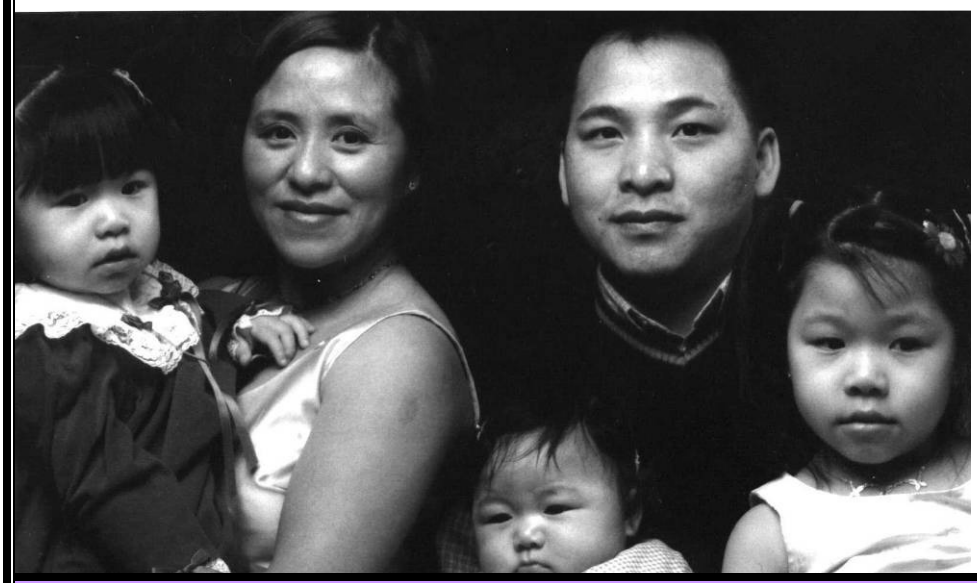
Refugee Mental Health

Psychological Testing

Video Workbook

Noriko K. Shiota, M.Ed.
James N. Butcher, Ph.D.



This is one in a series of training videotapes produced by the University of Minnesota's Refugee Assistance Program- Mental Health Technical Assistance Center, funded through a contract with the National Institutes of Mental Health in conjunction with the Office of Refugee Resettlement. The video workbooks have been updated by the MDH Refugee Health Program to promote continued use of these quality resources. Originals are available upon request.

Acknowledgements

Many individuals and organizations contributed to the development of this videotape and we would like to acknowledge their assistance and contributions.

We would like to thank our two segment hosts for participating in this project: Carolyn L. Williams, Ph.D., Associate Professor, School of Public Health, University of Minnesota and Rosa E. Garcia-Peltoniemi, Ph.D., Research Associate, Refugee Assistance Program—Technical Assistance Center Mental Health, University of Minnesota and Staff Psychologist, Center for Victims of Torture, Minneapolis.

The following individuals appeared in the videotape as guest speakers and are acknowledged for their generosity and cooperation: Elizabeth Gong-Guy, Ph.D., Director, Refugee Mental Health Program, Asian Community Mental Health Services, Oakland, California; Olivia Martinez, M.S.W., Executive Director, Miami Mental Health Center, Miami, Florida; Nguyen Nguyen, M.D., formerly of Department of Psychiatry, Tulane University Medical School, now staff psychiatrist at Chartres Mental Health Center and Pontchartrain Mental Health Center, New Orleans, Louisiana; and Saly Pin-Riebe, Senior Service Advocate, Refugee Assistance Program-Mental Health, Department of Mental Health, Massachusetts. We also wish to thank Laura Lam, M.S.W., University of Minnesota Hospital and Clinic for participating in the clinical scenes.

WCCO Television, Minneapolis, Minnesota, donated video footage on refugees. Nancy Mate, Acting Director of Public Affairs, WCCO, was particularly helpful in making this footage available to us. The American Refugee Committee (ARC), Minneapolis, Minnesota, provided numerous slides; Robert Anderson, Laura Crosby, and Sarah Whitehouse were very generous and helpful. Other photographs were provided by the United Nations High Commissioner for Refugees. Archival photographs and materials are courtesy of the Immigration History Research Center, University of Minnesota, the Library of Congress, and the New York Public Library. Permission to use the MMPI items was obtained from the University of Minnesota Press, University of Minnesota; we wish to thank Beverly Kaemmer for extending this permission.

The music used in the videotape is a 13th century Trouvere song entitled Reis Glorios. It was performed by The New International Trio, a Minnesota musical group specializing in Medieval, Cambodian, Celtic, and American swing music played on traditional instruments. The group members, Dick Hensold, Bun Loeung, and Barb Weiss, are acknowledged for their contribution.

Finally, we wish to thank Rosa E. Garcia-Peltoniemi, Ph.D. for her contribution to this project.

