the client and the clinician, but he/she also needs to possess the skills to assess, on the spot, the level of understanding of the client to be most effective and efficient in providing best practice services. The clinician is there to provide the modality of treatment in concert with the clinical interpreter. Especially when trauma is involved, it is important that the clinical interpreter is trauma-informed *(refer to page 32 for definition of trauma-informed interpreter)*.

The foundation of understanding trauma and treatment modalities has the potential to provide the "glue" for the professional relationship between the clinician and the clinical interpreter, as both will hear the traumatic experiences of the client, and both will work to provide a safe place for healing to occur. To be fair, it is the clinical interpreter that will hear the words of trauma in the native language and it is the clinical interpreter that will then speak the words of trauma in English to the clinician. The clinician will only "hear" those words once during the translation in English. The clinical interpreter is hearing, translating and repeating the words of trauma, which increases the dose of exposure, and creates risk for secondary traumatic stress (*see Chapter 6 for more information about STS*).

The partnership between the mental health clinician and interpreter is the opportunity for the client to benefit from the dynamics of a healthy triangle. The relationship between the mental health clinician and interpreter is a relational bond. They both hear the trauma presented by the client; they debrief together, assess situations as well as consult on possible outcomes. The clinician brings the expertise of the profession of mental health and the interpreter brings the expertise of being a native speaker, cultural foundation, and assessment of the client's ability from that ethnic or cultural lens. Together this combination/collaboration can provide the client with the possible best practice outcomes, the opportunity to heal and move forward.

"It is this delicate verbal dance of the clinical interpreter that I came to respect and have compassion for over the years of working with Sara. It became the spot from which we entered every session. We supported each other, as well as the client, with care about what we were being told. We started to notice that we could communicate without words by looking at each other and reading the non-verbal cues and nuisances. As a team, we became a containing space and healing force for the client to move forward. But it also provided us with a place to debrief and let go which is also an important part of doing this kind of work. This connection kept us "clear" of many of the pitfalls of secondary trauma as we did not always end the session and go our separate ways. We disengaged from the work together. Just as the clinician is usually provided supervision, the debriefing and sorting out of information provided the clinical interpreter with a type of supervision and it also gave me, the clinician, time to review and clarify and question anything that the client shared his connection was invaluable to us as a team. As we continued to work together, we started to recognize that it also provided the client with the relational support of a valuable, reliable, and trustworthy team."

-Personal communication, Laura Gassen Templet, MSW, LSW

Mental health clinicians are not all alike. An interpreter working with different mental health clinicians will see that one is very different from another. This does not mean one is better than the other; it may simply mean that they work with clients in ways that are different but equally helpful. Some mental health clinicians are directive and will be very active in talking during sessions. They will ask questions and give advice. Other mental health clinicians are non-directive and will ask a question only when they believe it is appropriate. They might allow periods of silence that sometimes feel uncomfortable but are intended to communicate acceptance and allow clients to express thoughts that enter their minds without direction from the mental health clinician.

Mental health clinicians work with clients in individual therapy, couples' therapy, family therapy, and group therapy. The demands on the interpreter in the mental health setting change in each of these therapy situations. During couples and family therapy, the interpreter must convey the spoken words for each person with no or LEP present in the session. It is important to give the direction that one person speaks at a time and to remind clients of the rule during times when more than one person speaks. During group therapy, it is essential that the interpreter and the clinician work out an agreement as to how to manage the interpretation. Groups are usually kept smaller to facilitate effective interpretation, but the demand for attention and concentration on the interpreter increases with each group member. Given that it could be challenging only using one interpreter at times, it may be best to consider the use of multiple interpreters particularly in couple's, family or group therapy contexts.

Relationship Dynamics in the Therapeutic Triad

In some settings, including an interpreter in a therapy session can be an unfamiliar idea to mental health clinicians because it alters the format from a dyad to a triad. Adding an interpreter into the clinical setting, physically adding to the room may have an impact on both the client and the mental health clinician. Mental health work involves strong emotions, both positive and negative in nature. Often, the stories that clients share can be difficult or emotional, and it can be challenging to listen to them. It is important that the interpreter be attentive to how these emotions and stories may be affecting his or her emotional state.

Mental health work involves a unique dynamic among the members of the therapeutic triad. It is about human emotions and interpersonal interactions. It is already complex work when the clinician and client are from the same culture and speak the same language, so introducing a non-English-speaking client and a mental health interpreter adds additional components to the interaction. Excellent communication is an essential ingredient of successful psychotherapy. The therapeutic triad must have an open channel to communicate accurately and effectively. Understanding some of the possible dynamics of therapy facilitates communication.

THERAPEUTIC TRIAD

THERAPIST Provides expertise on the psychological consequences of severe trauma and strategies for recovery

SURVIVOR
Expert on what trauma occured and its expression within his/her own cultural, linguistic, and political context

INTERPRETER
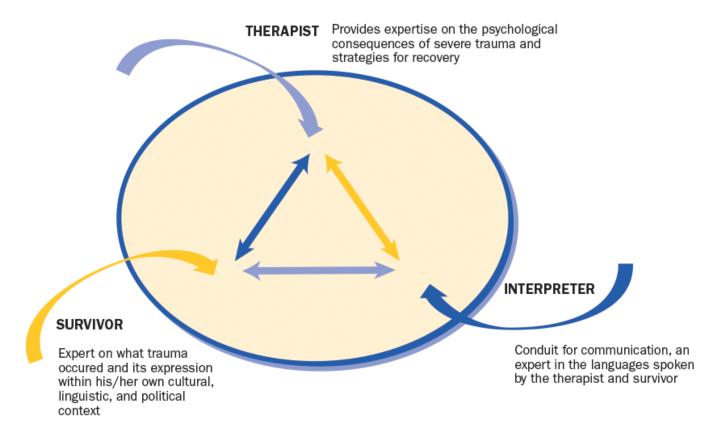Conduit for communication, an expert in the languages spoken by the therapist and survivor

Figure 1. This figure is from the Kovler Center[xi]. The Kovler Center engages interpreters using a Kovler Center designed therapeutic partnership in which the clinician, interpreter, and survivor form a collaborative team. This model acknowledges the expertise of each of these participants as an essential component of the therapy process: the clinician provides expertise on the psychological consequences of severe trauma and strategies for recovery; the survivor is an expert on what trauma occurred and its expression within his/her own cultural, linguistic, and political context; and the interpreter is the conduit for communication, an expert in the languages spoken by the clinician and client. This therapeutic triad translates to a therapeutic partnership that reflects respect and trust, necessary ingredients for psychotherapy.

Critical to the encounter also is a sense of rapport and a healthy relationship between interpreter and mental health clinician so that the dyad can work together in collaboration and partnership throughout the therapeutic process starting before a session begins, remaining during the session and then after a session.

The Importance of Building True Partnerships Before a Session

One means of assisting an easy interchange between the mental health clinician and client in a session is for the interpreter to meet separately beforehand with each of them in what is termed a "pre-session." This step will ease the flow of the actual mental health session and eventually allow the client and mental health clinician to focus on each other rather than on the interpreter.

In some cases, there may be additional members present, such as group counseling, or family therapy where multiple clients are present. If there are multiple speakers with multiple languages represented, this can be challenging to arrange. The principles set forth in this section about building relationships and preparing for a session stand, regardless of the number of members present, but participants should be aware of the additional challenges with a greater number of people present.

Setting Up a Session

Professional Interpreter: Before the pre-session, an interpreter should gather the following information from the appointment scheduler at the mental health clinic or hospital:

- Client's name
- Client's language or dialect
- Date, time, and location of the session
- Clinician's name
- General topic of the session
- Whether a phone call is necessary to remind the client of the appointment
- Client's level of understanding or ability to speak English
- Client's education level
- Clinician's profession
- Clinician's objectives for the session
- Clinician's expectations of the interpreter
- Whether any translation of written documents will be required

Qualified Mental Health Clinician: Before the pre-session, the mental health clinician should:

- Ensure an interpreter has been arranged
- Determine his or her goal for an upcoming client meeting
- Think about how language and socio-cultural factors may be integral to the content of the meeting. Be open to be in true partnership with the interpreter in order to have a successful meeting with the client with no or LEP.

An important aspect of empowering the client is to make an attempt to accommodate client choice within the interpretation setting.

Depending on organizational constraints, it may be possible to provide client choice in:
- Preference for phone versus in-person interpretation
- Allowing for choice in gender of interpreter*
- Allowing the client to change interpreters if desired (National Partnership for Community Training, 2015)

This may be especially important in situations where the client has experienced sexual violence.

Pre-Sessions

For interpreters to establish a rapport with clients and mental health clinicians, it is important that they take time at the beginning of each session to introduce themselves to the client and the clinician in separate, short meetings before the interpreting session. These pre-sessions create a foundation of trust with both parties, illustrate professionalism, assess the linguistic capability of the client, and provide a basic description of how the interpretation will be carried out.

The Professional Interpreter's Role

Interpreters should introduce themselves to the clinician in the pre-session, which usually takes place in the exam room before the start of a session. The following information about the interpreting process should be included in the pre-session with the clinician:

1. Give your name and that of your agency, mentioning that you will be the interpreter. Professional information worth sharing includes the interpreter's name, agency, credentials and any other information that related to the specific interpreting session.

2. Inform the mental health clinician that he or she should speak to and look directly at the client, and vice versa.

3. Stress that everything that is said will be interpreted exactly as it is said, both to and from the client, and first person will be used. First person is recommended, as:

   a. It emphasizes the relationship between the client and the mental health clinician
   b. It allows the interpreter to concentrate on repeating exactly what was said.
   c. It shortens the communication and avoids confusion as to who is speaking

4. Ask the mental health clinician to speak in short sentences in order to facilitate accurate interpretations, and to pause frequently when speaking to allow time for interpreting.

5. Establish a signal to be used when the interpreter needs more time before new information is introduced.

6. Inquire if the mental health clinician has any particular expectations or concerns about the subjects to be broached or interpreting to be done in this particular session.

The Mental Health Clinician's Role

Mental health clinicians should be prepared for a short introduction with the interpreter, which usually takes place in the exam room before the start of a session. In this pre-session, the interpreter will share information about the interpreting process. Mental health clinicians should be prepared to:

1. Share your name and your title to the interpreter in the pre-session

2. Accept the guidelines around interpretation that the interpreter shares, including:

    a. Speak to and look directly at the client during the session, not the interpreter

    b. Be aware that everything that is said will be interpreted exactly as it is said, both to and from the client.

    c. Speak in short sentences in order to facilitate accurate interpretations, and to pause frequently when speaking to allow time for interpreting.

    d. Establish a signal to be used when the interpreter needs more time before new information is introduced.

3. Share any expectations or concerns about the subjects to be broached or interpreting to be done in this particular session.

    a. e.g., Case, terminology, relevant background, vicarious trauma

4. Ask interpreter if she/he has any questions or suggestions before they meet with the client.

5. Check if by any chance, interpreter knows the client and if she/he knows client -- make sure to add an extra conversation about confidentiality and what to do if interpreter sees client out in her/his community.

Pre-Session between Clinician and Client

Often, pre-sessions with clients can be less formal. Important topics to cover include rules of confidentiality and the roles/boundaries for the interpreter. It is important to let the client know about this pre-session meeting between the mental health clinician and the interpreter as well as the reason why it is being scheduled. It may be also possible that the interpreter knows the client because they belong to the same community. In this instance, it would be important to clarify more issues of confidentiality and establish a good understanding of what to do the next time that they will see each other out in their communities.

Interpreters should avoid certain topics during pre-sessions with clients. Often, the client's mental health or medical history comes up, whether or not they are asked to share the information. Clients might mistakenly assume that the interpreter will share this information with the mental health clinician once the actual session starts. However, it is crucial that the client tells his own story, in his own words, to the provider. When the clients share medical information during the pre-session, give a reminder that they will be expected to share the information with the provider as well. Also, as mentioned in the "Values and Code of Ethics" chapter, it is wise to avoid issues that can become divisive, such as politics, religion, or morality.

When interpreting for the same client or mental health clinician repeatedly, pre-sessions may not be necessary before each appointment. After a basic rapport has been established through repeated sessions, a simple greeting and short summary of the role of the interpreter is sufficient.

Post-Sessions

Debrief After the Sessions

1. Thank the interpreter
2. Receive feedback about concerns
3. What did the interpreter see come up that was important?
4. Self-care and secondary traumatic stress prevention
5. Resources for the interpreter for support
6. Summarize with the interpreter – what were the more meaningful interactions between you and interpreter during the meeting? – and evaluate the areas of improvement.
7. Review of what to do if the interpreter sees the client in his/her community

In sum, it is vital to recognize that the interpreter plays an important role in the therapeutic alliance and as much as possible the collaboration between the interpreter and mental health clinician be based on sharing power[xii]. Forming a healthy and professional clinician and interpreter relationship takes time. It is highly recommended to take this time, particularly before and after sessions, not only to foster these relationships but also to prevent any missteps and miscommunications during the actual sessions.

Chapter 4 | Post-Test

1. Which of the following is part of the Trauma-Informed Interpreter-Clinician Relationship?

    a. Maintain strict power differentials

    b. Enhance transparency

    c. Disregard culture

    d. Do not discuss the client outside the session

2. In the therapeutic triad...

    a. The_____ provides expertise on the psychological consequences of severe trauma and strategies for recovery.

    b. The _____acts as a conduit for communication, an expert in languages spoken by the clinician and client.

    c. The _____ acts as an expert on what trauma occurred and its expression within his/her cultural, linguistic, and political context.

3. The clinician should look directly at, and speak directly to, the _____ during the session.

4. **True or False:** The interpreter should encourage the client to introduce themselves and share any personal medical information before the clinician enters the room, so that they are familiar with the case beforehand.

(Answer key is available in Appendix F)

Chapter 5 | Managing the Session

By the end of this chapter, readers will be able to:

1. Specify intake/evaluation specific information.
2. Describe the flow of a session.
3. Explore common issues that arise in the interpretation interaction
4. Identify opportunities for interpreter intervention.

Intentionally Left Blank

Chapter 5 | Pre-Test

1. When clinicians ask questions about sensitive areas during the assessment, (including parenting, sexuality, drug use, and suicidality/homicidality) what should interpreters do?

    a. Ask these types of direct questions, not softening or changing the wording.

    b. Re-word the questions so that they will be less harsh to the client.

    c. Ask a family member to assist you in interpreting, so that you are sure that the question is acceptable within the family and culture.

    d. Refuse to interpret these kinds of questions, as they are inappropriate.

2. When should the clinician outline the session?

    a. After the greeting

    b. At the midpoint of the session

    c. Towards the end of the session

    d. All of the above

3. **True or False:** An interpreter should translate an idiom or non-literal saying word-for-word, even if it has no meaning in the translated language.

4. In which of the following situations should the interpreter **NOT** intervene in the interaction?

    a. The speaker uses language the interpreter does not understand.

    b. The mental health clinician says something that could be offensive to the client's culture.

    c. The client becomes emotional when sharing his/her experiences.

    d. A speaker does not pause to let an interpreter interpret.

