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Training Psychologists in the Ethical Use of Language Interpreters: An Evaluation of Current Practices, Potential Barriers, and Proposed Competencies

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ABSTRACT

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Research indicates that general and mental healthcare services have been, and continue to be, underutilized by racial and ethnic minorities. Studies point to the language gap between limited English proficiency (LEP) individuals and mental-health clinicians as one of the factors in perpetuating that gap. Despite the legal and professional mandates that require professionals in healthcare to provide and use language interpreters in giving care, psychologists rarely make use of professional interpreters when conducting psychotherapy. Most clinicians have little experience providing mental-health treatment across differences in language, and it is supposed that clinicians usually receive little or no training on how to address those differences. This study involved a national survey of all APA-accredited programs to ascertain how student trainees are currently being prepared to work with language interpreters in professional training programs and to evaluate potential barriers to the implementation of training guidelines for use in those programs. Findings indicated that several instructors are addressing the use of language interpreters through a variety of pedagogical approaches. Guidelines for clinical practice with interpreters were also evaluated and ranked so as to establish consensus on the necessary competencies. Implications for instructors are also included.

Keywords: psychotherapy, interpreter, translation, foreign language, language, training

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I would like to dedicate this dissertation to my dear wife Teri, for the years of encouragement, love, and support that she provided. To my parents, for helping me to realize and pursue my dreams, and for believing in me. And, to Tim, for his enduring patience, thoughtful guidance, and hard work in my behalf.

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DESCRIPTION OF DISSERTATION CONTENT AND STRUCTURE

This dissertation, *Training Psychologists in the Ethical Use of Language Interpreters: An Evaluation of Current Practices, Potential Barriers, and Proposed Competencies*, is written in a hybrid format. This hybrid format combines traditional dissertation and journal publication layouts. The preliminary pages reflect requirements for submission to the university. The dissertation report is presented as a journal article and conforms to length and style requirements for submitting research reports to psychology and education journals. The literature review and additional information regarding the data are included in Appendices A, B, C, D, and E.

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Introduction

From 2000 to 2010 nearly 14 million people immigrated to the United States (Shultz, 2002), with the number of undocumented immigrants being unknown, but estimated at another 4 million. Since many migrants do not speak English fluently, a linguistic gap is a potential barrier facing many of those coming to the United States (Jacobs, Diamond, & Stevak, 2010). Currently, about 20% of the United States population speaks a language other than English in the home, and the number of individuals who have limited English proficiency (LEP) has risen to over 25 million (Searight & Armock, 2013; Shi, Lebrun, & Tsai, 2009; United States Bureau of the Census, 2011). Many would argue that the increase of linguistic and cultural diversity in the United States is a positive transformation; simultaneously, it creates a challenge for healthcare systems to prepare for multicultural encounters. This issue clearly impacts the field of psychology, in which treatment involves intensive verbal exchange between therapist and client.

In accordance with the rising number of immigrants entering and living within the United States, there has been an increased effort in the field of psychology to prepare trainees for encounters with culturally diverse individuals through the acquisition of knowledge, skills, and awareness (Arredondo, Toporek, Brown, & Jones, 1996; Smith, 2004; Sue, Arredondo, & McDavis, 1992). Such efforts are generally thought to have led to better mental healthcare for underserved and underrepresented populations (Smith, Constantine, Dunn, Dinehart, & Montoya, 2006). However, far less attention has been paid to the linguistic diversity of those entering and living within the United States. Acevedo, Reyes, Annett, and Lopez (2003) argued that "language may be a barrier to treatment even for culturally competent providers and researchers" (p. 193). In efforts to address this barrier, an increasing number of psychologists are utilizing language interpreters. The American Psychological Association (APA) has published guidelines

that include interpreter-facilitated assessment and treatment: “Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations” (APA, 1991). These guidelines recommend that psychologists provide services to clients in the language requested by the client. When psychologists do not speak the preferred language of the client, they should offer the client an interpreter, preferably one with cultural knowledge, a professional background, and appropriate training. Despite these clear professional guidelines, the marked demographic shifts mentioned earlier, and the emphasis on multiculturalism, it is assumed that there is currently minimal-to-no formal training offered in psychology graduate programs that would prepare trainees to ethically practice according to the aforementioned guidelines (Searight & Searight, 2009; Tribe & Raval, 2003; Yakushko, 2009).

It seems that many institutions that train mental-health clinicians in multicultural issues assume that therapy will be conducted in English only, yet we know that this is not the case (Clauss, 1998). If training institutions are indeed leaving psychologists unprepared to work with those speaking another language, this provides little incentive for linguistic minorities to seek mental healthcare. Furthermore, this lack of training puts psychologists at risk for practicing outside their area of competence (Hatcher et al., 2013; Romero, 2012; White, 2014). Experts in the field posit that working with LEP populations should be included in psychologists’ multicultural training and education; however, psychologists will most likely work with interpreters without the benefit of graduate training or continuing education on the topic (Searight & Searight, 2009). Thus it appears that a lack systematic training in working with interpreters may lead to unintended linguistic discrimination and may prevent clinicians from gaining skills that would ensure competency with linguistically diverse clients (Pazos & Nadkarni, 2010; Spencer, Chen, Gee, Fabian, & Chen, 2010; Yakushko, 2009).

A study by Yakushko (2010) further illuminates concerns with training in this area. Psychologists who had done extensive work with LEP populations were asked to reflect on important factors that contributed to positive or successful work with LEP clients. Training for both the therapists and interpreters was highlighted as key by all the participants. However, the participants noted that the training they received, as well as the current training offered in the mental-health field was "not adequate in preparing practitioners to work with clients from other cultures through interpreters" (Yakushko, 2010, p. 455). Furthermore, these psychologists indicated that the knowledge they obtained for working with interpreters was informal and came mostly through trial and error. These results raise questions concerning the current efforts of training programs that are intended to prepare trainees for work with culturally and linguistically diverse populations. Tragically, the underutilization of mental healthcare by LEP individuals is likely to stay unchanged unless competencies are established and training provided to ensure clinician skills in working effectively with interpreters (Tribe & Raval, 2003).

A better understanding of what barriers currently impede the provision of training in this area is clearly warranted. Common barriers and dilemmas associated with use of interpreters have been well documented. Issues such as interpreters intervening inappropriately, dual roles between client and interpreter, and the interpreter's lack of familiarity with mental-health issues (Searight & Armock, 2011) are common in literature on the topic. However, an understanding of what keeps multicultural instructors of graduate courses from raising awareness about these issues remains unknown. When speaking of the challenges generally faced by instructors of multicultural courses, Bigatti et al. (2012) stated that some faculty may be hesitant about introducing the topic because of personal bias, student backlash, or the absence of training in

their own graduate programs or current roles. It remains to be discovered whether any of these barriers is pertinent to the topic of language interpreters.

Effective training for psychologists in the provision of therapy in the client's preferred language is essential not only for the obvious reasons of optimal communication, but also to address the increased vulnerability of LEP populations to distress and mental illness. Relative to their native-speaking counterparts, LEP populations less frequently use general and mental healthcare services (Jacobs, Agger-Gupta, Chen, Piotrowski, & Hardt, 2003; Kim, et al., 2011; Sentell, Shumway, & Snowden, 2007); they have increased difficulty understanding healthcare information and treatment (Kim et al., 2011); and they are less likely to identify a need for mental healthcare when a disorder is present (Paone & Mallott, 2008). In addition, one study examining Hispanic immigrants revealed that the LEP of those receiving treatment was the leading cause of poor mental healthcare when controlling for other variables (Sentell, et al., 2007). However, such studies may have been limited by the use of self-reports rather than relying on more objective measures. Nevertheless, language barriers may stand as an independent contributor to difficulties in seeking, obtaining, understanding, and benefitting from physical and mental healthcare services (Farooq, 2003).

Fortunately, some researchers and clinicians have recognized that linguistic issues can and must be addressed in clinical work. Several sources provide clinical guidelines for the use of interpreters in mental-health settings (Gabrielson, 2010; Paone & Mallott, 2008; Searight & Searight, 2009; Tribe & Lane, 2009). These recommendations come largely from adapting guidelines used in medical settings and are more commonly utilized in outpatient clinics (Searight & Armock, 2013). However, unlike the specific training and comprehensive guidelines available in the medical field, the standards for mental-health practitioners are not yet

systematized, and clinicians are essentially left to compensate for linguistic barriers through their own interpretation of standards and recommendations (Searight & Armock, 2013). The resulting lack of clarity has led one researcher to postulate that the field has "essentially produced articles and recommendations that require a provider to invent his or her own car" (Partida, 2007, p. 347). Given the abstract nature of some of the suggestions regarding linguistic barriers, a more in-depth understanding of training and core competencies is vital to ensure high-quality care in the future (Jones, Sander, & Booker, 2013).

The present research seeks to remedy the aforementioned issues by discovering how graduate psychology programs are currently addressing linguistic diversity in training, by identifying what barriers are inhibiting formal training in this area, by gaining consensus on essential guidelines for practitioners working with language interpreters from several published articles and books detailing work with interpreters, and by seeking knowledge from participants as to how teaching to those guidelines can be included in existing multicultural training. The provision of appropriate training for clinicians and interpreters will clearly benefit clients whose preferred language is other than English (Tribe & Lane, 2009). It is the hypothesis of this study that such education will help mental health professionals better address the current situation in which language barriers prevent numerous individuals from receiving mental-health services.

Statement of the Problem

In recent decades, mental-health practitioners have faced an increasing number of multicultural, multilingual LEP clients seeking mental-health services (Gabrielson, 2010). It is widely predicted that the number of such individuals will continue to grow. Owing to the lack of bilingual mental-health providers to match the growing number of immigrants and LEP individuals who are seeking care, a third-party interpreter has become requisite. Previous

research examining interpreter-facilitated communication in mental-health care has focused almost specifically on anecdotal accounts, recommendations for practice, and calls for training in this area. Yet it is assumed that little-to-no practical training is offered in graduate psychology programs. Thus students and practitioners alike face the challenging task to overcome language barriers with little exposure to the challenges or practical knowledge required to provide interpreter-facilitated care.

If no changes are made to the field's current attempts to bridge the language barriers for LEP and minority clients, monolingual psychologists will face the task of providing care with little-to-no training on how to work with interpreters. Given the realities of a multi-lingual society, it is past due for the calls for training in this area to result in competency-based professional programs.

Statement of Purpose

To the knowledge of this researcher, an evaluation of current training practices and potential barriers to training on the utilization of foreign-language interpreters in graduate psychology programs has not yet been conducted. In addition, no consensus on guidelines and recommendations, beyond the generic APA mandate to utilize an interpreter when necessary, currently exists in psychology. The purpose of this research is to gain an awareness of current practices and barriers to further training as well as a consensus on the necessary professional competencies for conducting therapy through language interpreters. It is believed that the outcomes of this research will be a crucial next step in preparing students to work more frequently and effectively with language interpreters.

Research Questions

This study addresses the following research questions:

1. What current practices and instruction relevant to language interpretation characterize multicultural courses in graduate psychology programs according to course instructors?
2. What is the relative importance of guidelines for professional competence in working with language interpreters according to instructors of graduate multicultural psychology?
3. In what ways does the provision of guidelines of competence for training graduate psychology students affect the current or future practices of graduate multicultural instructors with regard to language interpretation?
4. According to multicultural psychology instructors, what barriers currently stand in the way of incorporating such guidelines and instruction into multicultural courses?

Method

This study involved a cross-sectional design and the administration of a questionnaire regarding training psychologists in the ethical use of a language interpreter in psychotherapy. The methods proposed for this study were reviewed and approved by the human subjects institutional review board (IRB) of Brigham Young University (BYU).

Procedure

This study sought to obtain responses from the instructors of multicultural psychology courses in APA-accredited Ph.D. programs in clinical and counseling psychology. Instructors from PsyD programs were not recruited for several reasons: (a) counseling psychology and clinical psychology programs tend to be similar to one another; (b) PsyD programs often hire adjunct instructors, which may introduce inconsistencies in teaching style and the training provided; (c) each participant was given $10 for participating, which limited the amount of participants because of lack of funding. At the time this study was conducted, the APA website listed 241 accredited PhD programs in clinical or counseling psychology. An undergraduate research assistant sought to obtain contact information for all instructors of multicultural classes for those 241 programs. Contact information for instructors was not obtained in 49 instances owing to several factors: (a) faculty or staff members at the university reported that multiculturalism was infused across the program, with no single course specific to multicultural psychology; (b) online program catalogs did not contain a specific course in multicultural psychology, and the staff member contacted could not identify such a course offered on a consistent basis; and (c) the online information was inadequate to ascertain whether there was a course specific to multicultural psychology, and/or staff members did not respond via telephone to several inquiries about the course.

The 192 instructors who were identified through our inquiries were sent an email requesting their participation in the survey (with a link to the online survey that was stored and distributed by Qualtrics; see Appendix B). Potential participants were also sent information providing informed consent and a link to a $10 Amazon gift card as an incentive for participation. A postal letter with a paper copy of the survey was also sent in case any potential participant preferred to complete a hard-copy survey and return it in a postage-paid return envelope. A follow-up email request to participate was sent about one week after the postal letter had been mailed. Of the 192 surveys distributed, 117 (60%) were electronically verified to have been opened online, with 85 of the surveys being completed online. An additional 17 surveys were completed and returned via postal mail. Thus, the total response rate was 102 out of 192 (53.1%).

The letter and the email contained information regarding informed consent. Participants were not asked to report personal information, and the anonymity of the data was maintained to encourage forthright responses to survey items. That is, identifying information was removed permanently from the data, and the received letters were destroyed after data entry. In addition, any identifying information was omitted from the results section of this article. Participants spent approximately 14 minutes completing the four parts of the survey, including time taken to review the nine competencies presented in it.

Participants

The target population consisted of instructors of multicultural psychology courses who had recently taught (within the last two years) or were currently teaching such a course in an APA-accredited psychology doctoral program. Multicultural psychology course instructors were chosen because they were most likely the faculty members best informed about the APA

guidelines addressing linguistic diversity. They would also be in the best position to evaluate current training efforts for working with interpreters as well as barriers to such training, and they would be in the best position to offer potential solutions to the problem. Lastly, those who had recently taught the course were sought after owing to their direct or recent involvement in training graduate students.

Of the 102 participants completing the survey, 95 indicated affiliation with APA-accredited Ph.D. programs in Clinical (57, 56.4%) and Counseling (38, 37.5%) Psychology, with seven participants reporting unclear information or not responding to the question. The participants reported having taught the multicultural course for an average of 7.5 years, with the average number of students enrolled in each course 18. Most participants (61%) stated that they taught the course once a year, with 33% teaching it less than once a year, and another 6% indicated that they taught it every semester.