January 1989

Dr. Amos Deinard

Amos Deinard, MD, MPH, has been on the faculty of the Department of Pediatrics, University of Minnesota, since 1969. Beginning in 1979, as the Pediatric Consultant to the Minneapolis Health Department's Bureau of Maternal and Child Health program, he became involved not only in the direct care of refugee children who were immigrating from the refugee camps of Southeast Asia, but in health care program planning and development as well. In addition, he was the Principal Investigator of a resettlement project and a project funded by the National Institute of Mental Health to create a technical assistance center that would provide mental health assistance to those State mental health programs that were serving large numbers of refugees (NIMH-TAC/MH). All of the print and videotape documents that were developed under the terms of the NIMH-TAC/MH contract are included in this collection.

Table of Contents

Overview

This training package is one in a series of four videotapes, each with its own workbook, designed to provide training in refugee mental health. The other topics covered in the series include: primary prevention, psychiatric interviewing, and the use of interpreters in mental health service delivery.

The primary audience for this program includes psychologists who administer and interpret psychological or those who are in training for this field. The secondary audience includes consumers of psychological testing—psychiatrists, social workers, nurses, school administrators, and other professionals who benefit from the results of psychological testing of their refugee patients, clients, or students.

This program examines the importance of using standard psychological assessment procedures with refugee patients and explores some problems and issues in cross-cultural testing. It describes briefly the steps involved in psychological scale construction and validation. The procedures for adapting psychological tests for use with refugee patients are highlighted. A number of important issues are raised which address the validity and usefulness of testing refugee patients. An illusion is provided of how one type of objective personality assessment procedure, the Minnesota Multiphasic Personality Inventory (MMPI), can be applied to refugee patients. The narrator is assisted by professionals working in refugee mental health who have either used psychological tests with or have requested psychological testing for their refugee patients.

The handouts and supporting materials included in this workbook summarize important points for the viewers and provide a further opportunity for review and discussion. The paper by Ben-Porath is included for individuals interested in psychometric aspects of cross-cultural test adaptation. Also included are guidelines for working with interpreters. Instructors can choose among the material to meet the needs of their audience. Sugg4estings for conducting post video discussion groups are included. Literature references are also provided.

For more information about this training package, please contact James N. Butcher, Ph.D., Department of Psychology, N218 Elliott Hall, University of Minnesota, Minneapolis, MN 554555; (612) 625-9880.

Issues in Refugee Psychological Assessment

The need for conducting cross-cultural psychological assessment has increased considerably in recent years due to the increase in contract that mental health professionals have with diverse groups of refugees. There are many issues that need to be addressed when conducting psychological assessment with individuals who are linguistically and culturally different, and there are additional obstacles that need to be overcome when administering psychological tests to refugee patients. However, if appropriate steps are taken to adapt tests for use with this population, the instruments can provide valuable information which the mental health professional can use. In this paper, several issues associated with the psychological assessment of refugee patients are briefly presented through highlighting the different perspectives which mental health professionals and refugee patients have of the testing situation. Suggestions are then offered for adapting and evaluating assessment instruments for use with refugees.

Issues in Psychological Assessment of Refugee Patients

Cross-cultural interactions in mental health settings are frequently characterized by a great deal of distance between the service provider and the patient. This may be due to both the mental health professional and the refugee patient misinterpreting the actions and intentions of the other. Thus, it is essential to recognize the different perspectives which each participant has of the psychological assessment situation.

The Mental Health Professional

Professionals in the United States tend to view the problems of refugees differently than do the refugees themselves. It is not uncommon for mental health professionals to view their refugee patients as experiencing primarily stress, depression, or come other Western-based mental health problem. In contrast, refugees themselves report that their problems are a lack of English language skills, family separation, unemployment, insufficient funds, lack of transportation, and insufficient child care (Strand & Jones, 1985). This difference in the way the parties perceive problems may strongly influence the mental health contact and result in incomplete or inappropriate services.

Mental health professionals who have had little contact with minority or refugee populations may view the mental health problems of refugees as identical to those of majority Americans. Therefore, the professional may initially respond to and treat a refugee patient in the same way as they would a majority patient. This mistake may be exacerbated by the refugee patient's inability to express problems, needs, or goals in ways that are familiar to the professional. Miscommunication may lead to inadequate or inappropriate assessments. For example, a refugee patient who reports many physical problems may be diagnosed as suffering from somatoform disorder when he/she is actually suffering depression.

When making clinical inferences with refugees it is necessary to consider that personality factors or characteristics commonly seen among individuals in the United States may not be expressed in the same way among individuals from different cultures. Moreover, familiar personality characteristics may have a different distribution that that to which Western professionals are accustomed. Assuming that there is a similar distribution of a trait between two groups could lead to diagnostic problems. For example, behaviors associated with extroversion or sociability, such as chattiness or easy displays of humor, behaviors which might frequently be observed in majority American patients, may not be displayed by certain minority of refugee patients. A mental health professional might misread the behavior of a refugee patient who appears "non-assertive and does not maintain eye contact" as indicating that the patient is shy, introverted, unfriendly and unsociable, when the behaviors actually reflect a culturally appropriate response to the social situation.