Intake/Evaluation Specific Information

When an individual first begins therapy, the mental health clinician may conduct an assessment. The purpose of the assessment is to develop a better understanding of the individual, his/her emotions and behavior difficulties, strengths, and overall functioning. This process may include formal measures like questionnaires, or it may just be through information gathered in therapy through talking or observations. The assessment process may be one session, or it may occur over the course of multiple appointments. During the assessment, the mental health clinician gathers historical information about mental and medical health as well as information related to family medical and mental health. Clinicians will also ask about trauma exposure, social and interpersonal skills; occupational or school functioning; emotions and behavior, including judgment, mood, and thinking; self-care and personal hygiene; and communication. It is important for interpreters to understand the reasoning behind the types of questions mental health clinicians might ask clients in the course of a session for the clinician to gather an accurate understanding of the child and family.

Types of Assessment Procedures

The Mental Status Examination (MSE) of Standard Psychiatric Assessment[77]

The formal MSE gathers information about symptoms, signs and experiences related to mental illness and distress in a systematic manner that involves open-ended questions and a semi-structured interview. The MSE is based on observation of the client (e.g., how the person is acts, talks, and acts) in the here and now. Some of the MSE assessment questions are culturally-, nationally- and educationally-relative and may be difficult to interpret. For example, during the MSE, as a measure of abstract reasoning, the client will be asked to explain proverbs. Proverbs are short simple sayings that have broader meanings like "Don't count your chickens before they hatch". Another challenge to interpretation is the use of certain terms or phrases for describing symptoms (e.g., butterflies in the stomach). It is important if an interpreter is to assist with the MSE, that he or she understands the goal of the interview and of other specific questions and tasks required of the client and the ways that culture and language may impact the assessment.

The MSE covers many areas including but not limited to Appearance (observed), Behavior (observed), Attitude (observed), Level of Consciousness (observed), Orientation (inquired), Speech and Language (observed), Mood (inquired), Affect (observed), Thought Process/Form (observed/inquired). Assessment of mental status is then referenced to the norms, which is often of the dominant cultural groups. *(As mentioned in Chapter 3, mainstream U.S. culture is primarily defined as White, English-speaking, middle-class,*

Christian, cisgender and heterosexual).

A number of socio-cultural and linguistic factors can impair a client's performance on the MSE such as lower educational attainment, lack of historical knowledge, and lack of cultural applicability of the items. The MSE relies on language and observation, which are influenced by a person's sociocultural background, development experiences as well as current sociocultural context and, in turn, influence his or her thoughts, feelings and behaviors. It is invaluable then for the clinician and interpreter to not only have a shared understanding of the goals of the MSE but also that the interpreter have the ability and be afforded the time to describe his/her observations of the person's expressions (not the person's words, but the way the person communicated). An interpreter can help the clinician determine whether the client's responses and observations are culturally normative or unusual. Understanding of these correctly by the interpreter and clinician is critical to develop adequate assessment, obtain an accurate diagnosis and proceed with treatment.

Assessing Sensitive Topics. Additionally, it is important to understand that clinicians will also need to assess sensitive areas, including parenting, sexuality, drug use, and suicidality/homicidality. Interpreters should be prepared to ask these types of direct questions - not softening or changing the wording (e.g., Have you ever thought about ways to kill yourself? Have you ever actually attempted to kill yourself?). Interpreters need to know that by asking about this, they are not planting a seed or increasing the risk that the patient will actually carry out a suicide attempt. This is a normal part of this process and may actually protect an individual's life when asked.

Note to Clinicians and Interpreters: If an aspect of the interaction with the clinician or interpreter resembles a past traumatic experience, the client may become dysregulated, the trust with the interpreter and/or clinician may be broken, and premature drop-out from treatment may result.

Strategies to avoid re-traumatizing the client: Clinician and interpreters should strive to maintain a calm, sincere tone of voice and to avoid being perceived as humiliating/interrogating the client (a common traumatic experience of some refugees/immigrants). Clinicians should avoid the use of sarcasm as this is often perceived as mean-spirited or misunderstood. Clients should be given choices during the session whenever possible (e.g., where to sit, how to position the door, having a support person present).

When the assessment is complete, the family and the mental health clinician should meet to talk about the results. This could be a time of great support for the family when they learn about what is going on and develop a plan for addressing the concerns. Alternatively, it may be a time of distress if a family becomes overwhelmed by the feedback and/or diagnosis. Ultimately, this time is to develop a shared understanding from both the perspective of the

family and professional about the concerns and then use this understanding to develop treatment goals (goals for what is focused on in therapy) and services goals (other goals focused on supports outside of therapy like tutoring, mentors, etc.).

Questionnaires and Semi-structured Interviews

If a mental health clinician uses questionnaires or semi-structured interviews, it is important to go over the questions with interpreter ahead of time. The mental health clinician should ask the interpreter if she/he has any questions. When possible, use semi-structured interviews that are already translated into the client's language. Review with the interpreter and client the questions that you will be about to ask may be triggering during or after the session. Make a safety plan or a list of coping skills that client can utilize after session or that it can be utilized during session if needed. Remind client at the end of the session about the plan and encourage client to utilize it even if she/he does not think that she/he needs it.

Note to Clinicians: Developmental assessment is more difficult when clinicians cannot directly interact with the client; the clinician may need to rely on the interpreter's assessment of language skills to determine if there is delay.[110] Try to guide the interpreter ahead of time so she/he can look for certain developmental parameters. More specifically ask questions to the child (if the child is old enough) that are developmentally appropriate and evaluate his/her responses with the interpreter's feedback. For example, is the child in elementary school? Does he/she speak clearly, in full sentences? Does he/she understand your questions? For children who are pre-verbal, the clinician will have to rely on clinical observation and on the caregivers'/parents'/family's report through questionnaires, open questions, or semi-structured interviews.

Managing the Flow of a Session

It is recommended that the clinician outline the session after the greeting, at the midpoint of the session and towards the end of the session. The clinician will ensure that enough time is left to help the client re-group before the end of the session. The clinician will often practice some healthy coping exercises with the client during session so that the client can utilize them after the session and until client comes to see the mental health clinician again. Though the mental health clinician and client ultimately manage the exchange of information within any mental health interview, the interpreter plays a necessary part by facilitating the flow of the entire conversation.

Proper Positioning for the Session

Three relationships exist in each interpreting session: the one between the clinician and the interpreter, the one between the clinician and the client, and the one between the client and

the interpreter, creating the therapeutic triad. The therapeutic triad must have an open channel to communicate accurately and effectively. It is recommended that the clinician, client and interpreter sit in a triangle shape facing one another (see *information on therapeutic triad above*).

Issues that May Arise in the Interpretation Interaction

The next section presents issues that may arise in the context of interpretation. For each "issue", a definition is provided and examples are used to be illustrative. In addition, when possible, the impact of these issues on the clinician-interpreter interaction is described and recommendations for "moving forward" or repairing this impact are offered.

The following issues may occur when the interpreter does not appropriately translate everything that the clinician has stated:

OMISSION: A message is partially or completely deleted.

ADDITION: Information is included that the speaker did not say.

CONSIDERATION: The client's message is simplified or summarized instead of a direct interpretation being provided.

SUBSTITUTION: When one concept is replaced with another concept. Example:
- Clinician: Do you hear voices?
- Interpreter: Do you hear noises? ("Voice" and "noise" are the same word in Chinese.)
- Client: Yes. I hear some noises all the time. I live on a busy street.

EXAGGERATION: When the speaker's message is overstated or embellished. Example:
- Client: I am glad I have decided to come to America.
- Interpreter: I am excited that my family and I are in America. We are now receiving welfare and living in an apartment with television.

INACCURACY AND POOR PARAPHRASING: The words of the speaker are not accurately restated Example:
- Client: I have been feeling very nervous and anxious lately. Sometimes I get headaches, too.
- Interpreter: I have anxiety and I get headaches.

DISTORTION OF MEANING: The meaning of a message is misrepresented. Example:
- Clinician: Are you allergic to any medication?
- Interpreter: Do Western drugs make you vomit?
- Client: No.

LACK OF FAMILIARITY WITH MENTAL HEALTH TERMINOLOGY: The interpreter's lack of understanding of mental health concepts interferes with the clinician's process of assessment. Example:

- Clinician: What kind of mood have you been in recently?
- Interpreter: How have you been feeling?
- Client: I have a headache all the time.

Impact on the clinician-interpreter interaction: When the interpreter does not translate exactly what the clinician has said, the client may receive incorrect diagnosis or treatment.

Moving Forward: There needs to be clarification and transparency on why the phrasing of everything that is said should be exactly translated. Mental health clinicians can also check with the interpreter if the pauses taken to conduct the translations are adequate. It is also important for interpreters to avoid words that indicate diagnosis, unless the client or clinician uses these words specifically.

The following issues may arise when the interpreter is navigating cultural issues:

INABILITY TO INTERPRET THE CULTURAL MEANING OF SYMPTOMS AND BEHAVIOR: The interpreter does not bridge cultural gaps between the mental health clinician and the client. Example:

- Client: I took the whole bottle of sixty po chia pills last night.
- Interpreter: I took the whole bottle of po chia pills last night.
- (Interpreter does not encourage client to explain that this Chinese pill requires the user to take the whole bottle.)
- Clinician: Were you trying to kill yourself?

Impact on the clinician-interpreter interaction: This situation may have implications for diagnosis and treatment.

Moving Forward: It is important that the interpreter explain the situation in a transparent manner, stop the interaction, and provide a moment of cultural education/interpretation.

Note for Cultural Brokering

When an interpreter becomes aware that a cultural misunderstanding may be occurring for either the client or the clinician, he or she must act in a transparent manner. For example, the interpreter should let the client/clinician know that he or she is going to offer key information (and a brief description of that information) to clinician/client to avoid a misunderstanding. Importantly, when providing key cultural information, the interpreter should make no assumptions and avoid stereotypes, (neither creating nor reinforcing them). The overall goal is to divert a cultural misunderstanding and to get back to interpreting as fast as possible.

Case #2: Jonathan, age six, also attended the after-school program. One afternoon, during the time when parents came to pick up their children, J started to cry and begged not to go with the person that was picking him up. Though it was an approved family member, the staff were not sure of the complexity of the family system.

J presented as developmentally younger than his biological age, and he had struggled with not only speaking English, but with verbal expression in general. Since J was not yet a client, it was difficult to ascertain the best approach. The clinician, along with the clinical interpreter, called the parent to explain the situation, and his mother arranged to come to the center to pick up her son and discuss the situation. J's mother explained her concerns about her son, and asked for help, as she thought that it would be a good idea for him to have support. J's mother was very focused on getting help for her son, and shared the fact that his father was in Mexico and would probably not be part of his daily life unless they could figure out a way to return to Mexico or bring him legally to the US.

J's mother P wanted help for her family but was also very guarded about what was going on in her life, including the trauma she and her son, as well as her daughter and granddaughters, had endured coming to the US. J was the identified client, but soon the mother began to share her trauma, and sometimes the story would shift and change. After a few months, her adult daughter began to share her version of the trauma that she and her young daughters had experienced, and within a few months, the clinical interpreter and the clinician were trying to untangle a web of complex trauma and a complex family system. For example, P, the mother of J, had worked hard to provide a home for her and her son and also for her adult daughter who had her own 3 daughters. J, age six, attended school with his aunt who was the same age (P and her adult daughter had children the same age).

This case was difficult for the clinician and the clinical interpreter to navigate through treatment due to several issues. Confidentially and trust were of utmost importance, due to the intricate connections of the people being treated. This case illustrates how important it is for a client to have the same interpreter for each session, because it would have been extremely difficult for a new interpreter to step into this family system and interpret words only, without an understanding of the family dynamics. The consistent team approach provided all parties involved with a safe foundation to start each session. Even with that foundation in place, unexpected and sometimes conflicting details started to unfold about the family trauma narrative. Those issues could only have been approached, challenged and addressed with compassion by the strong existing dyad

partnership.

As time went on and the family progressed and became more functional, it also became more challenging for the family to understand and maintain the professional boundaries that were set by the clinician and the clinical interpreter. Because they had shared their stories of trauma and the secrets that unfolded during treatment, they resisted and almost refused to honor boundaries. They started to treat the clinician and the clinical interpreter as part of their family. As their requests and demands continued, it was the strength of the connection between clinician and clinical interpreter that kept them firmly grounded in their commitment to never waver from their professional roles. This level of support was invaluable to both the clinician and clinical interpreter, and eventually to the family system as a whole.

INABILITY TO TRANSLATE SAYINGS: Non-literal sayings or concepts commonly used in one language are not able to be translated into another. Example:

- Clinician: What does the phrase "A rolling stone gathers no moss" mean to you?
- Interpreter: What does it mean to you when you hear that a stone is rolling and no grass is growing on it?
- Client: (Client is unsure of how to answer clinician's question due to confusion about how stones and grass relate to his/her mental health.)

Impact on the clinician-interpreter interaction: The client may feel confused and may not feel that the clinician is understanding her/him. This can have significant implications for rapport building.

Moving Forward: Interpreter can ask clinician to rephrase without using a saying/idiom, or provide an explanation that can be translated. Clinician needs to be more aware of possible language barriers when using certain expressions that are culturally bound. From time to time, it is recommended to check with client and interpreter to ensure that the all parties are on the same page, in agreement of understanding.

The following issues may arise when the interpreter takes on a role outside of his/her interpretation role:

ROLE EXCHANGE: The interpreter steps out of the interpreter's role and takes over the interaction by interviewing the client or making comments about what the clinician is saying.

Impact on the clinician-interpreter interaction: The client may become confused about the "interpreter's role" and "clinician's role." This is hard to determine if clinician does not

understand the language being interpreted. However, the clinician may be able to sense that something else is going on by interpreting some non-verbal cues.

Moving Forward: Ask for clarification on the interpretation of statements. If there are some non-verbal cues that clinician is picking up, name the non-verbal cues and ask for meaning without becoming defensive, but opening up opportunities to help the triad interaction keep the boundaries between "interpreter" and "clinician."

INTERPRETING NONVERBAL BEHAVIOR: Client's nonverbal behavior is explained instead of letting silences stand. Example:
- Clinician: Do you engage in regular sexual activity?
- Client: (Says nothing and looks at the floor.)
- Interpreter: She is embarrassed, but she will answer your question in just a moment.

Impact on the clinician-interpreter interaction: Client may feel "unsafe" or "unable to speak up"

Note for Interpreters: Observation and interpretation of nonverbal behavior to help the mental health clinician distinguish what is culturally normative vs. non-normative is beneficial and highly recommended.

Moving Forward: The clinician can reassure the client that she/he can take her/his time to answer the question or that she/he can decide not to answer it.

INTERPRETER DISCOURAGES DISCLOSURE OF EMOTIONAL MATERIAL FROM CLIENT TO CLINICIAN: Sometimes, interpreters may unintentionally stop clients from expressing certain emotions such as sadness or anger.