Measures

A survey (see Appendix B) containing questions about training relevant to the use of language interpreters in therapy was administered to psychologists teaching multicultural coursework in these APA-accredited programs. Similar to previous studies evaluating training on topics in psychology (e.g., Kleinfelder, Price, Dake, Jordan, & Price, 2012), the survey included questions about the current practices and proposed guidelines as well as potential barriers.

The survey consisted of four sections. The first inquired about current educational practices. The requested information included contextualization, including the average number of students enrolled in the multicultural course as well as specific information about content, like the degree to which client language and language interpretation are covered in the class.

The second part of the survey addressed the instructors' personal opinions about the topic of language interpretation (e.g., "To what degree do you believe client-therapist language differences impact psychotherapy?"; "How likely are you to discuss the use of language interpreters in the next multicultural class that you teach?"). The third part of the survey asked participants to rate the following nine skills in terms of their importance and usefulness in clinical practice. These skills or competencies were derived by the author of this study based on a systematic review of the literature. He reviewed previous recommendations and suggestions from published articles and adjusted both the content and format of these suggestions in order to cover the essential areas of training needed as determined by the author. They are as follows:

1. Ethical selection of an interpreter (professional background, certification, cultural background, comfort level with mental-health interpreting, availability for on-going therapy, etc.)
2. Orientation/coordination with the interpreter:
    - Maintaining confidentiality and role boundaries. Identifying and minimizing any conflict of interest or dual relationships.
    - Sharing essential information about the client that will assist in interpreting (vocabulary, activities, and mental-status exams).
    - Clarifying treatment processes regarding any testing procedures, interview protocols, or psychotherapeutic techniques that may be employed as well as any sensitive issues that may be raised like suicidal ideation or abuse history.
    - Identifying cultural considerations and information that the interpreter believes will be helpful to the clinician in his/her understanding of the client's cultural worldview.
3. Set-up for an interpreter-facilitated encounter (e.g., seating arrangement, written materials, increased session length to account for interpretation time).
4. With the client present, clarify roles, responsibilities, and confidentiality within the triad.
5. Appropriate communication within the triad:
    - Clinicians' verbalizations should be succinct (no technical language or colloquial expressions). In particular, compound or multiple questions should be avoided.
    - Clinicians should speak directly to client. Any side conversation between client and interpreter needs to be interpreted. Eye contact should remain with the client.

- Clinicians monitor client accuracy of understanding.

6. Addressing of relationship dynamics in the triad. Issues of transference and countertransference should be dealt with appropriately.
7. Post-session debrief with the interpreter. Therapists can benefit from an open-ended query seeking the interpreter's general impressions of the session, including fit with the client.
8. Gathering additional cultural or linguistic information from the interpreter that may help the clinician better understand the client and/or make a diagnosis or treatment plan.
9. Assessing the interpreter's comfort, fit, and needs. Assess interpreter reactions to client trauma, and if needed, provide emotional support, refer interpreter for further care, or suggest the possibility of using a different interpreter.

The fourth and final part of the survey obtained feedback from course instructors about possible implementation of the nine skills just presented as well as potential barriers to their implementation. Questions worded in generic terms in the second part of the survey (prior to the presentation of the instructional guidelines) were presented again in the fourth part, with wording specific to the instructional guidelines. This process allowed the researchers to ascertain the degree to which participants' exposure to the instructional guidelines resulted in any changes about the participants' opinions on using language interpreters or their willingness to include this content in their future classes.

Data Analysis

This study involved two types of analyses: (a) content analysis of open-ended responses and (b) descriptive statistics for numerical ratings. The analyses reported in this study are similar to those used in a previously published study addressing different specific areas of training in psychology (Kleinfelder et al., 2012). Specifically, participants provided both open-ended responses and descriptive ratings about (a) the content and format of the multicultural class they taught, (b) the importance and relevance of instruction specific to the use of language interpreters in psychotherapy, (c) the utility and relative importance of the above-mentioned nine skills when working with language interpreters, and (d) the barriers faced by instructors when considering

implementation of the aforementioned guidelines. Space was also provided for instructors to share their own insights or comments about the research or the topic of language interpretation in psychotherapy. Responses to these open-ended questions comprise the qualitative data that was analyzed using conventional content analysis methods.

Content analysis, as used in the current study, is a method for systematically classifying open-ended responses to survey questions so that frequent and notable themes may be identified. As is true in conventional content analysis, the data were used to establish the codes and themes; thus, no coding frames or interpretations were made prior to viewing the data (Hsieh & Shannon, 2005). This technique can be described procedurally through a number of steps including sampling, coding, drawing inferences, and validation (Krippendorf, 2004; Schreier, 2012). Essentially, this process involves the organization of subjective responses or units of data into distinct and meaningful categories. Such an approach enables the researcher to provide aggregate accounts of inferences from the data that reveal trends, patterns, and differences that may not be apparent without such an analysis (Krippendorf, 1989; Schreier, 2012).

To enhance the reliability of the coding, the same two coders were used throughout the data-analysis process. For reasons of external validity, the process of data analysis will be described in detail. Responses to open-ended questions were reviewed by a graduate student (Ph.D. candidate in counseling psychology) and an undergraduate research assistant to identify codes and establish a coding frame. In this study one or more codes were used for each of the qualitative responses provided. After coding frames were established independently, the raters collaborated on a single coding frame for each of the questions. The initial coding was completed independently by the raters, after which consensus meetings were used to reconcile discrepancies and to create a separate spreadsheet where reconciled data could be kept. It is

noteworthy that both the author and the undergraduate research assistant were equally responsible for adjusting the coding frame and that any adjustments made were arrived at through dialogue between coders. Coding continued in the aforementioned manner with consensus meetings occurring after every 50 responses were coded to ensure continuity and to address possible issues (i.e., coding frame additions/subtractions) as they arose. Inter-rater reliability for these units of data (see Table 1) met research standards of at least 80% for consensus among raters (Hayes & Krippendorf, 2007).

Table 1

Inter-rater Reliability for Qualitative Questions

Question	Inter-rater Reliability
Q5	88.3
Q8	83.4
Q9	73.8
Q12	87.1
Q14	90.1
Q15	87.3
Q16	80.5
Q19	73.8
Overall	83.04

Results

Responses to open-ended questions were analyzed separately from responses to numerical ratings. The content analyses of participants' responses to open-ended questions revealed several themes pertinent to addressing the proposed research questions. Themes occurring most frequently (accounting for at least 10% of the overall responses to the question) are detailed most extensively. Owing to the low frequency of responses shown in Table 5, responses were analyzed by comparing the themes to the actual list of provided competencies rather than discussing frequencies. Analyses of information ancillary to the four research questions are provided at the end of this section.

Research Question #1: Current Practices and Instruction in Multicultural Psychology Doctoral Courses

To address the first research question about current coverage of language interpretation in multicultural psychology doctoral classes, participants responded to questions about the content of their existing multicultural coursework. Responses indicated that 44% (45 out of 102) of instructors provide some form of training in language interpretation in psychotherapy. Specific responses can be found in Table 2.

Table 2

Responses to Questions Regarding Current Training Being Provided on Work With Interpreters in the Graduate Multicultural Course

Category	Example	Frequency	%
Class Lecture/Discussion	"Discussion of recommendations and implementation."	34	72
Provision of Resources to Students	"Readings on effective approaches."	25	53
Expert Instruction	"Lecturer who has worked with interpreters."	9	19
In-class Practice	"Role playing."	7	15
Clinical Opportunities	"Encourage exposure during practicum."	5	11
Address Topic in Separate Course	"This gets some coverage in classes like ethics."	4	9
Teach Practical Skills	"Methods and techniques to gauge meaning of language for…"	2	4

Note. Excluded from this table are the 55 (39%) responses that were left blank or that were of questionable validity (e.g., participants misunderstood or did not complete the questionnaire as intended)

Two themes were frequently reported: *class lecture/discussion* (n = 34, 72%) and *provision of resources to students* (n = 25, 53%) Two other themes were reported less frequently but still accounted for a significant percentage of responses*: expert instruction* (n=9, 19%), *in-class practic*e (e.g., role playing) (n=7, 15%), and *clinical opportunities* (n=5, 11%). An instructor wrote,

> Typically, I start with exercises where students have to act as translators, and the class gets a chance to observe the challenges in communicating through an interpreter. We then discuss some of the barriers students can foresee in working with interpreters. We then develop guidelines as a class for things to consider when working with interpreters (e.g., selecting of appropriate interpreters, clarifying roles, etc.). Lastly, students complete readings on working with interpreters.

While another instructor wrote:

> I have done some research in this area and have done a webinar for the NYS Department of Mental Health. I use those slides from that webinar that discusses types of interpreter roles (conduit, clarifier, cultural broker, etc.), why professional interpreters should be

> used (versus a family member or other ad-hoc interpreter), the pre-session meeting, how to negotiate the introduction (confidentiality, etc.), speaking in brief segments and directly to the patient, etc. I also show them some training clips on YouTube if time allows. UCLA has a good one.

Other respondents echoed the above sentiments with slight variations related to implementation. However, in several instances (as seen above), instructors appear to have been thoughtful about the topic and have implemented strategies that seem to be working well. Another instructor wrote:

> The implications of "language" differences are discussed—and by language we include worldview. The importance of and how to interface with cultural resources (e.g., local healers and holder of cultural wisdom) is part of this. Also discussed are how to select an interpreter, confidentiality issues, and pre-session work (e.g., letting interpreter know what some of the issues are, key terms, etc.).

As can be seen, some instructors incorporate training on the use of language interpreters into a broader conversation of language and psychology. Some instructors indicated that they included it during discussions about the intersection of psychotherapy and multiculturalism. Another indicated that training was provided through "individual supervision," which might be a possibility for several instructors depending on their job title and whether or not they were involved directly with clinical services.

One instructor, though not currently providing training on the topic, indicated that there was an increasing need for his students to receive training in this area. He wrote, "None at this time, yet this need has become increasingly apparent for our students at certain clinical practicum sites."

Given their uniquely situated position to know both the importance of and the barriers to including training on work with language interpreters, instructors were also asked how they could envision such training taking place in a multicultural course. It is noteworthy that themes derived from their responses almost exactly mirrored the reports of current training procedures occurring in graduate programs. Specific responses can be found in Table 3. Four themes were frequently reported: *expert instruction* (*n* = 26, 37%), *provision of resources to students* (*n* = 22, 31%), *instruction through separate lecture/module* (*n* = 15, 21%), *in-class practice* (*n* =1 4, 20%), *provision of relevant placements/experiences through practicum* (n=9, 13%), and *content infusion across required courses* (n=9, 13%). Themes that were discrepant from practices currently being utilized by instructors included *training for instructors* (*n* = 3, 4%), *content infusion across required courses* (*n* = 9, 13%), and *the development of instructional videos* (*n* = 1, 1%).

Table 3

Responses to Questions Concerning how Training on Work With Language Interpreters Could be Integrated Into Multicultural Coursework

Category	Example	Frequency	%
Expert Instruction	"Bring in guest speakers who are mental health trained language interpreters"	26	37
Provision of Resources to Students	"Provide assigned readings."	22	31
Provide Instruction Through Separate Lecture/Module	"As a lecture/discussion module, like we do with other important issues."	15	21
In-class Practice	"The use of demonstrations with a mock therapist, mock client, and interpreter would be helpful."	14	20
Provision of Relevant Placements/Experiences Through Practicum	"Through clinical sites/practicum experiences."	9	13
Incorporate Discussion Throughout Different Content Areas of Course Curriculum	"I think this should be integrated when discussing different dimensions of diversity…."	9	13
Content Infusion Across Required Courses	"Such work should be integrated in treatment and assessment courses"	7	10
Training for Instructors	"This would require faculty education/training first since this was not part of my Ph.D. curriculum."	3	4
Create an Advanced Multicultural Training Course	"An advanced multicultural psychology class can also devote time to skill building in this area."	3	4
Develop Instructional Videos	"It would be helpful if a training video was developed that could train the class on…"	1	1

Note. Excluded from this table are the 32 (23%) responses that were left blank or that were of questionable validity (e.g., participants misunderstood or did not complete the questionnaire as intended.

In regard to the inclusion of training on the use of foreign-language interpreters, one instructor wrote,

> This could be incorporated both empirically and experientially by including relevant academic articles, incorporating relevant training videos, encouraging the provision of continuing-education workshops for licensed psychologists and doctoral student trainees on this important topic, inviting experienced therapist-interpreter pairs to share their experiences and expertise with doctoral students and clinical faculty, creating opportunities for students to gain experience interacting with an interpreter firsthand while conducting therapy at a practicum site.

Another instructor identified a more specific way to integrate training:

> I think integrating training on interpreters into multicultural courses can be done by linking it to (a) establishing rapport/a therapeutic alliance and (b) the careful interpretation of information provided by clients. Since establishing a relationship and careful interpretation of information from clients are already central to courses on multicultural psychology, working effectively with interpreters can easily be integrated as an important part of attaining these objectives in the case where the client and therapist do not speak the same language.

Another instructor highlighted a pragmatic barrier as well as a solution to that barrier by stating, "It would probably have to be resource-based rather than instructional. Many students may not see clients in that context for years after the class and knowing about how to go about finding resources would probably be better than direct instruction. . . ." Thus, it appears that most instructors can at least conceive of ways in which such training could be implemented, even if it were simply through the provision of an article or a reference to an article.

One instructor indicated that "instructors need to be trained first," highlighting the possibility that integration may need to begin with training for instructors. Another instructor suggested that this training might be better integrated into other courses by stating, "I think this is more largely an important component to be regularly discussed during clinical practica." Both statements reflect suggestions outside the current practices mentioned above.

Research Question #2: Relative Importance of Proposed Professional Competencies

An additional area of investigation was the relative importance of the proposed competencies. Instructors were asked to read and re-arrange a list of nine competencies in rank order, reflecting their estimation of the relative importance of each. Results are presented in Table 4, which provides information regarding the two ways in which these data were analyzed.

An initial analysis revealed that in some instances the arrangement of competencies remained in about the same order in which they had been presented, such that the instructors could have either misunderstood the instructions or, more likely, invested little effort in evaluating the relative importance of each competency. When this lack of evaluation occurred, it could have led to unjustifiable importance being given to the first several competencies presented on the list. Thus, a separate analysis was undertaken in which only data that had been adjusted from the original presented list were analyzed. That is, this second analysis included only respondents (98 of 102) who had ranked concepts in an order different from that of the original list on the survey.

Table 4

Descriptive Statistics for Rank Ordering of Competencies

Rank	Overall Rankings of Proposed Competencies	Mean	Median	Standard Dev.	Overall Rankings When Changed from Initial Order	Mean	Median	Standard Dev.
1	How to ethically select an interpreter	2.37	1.0	1.97	How to discuss roles, responsibilities, and confidentiality in the triad	3.13	3.0	1.67
2	How to discuss roles, responsibilities, and confidentiality in the triad	3.23	3.0	1.59	How to facilitate effective communication in the triad	3.61	3.0	2.20
3	How to facilitate effective communication in the triad	3.98	4.0	1.98	How to ethically select an interpreter	4.08	4.0	1.86
4	How to orient the interpreter prior to the session	3.98	4.0	2.18	How to orient the interpreter prior to the session	4.61	4.0	2.14
5	How to set up the session to enable interpretation	5.44	5.0	2.23	How to collect relevant cultural and linguistic information from the interpreter	5.24	5.0	2.15
6	How to collect relevant cultural and linguistic information from the interpreter	5.61	6.0	2.21	How to address relationship dynamics in the triad	5.65	5.0	2.09
7	How to address relationship dynamics in the triad	5.74	6.0	1.78	How to set up the session to enable interpretation	5.83	6.0	2.20
8	How to assess an interpreter's comfort, fit, and needs	6.94	7.5	2.19	How to assess an interpreter's comfort, fit, and needs	5.86	7.0	1.98
9	How to conduct a post-session debriefing with the interpreter	7.84	8.0	1.18	How to conduct a post-session debriefing with the interpreter	8.09	8.0	1.24

Note. Four responses were excluded from this table due to the respondent leaving the competencies ranked in the same order originally presented.

Both analyses yielded similar results, with the same three competencies ranked in the top three spots. In the first analysis inclusive of all participants, instructors rated instruction on how to ethically select an interpreter as the most important competency to be gained by graduate

students. This was followed by knowledge of how to discuss roles, responsibilities, and confidentiality within the triad, with the third competency being knowledge of how to facilitate effective communication in the triad. The second analysis, which investigated only those data in which the initial ordering was changed, resulted in the knowledge of how to discuss roles, responsibilities, and confidentiality within the triad being ranked as the most important competency. Knowledge of how to facilitate effective communication in the triad and how to ethically select an interpreter were ranked as second and third, respectively.

It is noteworthy that while the results varied slightly as to the order of the three most important competencies, each analysis yielded the same result in regard to the two least important competencies. In both cases, how to assess an interpreter's comfort, fit, and needs was ranked in the eighth spot, while how to conduct a post-session debriefing with the interpreter was ranked as least important (ninth spot) in both analyses.

To ensure that the presented competencies not only accurately reflected current literary findings in the field but also the ideas of those responsible for ensuring that students gain the competencies, instructors were asked to reflect on the list of competencies provided by the researchers and indicate whether important items for consideration had been omitted. Specific responses are found in Table 5. When comparing the responses contained in Table 4 with the original list of competencies presented to respondents, it is apparent that there is some overlap. For example, the Relationship Issues theme derived from one response (e.g., "It is important to assess the relationship, if any, that may exist between the interpreter and the client that may interfere with ethical and truthful interpretation of the content of the session") is covered directly under the competency entitled how to orient/coordinate with an interpreter prior to the session. Another instructor wrote, "I'd be sure interpreter-therapist countertransference is on the table as

well." This particular issue is covered directly under the competency of Addressing Relationship Issues within the Triad. Thus, without further description of the provided competencies, instructors may have quickly passed over them or simply may have not viewed certain ones.

Table 5

Responses to Questions About Proposed Competencies That Were Omitted From the Presented List

Category	Example	Frequency	%
Interpreter Qualifications and Type of Interpreter	"Why professional interpreters are recommended over family members or other ad hoc interpreters."	6	30
Evaluation of Client Preferences	"How to determine if the client would prefer a therapist who speaks the same language."	4	20
Difficulties Finding an Interpreter	"What to do if you cannot find an interpreter."	3	15
Cultural Considerations	"How to understand cultural values of clients using interpreting services."	3	15
Ethical Issues	"Ethical considerations re: use of interpreters by necessity."	3	15
Methods of Interpretation	"Use of phone interpreter services."	3	15
How Interpretation Changes Accuracy of Information	"How the use of an interpreter impacts the accuracy of information gathered..."	3	15
Orientation of Client to Interpretation	"Orientating the client to an interpreter."	2	10
Legal Rights and Pertinent Laws	"How to discuss with the patient their rights to an interpreter."	2	10
Clarification of Terminology/Methods	"Difference between an interpreter and a translator."	2	10
Relationship Issues	"It is important to assess the relationship..."	1	5
Advocacy for Interpreter Services	"How to advocate for interpreter services within an agency."	1	5
Session Duration	"…duration of sessions/consultation/treatment."	1	5
Interpreter Consistency	"…because there is a different interpreter every time."	1	5
Reimbursement	"Guidelines for reimbursement of language interpreters."	1	5

Note. Excluded from this table are the 82 (69%) responses that were left blank or that were of questionable validity (e.g., participants misunderstood or did not complete the questionnaire as intended)

However, instructors provided several responses that addressed nuances of mental-health therapy interpreting, which could further enhance the list of competencies provided by this research. Some examples include "Actual process of finding the interpreter, especially in more isolated/smaller population areas." This response was echoed by other instructors who expressed concern about finding interpreters in certain geographic constraints. Another instructor wrote,

"Orientating the client to an interpreter; Assessing if client needs or would like an interpreter; Inclusion issues if client brings his/her own interpreter. Basically, competencies that are central to the client's role in working with an interpreter." This response seems to be advocating for a more client-centered decision-making process. Knowledge of patient and civil-rights laws was also highlighted by several instructors as was knowledge of how non-professional interpreters (e.g., family) can negatively affect the therapeutic process.

Research Question #3: Influence of the proposed competencies on changing participants' ratings.

Prior to viewing the proposed competencies, instructors were asked on a scale of 0-100 how likely they were to include training on work with interpreters in their next course they taught. Towards the end of the survey (after reviewing the presented list of competencies), instructors were again asked about the likelihood of incorporating training in this area in their next course. Results of statistical tests comparing initial responses to subsequent responses can be found in Table 6. A paired samples t-test revealed no significant difference after the competencies were presented. Although the mean difference (+4.50) from initial to post approached significance ($p = .057$), it did not reach the cutoff.

Table 6

Descriptive Statistics for Responses to Quantitative Questions

Question	Mean	Median	Standard Dev.	Range
Initial Response				
Importance of professional training on the use of language interpreters in psychotherapy (0-100)	72.58	72.5	19.03	10-100
Likelihood of addressing work with language interpreters in next taught course (0-100)	65.62	81.0	38.16	0-100
Subsequent Response				
Importance of professional training on the use of language interpreters in therapy (1-100)	72.29	74.5	22.42	2-100
Likelihood of addressing work with language interpreters in next taught course (0-100)	72.55	82.0	31.85	0-100
Other				
Degree to which language impacts psychotherapy (0-10)	7.64	8.0	1.97	2-10
Likelihood of incorporating competencies in next taught course (0-100)	63.57	70.0	31.45	0-100

A second question required instructors to rate (0-100) the importance of training on the use of language interpreters. After viewing the competencies, they were asked the same question again towards the latter end of the survey. In this case, a paired-samples t-test did not reveal any significant difference between initial (72.58) and subsequent (72.29) mean values.

Likelihood of incorporating proposed competencies. Connected to the rating of proposed competencies and the evaluation of their impact is the question of whether or not instructors would incorporate the competencies presented. After viewing the list of proposed competencies, instructors were asked to rate (0-100) how likely they would be to incorporate the competencies into the next time they taught this course. As seen in Table 6, the mean was 63.57, indicating that in general the instructors were more rather than less willing to incorporate the competencies into their next taught course. However, the results also indicated that instructors were not particularly enthusiastic about incorporating the content. Responses were also characterized by substantial variability.

Instructors' vision for utilization of proposed competencies. Instructors were asked to describe how they might utilize the proposed competencies in future courses. Five themes appeared most frequently across responses: *generate lecture/discussion* (n = 40, 65%) and *provision of resources* (n = 33, 53%), *in-class practice* (e.g., role playing) (n=13, 21%), *expert instruction* (n=12, 19%), and *content infusion within MC course* (n=10, 16%). As can be seen in Table 7, the responses closely mirror current teaching methods used by instructors (e.g., *discussion*, *resources*, *in-class practice*, and *expert instruction*). Responses provided to other questions concerning integration were also noted here (e.g., content infusion). However, one instructor uniquely responded that he would ". . . routinely include (them) in clinical supervision. . . ." As mentioned earlier, it appeared that some instructors might also provide supervision to student trainees and might thus be uniquely situated to provide both theoretical and applied training.

Table 7

Responses to Questions Concerning how the Instructor Would Integrate the Presented Competencies Within Multicultural Coursework

Category	Example	Frequency	%
Generate Discussion/Lecture	"Set aside a classroom session or a portion dedicated to the topic."	40	65
Provide Resources	"Provide a copy of the competencies."	33	53
In-class Practice	"…we can engage in role plays that allow students to practice…."	13	21
Expert Instruction	"Professional guest speaker who is an expert in this area."	12	19
Content Infusion Within MC Course	"I could include them as an example of addressing language issues..."	10	16
Would Not Incorporate Them	"I wouldn't in a ten-week multicultural course."	4	6
Content Infusion Across Courses	"Include in relevant sections of ethics classes."	3	5
Use for Clinical Purposes	"…routinely include in our clinical supervision..."	1	2

Note. Excluded from this table are the 40 (26%) responses that were left blank or that were of questionable validity (e.g., participants misunderstood or did not complete the questionnaire as intended)

Reasons for not incorporating competencies in next taught course. The instructors were asked to indicate whether they would utilize the proposed competencies in their next taught course. Those who declined to utilize the list of competencies were asked to provide a reason for their decision. Four themes were frequently reported*: time limitation given volume of topics* (n = 21, 53%), *intent of course* (n = 13, 33%) *topic priorities* (n=9, 23%), and *lack of instructor competence* (n=6, 15%). As can be seen in Table 8, more than half of the responses noted the barrier of time limitation given volume of topics, which is a dilemma detailed more extensively below. Others indicated that the purpose of the course might differ across programs. One instructor stated, "This course privileges a theoretical-philosophical approach and content." Likewise, instructors might also choose topics relevant to the intent of the course as they saw fit. For example, one instructor wrote, "Because it is not what I emphasize in multicultural counseling class. Also, I do not have the expertise to incorporate this into the way that I teach the class." This statement also highlighted the lack of training provided to instructors, which would prohibit a lecture or discussion in this area.

When providing demographic information, instructors indicated that on average there were 18 students enrolled in their multicultural course. Instructors provided responses, though occurring less frequently than those mentioned above, that showed the problems associated with teaching a course with a high volume of students as well as students from several different training programs both within and outside the field of psychology. For example, when talking specifically about this difficulty, one respondent stated, "My course roster includes school psychology and I/O psychology doctoral students as well as clinical students." Thus, it appeared that instructors were mindful of tailoring their instruction to their audience.

Table 8

Responses to Questions About why one Would not be Willing to Utilize the Presented List of Competencies During the Next Multicultural Course

Category	Example	Frequency	%
Time Limitation Given Volume of Topics	"…too many demands to meet and there would not be enough time to do justice."	21	53
Intent of Course	"This course privileges a theoretical-philosophical approach and content."	13	33
Topic Priorities	"I see the most important issues as promoting self-awareness...."	9	23
Lack of Instructor Competence	"I do not have the expertise to incorporate this..."	6	15
Not Applicable Geographically	"…not a huge need in region."	3	8
Opposed to Interpreter Usage	"Not a fan of using interpreters."	3	8
Student Priorities	"…most students will likely see this as an issue too far removed from their present training."	2	5
Diversity of Students Taking Course	"My course roster includes school psychology and I/O psychology doctoral students, as well as clinical students…"	1	3
Unaware of Resources	"I don't have a go-to article or chapter to slot in."	1	3

Note. Excluded from this table are the 62 (51%) responses that were left blank or that were of questionable validity (e.g., participants misunderstood or did not complete the questionnaire as intended)

Research Question #4: Barriers to Implementation

In order to obtain a clearer picture of the challenges facing instructors, they were asked to describe the barriers that currently impede the coverage of competencies related to work with interpreters. Specific responses can be found in Table 9. Four main themes emerged: *time limitations/volume of topics* (*n* = 40, 49%), *limited resources for training* (*n* = 19, 23%), *lack of training/experience for instructors* (*n* = 12, 15%), and *limited access to professional interpreters* (n=8, 10%).

Table 9

Responses to Questions Regarding Which Current Barriers are Impeding the Coverage of Competencies Related to Work With Interpreters

Category	Example	Frequency	%
Time Limitations/Volume of Topics	"Lack of time/space in the course."	40	49
Limited Resources for Training	"Resources—access to people who speak other languages for role plays, simulations."	19	23
Lack of Training/Experience for Instructor	"Many instructors are not competent themselves."	12	15
Limited Access to Professional Interpreters	"…cost of interpreters and facility ability to pay for them."	8	10
Intention/Structure of Course	"The class is multidisciplinary and very large, so it is challenging to cover specific training…."	6	7
Student Motivation to Learn Material	"…it can be hard to 'convince' some less culturally aware students of the practicality of these training elements."	6	7
Opposed to Interpreter Usage	"Not valuing the use of interpreters."	5	6
Prioritization of Topics to Cover	"Given the large number of racial-cultural variables that require coverage in a course, I won't likely have time to devote to this topic."	4	5
Ethnocentrism	"Ethnocentrism."	3	4
Relevance of Training to Future Work	"Many students have not, or may not in the future, work with interpreters."	2	2
Avoidance of Extra Work for Therapist/Facility	"Not wanting to do the extra work involved in using interpreters."	2	2
Lack of Special "Advanced" Course to Cover Topics	"I could imagine an advanced course where we engage in more hands on training."	2	2

Note. Excluded from this table are the 21 (16%) responses that were left blank or that were of questionable validity (e.g., participants misunderstood or did not complete the questionnaire as intended)

Of the 81 instructors that provided a response to this question, 40 mentioned that they experience difficulty managing time in relation to the number of topics that require coverage in the graduate multicultural course. One instructor wrote, "Time. There are so many topics that could be covered as well as a wealth of available resources. Not every topic can be covered in a deep and meaningful way within a 45-hour course." Another simply wrote, "Time, time, and time." In terms of limited resources for training, instructors emphasized a lack of access to professional interpreters in general as well as for training purposes (e.g., live simulations). They also noted that in some cases there is an inability for an individual or training site to pay for interpreter services.