Impact on the clinician-interpreter interaction: Client may feel that there are certain things that she/he is not allowed to share during this type of interaction.

Moving Forward: It is important for the clinician to talk to the interpreter ahead of time about this possible situation so it can be prevented. If the clinician senses that the interpreter is trying to console or calm the client, the clinician is encouraged to ask interpreter to let client know that they would like to pause and check in with client about how they are feeling at the moment. The clinician is also encouraged to tell the client that is alright to express his/her emotions in the room. After this session, it is recommended that the clinician debrief with the interpreter to address this experience and to learn from the interaction.

The following issues may arise in situations where the child/adolescent and parent(s) are both present in the session:

QUESTIONS DIRECTED TO PARENT INSTEAD OF THE CHILD/ADOLESCENT: Interpreters may struggle with knowing when to ask questions to parents and when to ask questions directly to the child/adolescent.

Impact on the clinician-interpreter interaction: Sometimes parents may feel that their authority is taken away if they are not being asked the questions directly and first. This may have some repercussions establishing rapport and building a trusting relationship between parent and clinician.

Moving Forward: It is recommended that clinicians ask the parent first if it is acceptable to ask some questions directly to his/her children/adolescent.

SENSITIVE QUESTIONS ARE ASKED OF AN ADOLESCENT IN FRONT OF PARENT (E.G., ABOUT SEXUAL ACTIVITY OR DRUG USE):

Impact on the clinician-interpreter interaction: This type of interaction can affect trust building between adolescent and clinician.

Moving Forward: Explain in advance to parents that it is your preference to meet with adolescent only for some part of the interview. Explain that it is sometimes easier for adolescents to divulge sensitive information without parents in the room and that you will keep their information private, only divulging information to parents if the youth divulges safety issues (e.g., abuse, suicidality, homicidality). Ask for parent's consent to do this if necessary.

FAMILY MEMBERS INSIST ON INTERPRETING FOR THE CLIENT, OR THE CLIENT EXPRESSES THAT THEY PREFER THAT A FAMILY MEMBER INTERPRET:

Impact on the clinician-interpreter interaction: Using family members as interpreters can be problematic for many reasons, including lack of understanding of complex terminology and ethical and legal guidelines for interpreting, and difficulty staying impartial. (*For more information see Ad Hoc Interpreting in Chapter 2*).

Moving Forward: In these cases, it is a good idea to allow the clinician to navigate this situation. The clinician may explain to the client the benefits of using interpreters with comprehensive and up-to-date training.

ALLOWING ONE'S FEELINGS TO BECOME VISIBLE:

Impact on the clinician-interpreter interaction: If a client perceives that the interpreter is becoming distressed by what the client is sharing, he or she may stop talking to protect the interpreter, thus shutting down the evaluation and treatment process.

Moving Forward: Engage in adequate self-care, seek supervision, and debrief with clinicians after sessions to prevent burnout and to process difficult stories/emotions. During session,

interpreters can engage in diaphragmatic breathing and calming self-talk to remain present for the duration of the session.

Intervening

There are times when an interpreter will need to interrupt a session in order to ensure understanding on the part of the client, the mental health clinician, or both. Interpreters should only intervene if doing so will promote clear communication. Interpreters will need to use their best judgment about when to intervene, and they should consider doing so in the following cases:

- When the speaker uses language the interpreter does not understand.
- When the interpreter misses part of the speaker's message.
- When the client's nonverbal cues indicate a lack of understanding.
- When a speaker uses a word or phrase that must be put into cultural context to be understood.
- When the mental health clinician says something that could be offensive to the client's culture.
- When cultural differences lead to misunderstanding.
- When a speaker does not pause to let an interpreter interpret.

When intervening, keep the following guidelines in mind:

- Ensure that the intervention is "transparent." Transparent communication means that one speaker understands what the interpreter is discussing with the other speaker. For instance, if one speaker uses a term that has a specific cultural context, interpreters should let the speaker know that they will be explaining the term to the other speaker, so that the first speaker will not wonder why the interpreter is speaking for so long.
- Switch from first person to third person. Since interpreters normally interpret for others using first person pronouns, they should change to the third person when asking their own questions or clarifying in order to avoid confusion. Questions or clarifications can be preceded with phrases such as "The interpreter has a question." or "The interpreter does not understand."
- Do not make assumptions. The interpreter should never assume to know what a client is feeling or thinking. While it is important to be attentive to signs that the client may be confused or uncomfortable, ask clients if they understand instead of making assumptions.
- Return to interpreting as soon as possible and allow the mental health clinician to resolve the problem. There are instances when an interpreter's intervention is very quick, such as a word clarification. Sometimes, however, the intervention highlights a problem that exists. When asked if a message has been understood, a client might simply say "no." In this

situation, the interpreter should interpret this response and allow the mental health clinician to decide how to proceed. There may be times, however, when the mental health clinician is unsure of how to improve communication that is breaking down. In this situation, the interpreter can offer suggestions. However, it is important that the interpreter's ideas are offered in the form of recommendations or suggestions. This keeps the mental health clinician in the decision-making role and the interpreter in the secondary role.

In Practice: Closing a Session

"Sara and I often used the TF-CBT relaxation technique from the manual, at the close of almost every session. We found that it developed into a ritual to close and calm each session for all parties in the room. We noticed with curiosity that clients with no prior experience of using meditation or mindfulness were surprisingly trusting and receptive to this exercise with good and measurable results that often provided a tangible relief from the impact of traumatic stress. I read the guided relaxation script in English a sentence or two at a time; and Sara would translate the words in Spanish. It was a beautiful process that provided another kind of connection in the room.

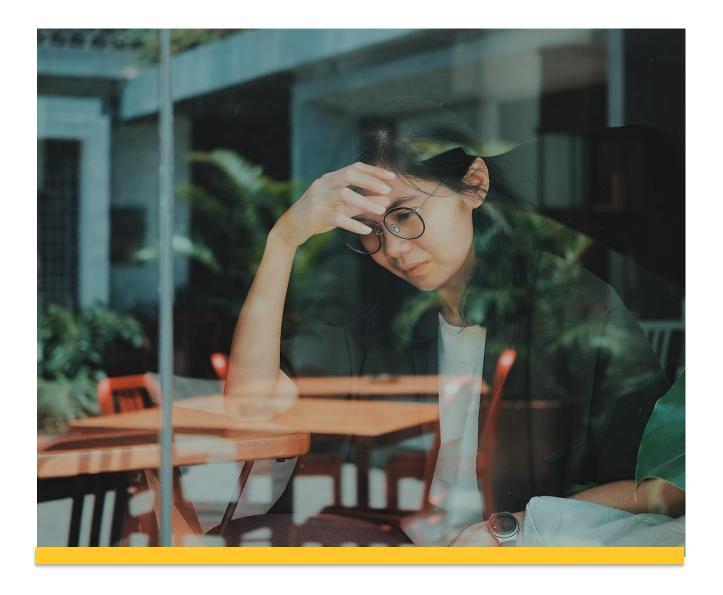*-Laura Gassen Templet, MSW, LSW, personal communication*

Chapter 5 | Post-Test

1. When clinicians ask questions about sensitive areas during the assessment, (including parenting, sexuality, drug use, and suicidality/homicidality) what should interpreters do?

    a. Ask these types of direct questions, not softening or changing the wording.

    b. Re-word the questions so that they will be less harsh to the client.

    c. Ask a family member to assist you in interpreting, so that you are sure that the question is acceptable within the family and culture.

    d. Refuse to interpret these kinds of questions, as they are inappropriate.

2. When should the clinician outline the session?

    a. After the greeting

    b. At the midpoint of the session

    c. Towards the end of the session

    d. All of the above

3. **True or False:** An interpreter should translate an idiom or non-literal saying word-for-word, even if it has no meaning in the translated language.

4. In which of the following situations should the interpreter **NOT** intervene in the interaction?

    a. The speaker uses language the interpreter does not understand.

    b. The mental health clinician says something that could be offensive to the client's culture.

    c. The client becomes emotional when sharing his/her experiences.

    d. A speaker does not pause to let an interpreter interpret.

(Answer key is available in Appendix F)

Chapter 6 | Secondary Traumatic Stress

By the end of this chapter, readers will be able to:

1. Define secondary traumatic stress and its impact.
2. Identify preventive intervention practices on the individual and organizational levels.
3. Develop understanding of strategies to build resilience.

Chapter 6 | Pre-Test

1. **True or False:** Interpreters may experience stressors such as: communication challenges, feeling overwhelmed or fatigued, aggressive clients, lack of closure, and boundary issues.

2. An interpreter might be experiencing _____if they find that a client's stories of traumatic experiences impact them outside of session in the form of intrusive thoughts, heightened anxiety, hyperarousal and vigilance, sadness, or nightmares.

3. Which of the following is **NOT** a way that interpreters can help manage stressors?
   a. Set boundaries within the interpreting setting, such as limiting personal relationships with clients and not offering additional services.
   b. Use pre-sessions with the clinician to establish expectations/guidelines for the session.
   c. Avoid discussion of the client after the session is over, and try to avoid interpreting for the same client multiple times.
   d. Engage with professional associations or interpreter support groups.

4. Which of the following are ways that organizations can support providers?
   a. Provide training on mental health and trauma for interpreters
   b. Limit contact with clients to a one-time session to prevent further distress for providers.
   c. Provide training for clinicians on working with interpreters in a collaborative partnership.
   d. A and C
   e. All of the above

Secondary Traumatic Stress

Clinicians and interpreters who work with youth and families in the delivery of mental health intervention will be exposed to and bear witness to the traumatic events experienced by their clients throughout the course of treatment. Exposure to this type of material or experience can be distressing for any individual and it may lead to secondary traumatic stress (STS). Any professional who works directly with traumatized youth and families is at risk of STS.

Secondary traumatic stress (STS) is the emotional hardship that occurs when an individual hears about the traumatic experiences of another. It is a set of observable reactions that mirror PTSD symptoms. These include re-experiencing, avoidance, hyperarousal symptoms, and negative changes in mood. STS is different from normal stress because of the nature of the content of the information and how it impacts a person. Stress is typically understood as mental or emotional strain that can come from the environment or from something internal like an illness. When the cause of the stress is removed, the response to stress usually decreases. STS is different from this because when an individual is exposed listening or witnesses traumatic events, there can be a change in one's own psychological functioning or the way one thinks or feels. After working with the youth or family in a session and the "stressor" is removed the story still stays emotionally with the person. This may lead to the person not wanting to think or talk about the events, he/she may experience feelings of guilt, fear, or have other re-experiencing symptoms, and he/she may become more hypervigilant or aroused in response to listening to the stories. This is secondary traumatic stress. Another word that may be used, and can be used interchangeably, to describe this type of response is compassion fatigue. STS can have a short- or long-lasting impact on a person and some individuals or professionals may need support to help address these reactions.

Research consistently shows that professionals who engage in work with individuals and families who have experienced trauma are at risk of experiencing STS. Studies also show that there are risk factors that may make a professional more vulnerable to STS. Some of these include: being a woman, being an individual that is highly empathic in nature, having a personal unresolved trauma history, working with a high caseload, feeling socially or professionally isolated, and/or having inadequate training.

There are also specific risk factors or experiences/exposure to trauma that mental health clinicians and interpreters face in the clinical context. The clinician-interpreter dyad may bear witness to trauma through the reporting of specific exposures to traumatic events by the client at intake or in the context of the therapeutic session, they may be required to read clinical notes that detail exposure, see pictures or medical documentation of the trauma, and/or be exposed to graphic material when debriefing with a colleague.[85]

Additionally, there may be situations or risk factors that are unique to interpreters who are part of mental health service delivery.

Note for Interpreters: Throughout this training, an emphasis is placed on cultural frameworks playing a role in how trauma and mental health is expressed, understood, and responded to in practice. This is no different for experiences of secondary traumatic stress. Although the information and descriptions of secondary traumatic stress and ways to both prevent and manage STS shared in this chapter are well document and researched in the United States, experiences of secondary traumatic stress may also be culturally bound how it is understood or expressed. As a provider of services, be aware of your own cultural experience of how stress manifests and how it may impact you or play out in your relationships and your professional work. It is also important to consider how your own individual culture and need as you identify ways to prevent or manage stress that may not be included here.

Interpreters:

- Often work in isolation

- Frequently communicate extremely distressing material

- Are involved in discussions that may have life-changing implications for a child or a family

- May lack the training that mental health and trauma specialists have to help prepare clinicians to process the information and see hope for the family/child

- May have one-time-only contact with the client child or family, and no sense of closure related to the experience with a particular client child or family

- May be required to utilize of a number of skills beyond the ability to speak two languages, which can be especially taxing when being exposed to content that can be potentially traumatizing

- Often is a lack of training for mental health clinicians in working with interpreters that prevents a collaborative and empowering partnership.[57,133]

The existence of one or multiple of these factors can result in increased vulnerability to develop STS in response to one's field of work.

Secondary Traumatic Stress refers to the presence of PTSD symptoms caused by at least one indirect exposure to traumatic materials. Several other terms capture elements of this definition but are not interchangeable with it.

Compassion fatigue is a less stigmatizing way to describe secondary traumatic stress and have been used interchangeably with the term.	**Vicarious trauma** refers to changes in the inner experience of the therapist resulting from empathic engagement with a traumatized client. It is a theoretical term that focuses less on trauma symptoms and more on the covert cognitive changes that occur following cumulative exposure to another person's traumatic material.
Compassion satisfaction refers to the positive feelings derived from competent performance as a trauma professional. It is characterized by positive relationships with colleagues and the conviction that one's work makes a meaningful contribution to clients and society.	**Burnout** is characterized by emotional exhaustion, depersonalization and a reduced feeling of personal accomplishment. While it is also work-related, burnout develops as a result of general occupational stress.

Preventing and Intervening with Stress

Essential Elements of Trauma-Informed Systems

The NCTSN STS webpages outline 6 essential elements to creating a trauma-informed system that adequately addresses STS. They include:

● Recognize the impact of secondary trauma on the workforce

● Recognize that exposure to trauma is a risk of the job of serving traumatized children and families

● Understand that trauma can shape the culture of organizations in the same way that trauma shapes the world view of individuals

● Understand that a traumatized organization is less likely to effectively identify its clients' past trauma or mitigate or prevent future trauma

● Develop the capacity to translate trauma-related knowledge into meaningful action, policy, and improvements in practices

● Be integrated into direct services, programs, policies, and procedures, staff development and training, and other activities directed at secondary traumatic stress

When attention is paid to each of these elements, the opportunity to not only prevent, but address and work toward resilience may be achieved. But what does this look like in practice?

Research shows that a multidimensional approach to prevention and intervention, which includes working with individuals, supervisors, and an organization as a whole, produces the most positive outcome for those impacted by STS and other types of work-related stress. This specifically includes a combination of providing education about STS and stress, skills training for identifying and addressing reactions, and supervision. As individuals become more informed about the indirect impact of trauma, they become increasingly knowledgeable about how to both reduce their risk and increase their resilience to STS.