Another frequently reported theme was noted as instructors cited their own lack of competence/prior training as a barrier to providing training to students. One instructor highlighted the barrier in this manner: "comfort level of the instructor with introducing the newer material, especially if they are inexperienced with working with an interpreter in psychotherapy themselves." Another instructor stated, "Many instructors are not competent themselves. I came to competence accidentally, having worked as an interpreter/translator for several years before applying for graduate school." It appears that training in this area was unavailable to graduate students who may have been trained some time ago.

Limited access to professional interpreters was another commonly cited barrier to training. Instructors indicated that there were other factors associated with this barrier including cost and geographic location. One instructor stated that this barrier might especially apply to those who would otherwise use an interpreter: "We do not have much access to professional interpreters at all, so we often don't have the choice even when it would be very helpful." This may be a point for further investigation of graduate programs and governing organizations.

Other noted barriers, though less frequent, are also instructive. One instructor responded in this way:

> The biggest problem seems to be when students have been exposed to "bad habits" of not utilizing or underutilizing professional interpreters and steering students from those habits—which they often counter with the limited resources [available] at community clinics and whether some service is better than no service when a professional translator is not available. Another barrier is that the large majority of my students are monolingual English speakers, and I think there can be a lack of appreciation or understanding regarding "native tongue," how this influences one's expression of self, emotionality, etc.

In a similar vein, another mentioned "ethnocentrism. Not wanting to do the extra work involved in using interpreters." Thus not all barriers may occur at an institutional or systemic level.

A final barrier that was previously mentioned by instructors was the intent/structure of their course. Here, instructors cited both the number of students and the diversity of their training programs as well as the course intent, which might have been more *exploratory*, for example, than *applied*.

Corollary Questions and Correlation Analyses

Instructor recommendations to increase adherence to APA's guidelines to provide psychotherapy in a client's preferred language. According to the "Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations" put forth by the APA, psychologists are required to interact in the language requested by the client, which can be done via a referral to a mental-health professional who is competent to interact in the language of the client or through the use of language interpreters. Adherence to this mandate is likely inconsistent at best, and it does not appear that the APA has created any way to systematically enforced this guideline. Given this predicament, multicultural-course instructors in this study were asked to provide recommendations for increased adherence. Table 10 lists the themes garnered from instructor responses. It is clear that many instructors perceived a general lack of awareness of the APA guidelines, civil-rights concerns, and/or ethical standards of practice to be a central issue (n = 13, 26%) and that efforts put into these areas would increase adherence. Other frequently mentioned themes included recommendations to *provide resources and incentives for training programs* (n=10, 20%), *increase opportunities for linguistically*

diverse students (n=10, 20%), *provide non-classroom-based training* (n=9, 18%), and *enforce the APA Guidelines* (n = 8, 16%),

Table 10

Responses to Questions Seeking Recommendations for an Increase Adherence to the APA Guideline to Provide Psychotherapy in a Client's Preferred Language

Category	Example	Frequency	%
Increase Awareness of APA Guidelines, Civil Rights, and Ethical Practice	"There should be more awareness about the guidelines in training programs...."	13	26
Provide Resources and Incentives to Training Programs	"APA can do a better job of disseminating these guidelines to training directors."	10	20
Increase Opportunities for Linguistically Diverse Students	"Recruit and train more multilingual therapists."	10	20
Non-classroom Based Training	"Webinar trainings"	9	18
Provide APA Enforcement	"APA needs to enforce the guidelines during accreditation..."	8	16
Increase Research/Articles on the Topic	"Continue to do this type of research and present at conferences."	4	8
Increase Access to Interpreter Services	"More access to interpreters, way to pay for services."	3	6
Require Certification of Both Interpreters and Therapists	"Greater efforts to promote training and certification of interpreters for clinical practice."	3	6
Encourage/Require Students to Learn Another Language	"I recommend students learn a language other than English and get training using that language in providing services."	3	6
Request Input from Other Relevant Organizations	"Request input from organizations such as NLPA."	1	2
Have Interpreters as Secondary Options	"…emergency cases where there is no other option."	1	2

Note. Excluded from this table are the 52 (44%) responses that were left blank or that were of questionable validity (e.g., participants misunderstood or did not complete the questionnaire as intended)

In regard to having APA enforcement, one instructor made this recommendation: "[The] APA needs to enforce the Guidelines during accreditation, along with issues of multicultural competency in general." Another stated, "I think adding this as a competency for APA-accredited programs is a good start. However, careful attention should be paid to what resources will be available to programs to support the use of interpretation services." Other instructors seemed less convinced that the APA would initiate such changes, with one instructor stating, "Language skills are not valued in tangible and substantive ways during APA accreditation processes. Create resources and incentives for training programs to train students with a variety of language skills." The desire for more enforcement from the APA seemed to be informed by a

concern about whether or not resources would be provided to enable programs to meet the guideline and reflected another central theme (*n* = 10, 20%).

Other instructors suggested that adherence to the APA mandate could come in the form of recruiting and training linguistically diverse students or by encouraging graduate students to learn a second language while in their program of study.

Impact of client-therapist language differences on psychotherapy. An investigation into the utilization of language interpreters is based on the straightforward assumption that language impacts psychotherapy. To determine whether or not this assumption was found at the graduate training level, instructors were asked to rate (0-10) the degree to which language impacted psychotherapy. As seen in Table 6, the mean response was 7.64, indicating that the majority of respondents believed that language did impact psychotherapy to a considerable degree.

Other areas/topics covered most frequently by multicultural-course instructors. Respondents were asked to indicate which topics/areas of instruction were given the most time in their respective courses. They were presented with four areas (cultural/racial issues, other diversity issues [gender, sexual orientation, etc.], assessment issues, and language issues). They were also given space to provide other areas given considerable attention. While it appears that respondents may have interpreted the aforementioned areas somewhat narrowly, their responses are worth noting. As seen in Table 11, five major themes emerged: *psychological issues/treatment* (n=12, 23%), *social justice/activism* (n=9, 17%), *self-awareness* (n=8, 15%), *research/science* (n=7, 13%), *intersectionality of topics* (n=6, 12%), and *socioeconomic status* (n=6, 12%). This table informs the reader of areas of instruction that received the most attention from multicultural instructors.

Table 11

Responses to Questions about Topics That Require Coverage in the Multicultural Education Course That Were Omitted From the Presented List

Category	Example	Frequency	%
Psychological Issues/Treatment	"Psychological processes varying by culture."	12	23
Social Justice/Activism	"Working for social justice."	9	17
Self-Awareness	"…understanding self in relation to others."	8	15
Research/Science	"Research issues."	7	13
Intersectionality of Topics	"…other policies that intersect with culture."	6	12
Socioeconomic Status	"Social class, economic disparities."	6	12
Immigrants/Refugees	Coverage of issues and ideas related to immigration	4	8
Models and Theories	"Cultural theory."	4	8
Disability	"Ability status."	3	6
Religion	Coverage of issues and ideas related to religion	2	4
Health Issues	Coverage of diverse health issues	1	2
Cultural Identity Development	Coverage of developmental factors and models as they relate to culture	1	2
Ethics	Discussion of ethical issues in multicultural psychology	1	2
International Issues	Discussion of topics related to international issues	1	2
Competencies (general)	Coverage of established competencies in the multicultural field	1	2

Note. Excluded from this table are the 50 (43%) responses left blank or were of questionable validity (where participants misunderstood or did not complete the questionnaire as intended).

Associations among variables. Lastly, correlation analyses revealed some important relationships among variables. These data may reveal associations between instructor behavior and the provision of instruction regarding the use of language interpreters. As for descriptive data, results revealed that the more years professors had taught the multicultural course, the greater percentage of their class they devoted to racial/cultural issues ($r = .30$, $p < .01$) and the more likely that they covered language issues ($r = .34$, $p < .01$).

Additionally, instructors who taught more content relevant to racial/cultural issues and language issues were more likely to indicate that language issues were important in therapy ($r = .29$, $p < .01$ and $r = .22$, $p < .05$ respectively). Likewise, instructors who covered more content relevant to multicultural assessment and language issues were more likely to spend greater time

covering language/interpretation issues in class ($r = .43$, $p < .01$) and to indicate that they planned to spend even more time covering language/interpretation issues in class in the future (Question 18 in the survey) ($r = .28$, $p < .01$).

Among those variables that were uncorrelated with any other variable, it is noteworthy that the average number of students enrolled in the multicultural class was unrelated to any of the other instructor responses.

Discussion

The purposes of this study were to (a) improve current understandings of how graduate training addressed the use of language interpreters, (b) determine the relative importance of proposed competencies for working with language interpreters in psychotherapy, (c) assess the instructors' suggestions for future improvement of training in this area, and (d) determine what barriers currently stood in the way of incorporating the aforementioned guidelines and improving instruction in multicultural coursework in APA-accredited doctoral programs.

Descriptive statistics for ratings and a qualitative analysis of open-ended survey responses suggest that not quite half of multicultural-course instructors currently provided some form of training in the area and that training methods varied widely (e.g., discussion, provision of readings, expert instruction, and in-class practice). Despite several formidable barriers (e.g., time, available resources, and training), instructors indicated that they were more willing than not to include training on this topic in future coursework. Furthermore, there was a consensus among the instructors surveyed about the most important elements of training that could ensure competency in their student trainees.

Summary of the Major Findings

To date, no previous research has investigated the actual training strategies used by multicultural instructors to address the topic of best practices for language interpreters in psychotherapy. According to the results of this study, 44% of respondents currently provided some form of training on the use of language interpreters in psychotherapy. This finding is surprising and largely discrepant from the assumptions made in most published articles, which have assumed that there is currently no training available in graduate programs. Despite the rising number of instructors addressing this topic, it seems to be the case that a slight majority (56%) are not. These findings suggest that while words such as "absent," and "minimal" previously used characterize training in this area may no longer be accurate, training is still inconsistent and insufficient in the field (Searight & Searight, 2009; Yakushko, 2009).

Instructors who addressed the issue of linguistic diversity did so using a broad range of techniques and instruction strategies. A number of instructors appeared to be covering the topic in great depth by developing PowerPoint presentations, accessing online training videos, engaging in thoughtful discussions with students, and inviting guest lecturers with experience of working with interpreters in a mental-health setting. Other instructors appeared to be content with providing readings/published articles or other resources like handouts. Several had created nuanced and thoughtful pedagogical strategies that would take an entire class period. However, such instructors were a numerical minority.

While many clinicians and providers can currently bypass (though ethically questionable) the use of interpreters, this may not be the case as immigrants, refugees, and asylum seekers continue to pour into the United States. Improvements are clearly needed. Hatcher et al. (2013) proposed that the psychology profession is responsible for changes in our knowledge of client

needs in connection to shifting demographics, and is then responsible to re-evaluate the competencies needed for professional practice. Multicultural researchers have suggested that this process is yet to occur in connection to linguistic diversity and work between clinician and interpreter, and that there is a need for clarity and consensus of competencies and training objectives for graduate students (Tribe & Thompson, 2011; Yakushko, 2010).

A major contribution of this research is that it allowed for multicultural course instructors to rank proposed competencies for training, and thus, provide some consensus on the most important aspects of training on the use of language interpreters for graduate students. In addition, instructors were encouraged to add their own thoughts and ideas about what should be included in the training competencies. Overall, it appears that the process of ethically selecting an interpreter and ensuring effective communication within the triad, including knowledge of how discuss roles, responsibilities, and confidentiality, were seen as the most important topics to be covered. Indeed, if limited by time and resources, instructors would do well to ensure the appropriate selection of interpreters and to instill effective communication skills in trainees.

The results were mixed in regards to the impact that exposure to proposed competencies had on respondent beliefs and attitudes. Clearly, instructors rated the training on the use of language interpreters as important. Yet, after viewing proposed competencies and answering questions about training in this area, instructors did not indicate that they viewed training in this area as more important than previously reported. It is possible that this may be due to their initial rating indicating a high level of importance, and thus, an increase to that rating may inflate the importance of this topic relative to the abundance of topics to be covered in the multicultural course. It is also plausible that within the mix of topics and issues necessary to cover, work with

interpreters in therapy may not have been seen as more important than many other issues thought to appear more frequently in therapy.

The researcher also expected the review of proposed competencies to impact the future instruction of the respondents. Even though there was a notable increase in instructor willingness to provide training in this area, it did not reach a significant level. One possible explanation for this finding is that instructors of multicultural coursework tended to closely follow APA guidelines, established competencies, and ethical principles. Given that the proposed competencies were only hypothetical in nature and were not specifically endorsed by the APA, instructors might have been wary about utilizing them in the future. Several instructors inquired as to whether or not such competencies were established by the APA. Also, similar to above, instructors initially indicated that they would be more willing than not to provide training on the use of language interpreters in future. Thus instructors may not have felt the need to increase their willingness to address this area of training.

Boyer and Ramsey (2005) posited that multicultural instructors face an "innumerable" amount of challenges as they deal with the complexities of teaching a multicultural course. The intention of this research was not to add to the already large amount of topics requiring coverage but to better understand the barriers that instructors face specific to training on the use of language interpreters and to learn how some instructors circumvent these barriers. Not surprisingly, instructors commonly cited a lack of time combined with too many topics to cover as a major barrier to adding additional training topics. Such findings emphasize a major dilemma that instructors face in regard to the prioritization of topics. Similar to the findings of Bigatti et al., (2012), instructors noted their lack of training on the topic, including the lack of training in their own graduate programs and the scarce opportunities for current training in this

area. Thankfully, as evidenced by those currently providing such training, some multicultural course instructors have found ways to circumvent these barriers.

Additional Findings

This study also sought the recommendations of current multicultural instructors in regard to what actions might be taken to ensure better adherence to the APA mandate to provide an interpreter when necessary. Instructors frequently suggested more coordination between APA accrediting committees and psychology training programs. Suggestions were made about increasing incentives or resources for training programs to take steps that would ensure ethical practice in this area. Other instructors indicated that questions regarding adherence to the aforementioned mandate ought to be a part of the accreditation process.

Since many instructors cited their lack of competence in this area as a major deterrent from providing training to students, non-classroom-based training (e.g., webinars) might be another way to increase competence in instructors and by extension increase the opportunity for students to receive training in this area.

In addition to the qualitative responses covered above, correlation analyses were also used to discover relationships among the variables in this study. Associations among variables revealed that instructors who were more experienced in terms of years of teaching tended to spend more time covering core multicultural issues like race and culture, and they are more likely to touch on linguistic issues in psychology than their less experienced counterparts. Furthermore, these same more experienced individuals displayed a marked tendency to consider language issues as important to therapy.

In regard to whether or not instructors were willing to implement change in this area, it was apparent that those who already exhibited interest in the topic would be more likely to do

something about it. But instructors not already covering such areas did not necessarily increase their plans to incorporate the presented content. This relationship among variables also extended to the competencies presented in the survey. Instructors who were already spending time covering language/interpretation issues were more willing to include the nine competencies noted earlier the next time they offered the multicultural course. This was also true for those willing to cover language/interpretation issues in their next course.

Implications for Doctoral Training in Professional Psychology

The present study has a number of implications for graduate multicultural training. The views and opinions of multicultural instructors undoubtedly influence the quality and breadth of training that students receive. Several instructors indicated that they believed language had a considerable impact on psychotherapy. Others stated that they were preparing to add training on the use of language interpreters to their semester curriculum. Still others indicated that they had not considered doing so to be a multicultural topic and were planning on investigating literature in this area. Thus greater awareness of these issues could inspire instructors to see the centrality of language to diversity and to the provision of mental-healthcare services.

One of the most significant implications for multicultural-psychology instructors was how to address the topic of language interpretation in a curriculum that was already packed with important concepts that students needed to learn. Language interpretation in therapy can be a controversial topic, with some traditionalists encouraging the exclusive focus of a multicultural psychology class on the core issues of race, ethnicity and gender. Nevertheless, proponents of a broader multicultural perspective would advocate for coverage of issues that typically receive infrequent attention, including language and language interpretation. If, as suggested by the results of this analysis, instructors occasionally addressed the topic of language interpretation in

spite of formidable barriers (with others planning to address it to some extent during their next taught course), then discussions between colleagues might be a helpful way of spreading ideas and solutions to the barriers of time and too many other topics. Such efforts to include issues of language, despite the large number of topics to be covered in a multicultural psychology course, should continue to receive additional focus in the professional literature. It remains to be seen whether the issue of language discrepancy in therapy will be given adequate attention in the future by the APA.

"The Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change" strive to reflect the "knowledge and skills needed by the profession in the midst of dramatic historic sociopolitical changes in United States society as well as needs from new constituencies, markets, and clients." (APA, 2002). The competencies presented in this study may fulfill the goals of the APA by providing a structured and systematized set of knowledge and skills to help clinicians adapt to a new and growing clientele of non-English speakers. Furthermore, the list of proposed competencies, with the top three being agreed upon by multicultural instructors, may present an opportunity for a more compact and time-sensitive discussion of this topic rather than a more expansive approach that would cover all of the potential competencies needed in this area. In essence, the provision of these proposed competencies to student trainees would in itself provide one solution to the barrier of limited time faced by most instructors.

This study also provided an overall picture of the current strategies and practices used by instructors who give training in this area. The most frequently cited strategies included classroom lecture and discussion of recommendations, provision of readings on effective approaches, and expert instruction from guest lecturers with expertise in the area. Instructors

also reported utilizing role-plays during class to build skills and generate discussion. Other instructors, possibly concerned about time limitations, encouraged exposure during clinical practicum or relied on other courses, like ethics, to address the topic in more depth. The pedagogical strategies of these instructors may provide a starting place for those instructors who indicated that they were either unaware of available resources on the topic or did not have a strategy or technique for classroom implementation.

Limitations

Although steps were taken to minimize apparent threats to validity and reliability, this study has several limitations. First, it appears that the length of time needed to complete the survey may have affected the accuracy of responses. In several instances, responses became shorter during the second half of the questionnaire, and more questions were left unanswered toward the end of the survey. This is likely to have had an impact on several questions, especially those investigating the impact of the information presented in a before-and-after sequence. Thus while the analyses of this study seemed sound, a different investigation utilizing a shorter survey might have resulted in more significant findings. However, the survey only took participants an average of 14 minutes to complete. This length of time does not seem excessive, and it would have been difficult to collect needed information in a shorter survey. In any case, more research is required to test the assumption that participants would have provided additional information if fewer questions had been asked.

A second limitation, also referred to above, was a methodological problem that occurred when trying to ascertain the rank order of proposed competencies. The competencies were presented in a "drag-and-drop" format that allowed instructors to use different competencies according to their relative importance for them. However, after the initial analysis, it was

apparent to the researcher that the competency that was presented to instructors initially in the first spot, was moved less frequently than would have been expected. This effect may have been caused by the heavier cognitive load required by rank-ordered items, which may have prevented some participants from completing the item fully. To mitigate this issue, the researcher investigated the rank order with item-placement removed. This change allowed for a more accurate evaluation of the competencies.

The utilization of content analysis introduced some limitation to the study design. First, content analysis typically describes what is present in observed patterns, but the method may not reveal the underlying motives or dynamics for the observed pattern. Nevertheless, given that the current study was intended to gain an overall evaluation of the language-diversity training in graduate psychology programs, underlying motives for answers to the questionnaire were not pertinent. Another possible limitation of content analysis is coder bias, which can occur if two different researchers code the same data differently or have different interpretations of the material. To account for this type of bias, two researchers coded data and compared results to ensure accuracy of coding. Thus these biases appear unlikely to have impacted the results of the study.

Another possible limitation concerns the possibility that training on the use of language interpreters occurs outside the context of the required multicultural course. It could be the case that training on work with interpreters is occurring in other areas of training programs like ethics courses, advanced multicultural courses, or supervision. Or as indicated by one respondent, training may occur at practicum sites where interpreters are commonly used. In any of these cases, this analysis of multicultural-course instruction would not accurately reflect the entirety of

training being offered through counseling or clinical programs. Thus future research is needed to investigate training that occurs outside the graduate multicultural course.

In an attempt to ensure anonymity among respondents, the author sought to obtain only a minimal amount of demographic information. While this protected the respondents, it limited the number and extent of the analysis completed. For example, factors such as whether or not programs were located in rural or urban areas as well as the associated context of percentage of language minorities in the surrounding areas were not evaluated.

Also of note, there were three (out of 102) psychologists who consistently declared that the use of interpreters is not empirically grounded and that focus should be exclusively on finding and training bi-lingual students or requiring the study of a second language during graduate training. These responses were not included elsewhere because of their content, which did not respond directly to the presented questions. Though these responses were somewhat rare in the present study, they may reflect the attitudes of other instructors in the psychological community. Nevertheless, it appears that the vast majority of respondents did not share those views.

Implications for Future Research

Multicultural psychology aims to address the concerns of marginalized and underprivileged groups and to investigate the ways in which services to these populations may be improved (Smith & Trimble, 2016). Although already identified as an area of common discrimination (Spencer et al., 2010), language differences have received little attention in the multicultural literature and hardly any attention at all in general psychotherapy literature. Fortunately, a desire for future research in this area was manifest in several of the instructor responses obtained by this study. For instance, one stated, “Work is needed to raise awareness of

the importance of this issue. More on this needs to be published in major journals as well." Several others echoed this sentiment and requested that more be done in this area. The field of psychology would do well to heed the requests of those most responsible for training future professionals in the field.

The description of current training practices in this article could guide future research regarding the effectiveness of the teaching methods used by course instructors. Additionally, and perhaps more importantly, researchers could analyze empirically whether or not the methods of instruction enhanced students' competencies working with language interpreters, perhaps by using the list of nine competencies evaluated in this study or a similar set of competencies to be formally endorsed by APA.

Some instructors expressed a concern about whether or not training in working with language interpreters is necessary for students in geographic areas with limited language diversity or for students who have no current interest in working with language interpreters or non-speakers of English. Thus a study investigating actual clinical practices may be warranted. The findings of such a study could reveal several important trends and factors including the number of clinicians who encounter linguistic diversity in their practice relative to the actual language diversity of the surrounding community (using United States Census data). Such research could possibly reveal proverbial "hotbeds" of cross-language psychotherapy, where practitioners are meeting community needs by provision of therapy in the clients' preferred language. Investigating how clinics in these areas are providing services and sharing that information with other clinics is critical owing to the fact that psychotherapists trained in areas with small percentages of people who do not speak English will eventually need this training.

Such research would be timely and informative because of the growing number of LEP individuals living in the United States.

Furthermore, research needs to evaluate how well students who receive instruction in the effective use of language interpreters actually utilize that information in their practice following graduation. Tori and Ducker (2004) have acknowledged that the commitment to multicultural principles may fade beyond graduation from a training program. Discovering which principles or competencies proved most helpful for post-graduates, including those that they currently and frequently utilize, would help guide the establishment and re-evaluation of competencies for this area of training.

Lastly, but equally important, a current account of clients' experiences with interpreters in psychotherapy is needed. This account may be more important given the number (44%) of instructors now providing training for clinicians as well as the increased requirements and training for foreign language interpreters. Such shifts would likely lead to better experiences for clients than those previously described where poorly trained therapists and interpreters were utilized. In addition, if positive accounts are reported, there may be an increased incentive for linguistic minorities to access mental-health services.

Conclusion

Linguistic minorities stand ready to benefit greatly from increased access to mental-health services. The use of language interpreters provides one way to increase access to mental healthcare for minority populations. In 2009, Searight and Searight proposed that "psychologists would benefit from further education" on the topic, and that "knowledge and skills in working with interpreters should be included in graduate courses on multiculturalism as well as practica and internships" (p. 449). The current study provided a clearer picture of the current teaching

methods being used and the extent of instruction being provided at the graduate level. It also indicated that multicultural instructors believed that providing training in this area is important and that they were more willing than not to provide training during upcoming semesters. Lastly, the study also addressed a concern voiced by Yakushko (2010), who highlighted the fact that the mental-health field lacked guidelines and standards specific to clinical work with interpreters. Proposed competencies were ranked according to their importance by instructors. Those rankings can inform instructors about which topics are most important for coverage in multicultural coursework. And they can provide a template for future training and future research on the topic.

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APPENDIX A: REVIEW OF LITERATURE

Evidence of large demographic shifts within the United States has been documented in recent decades. In 2010 the nation's immigrant population, also referred to as its foreign-born population, reached 40 million, the highest number to date (Camarota, 2011). Since many migrants do not speak English fluently or at all, a linguistic gap has emerged as a barrier facing many of those coming to the United States (Jacobs, et al., 2010). Currently, about 20% of the United States population speaks a language other than English in the home, and the number of individuals who have limited English proficiency (LEP) has risen to over 25 million (Zong & Batalova, 2015). In addition to those already living in the United States, there are a growing number of immigrants and individuals with limited English proficiency including asylum seekers and refugees are seeking mental-health services. Thus a problem arises when a monolingual service provider lacking formal training in linguistic diversity is required to provide services to an LEP client. In order to remedy this situation, many providers have turned to third-party interpreters. Despite the documented utility of language interpreters, to facilitate therapy above and beyond therapy without an interpreter, including increasing client willingness to return for subsequent visits, training in this area remains sparse (Karliner, Jacobs, Chen, & Mutha, 2007; Kline, Acosta, Austin, & Johnson, 1980; Paone & Mallott, 2008). In fact, the psychology profession as a whole seems to have largely overlooked training students to address linguistic diversity in their clinical work. The research done here seeks to remedy the aforementioned issues by discovering how graduate-psychology programs are currently addressing linguistic diversity in training by identifying what barriers are inhibiting formal training in this area by gaining consensus on essential guidelines for practitioners working with language interpreters from several published articles and books detailing work with interpreters and by seeking

knowledge from participants as to how those guidelines might be included in existing multicultural training.

In this review of the literature, research findings will be summarized which highlight demographic shifts and seek to explain the impact of limited English proficiency on current general and mental-health practices. In addition, current practices and instruction relevant to language interpretation in clinical work will be examined and past calls for further training in this area will be reviewed. A brief presentation of terminology will be followed by a notation of the centrality of language to health services. Then the impact of LEP individuals on healthcare systems will be discussed. Next, the responses of general and mental-health fields will be examined and contrasted. The review will shift to a summary of relevant studies that address the use of language interpreters in psychotherapy. Next, essential skills in working with interpreters will be examined and a literature-based rationale for the distilling these skills into nine core competencies will be offered. The review will then discuss multicultural competence and linguistic diversity training. Lastly, studies resulting in a call for further training in the use of interpreters will be reviewed.

Terminology

The term *limited English proficiency* (LEP) is used to refer to a linguistically diverse population that speaks English less than "very well" and may also refer to an individual's less-than-average ability to read or write. LEP individuals may come from a variety of cultural and ethnic groups, countries of emigration, and socio-economic groups and may have wide array of English-language speaking abilities (Gabrielson, 2010). The term LEP is also used across educational topics and research domains. Thus it will be used when referring to individuals seeking both general and mental healthcare.

Another important distinction that should be made at the outset of this literature review is the difference between the terms *interpreter* and *translator*. Although the words interpreter and translator are often used synonymously, they refer to two very different linguistic tasks. Interpreters mediate spoken language. That is, they concurrently or consecutively transform the spoken word from one language to another (Gabrielson, 2010). In contrast, translators work specifically with the written word, transforming it from one language to another. Although both can be used in reference to mental-health practices, the term *interpreter* will be used primarily in this dissertation owing to the importance of vocalized language in psychotherapy.

Language and Healthcare

Language is central to our ability to provide meaning to our experiences, to convey complex messages, to express emotions and needs, and to relate with and understand others (Farooq, 2003; Imberti, 2007). Furthermore, it provides a medium for the person-to-person transmission of experiences, narratives, and memories (Pazos & Nadkarni, 2010). Thus one could make the argument that much of human activity revolves around the use of language, both interpersonally and intrapersonally. By extension, it should not be surprising that human-service fields tend to rely heavily on the communicative aspects of language during provider-client exchanges. In fact, language is often thought to be the primary tool for clinicians who provide such services (Farooq, 2003). Therefore, a better understanding of how partial communication between client and provider affects those with limited ability to speak English is warranted.

Providers must be able to communicate through some form of language with their clients be it written or spoken. They must also recognize that commonly used health and mental-health constructs do not have equivalents in all languages (Romero, 2012). Instead, it appears that culture and language are not distinct concepts; they rely on and inform one another in a very

interconnected way (Pazos & Nadkarni, 2010). Given that personality, identities, and psychological experiences are influenced and dependent on the language being used to communicate, these psychological constructs may lose meaning when expressed in a different language (Tribe & Raval, 2003). In addition, language has a clear impact on cognition, psychological processes, group behaviors and identity, all of which may be altered in meaning and expression when communicated in a language foreign to the speaker (Pazos & Nardkani, 2010). Therefore, it is important for human service providers to consider what occurs when individuals who are LEP clients are forced, because of the absence of adequate linguistic services, to express emotions, symptoms, or ideas in English.