Prevention Strategies

Preventive strategies in the workplace may include:

- Self-report assessments
- Participation in self-care groups in the workplace
- Caseload balancing
- Use of flextime scheduling
- Use of the self-care accountability buddy system.

Preventive Strategies on One's Own

- Proper rest
- Nutrition, exercise
- Stress reduction activities

Intervention Strategies

Interventions designed to decrease the symptoms of STS are steadily increasing and are typically targeted at the individual and organizational levels.[11] However, there are differences between these two approaches, which are most successful when practiced concurrently.

On an individual level, cognitive behavioral strategies and mindfulness based practices are emerging best practices for STS. Individual and group therapy, and interventions developed in response to crises such as crisis debriefing[11] are also helpful to directly target symptoms and teach skills.

On an organizational level, opportunities to adjust caseloads, conduct reflective supervision, host peer supervision or processing groups are known to be effective, and provide workshops and training about STS are effective practices. Additionally, organizations can consider making outside referrals to Employee Assistance Programs (EAPs) or if large scale disasters have occurred, the possibility of hiring external supervision services may be of support.

It is important for organizations that serve clients with no or limited English proficiency to employ interpreters and provide training for clinicians to learn how to effectively work with and develop a strong interpreter-clinician dyad, in an effort to provide the best services possible for their clients.

Strategies to Build Resilience

Building in protective factors to help reduce STS is an important part of all practice. This may include:

ORGNIZATIONAL	INDIVIDUAL
• Provide adequate clinical supervision, including reflective supervision • Maintain trauma caseload balance • Support workplace self-care groups • Enhance the physical safety of staff • Offer flextime scheduling • Incorporate STS training into EBP training for clinical staff • Create external partnerships with STS intervention providers • Train organizational leaders and non-clinical staff on STS • Train organizational leaders on organizational implementation and assessment • Provide ongoing assessment of staff risk and resiliency	• Use supervision to address STS • Increase self-awareness of STS • Maintain healthy work-life balance • Exercise and good nutrition • Practice self-care • Stay connected • Develop and implement plans to increase personal wellness and resilience • Continue individual training on risk reduction and self-care • Use Employee Assistance Programs or counseling services as needed • Participate in a self-care accountability buddy system

Another concept to consider when preventing and building resilience is called compassion satisfaction. Compassion satisfaction refers to the pleasure one derives from being able to his/her work; "the experience of energizing and uplifting emotions, perceived self-efficacy, and professional competence related to providing care to others.[68] Vicarious resilience on the other hand refers to "positive effects following upon witnessing another's recovery from trauma, such as increased hopefulness and capacity for emotional engagement.[68] Time spent reflecting upon and recognizing these experiences individually, in groups, and/or part of supervision can mediate the impact of STS.

For the Interpreter: Special Considerations and Tips

To help reduce the stress associated with interpretation in a mental health context, it is important to set boundaries within the interpretation setting. Pre-sessions, as discussed earlier in Chapter 5, are useful tools in establishing the interpreter's role and providing guidelines for what interpretations should be like. Interpreters should never give home phone numbers to a client or agree to give them additional services outside of the agreed upon business contract.

It is also important for an interpreter to work toward not internalizing and emotionally taking on the experience of a client, and be aware of his/her own emotional reactions. This is not easy, and the interpreter may need supervision support or education around to determine this. If an interpreter finds the interpretation session being affected by his/her personal emotions, the interpreter should discuss this in his/her supervision and consider the possibility of discontinuing with this specific client.

Something to be aware of as an interpreter is that a situation that may arise when the interpreter becomes emotionally overwhelmed and makes a decision to discontinue with the client. If this happens the interpreter does not have the opportunity to be able to witness the follow-up and how the client can heal. This may the appropriate choice for the interpreter, but it is also important to remember that healing is a process and the client may improve over time.

Chapter 6 | Post-Test

1. **True or False:** Interpreters may experience stressors such as: communication challenges, feeling overwhelmed or fatigued, aggressive clients, lack of closure, and boundary issues.

2. An interpreter might be experiencing _____if they find that a client's stories of traumatic experiences impact them outside of session in the form of intrusive thoughts, heightened anxiety, hyperarousal and vigilance, sadness, or nightmares.

3. Which of the following is **NOT** a way that interpreters can help manage stressors?

    a. Set boundaries within the interpreting setting, such as limiting personal relationships with clients and not offering additional services.
    b. Use pre-sessions with the clinician to establish expectations/guidelines for the session.
    c. Avoid discussion of the client after the session is over, and try to avoid interpreting for the same client multiple times.
    d. Engage with professional associations or interpreter support groups.

4. Which of the following are ways that organizations can support providers?

    a. Provide training on mental health and trauma for interpreters
    b. Limit contact with clients to a one-time session to prevent further distress for providers.
    c. Provide training for clinicians on working with interpreters in a collaborative partnership.
    d. A and C
    e. All of the above

(Answer key is available in Appendix F)

Chapter 7 | Supervision

By the end of this chapter, readers will be able to:

1. Describe reflective supervision in the clinician-interpreter dyad.
2. Understand how reflective supervision aligns with being trauma-informed.
3. Identify linguistic considerations in the provision of reflective supervision for interpreters.

Chapter 7 | Pre-Test

1. _____ is a supervision methodology that supports different models of relationship-based service practice, and builds environments that allow and encourage self-reflection and professional use of self.

2. Which of the following is **NOT** a function of reflective supervision?

    a. Reinforcing the power structure between clinician and interpreter
    b. Assuring a safe place for the expression of feelings and thoughts
    c. Offering opportunities to discuss goals and evaluate progress
    d. Exploring content and process in the clinical work

3. The relationship between the supervisor and supervisee models the desired relationship between the provider and the client family/child or provider and co-worker, in a process often referred to as "_____ affects_____."

4. **True or False:** Reflective Supervision is a compatible model with Trauma-Informed Care.

The Impact of Reflective Supervision in the Clinician-Interpreter Dyad

There is vast evidence that, in clinical work with clients exposed to traumatic events and their families, it is the relationship that promotes therapeutic change. The restoration and enhancement of the child-caregiver relationship is the focus of the therapeutic intervention, as it is believed that it will have self-sustainability after the intervention is finished. This focus includes the alliance between the provider(s), the child, and his/her/their caregivers, supported by the premise that" relationship affects relationship."[79]

From the practitioner's perspective, the nature and complexity of working with traumatized children and families, and therefore being the holder of their psychological realities, unavoidably awakens intricate feelings and reactions. These experiences can compromise the quality of service unless there is a way to for the provider to explore, make meaning and filter the difficult emotions elicited from the work.[118]

In order to address provider burnout and vicarious traumatization, as well as prevent secondary traumatic stress (and programs from early staff turnover) and promote vicarious resilience[55]/compassion satisfaction, it is crucial to implement effective approaches to supporting providers- frontline workers and clinical staff, including cultural brokers and interpreters. Interpreters have an invaluable role at helping close the gap in the provision of services to culturally, ethnically and diverse vulnerable children and their families, yet historically have been left unprotected from occupational stress.[57,132,133] Unfortunately, as it has been mentioned previously in this manual, often interpreters are not viewed as part of clinical teams by organizations or clinicians, and therefore the training, professional development and psychological needs of these practitioners is frequently overlooked, not only in the field of mental health but also in the interpreting profession. This constitutes a social justice issue that can no longer be ignored by organizations and practitioners committed to trauma-informed care. According to Hetherington (2012) "the absence of literature into occupational stress for interpreters implies that such stress is unrecognized or considered unproblematic by the profession."

One of the proposed approaches as means for accountability and support for interpreters and for the clinician-interpreter dyad, is reflective supervision which has been recognized by the NCTSN as a key tool in combating work-related stress in the trauma field workforce.[93] Reflective supervision is a supervision methodology that supports different models of relationship-based service practice that builds environments that allow and encourage self-reflection and professional use of self.[32,51] Reflective supervision has been defined as, "the regular collaborative reflection between a service provider (clinical or other) and supervisor that builds on the supervisee's use of her thoughts and feelings, and values within a service encounter.[138] It is a "relationship for professional growth that improves program quality and practice by cherishing strengths and partnering around vulnerabilities to generate growth[118]" and "a respectful, understanding and thoughtful atmosphere where exchanges of information,

thoughts and feelings about the things that arise around one's work can occur.[32]" It can be used across disciplines, different models and systems of care, and individually or in group modalities.[52] It includes core components like protected time for regular meetings, confidentiality, a collaborative-relational approach and the cultivation of reflective capacity.[36]

Some of reflective supervision's functions include:

- Promoting learning

- Assuring a reliable, confidential and safe place for the expression of a full range of feelings and thoughts evoked by the clinical work

- Offering opportunities to discuss goals and evaluate progress towards goals

- Exploring content (what happened) and process (how it was experienced) in the work with children and families[32]

Reflective supervision and practice offer the opportunity for providers to attend to their internal reactions to the work, and attempt to understand their emotional and cognitive experience, as well as that of the client child/ family or of a colleague,[96] and to think rather than act upon thoughts and feelings. In this way, practitioners are better able to tolerate and make meaning of experiences of greater emotional difficulty and to remain emotionally available in the face of uncertainty and ambiguity.[122] Having a reflective supervisor to rely on when practitioners feel overwhelmed, tired or discouraged by the emotional or physical strains of the work or when faced with dilemmas can reduce stress and isolation while increasing a sense of support and accompaniment.[32] Moreover, reflective supervision offers a safe space for providers to: (1) explore the impact of their own values, beliefs and implicit biases; (2) analyze the role of contextual forces (racism, historical trauma, inequities) in their practice and relationships with families and colleagues whose socio-cultural, language, racial, ethnic background and values differ from or are similar to their own and (3) address barriers to diversity-informed practice.[32,51,97]

The essential aim of reflective supervision is to elevate the quality of services for children and their families. This model pays attention to the relationship between the practitioner and the client, the practitioner and his/her colleagues (e.g. interpreter and clinician), the practitioner and his/her supervisor and so on. It assumes that learning takes place within this cascade of relationships[96] through a parallel process where change along either of these pathways gives place to a similar change in the others.[12] It is in this space is where professional development and personal transformation takes place[141] and the agent of change is "reflection" in contrast to "interpretation" or "reframing," which are the agents in traditional supervision. The distinction between authority and power in reflective supervision and traditional supervision is that in reflective supervision, the supervisor provides mentorship instead of instruction, collaborates with the supervisee and acknowledges that the interaction between the supervisee and the client family is unique; therefore, the supervisee's knowledge and expertise

is included in the process. As a result of this respectful and transparent exchange of resources and experiences, a sense of co-construction[118,53] can be generated in the supervisor-supervisee relationship. Reflective supervision challenges both the supervisor and supervisee to mutual growth

Due to the centrality of the parallel process, supervision becomes an intimate relationship requiring a great deal of trust. The supervisory task becomes one of creating a non-judgmental space in which the supervisee can explore doubts, mistakes, misperceptions in a way that leads to self-forgiveness and acceptance.[53] The supervisor self-regulates by reflecting on feelings before responding to the supervisee. The supervisor helps the provider to turn his/her attention to the feelings, thoughts, bodily sensations experienced in an encounter (with a family/child or colleague) and to voice his/her reflections on the family or colleague/co-worker and his/her response to them, and to go deeper into the meanings in his/her relationship with the family and the family member's relationships with one another.

In this model the supervisor focuses on supporting the supervisee's use of the self, developing awareness of the perspective of others, and expanding the supervisee's critical thinking abilities as well as knowledge and skills to work with families and children.[53]

Reflective Supervision, Trauma-Informed Care and a Model for Support and Accountability for Interpreters

In reflective supervision, the relationship between the supervisor and supervisee models the desired relationship between the practitioner and the client family/child or practitioner and co-worker[138] in a helping relationship. As explained above, reflective supervision is based on principles of consistency, transparency, collaboration trust, co-regulation, making meaning of experiences and behaviors, increasing reflective capacity, benevolence, strength-based practice all of which parallel the principles of trauma-informed systems.

Trauma-Informed Systems have the goal to provide services from practitioners that are trustworthy, in an environment that is safe, both physically and psychologically. They "prioritize consumer empowerment, choice, and control, maximizing collaboration with the consumer.[47]" Reflective supervision is a consistent model within this approach, and there is evidence that implementing reflective supervision is associated with greater resiliency among providers and lower rates of staff turnover.[135] It can be used across disciplines and setting, and there is some literature that describes implementation and advantages of use with interpreters.[58,132,133]

Given the core components explained above, Reflective Supervision is a desirable model to train and support interpreters and interpreters-clinician dyads serving the mental health needs of children affected by trauma and their families. The safety offered by reflective supervision, and the trickledown effect where "relationship affects relationship" can promote the development of collaborative and supportive models of work between interpreters and

clinicians, while increasing accountability and protection for all parties involved, and improving consequently the quality of services offered to families. The provision of a trusting and reflective learning environment, in which clinicians and interpreters, feel safe, respected and open to sharing both their strengths and vulnerabilities can enable organizations and, in particular, supervisors, to provide an empathic, supportive, and reflective environment for the providers to share their experiences of doing this work. This in turn allows caregivers to feel this same type of safety, trust and collaborative stance with the provider.

Although the capacity for self-reflection has been vastly recognized as vital to professional competence in the childhood trauma and family mental health arena, fiscal and time limitations make it increasingly challenging for programs and systems to integrate reflective supervision into their practice. Reflective supervision and practice represent an investment in the professional development of staff and in the future of mental health programs serving trauma exposed children and families.[102]

Linguistic Considerations in the Provision of Reflective Supervision for Interpreters

It is essential to consider the primary and secondary language(s) of the interpreter when processing emotions, and the implications of the language in which the supervision is provided. In order to truly address the emotional needs of the interpreter workforce, what language should be used for supervision? The primary or preferred language identified by the interpreter? Or the language spoken by the supervisor?

Before attempting to answer to these questions, it is important to reflect on a few important points/reminders related to bilingualism or multilingualism in shaping and expressing our emotional experience:

- The language or languages that we acquire in childhood are deeply intertwined with the internalized representations of ourselves, and the others we learned languages from as children. These languages become integral aspects of self-experience, and of these language-specific relationships. Language, therefore, is closely linked with our identity, and is also part of our coping mechanisms.[63,105,106] In addition, certain experiences seem to be intimately connected to the first language learned and cannot be "recoded[113]" in another language, no matter how proficient and cognitively integrated in both languages are within a bilingual individual.

- The notion of "native tongue", "mother tongue", or primary language, and its centrality to the cognitive, affective, and sensorial dimensions of early experiences, underscores the importance of using linguistically appropriate strategies not only for the families and communities served, but also for those who serve them, such as bilingual providers and interpreters.[97]

- According to Perez-Foster (1998), it has been assumed that a person's verbal fluency or mastery in a second or third language allows him/her to translate the emotional experience lived in the primary language, and that languages, for the bilingual or multilingual person, work as interchangeable modules for the expression of the same idea. However, as mentioned above, certain aspects of a person's cultural identity, memories, and even the sense of self, may be linguistically represented, recalled and perceived in one language (i.e., Spanish) and others associated with another language (i.e., English).[106,116]

- These internal experiences can have implications regarding the interpreter's experience during the encounter with clients, and his/her own presentation (present, disengaged), depending on the languages used at different moments during a session/encounter with a client and his/her clinician.

It can be surmised that the use of dual languages increases the complexity of the supervisory relationship, particularly when the supervisee (interpreter) and the clients use a language that the supervisor cannot speak, or when the supervisee has identified his/her primary/ preferred language or affective language as other than English. This has implications for the supervisee (interpreter) and the supervisor.[97]

For the Supervisee

1. Translating the themes or content of a session in order to receive supervision can become burdensome for the interpreter, and add to feelings of emotional exhaustion and isolation.
2. The choice of language may impact emotional expression, recall, or interpretation of events, all of which can affect engagement in the supervisory process.
3. Receiving supervision in the language in which services are provided to clients can provide opportunities for professional development and training (increasing technical/clinical vocabulary, increasing confidence in the role as a partner in the clinician-interpreter dyad)[19,28,140, 97]

Given that it can be challenging to find supervisors that can speak the diversity of languages currently spoken by immigrant communities in the US, the following are suggested strategies to implement RS in this context.

Strategies to Build the Linguistic Gap in the Supervisory Relationship

The Supervisor

1. Use of a videotape as an instrument to facilitate supervision: focus on non-verbal cues and behavior (social use of space, body language, changes in voice and rhythm, client's non-verbal interaction, interpreter-clinician interaction)
2. Remain attuned and present to the supervisee's experience
3. Establish sensitive and brave relationships with supervisees so issues of diversity can be discussed transparently and respectfully
4. Directly address with supervisee diversity factors that may be crucial in terms of establishing trust in the supervisory process
5. Develop knowledge of bilingualism, biculturalism, and cross-cultural communication
6. Build intentional self-awareness regarding implicit biases and issues of privilege and oppression[5]

Benefits of Bilingual/Multilingual Supervision

1. Allows access to emotional resources, and furthers self-reflection in supervisee
2. Supervisor may reduce burdens for supervisee by:
    a. Ensuring that the process stays close to the experience of the supervisee and the client
    b. Increasing supervisee's awareness of the cultural meanings conveyed in languages, and how the use of language may reflect the family's beliefs, values, or psychological realities
    c. Use supervisee's language preference as a vehicle for self-regulation
    d. Providing the words and ideas to transmit to clients
    e. Providing validation of the work complexity
    f. Advocating for fair treatment and distribution of responsibilities for supervisee[5]

Chapter 7 | Post-Test

1. _____ is a supervision methodology that supports different models of relationship-based service practice, and builds environments that allow and encourage self-reflection and professional use of self.

2. Which of the following is **NOT** a function of reflective supervision?

    a. Reinforcing the power structure between clinician and interpreter
    b. Assuring a safe place for the expression of feelings and thoughts
    c. Offering opportunities to discuss goals and evaluate progress
    d. Exploring content and process in the clinical work

3. The relationship between the supervisor and supervisee models the desired relationship between the provider and the client family/child or provider and co-worker, in a process often referred to as "_____ affects_____."

4. **True or False:** Reflective Supervision is a compatible model with Trauma-Informed Care.

(Answer key is available in Appendix F)

Chapter 8 | Values and Ethics

At the end of this chapter, readers will be able to:

1. Understand one's own values, and the process of values clarification.
2. Recognize the ethical guidelines for confidentiality in a clinical setting.
3. Identify at least two key ethical guidelines for interpreters and clinicians.

Chapter 8 | Pre-Test

1. Through _____, one can determine the priority values they hold in personal decision-making and then behave in ways that are appropriate to personal values. This process also helps one understand the behavior of others by considering alternative ways of thinking and behaving.

2. Which of the following are true about patient confidentiality? Circle all that apply:

   a. Many clients may fear that receiving treatment will affect their immigration proceedings, asylum applications, college admissions, or future employment.
   b. Interpreters should share information that clients share with them before the start of the session, as clinicians should receive all relevant information about a client.
   c. Confidentiality must be broken in cases of child or elder abuse, or in situations in which the client is threatening to harm themselves or others.
   d. If a family member is asking about a session, they have the right to receive details about diagnosis and treatment.

3. Under the _____ Act, interpreters and all medical providers are bound by law to keep client information private.

4. **True or False:** Interpreters should accept gifts of money from clients, as it would be culturally inappropriate to refuse.

5. When an interpreter senses that a client does not understand the high register speech of the clinician, they should:

   a. Change the content of what the clinician is saying so that it can be understood
   b. Ask the mental health clinician to speak in simpler language.
   c. Speak in the same register as the clinician and translate word-for-word, even if the client does not understand.
   d. Refuse to interpret.

Values

Everyone has an internal set of standards for behavior that reflects their personal values system, as a product of living and growing within a family, culture, and society. As interpreters and clinicians progress professionally, they might recognize a need to adjust past values to incorporate new professional knowledge. Change might be accompanied with a feeling of being conflicted between values.

Conflict can also arise when values systems are different among the interpreter, clinician, and client. Each member of the therapeutic triad may be introduced to new information inconsistent with current values or exposed to information that highlights inconsistencies within central values, which may cause conflict. In these cases, it is important that the interpreter and clinician set their individual beliefs and values aside in order to facilitate the session at hand.

Being Trauma-Informed as a Value

Providing a socio-culturally, linguistically responsive, trauma-Informed approach to mental health interpretation with people with no or LEP and who have been exposed to multiple potentially traumatic events must be based on principles and be reflected that in the policies and procedures set forth.

PRINCIPLES OF BEING TRAUMA-INFORMED	VALUES IN ACTION
Safety	• Do no harm • Recognize that safety is relative • Create a physical and emotional safety environment • Prevent and intervene on secondary traumatic stress
Trustworthiness and transparency	• Recognize histories of mistrust and abuses by authorities • Be authentic and genuine • Be clear and consistent in what you can offer and acknowledge limitations • Maintain appropriate boundaries
Peer support	• Foster connection with others • Encourage genuine relationships with others • Encourage mutual support
Collaboration and mutuality	• Share power with the client • Partner with them and their family and community
Empowerment	• Recognize resiliency • Build self-advocacy skills

	• Understand people are capable and able to heal • Provide hope
Voice and choice	• Hear your clients' stories; allow time for their narrative • Offer clients choices (e.g., where to sit) • Offer clients control (e.g., determine treatment outcomes/what is meaningful to them) • Encourage clients to make their own decisions
Cultural, historical, and gender Issues	• Practice cultural humility • Learn about implicit bias • Cultivate cultural connections • Attend to a client's multiple identities • Recognize a legacy of trauma • Offer gender responsive services

Challenges to Values Systems

Below are several common areas in which many people hold strong values, and may cause conflict:

COMMON AREAS OF VALUES CONFLICTS		
Politics	Personal taste, opinion, individuality	Rules / authority
Religion	Friends	Parenting
Work	Financial security	Gender roles
Leisure time	Aging / death	Material possessions
Ethnicity	Romantic relationships, marriage	Gender identity
Education	Health	Children
Family	War, Peace	

Values Clarification

It is easy to lose a sense of impartiality when surprised with opposing views. In order to stay in control of one's emotions in the face of disparate views, it is important that interpreters and clinicians take time to clarify their values or examine their own beliefs about the world. Then,

think about the possible situations that they might encounter while working with clients. After this process of values clarification and reflection, they may find they are more prepared to handle conflicts that may arise.

Values clarification involves several steps:

- Determining what one's core values are.
- Ranking values. During this step, individuals figure out which values are more important when in conflict.
- Sharing values with others. At this step, one might notice that there are some values they hold that they are reluctant to share with others, which may indicate a need for further exploration of these values.

Through values clarification, one can determine the priority values hold in personal decision-making and then behave in ways that are appropriate to personal values. This process also helps one understand the behavior of others by considering alternative ways of thinking and behaving.

Physical Manifestations of Conflict

Generally, when people do something that does not fit in with their core beliefs, their body shows it. Physical signs of feeling uneasy include sweating, increased heart rate, and indigestion. When these and other physical signs of discomfort arise, one should consider whether the current situation is causing the discomfort. By identifying the source of discomfort, interpreters and clinicians are better able to keep feelings from influencing professional performance. Once the situation is over, one should examine what happened and come up with a plan for if it occurs again in the future.

Value Conflicts with Institutional Practices

Some uncomfortable situations might arise from problems within a system rather than a difference in values. When working in mental health settings (*see Appendix C for an Overview of Mental Health Systems and Institutions),* messages conveyed regarding challenging life circumstances, insurance issues, or financial issues can be difficult to deliver. One may also be uncomfortable with the performance techniques and standards set up by the institution. If assignments are accepted without giving thought to potential values conflicts, professionals may be faced with two unacceptable choices: assisting in a procedure with which they disagree or abandoning the client's care. Interpreters and clinicians are advised to do research about the institutions with which they agree to work. This will lead to a greater awareness of possible conflicts between personal value systems and institutional practices.

Confidentiality

Confidentiality is an ethical issue to be observed by all professionals working in mental health settings, including interpreters and mental health clinicians (*see Appendix for a list of select websites that contain the code of ethics for interpreters and mental health clinicians respectively*).

Interpreters and mental health clinicians must treat all information revealed within a session as completely confidential, divulging nothing without the approval of the client. When using interpreters, clients sometimes fear that their mental health issues could become common knowledge in their community. Societal stigma regarding mental illness, especially within certain immigrant and refugee communities, can be a serious concern for clients, which is why it is imperative for interpreters and clinicians to keep client information confidential. In some cases, lack of confidentiality may even put clients' safety at risk, such as situations of domestic violence.

For many refugees, immigrants and others with no or LEP, their country of origin may not have patient protection laws and the concept of privacy of medical records is new to them. For these reasons, many refugee/immigrant/other clients with no or LEP have fears that engaging in psychiatric treatment, receiving a diagnosis, being hospitalized, or taking psychotropic medicine will jeopardize their immigration proceedings or asylum applications. Others fear that diagnoses might be on a permanent record accessible to potential college admissions offices or future employers. Therefore, it will be crucial for interpreters and clinicians to clarify the Health Insurance Portability and Accountability Act (HIPAA) and to explain that interpreters and all medical providers are bound by law to keep client information private. Interpreters can also explain that a client's legal status will not prevent them from receiving care, nor will it be documented in the medical record.

In order to allay client fears about exposure, interpreters and clinicians should remind clients during pre-sessions that information discussed will not be revealed to anyone outside of sessions. Giving this reminder can also help interpreters and clinicians avoid awkward situations involving family members and others who attend sessions with clients. When in this situation, interpreters or clinicians should remind clients and their family members that they are only allowed to discuss client information with the client.

In cases where interpreters work with clients in multiple settings, it is essential that information translated in each session pertains solely to what is being discussed within that session. Information shared within a session should stay in that session, regardless of the relevance the information might have to other sessions. For example, an interpreter might work with a client during sessions with counselors, medical doctors, and psychiatrists. If a client reveals to her counselor that she is a victim of domestic violence, the interpreter should not make reference to this information in subsequent sessions with the medical or psychiatric professionals. The

client has the right to share or withhold personal information with professionals. The interpreter's job in this situation is to focus on the session at hand and communicate to the professionals only what the client chooses to share.

Another difficult situation can arise when clients reveal information to interpreters before sessions actually start. It is natural for clients to want to discuss medical or mental health information as soon as the interpreter arrives. However, due to the nature of mental health interpretation, interpreters should always remind clients that they can only share information with mental health clinicians if the client discusses it within a session. Therefore, if a client reveals information prior to a session, an interpreter cannot share the information with the mental health clinician unless the client repeats it within a session. If a client seems confused about this, it is appropriate for the interpreter to explain the process before and during sessions.

Because of the complicated situations that interpreters face in mental health interpretation, it is recommended that they work with a supervisor who is also a mental health clinician. These supervisors are bound by the same confidentiality guidelines as the interpreters; as a result, the interpreters can discuss specific cases and situations in order to get feedback and support.

IMPORTANT TO NOTE: EXCEPTIONS TO CONFIDENTIALITY GUIDELINES

There are two legally mandated exceptions to the confidentiality rule that would necessitate a provider informing parents and/or contacting child protective services:

1. Cases of child or elder abuse
2. Situations in which the client is threatening to harm himself or others.

If either of these circumstances arises, interpreters are legally required to inform the clinician, regardless of whether the client shares the information.

Obviously, there are myriad situations in which confidentiality rules can be confused or tested. Interpreters should learn the legal issues surrounding client confidentiality as well as the specific rules of their agencies or the institutions they work at. When in doubt, ask a professional for guidance.

Ethics

Codes of ethics guide professionals as they make decisions in challenging situations when providing a socio-cultural, linguistically responsive and trauma-informed approach to mental health interpretation with clients with no or LEP (*see Appendix D for a list of select websites that contain the code of ethics for interpreters and mental health clinicians respectively*).

Ethical Guidelines for the Interpreter and Clinician

ACCURATENESS OF CONVEYED MESSAGE	
INTERPRETER	**CLINICIAN**
• Interpreters should convey messages accurately, without letting their system of values decide what should be interpreted. • Interpreters should convey the spirit of the original message, so that it is easily understandable and culturally appropriate for the listener. • Over one-half of the concepts expressed in the English language have no equivalent in other languages: • An interpreter can ask the mental health clinician to more thoroughly explain the confusing word or concept, or they can "paint a word picture", which is a description of the term. When using word pictures for technical terms, it is best that interpreters first tell the clinician exactly what is going to be said to the client. • The style of language used in the source language should be observed, in that the appropriate register and tone should be communicated, including any obscene language. • Register is the level of formality or complexity of a language a person uses. If an interpreter senses that a client does not understand the high register speech of the clinician, there are several options:	• Clinicians should set their individual beliefs and values aside in order to facilitate the session at hand. • Clinicians should take into consideration any cultural information that the interpreter shares about the client. • Clinicians should be aware that interpretation may take more time than the original message, as over one-half of the concepts expressed in the English language have no equivalent in other languages. • Clinicians should be prepared to re-phrase language or use a lower register (lower formality or complexity of language), if the interpreter requests this for clarity. • Clinicians should not request that interpreters add, eliminate, or summarize information to save time. • When an interpreter is not interpreting accurately or is acting in a disrespectful or biased manner towards the client, it is appropriate for a clinician to take on an advocacy role. (Advocacy is discussed in more depth in Chapter 9).