In addition to the changes in meaning mentioned above, it is notable that the emotional content of words is considered to be encoded in the language in which the emotional concepts were first learned, and words were first applied to emotional experiences (Silva, 2000). Therefore it may be difficult for LEP individuals to communicate their true or unique emotional experiences. Rather, they may tend to focus more on how (grammar or pronunciation) to say something rather than on what (thoughts and emotions) they are trying to communicate to the provider (Marcos, 1976; Santiago-Rivera & Altarriba, 2002). The result may be a sense of frustration for provider and client, confusion, or the eventual discontinuation of treatment (Gabrielson, 2010). One could easily imagine this scenario when thinking of how refugees experience treatment. After spending a few weeks, or months in foreign country, many refugees are asked to vocalize the deep emotional and/or adjustment difficulties they are experiencing using only a severely restricted vocabulary. Often, the result may be frustrating miscommunications or a potential for more harm.

Gabrielson (2010) reviews a number of reasons why language can hinder the transmission of physical- or mental-health concerns. First, a full or accurate expression of experience or symptoms will be limited as well as an understanding of the directions being given by the clinician/provider. In addition, a client may feel embarrassed by their limited capacity to express themselves in English, which may be compounded by their inability to express their shame. As mentioned above, there is likely to be a disconnection between the client's spoken words and true emotions, which may unfairly alter the practitioner's impression of the LEP individual's interpersonal nature or presenting concerns. Such issues lead to further misunderstandings and may completely hinder the delivery of services, which has been the case for a number of decades.

Limited English Proficiency and Healthcare

Currently, about 20% of the United States population speaks a language other than English in the home, and the number of individuals who have limited English proficiency (LEP) has risen to over 25 million (United States Census Bureau, 2011; Zong & Batalova, 2015). Many LEP individuals are seeking and requesting healthcare. However, given that general and mental healthcare is often provided only in English, non-native speakers are immediately disadvantaged, and the result is frequent miscommunication and disparities in healthcare (Clauss, 1998; Flores, 2005; Jacobs, et al., 2006; Sue, 1997). Specific instances of exacerbated medical issues, reduction in quality of care, decreased likelihood to seek out services, and increased difficulty navigating the healthcare system, have all been associated with limited English proficiency (Flores, 2005). Other complications like a decreased understanding of diagnosis and treatment, higher medical costs, complications with medication, and a reduced likelihood of

scheduling a healthcare visit have also been documented in the research on healthcare disparities (Flores, 2005; Ngo-Metzger et al., 2007; Shi, Lebrun, & Tsai, 2009).

Limited English proficiency can also limit a clinician's ability to understand patient symptoms and provide adequate treatment (Karliner et al., 2007). Moreover, another study suggests that limited English proficiency is correlated with both access to care and emotional health (Ponce, Hays, & Cunningham, 2006). A telephone survey of 1,200 Californians, conducted in 11 languages, revealed that limited English proficiency decreases medical comprehension and increases the risk of negative medical reactions (Wilson, Chen, & Fernandez, 2005). The same study indicated that when provided service by a language-concordant physician, language barriers were mitigated but not eliminated. These as well as the complications listed above are not unique to general healthcare and may be compounded in the mental-health field, which relies heavily on communication rather than objective testing (Sentell et al., 2007).

A systematic review examining the impact of language barriers on the quality of psychiatric care revealed multiple potential sources of miscommunication and distortion resulting from gaps in communication, specifically in instances where no interpreters or ad-hoc interpreters were used (Bauer, Chen, & Alegria, 2010). Other studies indicated that individuals who are considered English proficient (EP), and able to communicate freely in health settings, were more inclined to use mental health services in their lifetime in the USA (Kang, et al., 2010). However, this study was limited by the absence of attitudinal and cultural considerations.

Several studies have explored these same factors in specific linguistic-minority populations. For example, one revealed that following the onset of a mental disorder, LEP Latino and Asian Americans are less likely to perceive a need for treatment and are more likely

to remain untreated for a longer duration than are their EP counterparts (Bauer, et al., 2010). Results of the same study indicate that LEP is associated with a lower likelihood of lifetime treatment after adjusting for such other factors as age, lack of insurance, and education. However, these findings are somewhat limited given that most of the measurements in the study were based on client self-reports rather than being directly measured. A similar study revealed that LEP significantly decreased the odds of mental-health service among Latino immigrants, even after attempting to control for additional factors like mental-health needs, among others (Kim et al., 2011). These findings suggest that LEP may be viewed as an independent factor that contributes to disparities in caring for mental disorders.

Another study conducted by Sentell et al. (2007), which assessed access to mental-health services by nearly 42,000 individuals, revealed that limited English proficiency is associated with lower use of mental healthcare, especially among Asian Americans and Latinos, and thus may contribute to racial/ethnic disparities in terms of using such services. Others have reported similar findings, for example Wong et al. (2006) reported that responses from an Asian American refugee sample showed that language and cost, rather than cultural factors, were the most significant barriers to mental-health treatment. In light of these linguistic barriers and the rising number of LEP clients seeking care, it is likely that clinicians will need to employ the services of interpreters more regularly (Pazos & Nadkarni, 2010).

Limited English proficiency may also be a factor when considering issues other than the access to and use of mental-health services. Particularly, lack of English proficiency may put refugees, asylum seekers, and immigrants at greater risk for developing psychological disorders because they are unable to respond to surveys, and mental health research (Gabrielson, 2010). According to one study examining language discordance and inclusion for mental health surveys,

foreign-born individuals living in Australia are likely to be overlooked, and uncontacted when national mental health research is conducted (Minas, et al., 2013). A similar study conducted in the United States reported that limited English proficiency was associated with increased levels of major psychological distress for Asian Americans (Zhang, Hong, Takeuchi, & Mossakowski, 2012). Interestingly, the same phenomenon has also been shown in a sample of English-speaking individuals living in Japan, who were at greater risk for being diagnosed with an adjustment disorder owing to communication problems as a result of language barriers (Koyama et al., 2012). Thus LEP or limited use of the dominant spoken language may have an influence on mental health that puts these individuals at greater risk.

Further exacerbating the issues of underutilization and miscommunication in mental-health services among LEP individuals is the fact that, for some LEP individuals, there is an increased need for mental-health services. Specific stressors associated with immigration and acculturation have been noted in many LEP individuals (Eibner & Strum, 2006; Gabrielson, 2010). Furthermore, individuals with LEP may be acutely aware of the possibility of being denounced or overlooked as a result of their language abilities, or they may be wary of speaking publically due to potential embarrassment (Mui, Kang, Kang, & Domanski, 2007). Moreover, a client's accent may prove to be a barrier to communication with others and may simultaneously trigger discriminatory biases. (Kim, Wang, Deng, & Alvarez, 2011; Yakuskho, 2009). Thus LEP may compound the difficulties associated with acculturation and further exacerbate discriminatory behavior towards an already-vulnerable population.

Discrimination is generally defined as the unjust treatment of different categories of people, especially on the grounds of race, age, or sex, among other factors. In this case, however, the lack of access to mental-health services has been highlighted as discriminatory on

the grounds of language (Spencer et al., 2010; Yakushko, 2010). More than two decades ago researchers warned the field about the potential negative influence of the "English only" movement, which has clearly impacted psychology (Padilla et al., 1991). Due to the lack of ethnic-minority bilingual providers, any further linguistic constraints placed on the LEP populations would severally restrict the already-limited general medical, mental-health, and other social services theoretically available to LEP individuals. Furthermore, the assumption that the absence of proficiency in English is not an issue in therapy may further justify the lack of concern for the needs of linguistic-minority clients (Padilla et al., 1991). By extension, it could send a message to training programs that linguistic and other diversity issues are not important and that the provision of skills and knowledge in these areas are not required for effective therapy with minorities. Now, over two decades later, language-appropriate services continue to be limited to LEP clients, and psychotherapy remains predominantly an English-only enterprise (Clauss, 1998).

The Response of General and Mental Healthcare Organizations

Efforts to address linguistic barriers in general healthcare are well under way. As of 2007, 33% of United States hospitals were reportedly attempting to improve the quality of their language-access programs, while 23% of United States teaching hospitals provided training on work with interpreters (Armada, 2010). In addition, there have been numerous articles published on the topics of language interpretation, language access, and work with LEP individuals (Gadon, Balch, and Jacobs, 2007; Meeuwesen, 2012; Wilson et al., 2005). Regarding education, several modules and curricula have been created that are currently being utilized in an effort to train physicians on how best to work with interpreters in practice (Jacobs et al., 2010; Marion,

Hildebrandt, Davis, Marin, and Crandall, 2008; McEvoy, Santos, Marzon, Green, & Milan, 2009; Phillips, Lie, Encinas, Ahearn, & Tiso, 2011).

Beyond the general changes mentioned above, Au, Taylor, and Gold (2009) highlight recent requirements for language services established by national accrediting organizations. They report that both the National Committee for Quality Assurance (NCQA) and the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) are setting norms for recognizing language services as an important part of high-quality healthcare. One such step was taken in December 2008, when the NCQA released a set of standards for assessing the quality of culturally and linguistically appropriate services in health-care organizations with the intent of integrating such standards into its accreditation programs (Au et al., 2009).

Several studies including the Institute of Medicine's (IOM's) 2003 Unequal Treatment report have highlighted disparities in health care for minority groups and the need for interventions such as language services (Institute of Medicine, 2003). Other studies that directly attempt to address language barriers have also become common. For example, Jacobs et al. (2010) evaluated the use of language interpreters in hospital settings and found that providing professional interpreter services significantly increased the receipt of preventive services, physician visits, and prescription drugs for LEP patients. Such studies provide a research base for the integration of language interpreters and the overall effort to address linguistic diversity in healthcare.

Additionally, in 1997 the Office of Minority Health (OMH) undertook the development of national standards in order to move beyond the inconsistent definitions and practices relevant to providing care to LEP populations. These standards were created for policymakers, accrediting bodies, patients, providers, and educators. In 2000 fourteen such standards were

provided. They included such areas as competencies in providing services to LEP clients, diversification of staff members, provision of language services including interpreters, and others (United States Department of Health and Human Services Office of Minority Health, 2001).

In contrast to the medical field, the mental-health profession has taken a more passive approach in responding to linguistic diversity. The APA has formed guidelines aimed at addressing the growing diversity in the United States. These include the "Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations" (APA, 1991) and later the "APA Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists" (APA, 2002). The former includes nine principles to be followed by psychologists when working with diverse populations. Guideline six states, "Psychologists interact in the language requested by the client and, if this is not feasible, make an appropriate referral" (APA, 1991, p. 3). Furthermore, if a language-concordant professional is not available, "psychologists offer the client a translator with cultural knowledge and appropriate professional background. When no translator is available, then a trained paraprofessional from the client's culture is used as a translator/culture broker" (APA, 1991, p. 3). These guidelines, important though they are, do little to ensure that the essential skills and micro-skills associated with work through interpreters are being provided by graduate training programs. Hence the need to further operationalize these guidelines so as to avoid vague lists of competencies.

In addition to the problem of generality, Gabrielson (2010) points out that the APA misused the term *translator* in guideline six when referring to a spoken-language interpreter. He states that this faux pas highlights the importance of furthering education in this area. If the governing body is misusing terminology central to work with the linguistically diverse, then it is

expected that those being governed are doing the same. In spite of these shortcomings, the guidelines are clear in stating that psychologists are to provide an interpreter if needed. By extension, the APA is assuming that clinicians will know how to work with an interpreter. Unfortunately, there is currently minimal-to-no formal training offered in psychology graduate programs that would prepare trainees to ethically practice according to the aforementioned guidelines (Searight & Searight, 2009; Tribe & Raval 2003; Yakushko, 2009).

Although efforts have been made to diversify trainees and faculty at graduate psychology programs, the current number of clinicians and trainees who speak multiple languages is not adequate to meet the demands of all LEP clients. Likewise, most clinicians continue to be monolingual and European American. A recent study indicated that 83.6% of psychologists who are service providers are European American, whereas only 5.0% are Hispanic, 5.3% are Black, 4.3% are Asian/Pacific Islander, and less than 1.7% are Other (American Psychological Association Center for Workforce Studies, 2013). Furthermore, those clinicians who do report the ability to provide therapy in a second language may have a proclivity to over-estimate their proficiency in their non-native language **(**Diamond, Luft, Chung, & Jacobs, 2012). Thus interpreters may play a greater role for psychologists in the future.

Both physical- and mental-health fields have turned to third-party interpreters to bridge the linguistic gap that occurs when LEP clients seek services. The use of interpreters has been shown to facilitate communication and improve the quality of healthcare, the patient experience, adherence to recommended-care guidelines, and ultimately health outcomes (Flores, 2005; Jacobs et al., 2006; Karliner et al., 2007). Such services are more commonly used in general healthcare settings, where contact information for interpreters is easily accessible to employees. In the mental-health field, the use of interpreters in psychotherapy can facilitate the disclosure of

sensitive material and enhance client satisfaction and self-understanding (Bauer & Alegría, 2010). In some distinct cases, clients themselves have reported that the presence of interpreters has increased their willingness to return for counseling (Hillier, Loshak, Rahman, & Marks, 1994). One additional study indicated that the use of interpreters increased the client's sense of feeling helped after a session (Kline et al., 1980). Thus, despite the lack of use, interpreters appear to provide some advantages over treatment with language-discordant clients that take place without interpreters.

Interpreters in Mental Health Services

An innovative study conducted by Marcos (1976) researched the use of language interpreters in psychotherapy and other health services. He investigated misdiagnosis and evaluation of clients based on interpreter-related errors. Recordings of psychiatric interviews from two New York hospitals comprised the data for this study. Given that the participating interpreters were unfamiliar with work in mental-health settings, as is commonly the case, they reported discomfort with clients' personal disclosures and they harbored negative feelings about their responsibilities. The psychiatrists interviewed in this study also expressed skepticism regarding the appropriateness of using untrained interpreters. In essence, the results of this study highlighted the importance of utilizing trained interpreters who have some familiarity with mental health and the emotional tasks associated with counseling.

Another landmark study examined perceived clinical outcomes for interpreter-facilitated sessions compared with sessions without language interpreters (Kline et al., 1980). Results from a questionnaire showed that clients who participated in interpreter-facilitated sessions were twice as likely to perceive their sessions as helpful. Kline and colleagues concluded that the presence of interpreters was experienced positively by clients, who reported increased comfort and

satisfaction. This study also examined therapists' perceptions of client likelihood to return for an additional session. Interestingly, only 31% of therapists reported believing that clients would return, when in actuality 76% of clients asked for an additional session. This finding was thought to be more directly related to therapist discomfort with interpreter-facilitated care.