• The interpreter can lower the register, without altering the message's meaning (though some interpreters may be concerned that this may seem condescending). • The interpreter can ask the mental health clinician to speak in simpler language. • The interpreter should not omit information, even if it is uncomfortable, shameful, intimate, or believed to be immoral or untrue. Repetitive statements, incomplete phrases, pauses, stall words like "um" or "uh," and meaningful gestures should all be interpreted. • When a clinician says things that may be perceived as insensitive, culturally offensive, or damaging to the well-being and dignity of the client, it is appropriate for an interpreter to take on an advocacy role. • (Advocacy is discussed in more depth in Chapter 9).	

STAYING WITHIN BOUNDARIES OF PROFESSIONAL COMPETENCE

INTERPRETER	CLINICIAN
• If clients ask interpreters for opinions on treatment options, interpreters can restate the information presented by the mental health clinician, but they should not influence the client's opinion by advising on which action to take. • To avoid unprofessional interactions outside of the work setting, interpreters should avoid giving clients their personal phone numbers. • An interpreter who happens to also be a mental health paraprofessional or professional may not serve in both capacities at the same time.	• A clinician with basic or intermediate foreign language skills should not attempt to "make do" or "get by" without the use of an interpreter. • A clinician who happens to also be an interpreter may not serve in both capacities at the same time. It should be pre-established in what language treatment will be provided. • Clinicians should not assume that clients with no or LEP understand the information exchanged based on nonverbal clues, such as nodding or smiling (when an interpreter is not present).

ACCEPTING ASSIGNMENTS	
INTERPRETER	**CLINICIAN**
• Reasons to turn down an assignment might involve: • Relationship to the client, including any conflict of interest that may affect their objectivity in the delivery of services. Interpreters should refrain from providing services for close personal friends or family members. • Professional level of understanding of the topic to be discussed during a session. If an interpreter is unfamiliar with material presented, they should decline the assignment. In an emergency, where an interpreter is asked to do an interpretation for which they are not qualified, they can consent to do the interpretation given that all parties involved understand that there are limitations. • Trauma: • Mental health interpretation for trauma cases may not be a comfortable assignment for all interpreters, as they may hear about atrocities committed toward clients, including sexual abuse and torture. • Interpreters should be aware of their own trauma experiences and how they might be triggered by hearing a client's story that is similar to their own. If the subject matter of the interpretation makes an interpreter uncomfortable, they should decline to participate.	• Clinicians should seek out a professionally trained and qualified interpreter to partner with when working with clients with no or LEP whenever possible. • Clinicians should decline use of family members, friends, or non-professional, non-qualified staff as interpreters whenever possible. • Clinicians should never use children for interpretation. • Clinicians with basic or intermediate foreign language skills should not attempt to "make do" or "get by" without the use of an interpreter.

COMPENSATION	
INTERPRETER	**CLINICIAN**
• Generally, an interpreter should only accept the fee his/her agency has agreed to pay as compensation. • However, in many cultures, refusing a gift can be considered offensive. Many interpreters draw a distinction between monetary gifts and homemade gifts, including food. Accepting money directly from a client is never appropriate. Most interpreters will accept small homemade gifts, flowers, or homemade traditional food, as long as the gifts do not have a large cash value, the interpreter expresses that the gift was unnecessary, and the interpreter informs the client that all gifts will be shared with the others who work for the primary interpreting agency.	• Clinicians only accept the fee they/their agency has agreed to charge for services (e.g., insurance copayment). • If a client is offering a gift, similar rules to the interpreter apply. • Clinicians should express that a gift is unnecessary. • Clinicians may accept small and inexpensive gifts (under $10). • Clinicians should never accept monetary gifts over $10, jewelry or other expensive items. • Clinicians should never accept offered services (e.g., moving the lawn, repairs, sewing etc.).

Chapter 8 | Post-Test

1. Through _____, one can determine the priority values they hold in personal decision-making and then behave in ways that are appropriate to personal values. This process also helps one understand the behavior of others by considering alternative ways of thinking and behaving.

2. Which of the following are true about patient confidentiality? Circle all that apply:

    a. Many clients may fear that receiving treatment will affect their immigration proceedings, asylum applications, college admissions, or future employment.

    b. Interpreters should share information that clients share with them before the start of the session, as clinicians should receive all relevant information about a client.

    c. Confidentiality must be broken in cases of child or elder abuse, or in situations in which the client is threatening to harm themselves or others.

    d. If a family member is asking about a session, they have the right to receive details about diagnosis and treatment.

3. Under the _____ Act, interpreters and all medical providers are bound by law to keep client information private.

4. **True or False:** Interpreters should accept gifts of money from clients, as it would be culturally inappropriate to refuse.

5. When an interpreter senses that a client does not understand the high register speech of the clinician, they should:

    a. Change the content of what the clinician is saying so that it can be understood

    b. Ask the mental health clinician to speak in simpler language.

    c. Speak in the same register as the clinician and translate word-for-word, even if the client does not understand.

    d. Refuse to interpret.

(Answer key is available in Appendix F)

Intentionally Left Blank

Chapter 9 | Advocacy

By the end of this chapter, readers will be able to:

1. Understand advocacy from the interpreter perspective.
2. Identify costs and benefits of an interpreter taking on an advocate role.
3. Distinguish when and how an interpreter should advocate.
4. Understand advocacy from the clinician perspective.
5. Recognize effective communication in advocacy.

Chapter 9 | Pre-Test

1. An interpreter is taking on an_____ role when they take action on the client's behalf because they are concerned with the client's quality of care.

2. Which of the following is a **cost** of the interpreter taking on an advocacy role?

    a. May help client understand the health care system more completely

    b. May make the client feel supported

    c. May compromise the neutrality of the interpreter

    d. May help the client in emergency situations

3. **True or False:** Clinicians should take on an advocacy role if they see an interpreter allowing his/her biases about the client to interfere with the session.

4. In which of the following situations should the clinician advocate for the interpreter? (Circle all that apply):

    a. The client asks the interpreter for additional services or asks them personal questions.

    b. You feel that the interpreter may be interpreting incorrectly

    c. You see that the interpreter is exhibiting signs of secondary traumatic stress.

    d. The session is taking a long time.

5. Which of the following is **NOT** an effective communication skill?

    a. Speak calmly.

    b. Articulate the problem to all of those involved in the situation.

    c. Eye contact and open body language.

    d. Speak in a confrontational manner.

Advocacy

As discussed earlier, there are times when interpreters might step out of their role as a communication facilitator to advocate on behalf of the client they are serving. When interpreters serve as advocates, they are taking action on the client's behalf that goes beyond transmitting the message from speaker to speaker. When acting as a conduit, clarifier, or cultural broker, the interpreter is focused on conveying the words and meaning of a speaker's message exactly as they were spoken and intended. An advocate, on the other hand, is not merely focused on facilitating communication but is also concerned with the client's quality of care. For example, the interpreter is acting as an advocate if he helps a client schedule an appointment or explains to a client his rights within the mental health facility. Asking questions and relaying important information to the staff members of the health care system who can help solve problems for the client is another form of advocacy. Advocacy is done to equalize an imbalance of power and help the client become more informed so that better choices about care can be made. An interpreter also moves into the roles of advocate when meaning is unclear or misunderstood with the goal being to help facilitate mutual understanding and consensus.

Because the interpreter steps out of the neutral job of facilitating communication, advocacy is the most controversial role one takes on. There are costs and benefits to acting as an advocate, and they must be carefully considered in every situation.

Costs and Benefits of Taking on Advocate Role

BENEFITS	COSTS
Client may be better informed about the health care system	May make clinician uncomfortable and undermine clinician trust in interpreter
Client may feel supported by interpreter	May compromise neutrality of interpreter
Client's comfort level may increase	May create client dependency
Client's trust in clinician may increase	May be perceived as patronizing by clients who feel that they already understand the system
Chance of receiving quality care may increase	May create potential legal issues
May help client in emergency situations	Beyond the boundaries of the traditional interpreter role

When and How to Advocate

The following guidelines can help interpreters know when advocating is appropriate.

- First, identify the problem. Ask the clinician and/or the client enough questions to determine exactly what the actual problem may be

- Make sure that the client understands your concerns regarding his/her care and ask the client if they want to pursue the question any further

- Continue only if the client agrees

- Keep agency and institutional policies in mind when deciding upon a course of action, and choose the most appropriate person to whom you can express your concern(s). Be sure to speak with someone who will be able to resolve the problem. If a person is unhelpful, courteously ask to speak to a supervisor

- Introduce yourself and the client to the person attempting to resolve the problem. Clearly explain the problem, and politely enlist the person's help in solving it. Do not blame the person for the problem

- Ask questions to determine what options are available for problem resolution rather than deciding independently how to handle the issue

- Present all options to the client and encourage the client to decide how to proceed

- Avoid giving advice to the client regarding the correct course of action. Instead, provide them with as much information as possible

- Avoid placing blame, embarrassing others, getting emotional, making threats, being sarcastic or contradictory, and interrupting

- Practice trauma-informed verbal communication such as using non-threatening words, such as "I am concerned about . . ." "What do you think about . . . " "What do you normally do when . . . " or "I was wondering if it might be possible . . ."

- Practice trauma-informed non-verbal communication such as using non-threatening body language. Avoid crossing your arms in front of you or standing with your hands on your hips

- Use a trauma-informed approach to the person whom you are asking for help with a smile. Focus your full attention on the person and make eye contact

- Be sure that the client always knows and agrees with what is being done. You must faithfully represent your client's wishes and circumstances

Advocacy Example

The following example presents a situation where an interpreter might appropriately step into the advocate role: You are interpreting for a client who is being treated for depression. At the end of the session, the clinician provides the client with a prescription for two months' worth of medication. When the receptionist sets the date for the client's next appointment, however,

you notice that it is scheduled for three months from today. Because of this scheduling, the client will run out of medication before the next appointment.

If you choose to be an advocate in this situation, you should first tell the client what you are doing, then approach the receptionist, and express your concern that the appointment date conflicts with the client's medication needs. You should then ask to check back with the clinician to explain your concern.

Advocacy: The Clinician's Perspective

Using an interpreter in a clinical session can add an extra layer of complexity as you, the clinician, seek to build a relationship with the client. The dyad you are trying to form is now a triad with the increased potential for complex dynamics, depending on factors like the demographics (gender, age, ethnicity, educational status, etc.), personality, and/or other unique situational factors of the client and interpreter in your office. There could be times you may need to advocate for the client and at other times advocate for the interpreter.

Advocating for the Client

- Confirm, to the best of your ability, that the client understands the interpreter and is comfortable with the particular interpreter. Even if the interpreter is fine with the arrangement, the client may not be.

- Assure, to the best of your ability, that the interpreter is asking the client the questions you are asking and not answering for them. If you see a pattern form where the client is barely talking, but interpreter is talking a lot there may be something off.

- Do not let the interpreter taint your view of the client by making condescending or discriminatory statements about the client or his/her situation.

- Some interpreters can be well meaning, but too dominant to where you and the client are not able to fully express yourselves and/or not able to connect. You may have to ask an interpreter to back off some and allow you and the client's personality to also come out in the session.

- Assure that the interpreter is acting in a respectful manner towards the client and is not allowing his/her own biases to interfere with the session. It is usually best to match the gender and age (and oftentimes ethnic background or tribe) as closely as possible between the interpreter and client to mitigate some difficult dynamics.

Advocating for the Interpreter

- Assure that the client is acting in a respectful manner towards the interpreter. The interpreter is an important professional that makes your work possible and should be respected by both you and the client. It is usually best to match the gender and age, as closely as possible, between the interpreter and client to mitigate some difficult dynamics.

- Advocate for the well-being of the interpreter. If it was a difficult session or you are beginning to see signs of secondary traumatic stress, consider what support they may need.

- Advocate for the interpreter if the client is putting undue pressure or expectations on them. For example, a client asks the interpreter for a ride, insists they spend time after the session to help them fill out an employment application, or asks personal questions. This may be an opportunity for you to step in and take the pressure of the interpreter to have to say "no". You could explain that due to agency policy the interpreter cannot do these things or simply explain the roles of the interpreter in the session and that what they are asking is not appropriate.

Advocacy Example

The following example presents a situation where a clinician might appropriately step into the advocate role: A clinician, interpreter, and client are having a session where they are safety planning about different situations that could potentially impact the client and her children. The client is an Afghani woman and the interpreter is an Afghani woman. They are from different ethnic groups. The client is not answering the clinician's questions and seems confused. The clinician seeks clarification about what the client isn't understanding and tries to explain again what they are doing. The interpreter stops interpreting and tells the clinician that this client is from an uneducated ethnic group in Afghanistan and she probably isn't going to be able to do this exercise. The interpreter says it is better for the clinician just to tell the client what she should do for safety in each situation because that is what the client is used to and honestly probably prefers to just be told what to do.

In this situation the interpreter has his/her own bias about this client, and you should not allow your clinical work and perception of the client to be influenced by this stereotype. It is probably best to address the interpreter one-on-one after the session explaining you seek to treat all clients fairly and do not want to make assumptions or judgments based on someone's ethnicity. You can express appreciation for his/her desire to help explain a cultural difference, but that you strive to treat all people the same regardless of his/her diversity. This will hopefully set the tone for future sessions.

Effective Communication in Advocacy

When acting as an advocate, interpreters and clinicians must employ effective communication skills. They should always speak calmly and confidently, and articulate the problem to all of those involved in the situation. Eye contact and open body language are good ways to show active listening. Keep in mind that in possible advocacy situations, the interpreter, the clinician and/or system involved are probably actively acting in the interest of the client. Interpreters and clinicians should remember that everyone involved in the situation has the best of intentions, and move forward in a non-confrontational way.

Chapter 9 | Post-Test

1. An interpreter is taking on an_____ role when they take action on the client's behalf because they are concerned with the client's quality of care.

2. Which of the following is a cost of the interpreter taking on an advocacy role?

    a. May help client understand the health care system more completely
    b. May make the client feel supported
    c. May compromise the neutrality of the interpreter
    d. May help the client in emergency situations

3. **True or False:** Clinicians should take on an advocacy role if they see an interpreter allowing his/her biases about the client to interfere with the session.

4. In which of the following situations should the clinician advocate for the interpreter? (Circle all that apply):

    a. The client asks the interpreter for additional services or asks them personal questions.
    b. You feel that the interpreter may be interpreting incorrectly
    c. You see that the interpreter is exhibiting signs of secondary traumatic stress.
    d. The session is taking a long time.

5. Which of the following is **NOT** an effective communication skill?

    a. Speak calmly.
    b. Articulate the problem to all of those involved in the situation.
    c. Eye contact and open body language.
    d. Speak in a confrontational manner.

(Answer key is available in Appendix F)

[i] For the purposes of this resource, professional interpreter is defined as an individual who has completed a basic interpretation training (spoken language) for community, medical and/or legal settings or an individual who is in the process of completing this basic interpretation training. The term interpreter will be used throughout this resource in reference to a professional interpreter as defined as above.

[ii] For the purposes of this resource, qualified mental health clinician is defined as an individual who has been trained and has experience in providing psychiatric or mental health services to individuals who have a mental illness or an individual who is in the process of completing a mental health services training program. The term mental health clinician will be used throughout this resource in reference to a qualified mental health clinician as defined as above.

[iii] The full definition of refugee can be found on the United Nations High Commission on Refugees (UNHCR) website at http://www.unrefugees.org/what-is-a-refugee.

[iv] https://www.samhsa.gov/nctic/trauma-interventions

[v] Increasingly, there are individuals who leave their home countries for involuntary reasons (e.g., natural disaster, escaping gang violence or abject poverty) but the situations from which they are fleeing may not qualify as a humanitarian crisis and therefore they are unable to apply for refugee/asylum status.

[vi] Taken from the NCTSN' Refugee Trauma Webpages.

[vii] Drawn from http://faculty.css.edu/dswenson/web/culture/cultdim.htm

[viii] Drawn from the Public Broadcasting Service (PBS)'s webpage entitled, "Working on Common Cross-cultural Communication Challenges" authored by Marcelle E. DuPraw and Marya Axner for more information about how cultures may differ from one another. http://www.pbs.org/ampu/crosscult.html

[viiii] Drawn from http://faculty.css.edu/dswenson/web/culture/cultdim.htm

[x] Drawn from the Public Broadcasting Service (PBS)'s webpage entitled, "Working on Common Cross-cultural Communication Challenges" authored by Marcelle E. DuPraw and Marya Axner for more information about how cultures may differ from one another. http://www.pbs.org/ampu/crosscult.html

[xi] The Heartland Alliance Marjorie Kovler Center, formerly known as Marjorie Kovler Center for the Treatment of Survivors of Torture, is a program of Heartland Alliance International, LLC and is a subsidiary of Heartland Alliance for Human Needs & Human Rights. Kovler Center was established in 1987 and is leader in the field of treatment for torture survivors. The original service model offered provision of medical, mental health, social services, and access to legal services to survivors and their families. These same efforts and services have endured over the last three decades and continue today.

Kovler Center helps transform the lives of individuals and families recovering from the complex consequences of torture. Kovler Center offers services and treats survivors of politically sanctioned torture, as well as family members effected by this brutal human rights violation, with holistic, integrated, trauma-informed, empowerment-focused, culturally-sensitive, spiritually supported services with an emphasis on rebuilding community and access to justice. In helping to transform the lives of individuals recovering from torture, Kovler Center's three-fold mission is to: (1) provide medical, mental health, and social services; (2) train and educate locally and globally; and (3) advocate for the end of torture worldwide.

Each year approximately 350 survivors representing over 50 countries globally -- 84 countries since inception-- engage in services to overcome trauma and begin a life without fear. Services are community-based in our building on the north side of Chicago and in practitioners' offices around Chicago. Kovler Center also has a volunteer-base with nearly 200 professionals and paraprofessionals engaged in pro bono service. Among the first torture treatment centers in the United States effectively serving one of the most diverse and vulnerable populations (asylum seekers and refugees), Kovler Center is a leader in the torture treatment field.

[xii] The concept of "sharing power" is included under the Collaboration and Mutuality principle of trauma-informed care, stating that, "Importance is placed on partnering and the leveling of power differences... Healing happens in relationships and in the meaningful sharing of power and decision-making (*see SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach, p.11.)*

APPENDIX A: Key Terms & Concepts

(In alphabetical order)

Ad hoc interpretation: Ad hoc interpreting refers to interpreting that is done by a person who is not trained as an interpreter but happens to speak the two languages needed for a specific interaction. For example, a bilingual receptionist, nurse, or family member may be asked to interpret if a trained interpreter is not available.

Advocate*:* An interpreter takes on the role of advocate when they take action that is not merely focused on facilitating communication but is also concerned with the client's quality of care.

Asylum-seeker: An asylum-seeker is someone whose request for sanctuary has yet to be processed.[6]

Certified interpreter: A certified interpreter is a professional interpreter who is certified as competent by a professional organization or government entity through rigorous testing based on appropriate and consistent criteria.[38]

Clinician: A service provider who has direct contact with clients.

Client advocacy: A specialized role in healthcare in which a provider focuses on what is deemed to be best for the client. Providers seek to protect the client's human and legal rights and provide facilitation in asserting those rights if the need arises.

Compassion satisfaction: Compassion satisfaction refers to the positive aspects of helping; the pleasure one derives from being able to do his or her work.[121]

Consecutive interpretation: The most common method of interpreting, in which an interpreter remains silent and listens to the first speaker relay his/her entire message, and then the interpreter relays the message to the second speaker in the appropriate language. This action is repeated back and forth throughout the interpreting session.

Cultural broker: An interpreter takes on the role of cultural broker when he or she takes action when potential cultural differences are identified that may lead to a misunderstanding on the part of the client or the clinician to ensure that a necessary cultural framework for understanding the message that is being interpreted is explicit.

Cultural brokering: The action of adding key cultural information during the interpretation process to avoid a cultural misunderstanding on the part of the client or clinician.

Deaf: "When a person's auditory input is minimal such that there is limited functional access to spoken language.[124]"

Deaf: "When an individual has significantly reduced hearing sensitivity, they may identify as Deaf and belong to the Deaf community, and share a sense of linguistic and cultural belongingness. For those who self-identify as members of the Deaf community, the use of a uniform signed language and the incorporation of Deaf cultural norms are common. For "capital D (Deaf)" individuals, reduced hearing sensitivity is not perceived as a loss but rather as Deaf gain, the recognition by members of the Deaf community that being Deaf has added numerous benefits to their lives.[124]"

Hard of hearing: "Typically, an individual who identifies as *hard of hearing* has some degree of reduced hearing yet can still access sound and spoken language.[124]"

Hearing impairment: "This a term that has historically been applied to individuals with reduced hearing. However, this term is not accepted by members of the Deaf community and is perceived as disrespectful.[124]"

Health Insurance Portability and Accountability Act (HIPAA): HIPAA, passed in 1996, establishes laws for health insurance coverage, maintains standards for health care information, and mandates health care privacy procedures. These regulations "require health care providers and organizations, as well as their business associates, to develop and follow procedures that ensure the confidentiality and security of protected health information (PHI) when it is transferred, received, handled, or shared. This applies to all forms of PHI, including paper, oral, and electronic, etc. Furthermore, only the minimum health information necessary to conduct business is to be used or shared.[18]"

Immigrant: Someone who voluntarily leaves his/her home country for better economic, educational, or other opportunities.

Interpreter: Interpreters serve as verbal connections between people who need to communicate but do not speak the same language.

Limited-English proficiency (LEP): Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English.[39]

Linguistically-responsive: A linguistically responsive perspective seeks to understand language, how language impacts an individual's experience, and how linguistically relevant factors that can be addressed to improve the services (e.g., interpretation mental health treatment, etc.) provided to an individual.

Refugee: A refugee is "someone who has been forced to flee his or her country because of persecution, war, or violence. A refugee has a well-founded fear of persecution for reasons of

race, religion, nationality, political opinion or membership in a particular social group. Most likely, they cannot return home or are afraid to do so. War and ethnic, tribal and religious violence are leading causes of refugees fleeing their countries.[6]"

Secondary Traumatic Stress (STS): The emotional duress that results when an individual hears about the firsthand trauma experiences of another; its symptoms mimic those of post-traumatic stress disorder.

Self-care: It a term that refers to physical and emotional health strategies and general lifestyle changes an individual can adopt to help prevent, manage, and/or ameliorate psychological distress.

Socio-cultural: The sociocultural perspective seeks to understand the social and cultural factors that may influence an individual, his or her beliefs, custom, practices and behaviors and the social policies and practices of the systems in which he or she interacts and of society at large.

Simultaneous interpretation: During simultaneous interpretation, the interpreter relays the speaker's message while the speaker is speaking, following only a few words behind.

Survivor: A term for an individual who has experienced trauma, and has moved through this experience with resilience. Some prefer this term to "victim," though it is best to ask the individual which term he or she prefers.

Translator: A translator renders written material from one language to another.

Trauma: From a psychological perspective, trauma occurs when a child experiences an intense event that threatens or causes harm to his or her emotional and physical well-being.[94] Trauma is an experience that overwhelms our capacity to:
- have a sense of control over ourselves and our immediate environment;
- maintain connection with others; and
- make meaning of our experiences.[54]

Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being.[128]

Trauma-informed approach: According to SAMHSA, a trauma-informed approach is when a program, organization, or system[129]:

1. Realizes the widespread impact of trauma and understands potential paths for recovery;
2. Recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
3. Responds by fully integrating knowledge about trauma into policies, procedures, and practices; and
4. Seeks to actively resist re-traumatization.

Unaccompanied minor: An unaccompanied minor is a person who is under the age of eighteen, who is separated from both parents and is not being cared for by an adult who by law or custom has responsibility to do so.[137]

Undocumented immigrant: An immigrant without legal documentation to reside in the US.

Vicarious resilience: Refers to the positive outcomes for and positive effects on helping professionals who work with those who have experienced trauma (e.g., through witnessing the healing, recovery, and resilience of persons).[55]

APPENDIX B: Interpreter/Translator Comparison Table

INTERPRETER / TRANSLATOR COMPARISON		
	INTERPRETER	**TRANSLATOR**
SKILLS NEEDED	Verbally renders speech from one language to another	Renders written material from one language to another
	Skills used in the moment	Skills used over a the course of a specified period of time, determined by length of document and needs of client
	Oral command of both languages	Strong grammar skills and large vocabulary in each language
	Good listening and interpersonal skills	Good organizational skills
	Short-term memory use	Effective use of resources
	Good at working under pressure	Good at maintaining appropriate contact with client and sticking to deadlines

APPENDIX C: Overview of Mental Health Systems and Institutions

There are a wide variety of mental health settings. In most states, the mental health service system is composed of the following settings:

- *Community mental health centers* – designed to meet a broad range of mental health services, including inpatient, partial hospital, crisis services, outpatient, and community outreach services, necessary to treat and sustain people living in the community.

- *Correctional institutions* – services for those who are in jail or who have completed their sentences and are re-entering the community.

- *Emergency and crisis care centers* – either freestanding or located within general hospitals to respond to acute psychiatric situations, which include suicide attempts and toxic reactions to alcohol or other drugs; often open 24-hours per day.

- *Freestanding psychiatric hospitals* – focus only on serving seriously mentally ill clients.

- *Halfway houses* – designed as bridges between inpatient or residential programs and reintegration into full community living.

- *Homeless shelters* – places where many people with a mental illness and/or substance use disorder often find themselves where they may or may not receive services designed to help them with their illness.

- *Hospitals with inpatient psychiatric units* – units set aside for short-term care of seriously mentally ill clients within general hospitals that otherwise provide care for physically ill clients.

- *Intensive outpatient* – group treatment, multiple times a week for clients needing more than once-a-week outpatient care.

- *Outpatient clinics* – provide non-acute therapy services for people able to come to a site; services include appointments with psychiatrists and other clinicians.

- *Outreach programs* – designed to reach persons with mental health problems that would not come to a facility without someone coming to them, meeting them, and working with them in the community.

- *Residential treatment programs* – usually provided for persons with substance abuse disorders when they need a period of time out of the community so that they can experience a prolonged period of sobriety and otherwise engage in recovery.

- *Partial hospitals (day or night hospitals)* – considered "step downs" from 24-hour care and provide four or more hours of treatment per day as the client gets acclimated to living out in the community.

- *State and federal mental hospitals* – operated by government employees; generally intended for the most severely mentally ill.

Additional settings include religious institutions, schools and counselors, and school-based clinics and clinical interventions.

APPENDIX D: Selected Websites for Code of Ethics for Interpreters and Mental Health Professionals

Below is a list of select websites that contain the code of ethics for both interpreters and mental health clinicians to guide these professionals as they make decisions in challenging situations when providing a socio-cultural, linguistically responsive and trauma-informed approach to mental health interpretation with clients.

Ethic Codes for Interpreters

1. National Council on Interpreting in Health Care (NCIHC)

   - Website: http://www.ncihc.org/ethics-and-standards-of-practice

2. International Medical Interpreters Association (IMIA)

   - Website: http://www.imiaweb.org/code/

3. The National Association of the Deaf (NAD) and Registry of Interpreters for the Deaf (RID), Inc. Co-Authored Code of Ethics

   Website: https://drive.google.com/file/d/0B-HBAap35D1R1MwYk9hTUpuc3M/view

4. National Association of the Deaf (NAD)'s Position Statement on Mental Health Services for Deaf Children (2008)

   - Website: https://www.nad.org/about-us/position-statements/position-statement-on-mental-health-services-for-deaf-children

Ethics Codes of the Major Mental Health Professions

Below are links to Ethics Codes of the major mental health professions followed by a link to the Code of Professional Conduct for Interpreters for the Deaf:

1. Counselors: "ACA Code of Ethics" (2014)

   - Website: http://www.counseling.org/docs/ethics/2014-aca-code-of-ethics.pdf?sfvrsn=4

2. Psychiatrists: "Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry"

   - Website: http://www.psychiatry.org/practice/ethics

3. Psychologists: "APA Ethical Principles of Psychologists and Code of Conduct"

   - Website: http://www.apa.org/ethics/code/index.aspx

4. Social Workers: "NASW Code of Ethics"

   - Website: http://www.socialworkers.org/pubs/code/code.asp

5. Marriage & Family Therapists: AAMFT Code of Ethics

   - Website: https://www.aamft.org/imis15/content/legal_ethics/code_of_ethics.aspx

6. Psychiatric Nurses: APNA (Amer. Psych. Nurses Assn.) Position Papers

   - Website: http://www.apna.org/resources/positionpapers.html

7. School Psychologists: NASP Principles for Professional Ethics

   - Website: http://www.nasponline.org/standards/2010standards/1_%20Ethical%20Principles.pdf

8. School Social Workers

   - Website: http://www.socialworkers.org/pubs/code/code.asp

9. Interpreters for the Deaf: "Code of Professional Conduct"

   - Website: http://www.rid.org/UserFiles/File/pdfs/codeofethics.pdf

APPENDIX E: Additional Resources for Interpreters Working in Mental Health Settings

Resource	Title; Organization	Targeted Population
Information guide	*Working with Interpreters: Service Provision with Torture Survivors*[95]	Those who work with interpreters to provide services to torture survivors.
Webinar	*Working with Interpreters: Service Provision with Torture Survivors*[95]	Those who work with interpreters to provide services to torture survivors.
Webinar	*Working with Interpreters in Refugee Services*[44]	Those who work with interpreters to provide services to refugees.
Webinar	*Deaf 101: How to Navigate Clinical Interactions with Deaf Sign Language Users*[3]	Those who provide services to Deaf clients.
Book	*Deaf Mental Health Care*[41]	Those who provide services to Deaf clients.
Book	*Mental Health Care of Deaf People: A Culturally Affirmative Approach*[42]	Those who provide services to Deaf clients.