Another study assessed the relative impact of interpreters on counseling outcomes (Raval & Smith, 2003). Qualitative responses from therapists indicated that therapists felt less connected as interpreters engaged more with clients. Therapists also noted the increased time needed for communication. However, the therapists did note the positive impact that the interpreters had on the communication process by increasing client willingness to engage in sessions and providing useful information and insight relevant to clients' cultures. Lastly, Raval & Smith (2003) noted the tri-directional influence of the interpreter, therapist, and client working together in a triad.

Both positive and negative aspects of interpreter-facilitated therapy were identified in another study (Miller, Martell, Pazdirek, Caruth, & Lopez, 2005). Therapists and interpreters were interviewed regarding their experiences of working in torture-treatment centers, where services were provided to refugees. The study revealed additional insights into therapy that involves interpretation, such as the interpreter's impact on therapeutic alliance, the complexity of working within a triad, and the management of multiple roles. Furthermore, the authors suggested that interpreters who participate in mental-health services be trained on collaborative work with a therapist. Additionally, therapists should engage in a post-session debriefing with interpreters, especially in cases where disturbing content has been discussed.

More recently, Yakushko (2010) produced a phenomenological study that utilized open-ended interview questions aimed at attaining therapists' descriptions of their experiences in

providing care to LEP clients through interpreters. The participants included eight psychotherapists who indicated that they had worked with LEP individuals over the span of 12 to 30 years and thus were considered experienced in the provision of mental-health care to LEP clients. Responses covered several areas connected to work with this population—research most relevant to this dissertation. A key finding was that training for both the therapists and interpreters was essential. Moreover, this training should go beyond general multicultural competence and focus on the practical aspects of working with interpreters. Yakushko (2009) stressed that such training appeared to be absent in institutions that would currently be responsible for its oversight. In essence, these studies affirmed that work with interpreters in mental healthcare is complex and multifaceted and above all requires adequate training.

Several researchers have commented on the difficulties associated with using an interpreter (Miller et al., 2005; Paone & Mallott, 2008; Searight & Amock, 2013). Others have noted that the research studies highlighted above are far from convincing and do not prove that interpreters are really necessary or helpful. However, there seems to be a general consensus that work through interpreters is preferable to providing no care at all (Baxter & Cheng, 1996). Searight and Armock (2013) highlighted several challenging dilemmas that might arise as a result of utilizing interpreters in mental healthcare. When possible, the ideal situation would be for a linguistic match between client and therapist (Griner & Smith, 2006). However, such matches are rare, and it is far more likely that therapists will need to utilize an interpreter. Therefore, this dissertation was conducted from the perspective that while not ideal, the use of interpreters allows access to treatment for LEP individuals and is preferable to no treatment at all (Snowden, Masland, & Guerrero, 2007). Thus a comprehensive set of skills should be provided to trainees to assist them in their future work with LEP clients.

Essential Skills for Interpreter-Mediated Clinical Work

Despite the generally meager amount of research addressing language interpreters in mental healthcare, a few researchers have made consistent and meaningful efforts to identify skills and micro-skills that are central to work with interpreters (Gabrielson, 2010; Miletic et al., 2006; Paone & Mallott, 2008; Searight & Searight, 2009; Tribe, 2009). These recommendations, which are derived mostly from adapting guidelines used in medical settings, typically target practices in outpatient clinics (Searight & Amock, 2013). In addition, the majority of articles providing such recommendations used a classification heuristic categorizing the essential skills into pre-, during, and post-session. The skills and recommendations contained in articles that have not used this heuristic can easily be categorized in a similar manner.

There are a number of matters a clinician must consider prior to an interpreter-facilitated therapeutic encounter. Once a need for language services has been recognized, the initial task of the clinician is to make an ethical selection of an interpreter. In doing so, the clinician should consider the specific language/dialect required, the ethnic background of the client, and a potential gender match (Miletic et al., 2006). Tribe & Morrissey (2004) suggested that whenever possible an attempt should be made to match an interpreter to the client's background. Possible factors here would include country of origin, religion, education, age, gender, etc. The researchers also suggested that a brief assessment be conducted with the interpreter to ascertain the extent of mental-health interpreting they have done and to gauge the interpreter's comfort level in providing linguistic services in a therapeutic setting (Tribe & Morrissey, 2004). Given the importance of confidentiality, therapeutic alliance, and continuity of care, interpreters' availability to provide services across multiple sessions should also be queried (Raval & Smith,

2003; Tribe & Raval, 2003). Lastly, inquiries about certification, professional background, and prior training and/or experience are essential to ensure that the interpreter has the needed competencies for work in a therapeutic triad (Miletic et al., 2006).

Several researchers have emphasized the importance of a pre-session meeting between clinicians and their proposed interpreters (Gabrielson, 2010; Miletic et al., 2006; Paone & Mallott, 2008; Searight & Searight, 2009; Tribe, 2009). First, it is ethically responsible for a clinician to take steps to ensure that interpreters are compensated for the additional time spent during a pre-session meeting (Tribe & Lane, 2009). Ideally, this brief meeting will allow for the case history, presenting problem, unique terms/technical language, interventions to be used, and relevant cultural issues to all be discussed (Miletic et al., 2006). In addition to the task of interpreting the client's spoken language in English, interpreters may also be considered cultural brokers, with knowledge about culturally relevant issues that may be arising in the room (Pazos & Nardkani, 2010). Thus a discussion of how cultural information can be shared during therapy is warranted in a pre-session meeting.

In addition, orienting the interpreter to psychotherapy including the rules for interaction within the triad of counselor, client, and interpreter. Questions regarding how the interpreter may interrupt the client or provider may also be a central focus of a pre-session meeting (Gabrielson, 2010; Searight & Armock, 2013). Such a need often arises when meanings or emotions are being conveyed as detailed elsewhere in this review. Ideally, confidentiality, screening for dual relationships, role boundaries, and elements of psychotherapy (e.g., testing procedures, interview protocols, techniques, or sensitive issues like client suicidality) would all be addressed during the pre-session briefing (Gabrielson, 2010).

Another important issue to be discussed at that time would be the physical set-up and formation, particularly the triadic seating arrangement. There are several options that may be considered. Among them, a common configuration is when the interpreter is seated beside but slightly off to the side from the patient (Tribe & Lane, 2009). Although this arrangement allows for the focus to remain on the client–psychologist interaction or verbal exchange, it may block the interpreter's view of the client, which could potentially limit access to culturally relevant, non-verbal communications (Searight & Searight, 2009). An additional configuration is known as the triangle configuration, where client, therapist, and interpreter are equally spaced to form a triangle. While practical, this arrangement may lead to some role and relationship confusion given the equal spacing and collaborative arrangement (Miletic et al., 2006). While there may be costs and benefits to each configuration, a pre-session discussion is warranted to decide on the best configuration for each client.

Once the client has arrived for the session, each member of the triad may be introduced, and a brief explanation detailing the roles of the therapist and the interpreter may be provided to the client (Gabrielson, 2010). Once settled, the client may remain acutely aware of an additional presence in the room, thus, a further explanation of ethics and confidentiality may serve to provide clients with some comfort (Miletic et al., 2006). It may help to provide details abou the extent of the interpreter's tasks while also highlighting that an interpreter is a neutral party who is not involved in decisions regarding therapeutic goals or progress (Miletic et al., 2006).

Throughout the session, the counselor should be aware of limitations regarding the amount of content an interpreter can relay, and use effective pacing as needed (Tribe & Morrissey, 2004). Specifically, a provider should speak relatively slowly and directly, using non-technical language. Paying attention to whether segments of speech are too short or too long

is also a crucial skill for providers. Essentially, clinicians should work towards finding a rhythm with the interpreter (Paone & Mallett, 2008). Additionally, proverbs, sayings, and colloquial should be avoided if possible (Tribe & Lane, 2009). As a general rule, clinicians should remember that meanings are often not directly translatable, and require some thought on the part of the interpreters, which requires time. Likewise, one sentence in English may take several sentences to explain as the interpreter attempts to transmit the message to the target language (Tribe & Lane, 2009).

During the session, a clinician is expected to refrain from direct eye contact and interaction with the interpreter so as to maintain a continuous connection with the client and model communication styles (Gabrielson, 2010). Likewise, direct discussion with the interpreter should be minimized so as to limit feelings of exclusion for the client (Paone & Mallott, 2008). If such issues do require discussion, the interpreter should explain this fact to the client and start by indicating that the he or she will be speaking (Tribe & Morissey, 2004). In most cases, discussion between provider and interpreter should be postponed until a post-session debriefing. In some cases a client may directly address an interpreter. When this occurs, it is the provider's responsibility to gently re-direct the client. Lastly, the clinician should model for the client by using the first person (I) and second person (you) instead of saying "ask him" or "ask her" so that the client-provider relationship remains in focus (Searight & Searight, 2009).

When considering the alteration of relationship dynamics within a triad, several important issues must be considered by a competent and ethical provider. Several common issues include, and are not limited to, transference/countertransference, role conflicts, and interpersonal difficulties (Gabrielson, 2010). Miletic et al. (2006) provides the example of a interpreter-client over-identification, which can easily occur when the client and interpreter share several

characteristics (e.g., gender, ethnicity, country of origin). In this type of situation, the clinician may easily feel excluded, and his/her negative reactions could potentially be harmful to the client. In these and other similar cases, Miletic et al., (2006) suggest that the issue be addressed through a conversation between therapist and client, with the interpreter facilitating. As mentioned above, an effect discussion that clarifies roles at the outset of therapy may be helpful in mitigating these issues as the interpreter and the client may become aware of the potential for a relationship to form.

After the session is completed and the client gone, a post-session debriefing with the interpreter is warranted (Gabrielson 2010; Miletic et al., 2006; Paone & Mallott, 2008; Searight & Searight, 2009; Tribe, 2009). Researchers suggest scheduling up to 15 minutes with the interpreter after the session for review and discussion, with the interpreter compensated for this time (Tribe & Lane, 2009). This session can be used to address a number of issues including clarifying any cultural issues, providing feedback to both parties about the interview and interpretation process including the conduct of the session, and discussing improvements needed for effective cross-language exchanges (Searight & Armock, 2013). There are several ways to approach this post-session debriefing including open dialogue, direct use of standard questions by the provider, or sharing general impressions. Questions may be used to elicit the interpreter's insights into culturally relevant behaviors or exchanges noted during the session or to encourage reflection and impressions (Miletic et al., 2006). As mentioned above, relationship or communication issues that occurred during the session (e.g., interpreter over-engagement with client) should be addressed through a respectful and professional dialogue with the interpreter during the post-session discussion (Tribe & Lane, 2009).

Finally, there may be instances where a post-session meeting may allow the interpreter to process and/or express his or her internal reactions to the session in general, or the content covered during the session. This may be particularly helpful in situations where abuse, trauma, or suicidality were covered (Searight & Searight, 2009). Providers are expected to be aware of negative and/or traumatic reactions being manifested by the interpreter. In such cases, the clinician may have an ethical obligation to provide emotional support or an appropriate referral and if necessary, recommend that the interpreter discontinue work in the mental-health field until they have successfully dealt with their own difficulties (Searight & Searight, 2009). Tribe and Lane (2009) urged clinicians to remember that it is their duty to care for the interpreter when needed. The combination of knowledge and skills that allow for effective pre-, during, and post-session encounters with interpreters and clients is central to the trainee's task of becoming competent in addressing linguistic issues.

Multicultural Competence

The importance of multicultural competence associated with graduate-level training has been and continues to be stressed by the American Psychological Association (APA, 2010). Multicultural competence has been generally defined as a combination of skills that allows for the provision of adequate, appropriate services to culturally diverse and underrepresented populations. Multiculturally competent counselors, then, are those professionals who possess the necessary skills to work effectively with clients from various cultural/ethnic backgrounds (Sue et al., 1992). An important factor in encouraging the development and use of multicultural competencies in professionals is education. Graduate students will be the psychologists face the task of provide services to an ever diversifying clientele; thus the training of doctoral-level clinical- and counseling-psychology students should be central to efforts to improve clinical

services to underserved and under-represented populations (White, 2014). Currently lacking in such training is an emphasis on the growing linguistic diversity amongst counseling clientele and effective skills that ensure adequate treatment of this population (Searight & Searight, 2009; Tribe, 2009; Yakushko, 2009). The psychology profession is responsible for changes in the professional's knowledge of client needs as brought about by shifting demographics and then to re-evaluate the competencies required for professional practice (Hatcher et al., 2013). Given the evident demographic shifts as well as the documented difficulties associated with limited English proficiency, it appears that now is the time to re-evaluate the competencies needed for clinical work with a linguistically diverse clientele.

Just as the multicultural competencies were first enumerated and described, then subsequently operationalized and put into practice, the same process should occur with skills and dispositions for the provision of mental-health services in the client's preferred language. Specifically, the field needs to identify the concrete skills and micro-skills that are essential to effective use of language interpreters in therapy. Such efforts may go a long way toward addressing the current situation where training in this area has been characterized as patchy and variable (Tribe & Raval, 2003).

Examples of how this new approach may occur have been provided by Mailloux (2004), who has provided a detailed list of standards necessary for an interpreter to be considered competent. Likewise, mental-health practitioners should also be held to standards that ensure their competency for the effective work with interpreters that are needed in a multilingual society. However, currently there are no widely agreed-upon standards for interpreter training in mental health (Searight & Armock, 2013).

Legal and Ethical Issues

Due to the lack of training to address the ethical and competent use of language interpreters, psychologists are placed in an ethical and legal dilemma (White, 2014). In accordance with ethical standard 2.01(e), until formal training is obtainable psychologists are to "take reasonable steps to ensure the competence of their work and to protect clients/patients . . . and others from harm" (APA, 2010, p. 4). However, without any training on how to work with linguistically diverse clients, the phrase "reasonable steps" may be ambiguous for many clinicians.

Mailloux (2004) provides some insight into what might be considered "reasonable steps." He asserts that they might include clinician actions like employing an interpreter and learning how to work with him/her to provide adequate care for LEP individuals. It may also include ensuring that the client is paired with a therapist who has access to interpreters or is bilingual. In essence, the taking of reasonable steps would ensure that no person with Limited English Proficiency be turned away, whether by an interpreter or a bilingual clinician, and that they receive care. In addition, Mailloux (2004) addressed Ethical Standard 2.05 from the APA Code of Ethics. This standard holds psychologists responsible for utilizing interpreters in an appropriate and ethical manner. In order to uphold this standard, psychologists would be required to understand training issues and learn appropriate skills for working with interpreters. Mailloux (2004) covered several other ethical obligations required of psychologists including 2.05 (1), which places responsibility on psychologists to ensure that the client does not share a dual relationship with the interpreter. Section 2.05 (2) also requires psychologists to ensure that interpreters are qualified for the job based on training and experience. Lastly, 2.05 (3) addresses the potential need for supervision of interpreters. While Mailloux (2004) further discussed the

Ethical Standards in relation to work with interpreters, there is obviously a gap between what is required of psychologists and the training is currently being provided in graduate psychological training.