APPENDIX F: Answer Key for Pre/Post Tests

Chapter 1

Q.	ANSWER
1	B. It is a "one-size fits all" approach.
2	Implicit bias
3	False
4	Trauma-informed
5	a. Each child is unique in his/her own developmental patterns; b. Knowing about typical and atypical child development can help assess development and intervention; and d. Children should be met where they are at developmentally.
6	Reduce the time before and after sessions in order to streamline the interpretation process.
7	True

Chapter 2

Q.	ANSWER
1	a. Clarifier c. conduit; and e. advocate
2	False
3	Psychiatrists = c Psychologists = a Case managers = d Occupational, music, dance, art, and activity therapists = b
4	Unaccompanied minor = d Immigrant = a Asylum seeker = c Refugee = b
5	True
6	B. Timeliness and swift diagnosis

Chapter 3

Q.	ANSWER
1	Mood Disorders = b Anxiety Disorders = c Disruptive Behavior Disorders = a Psychotic Disorders = d
2	True
3	Poverty
4	True
5	Rapport and empathy
6	False
7	Exposure
8	Recreate the trauma through play = b Become clingy with a teacher or parent = c Develop self-harming behaviors = a
9	a. Treatment plan b. Progress note c. Discharge summary
10	Outpatient care = b Inpatient (IP) = c Partial Hospitalization (PHP) = a Intensive Outpatient (IOP) = d

Chapter 4

Q.	ANSWER
1	B. Enhance transparency
2	a. Clinician b. Interpreter c. Client
3	Client
4	False

Chapter 5

Q.	ANSWER
1	A. Ask these types of direct questions, not softening or changing the wording.
2	D. All of the above
3	False
4	C. The client becomes emotional when sharing his/her experiences.

Chapter 6

Q.	ANSWER
1	True
2	Secondary traumatic stress
3	C. Avoid discussion of the client after the session is over, and try to avoid interpreting for the same client multiple times.
4	D. A and C

Chapter 7

Q.	ANSWER
1	Reflective supervision
2	A. Reinforcing the power structure between clinician and interpreter
3	Relationship and Relationship
4	True

Chapter 8

Q.	ANSWER
1	Values clarification
2	A. Many clients may fear that receiving treatment will affect their immigration proceedings, asylum applications, college admissions, or future employment; and C. Confidentiality must be broken in cases of child or elder abuse, or in situations in which the client is threatening to harm themselves or others.
3	Health Insurance Portability and Accountability
4	False
5	B. Ask the mental health clinician to speak in simpler language.

Chapter 9

Q.	ANSWER
1	Advocacy
2	C. May compromise the neutrality of the interpreter
3	True
4	A. The client asks the interpreter for additional services or asks them personal questions; and C. You see that the interpreter is exhibiting signs of secondary traumatic stress
5	D. Speak in a confrontational manner

APPENDIX G: Training Resources (To Date) for Interpreters Who Will Be Working with Trauma

GUIDELINES FORMAT	CITATION
BOOK	Boyles & Talbot (2017). *Working with interpreters in psychological therapy: the right to be understood.* New York, NY: Routledge.
BOOK	Gabrielson, E. (2010). *Cultural responsiveness: Working with interpreters when providing mental health services to LEP clients.* Malibu, CA: Pepperdine University Press.
ARTICLE	Paone, T. R., & Malott, K. M. (2008). Using interpreters in mental health counseling: A literature review and recommendations. *Journal of Multicultural Counseling and Development, 36(3),* 130-142. Doi:10.1002/j.2161-1912.2008.tb00077.x
ARTICLE	Searight, H. R., & Searight, B. K. (2009). Working with foreign language interpreters: Recommendations for psychological practice. *Professional Psychology: Research and Practice, 40(5),* 444-451. Doi:10.1037/a0016788
ARTICLE	Tribe, R., & Thompson, K. (2011). Developing guidelines on working with interpreters in mental health: Opening up an international dialogue? *International Journal of Culture and Mental Health, 4(2),* 81-90. Doi:10.1080/17542863.2010.503365
TRAINING MANUAL	Bancroft, M. A., Allen, K., Carola. E. G., & Feuerle, L.M. (2016). Breaking Silence: Interpreting for Victim Services. *Ayuda.* Retrieved from: http://ayuda.com/wp-content/uploads/2017/06/Breaking-Silence-Training-Manual-1.pdf

APPENDIX H: Identified Clinical Guidelines (To Date) for the Use of Interpreters in Mental-Health Settings

- National Council on Interpreting in Healthcare (NCIHC): http://www.ncihc.org/
- *The Voice of Love:* http://voice-of-love.org/

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APPENDIX I: NCTSN's 12 Core Concepts for Understanding Traumatic Stress Responses in Children and Families

Core Curriculum on Childhood Trauma

The 12 Core Concepts

Concepts for Understanding Traumatic Stress Responses in Children and Families

NCTSN   The National Child
Traumatic Stress Network

The National Child Traumatic Stress Network

Established by Congress in 2000, the National Child Traumatic Stress Network (NCTSN) brings a singular and comprehensive focus to childhood trauma. NCTSN's collaboration of frontline providers, researchers, and families is committed to raising the standard of care while increasing access to services. Combining knowledge of child development, expertise in the full range of child traumatic experiences, and dedication to evidence-based practices, the NCTSN changes the course of children's lives by changing the course of their care.

Financial Support

Citation

NCTSN Core Curriculum on Childhood Trauma Task Force (2012). *The 12 core concepts: Concepts for understanding traumatic stress responses in children and families. Core Curriculum on Childhood Trauma*. Los Angeles, CA, and Durham, NC: UCLA-Duke University National Center for Child Traumatic Stress.

Correspondence Relating to the Core Curriculum on Childhood Trauma

Anyone wishing to use any of these materials for commercial use must request and receive prior written permission from the NCTSN. Permission for such use is granted on a case-by-case basis at the sole discretion of the NCTSN. Requests for permission to adapt or license these materials, as well as general requests relating to the Core Curriculum on Childhood Trauma should be directed to the NCTSN Learning Center Help Desk at help@nctsn.org with "CCCT" in the Subject Line. General inquiries relating to products produced by the National Child Traumatic Stress Network can be directed to the NCTSN National Resource Center at info@nctsn.org. Other NCTSN products can be viewed on its website at NCTSN.org, as well as the Learning Center for Child and Adolescent Trauma at http://learn.nctsn.org/.

Acknowledgements

12 Core Concepts for Understanding Traumatic Stress Responses in Childhood

1. Traumatic experiences are inherently complex.

Every traumatic event—even events that are relatively circumscribed—is made up of different traumatic moments. These moments may include varying degrees of objective life threat, physical violation, and witnessing of injury or death. Trauma-exposed children experience subjective reactions to these different moments that include changes in feelings, thoughts, and physiological responses; and concerns for the safety of others. Children may consider a range of possible protective actions during different moments, not all of which they can or do act on. Children's thoughts and actions (or inaction) during various moments may lead to feelings of conflict at the time, and to feelings of confusion, guilt, regret, and/or anger afterward. The nature of children's moment-to-moment reactions is strongly influenced by their prior experience and developmental level. Events (both beneficial and adverse) that occur in the aftermath of the traumatic event introduce additional layers of complexity. The degree of complexity often increases in cases of multiple or recurrent trauma exposure, and in situations where a primary caregiver is a perpetrator of the trauma.

2. Trauma occurs within a broad context that includes children's personal characteristics, life experiences, and current circumstances.

Childhood trauma occurs within the broad ecology of a child's life that is composed of both child-intrinsic and child-extrinsic factors. Child-*intrinsic* factors include temperament, prior exposure to trauma, and prior history of psychopathology. Child-*extrinsic* factors include the surrounding physical, familial, community, and cultural environments. Both child-intrinsic and child-extrinsic factors influence children's experience and appraisal of traumatic events; expectations regarding danger, protection, and safety; and course of posttrauma adjustment. For example, both child-intrinsic factors such as prior history of loss, and child-extrinsic factors such as poverty may act as vulnerability factors by exacerbating the adverse effects of trauma on children's adjustment.

3. Traumatic events often generate secondary adversities, life changes, and distressing reminders in children's daily lives.

Traumatic events often generate secondary adversities such as family separations, financial hardship, relocations to a new residence and school, social stigma, ongoing treatment for injuries and/or physical rehabilitation, and legal proceedings. The cascade of changes produced by trauma and loss can tax the coping resources of the child, family, and broader community. These adversities and life changes can be sources of distress in their own right and can create challenges to adjustment and recovery. Children's exposure to trauma reminders and loss reminders can serve as additional sources of distress. Secondary adversities, trauma reminders, and loss reminders may produce significant fluctuations in trauma survivors' posttrauma emotional and behavioral functioning.

4. Children can exhibit a wide range of reactions to trauma and loss.

Trauma-exposed children can exhibit a wide range of posttrauma reactions that vary in their nature, onset, intensity, frequency, and duration. The pattern and course of children's posttrauma reactions are influenced by the type of traumatic experience and its consequences, child-intrinsic factors including prior trauma or loss, and the posttrauma physical and social environments. Posttraumatic stress and grief reactions can develop over time into psychiatric disorders, including posttraumatic stress disorder (PTSD), separation anxiety, and depression. Posttraumatic stress and grief reactions can also disrupt major domains of child development, including attachment relationships, peer relationships, and emotional regulation, and can reduce children's level of functioning at home, at school, and in the community. Children's posttrauma distress reactions can also exacerbate preexisting mental health problems including depression and anxiety. Awareness of the broad range of children's potential reactions to trauma and loss is essential to competent assessment, accurate diagnosis, and effective intervention.

5. Danger and safety are core concerns in the lives of traumatized children.

Traumatic experiences can undermine children's sense of protection and safety, and can magnify their concerns about dangers to themselves and others. Ensuring children's physical safety is critically important to restoring the sense of a protective shield. However, even placing children in physically safe circumstances may not be sufficient to alleviate their fears or restore their disrupted sense of safety and security. Exposure to trauma can make it more difficult for children to distinguish between safe and unsafe situations, and may lead to significant changes in their own protective and risk-taking behavior. Children who continue to live in dangerous family and/or community circumstances may have greater difficulty recovering from a traumatic experience.

6. Traumatic experiences affect the family and broader caregiving systems.

Children are embedded within broader caregiving systems including their families, schools, and communities. Traumatic experiences, losses, and ongoing danger can significantly impact these caregiving systems, leading to serious disruptions in caregiver-child interactions and attachment relationships. Caregivers' own distress and concerns may impair their ability to support traumatized children. In turn, children's reduced sense of protection and security may interfere with their ability to respond positively to their parents' and other caregivers' efforts to provide support. Traumatic events—and their impact on children, parents, and other caregivers—also affect the overall functioning of schools and other community institutions. The ability of caregiving systems to provide the types of support that children and their families need is an important contributor to children's and families' posttrauma adjustment. Assessing and enhancing the level of functioning of caregivers and caregiving systems are essential to effective intervention with traumatized youths, families, and communities.

7. Protective and promotive factors can reduce the adverse impact of trauma.

Protective factors buffer the adverse effects of trauma and its stressful aftermath, whereas *promotive* factors generally enhance children's positive adjustment regardless of whether risk factors are present. Promotive and protective factors may include *child-intrinsic* factors such as high self-esteem, self-efficacy, and possessing a repertoire of adaptive coping skills. Promotive and protective factors may also include *child-extrinsic* factors such as positive attachment with a primary caregiver, possessing a strong social support network, the presence of reliable adult mentors, and a supportive school and community environment. The presence and strength of promotive and protective factors—both before and after traumatic events—can enhance children's ability to resist, or to quickly recover (by resiliently "bouncing back") from the harmful effects of trauma, loss, and other adversities.

8. Trauma and posttrauma adversities can strongly influence development.

Trauma and posttrauma adversities can profoundly influence children's acquisition of developmental competencies and their capacity to reach important developmental milestones in such domains as cognitive functioning, emotional regulation, and interpersonal relationships. Trauma exposure and its aftermath can lead to developmental disruptions in the form of regressive behavior, reluctance, or inability to participate in developmentally appropriate activities, and developmental accelerations such as leaving home at an early age and engagement in precocious sexual behavior. In turn, age, gender, and developmental period are linked to risk for exposure to specific types of trauma (e.g., sexual abuse, motor vehicle accidents, peer suicide).

9. Developmental neurobiology underlies children's reactions to traumatic experiences.

Children's capacities to appraise and respond to danger are linked to an evolving neurobiology that consists of brain structures, neurophysiological pathways, and neuroendocrine systems. This "danger apparatus" underlies appraisals of dangerous situations, emotional and physical reactions, and protective actions. Traumatic experiences evoke strong biological responses that can persist and that can alter the normal course of neurobiological maturation. The neurobiological impact of traumatic experiences depends in part on the developmental stage in which they occur. Exposure to multiple traumatic experiences carries a greater risk for significant neurobiological disturbances including impairments in memory, emotional regulation, and behavioral regulation. Conversely, ongoing neurobiological maturation and neural plasticity also create continuing opportunities for recovery and adaptive developmental progression.
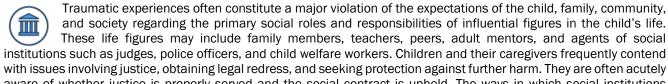
10. Culture is closely interwoven with traumatic experiences, response, and recovery.

Culture can profoundly affect the meaning that a child or family attributes to specific types of traumatic events such as sexual abuse, physical abuse, and suicide. Culture may also powerfully influence the ways in which children and their families respond to traumatic events including the ways in which they experience and express distress, disclose personal information to others, exchange support, and seek help. A cultural group's experiences with historical or multigenerational trauma can also affect their responses to trauma and loss, their world view, and their expectations regarding the self, others, and social institutions. Culture also strongly influences the rituals and other ways through which children and families grieve over and mourn their losses.

11. Challenges to the social contract, including legal and ethical issues, affect trauma response and recovery.

Traumatic experiences often constitute a major violation of the expectations of the child, family, community, and society regarding the primary social roles and responsibilities of influential figures in the child's life. These life figures may include family members, teachers, peers, adult mentors, and agents of social institutions such as judges, police officers, and child welfare workers. Children and their caregivers frequently contend with issues involving justice, obtaining legal redress, and seeking protection against further harm. They are often acutely aware of whether justice is properly served and the social contract is upheld. The ways in which social institutions respond to breaches of the social contract may vary widely and often take months or years to carry out. The perceived success or failure of these institutional responses may exert a profound influence on the course of children's posttrauma adjustment, and on their evolving beliefs, attitudes, and values regarding family, work, and civic life.

12. Working with trauma-exposed children can evoke distress in providers that makes it more difficult for them to provide good care.

Mental healthcare providers must deal with many personal and professional challenges as they confront details of children's traumatic experiences and life adversities, witness children's and caregivers' distress, and attempt to strengthen children's and families' belief in the social contract. Engaging in clinical work may also evoke strong memories of personal trauma- and loss-related experiences. Proper self-care is an important part of providing quality care and of sustaining personal and professional resources and capacities over time.

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