Other authors have written on the ethical concerns related to therapeutic work with interpreters. They have concentrated on issues related to APA Ethical Standard 2.05(1-3). For example, Acevedo et al., (2003) discussed potential ethical pitfalls arising from creating a therapeutic triad. They argue that these issues are further complicated when interpreters are either untrained or are bilingual family members. These are concerns that would be considered ethical dilemmas under APA Ethical Standard 2.05 and would likely require some training to be provided so that providers do not use potentially harmful methods of communication.

Calls for Training

In spite of the general lack of professional literature addressing LEP populations and the clinical use of interpreters, there have been consistent calls in most of the published articles on the topic for further linguistic diversity training in graduate psychology programs (Searight & Amock, 2013; Searight & Searight, 2009; Tribe, 1999, 2009; Tribe & Raval, 2003; Yokusko, 2010). Particularly, the focus has been on training for collaborating effectively with language interpreters, training ". . . needed to ensure competency when working with linguistically diverse clients" (Pazos & Nadkarni, 2010 pp. 170-171). Tribe and Raval (2003) clearly made such a call by stating,

> the training provision for clinicians remains largely unattended to, and this is likely to stay unaltered unless there are mandatory requirements for clinicians to develop their skills in being able to work more effectively with interpreters. Quality training that is

> provided at the highest standard is very much needed in order to minimize the patchy and variable training that is currently carried out (p. 74).

In this instance the authors highlighted the importance of consensus on the mandatory requirements for clinicians to develop skills relevant to working with linguistically diverse populations. Yakushko (2010) also highlighted the fact that the mental-health field lacks guidelines and standards specific to such clinical work for both the clinicians and the interpreters.

Another call was even more specific about where such training should be included. The authors stated that ". . . psychologists would benefit from further education; . . . knowledge and skills in working with interpreters should be included in graduate courses on multiculturalism as well as [in] practica and internships" (Searight & Searight, 2009, p. 449). Such an integration has yet to occur in professional training. In fact, a thorough review of the literature relevant to multicultural coursework in graduate psychology programs did not reveal that linguistic issues are formally covered to any degree. Yakushko (2009) also asserted that such training on work with interpreters appears to be lacking in a majority of institutions that are responsible for the training of mental-health clinicians. Alarmingly, these calls have consistently appeared on this topic for the last two decades. In the meantime, the hypothetical questions concerning a multilingual society have now become a pressing reality.

This dissertation sought to answer these calls by evaluating current attempts to integrate training on linguistic diversity into graduate multicultural coursework. Further, the lack of consensus about training content and core competencies has historically required each individual clinician to address these barriers in their own way. This issue was also addressed through an attempt to collaborate with instructors of graduate multicultural courses to find out what might

be consider core competencies that clinicians would need on graduation. It is hypothesized that such additions to the literature are a crucial next step in minimizing discrimination based on language concerns in the field of psychology.

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APPENDIX B: DEMOGRAPHIC TABLES

Program	Frequency	Percentage
Clinical Psychology	57	56.4
Counseling Psychology	38	36.6
PsyD	4	3.0

Regularity of Teaching	Frequency	Percentage
Every semester	6	5.9
About once per year	62	61.4
Less often than once per year	33	32.7

Course Statistics	Mean	Median
Years Taught	7.53	5.00
Number of students enrolled in course	18.04	15.00

APPENDIX C: INSTRUMENT

Training Students to Work Effectively with Language Interpreters

1. In what type of APA accredited program do you work?

___ PhD Clinical ___ PhD Counseling ___ PsyD Clinical

2. How many years have you taught a multicultural psychology course? _____

3. How often do you teach a course on multicultural psychology?

___ Every semester ___ About once per year ___ Less often than once per year

4. About **how many students** typically enroll in the multicultural psychology course?_____

5. About **what percent** of the entire multicultural course is devoted to each of the following topics?

_____ % Cultural/racial issues
_____ % Other diversity issues (gender, sexual orientation, etc.)
_____ % Assessment issues
_____ % Language issues
_____ % Other (specify) _____

6. **How many hours** in class do you spend educating trainees on working with language interpreters in psychotherapy? (when the therapist does not communicate in the language used by the client, such as American Sign Language or Spanish)

_____

7. To what degree do you believe client-therapist language differences impact psychotherapy? (When client and therapist cannot use the same preferred language to communicate)
Please put an X in the desired box or on any line

	No Impact				**Moderate Impact**					**Large Impact**	
	0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Degree of Impact in Therapy											

8. How important is professional training on the use of language interpreters in psychotherapy?
Please put an X in the desired box or on any line

9. If you currently provide training on how to work effectively with language interpreters in clinical settings, please briefly describe **how** you provide that training (content/topics, method/techniques).

	Unimportant				Neither Unimportant Nor Important						Very Important
	0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Importance of Training											

10. In your opinion, how could training on working effectively with language interpreters in psychotherapy be integrated into multicultural coursework?

11. How likely are you to address the topic of working with language interpreters in the next multicultural psychology class that you teach? **Please put an X on the desired box or line**

	Unlikely				Undecided						Very Likely
	0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Likelihood of Incorporation											

12. **(Rank Order)** Listed below are nine competencies central to working with language interpreters in therapy. Please rank order the nine competencies in terms of their value for trainees to gain before graduation. **Write numbers 1-9 on the lines below according to your ranking**:

_____ **How to ethically select an interpreter** Evaluating professional background, certification, cultural/linguistic background (compatibility with client ethnicity, gender, age, religion, etc.), comfort with mental health interpreting, availability for ongoing therapy.

_____ **How to orient the interpreter prior to the session** Discuss confidentiality, roles, and boundaries; clarification of treatment processes.

_____ **How to set up the session to enable interpretation** Logistics, seating, provision of written materials, accounting for the process taking twice as long as normal, etc.

_____ **How to discuss roles, responsibilities, and confidentiality in the triad** Discuss roles of the clinician and interpreter with the client; address client concerns; if the interpreter is not certified, explain reasons and common issues to avoid in interpreted clinical sessions.

_____ **How to facilitate effective communication in the triad** Effective ways to communicate in the triad: succinct verbalizations, without technical/slang terms; avoiding side conversations and compound questions; maintaining eye contact with client.

_____ **How to address relationship dynamics in the triad** Skills to effectively handle issues such as transference and countertransference that impact working relationships in the triad.

_____ **How to conduct a post-session debriefing with the interpreter** Open dialogue of the interpreter's impressions of the session, including fit with the client, settling financial arrangements with the interpreter, planning for future sessions, etc.

_____ **How to collect relevant cultural and linguistic information from the interpreter** Skills to gather information from the interpreter to better understand the client's concerns, inform the diagnosis, and/or modify the treatment plan.

_____ **How to assess an interpreter's comfort, fit, and needs** Assess the interpreter's comfort with the content during the session (including sensitivity to client trauma) and if needed, provide emotional support, refer interpreter for further care, or suggest using a different interpreter.

13. Please describe any competencies in working with language interpreters that were omitted from the list of nine on the previous page

14. To what degree would you be willing to include the above list of competencies in the next multicultural psychology course that you teach? **Please put an X on the desired box or line**

	Very Little Chance				**Some Chance**						**Highly Likely**
	0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Incorporate the Competencies											

15. If not (or to a small degree), why not?

16. Specifically, how might you include these competencies in multicultural coursework?

17. What are the barriers to covering competencies for working with language interpreters in psychotherapy in a class on multicultural psychology?

18. How important is professional training on working effectively with language interpreters in psychotherapy? **Please put an X in the desired box or on any line**

	Unimportant				**Neither Unimportant Nor Important**						**Very Important**
	0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Importance of Training											

19. How likely are you to address the topic of working with language interpreters in the next multicultural psychology class that you teach? **Please put an X on the desired box or line**

	Unlikely				**Undecided**						**Very Likely**
	0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Likelihood of Incorporation											

20. What recommendations do you have to foster widespread implementation of the APA Guidelines to provide psychotherapy in a client's preferred language?

APPENDIX D: NINE CORE COMPETENCIES

The purpose of the competencies listed below is to clarify the minimum awareness, knowledge, and skills a mental-healthcare professional will need to engage ethically in an interpreted therapeutic encounter. This list is broken down into three stages: successful navigation of pre-interpreted encounter, successful navigation of interpreter-facilitated therapeutic encounter, and post-interpreted therapeutic encounter.

Successful navigation of pre-interpreted encounter (approx. 10 minutes prior to each session)

1. Ethical selection of an interpreter (professional background, certification, cultural/linguistic background--preferably from same country as client, gender, age, religion, comfort level with mental health interpreting, availability for on-going therapy, etc.)

2. Orientation/coordination with the interpreter

- **Maintaining confidentiality and role boundaries** each individual will have within the therapeutic triad, examine any conflict of interest or dual relationships. How the interpreter should interrupt the clinician or client (if needed), such as "This is the interpreter speaking."

- **Sharing (brief) information about the client**. Informing the interpreter (ensure they are paid for this time) about anything/he/she will need to know about the client and the presenting problem that will assist him/her in interpreting (vocabulary, activities, mental status exams). Make sure the interpreter has the correct pronunciation of the client's name.

- **Clarifying treatment processes** to any testing procedures, interview protocols, or psychotherapeutic techniques or processes that may be employed as well as any sensitive issues that may be raised such as suicidal ideation or abuse history

- **Identifying cultural considerations** and information that the interpreter believes will be helpful to the clinician in his/her understanding of the client's cultural perspective and what information will be shared during session.

3. How to set-up for an interpreter facilitated encounter. Logistical set-up (seating arrangement: triadic?), written materials provided to interpreter, account for the process taking twice as long as normal (schedule longer sessions).

Successful navigation of interpreter-facilitated therapeutic encounter

4. **How to discuss roles, responsibilities and confidentiality within the triad.** In the first meeting of the triad the clinician should discuss the professional roles and responsibilities of the clinician and interpreter with the client. If this is an untrained interpreter, explanations should be given as to why.

5. How to use appropriate communication within the triad.

- The clinician's verbalizations should be succinct. No technical or colloquial language should be used. In particular, compound or multiple questions should be avoided.

- Communicate directly with client ("Please ask Mrs. Lopez to explain her mood" would be inappropriate.) Ask for any side conversation between client and interpreter to be interpreted. If a side conversation must occur, indicate to the client what is about to happen after the conversation and interpret it for the client. Eye contact, however, should remain with the client at all times.

-Keep the interpreter on track**.** Pay attention to interpreter (interpreting is tiring), give reminders if needed, ask for clarification if at any time communication is unclear, even if this is a cultural clarification. [Is this step essential, meaning would it be accomplished by a competent therapist anyway?]

6. How to address relationship dynamics in the triad. Issues of transference and countertransference should be dealt with within the triad.

Successful navigation of post-interpreted encounter (approx. 10 minutes after each session)

7. Open debrief with the interpreter (ensure interpreter is paid for this time). Therapists can benefit from an open-ended query seeking the interpreter's general impressions of the session, including his/her fit with the client.

8. Gather additional cultural or linguistic information from the interpreter that may help the clinician better understand the client and/or make a diagnosis or treatment plan.

9. Assess the interpreter's comfort, fit, and needs. Asses the comfort level of the interpreter with the content during the session (including sensitivity to client trauma). If need be, provide emotional support, refer the interpreter for further care, or suggest the possibility of using a different interpreter.

APPENDIX E: TRAINING FRAMEWORK

A framework specific to working with language interpreters in psychotherapy has been developed by the author of this dissertation. This framework is not central to the design or procedures of this study, but it serves as a corollary resource to other aspects of the study. The curriculum is based on the framework set forth by Jacobs, Diamond, and Stevak (2010). What follows is a description of a 90-minute training curriculum for students in graduate psychology programs.

Instructional Framework

This curriculum has four main components: (a) a trigger tape followed by discussion of the implications of working within a triad, (b) a didactic portion in which students are provided with best principles for choosing and working with interpreters, (c) a modeling session in which the instructor models how to effectively work with interpreters, and (d) a role-playing session in which students have the opportunity to practice working with an interpreter.

Trigger-tape (10 min)

In order to engage students to think about and discuss how psychotherapy changes when working within a triad, a five-minute teaching tape may be shown of work with an interpreter. Students may be asked to brainstorm and discuss what they saw and how they might interact using an interpreter. Additionally, instructors may highlight points during the tape where communication issues are present and encourage students to come up with alternative strategies to those utilized by the psychotherapist in the tape.

Didactic session (10 min)

The didactic session may be designed to be brief yet provide students with guidelines on how to select and orient an interpreter to psychotherapy; how best to work with a professional

interpreter during the therapeutic encounter; and how to effectively debrief an interpreter post-session. Students learn that there are several considerations when ethically selecting an interpreter. In addition, they may not have considered the impact of using an interpreter from the same country, same religious background, or gender as a client. These as well as other central competencies in working with interpreters would be covered during this portion of the training.

Modeling session (10 min)

Before role playing, the instructor and a trained interpreter model an effective approach to an interpreted psychotherapy session. In this session the instructor plays the psychologist, and an additional faculty member or student plays the client. Specific demographic details (e.g., a Japanese client who has recently immigrated to the United States) may enhance the applicability and reality of such work. The psychologist models the pre-session briefing of the interpreter, briefly introduces the client, orients the interpreter to psychotherapeutic tasks and vocabulary, encourages the interpreter to be aware of cultural nuances, and covers preferable communication strategies. The seating arrangement is also demonstrated, after which the therapeutic encounter is played out.

Role-playing session (60 min)

The majority of the session is devoted to a role-play in which the students gain first-hand experience of working with an interpreter and receiving feedback from the interpreter as well as the other students present. Students are split into three groups, with each group rotating through different role-playing scenarios. Each role-play is observed, after which feedback and teaching are provided by one on the instructors, the interpreter, the simulated patient, and the other students.

This curriculum is not meant to be exhaustive in terms of covering all aspects and nuances of training clinicians how to ethically work with interpreters in psychotherapy. Rather, it was created as one of many possible ways in which this type of training might be implemented. Given that caveat, it is important to note that the author examined all available curricula (in relation to the topic) and to the best of their knowledge selected one that seemed most appropriate for and applicable to a graduate psychology multicultural course.