Overall, mental health professionals have a number of well-ingrained expectations about what patients are like and how they will behave. They expect for example, that patients come to a mental health clinic with the knowledge that they will be assisting the professional in forming an understanding of their situation and the factors which contributed to the development of their problem. They further expect that patients will be willing to participate in interviews that ask for personal information and to submit to a range of psychological tests or procedures that help the clinician obtain a more complete perspective on their problems. Underlying these expectations are even more fundamental expectations that the patients have sufficient experience with such things as answering questions on tests and that they will be able to complete such tasks with little difficulty. However, when working with refugee patients, these expectations are frequently not met.

The Refugee Patient

Individual reared in less developed parts of the world may harbor specific beliefs about causation and accept particular explanations of phenomena that are quite different from those accepted in technologically-oriented societies. Therefore, it is likely that refugee patients may hold views that are different from those of the mainstream clinician regarding how psychological problems should be treated. For example, the notion that a troubled person might benefit from talking over problems with a stranger is an alien idea to many refugees. Indeed, most refugees have never had contact with mental health professionals, even in their native country. When problems developed, they went to family members or community leaders for advice. They typically would not have told their problems to strangers. Of course, this familiar pattern of limited help seeking persists after resettlement. Consequently, refugee patients may not be very open to providing personal information for evaluation.

Important information regarding the patient's clinical status also may be unavailbable to the clinician because the refugee patient fails to see its relevance. Although all cultures have a conceptualization for deviance (Murphy, 1976), the nature and extent of what is considered a problem is likely to vary. Consequently, behaviors or attitudes that clinicians might view as problematic, and, hence, crucial for complete assessment, might be minimized or ignored by refugees. Relatedly, many psychological tests incorporate stimuli that only indirectly reflect the characteristics being measured. Thus, many

refugees do no see the relevance of the questions being asked and they fail to see the importance of some of the tasks that psychologists request them to perform. This may lead to lack of cooperation in testing which can produce poor invalid results. Therefore, mental health professionals must take time to develop rapport with their patients to overcome initial resistance or hesitancy in disclosing information and participating in testing.

Another basic and frequently encountered problem in refugee mental health service delivery is that the typical patient has little facility with the English language and the mental health professional has no skill in the refugee patient's language. Many communities have interpreters but they are often very limited in number. Even when an interpreter is available, interpretation distortions frequently occur, a problem which has been discussed in detail by others (Egli, 1987; Marcos, 1979; Williams, 1985).

Test Adaptation and Evaluation

Many clinicians have found themselves in situations of having to evaluate and make dispositional recommendations for individuals who are culturally different and speak little or no English. Fortunately, psychological tests provide valuable information that mental health professionals can effectively employ with these individuals. However, it is important to be aware of the factors which limit the validity of standardized psychological procedures when used with individuals from different cultures.

The use of psychological tests with a cultural group different from the one on which the test was developed is fraught with problems which extend beyond the obvious one that the test was constructed in another language. In developing or selecting a psychological test for use with a refugee patient, it is important to consider the issue of measurement equivalence. The test user should be sure that test development or adaptation procedures sufficiently address the matter of test equivalency and that the new instrument has been shown to measure the same constructs in the same way in the new cultural group as it does in the original cultural group in which it was developed.

Several other aspects of psychological test development are also relevant when considering a test for cross-cultural use:

1) The format of the test might be problematic for refugees. The test user should make that the format of the test is relevant for the population with which it is to be used.
2) Item translation needs to be evaluated prior to broad usage with refugees. The adequacy of the translation used for verbal instructions also needs to be carefully evaluated. Special care should be taken when translating items for self-administered questionnaires.
3) If standard objective psychological tests are unavailable for use, the clinician may need to adapt or attempt to use a less structured but potentially less reliable and valid procedure, such as projective technique.

When tailoring a psychological procedure for use with refugee patients, it is important to:

1) choose relevant and appropriate stimulus material,
2) provide careful translation or test content into the refugee languages,
3) acknowledge variations from standard procedures and take these deviations into account when interpreting the results, and
4) evaluated, where possible, the adaptation procedures to determine the equivalency and test adequacy.

Some psychological procedures, such as symptom checklists, significant life event forms, and face valid health questionnaires, are fairly straightforward and require little theoretical discussion. Clinical interpretation of translated instruments like the SCL-90 or Social Readjustment Schedule requires little deviation from standard interpretation procedures. By contrast, the use of standardized psychological tests where interpretation of the results requires reference to norms is more complicated. It is important that the clinician employs standardized psychological tests which are culturally relevant and possess valid test norms and interpretations. Tests with substantial empirical bases which have been adapted in numerous languages, such as the MMPI, may have considerable interpretive generality. The clinician is justified in applying an MMPI interpretation developed in one country for populations in another since numerous studies have demonstrated the validity of such generalization.

However, for instruments that have a limited empirical base or which have not been researched cross-culturally, interpretations based on a single culture should be applied only cautiously.

To summarize, prominent issues that need to be addressed in any cross-cultural test adaptation include:

a) assurance of test translation adequacy,
b) assurance of test equivalence with the target population,
c) determination of test reliability in the new testing situation,
d) determination of test validation, and
e) assurance of test relevance for the target population.

Concluding comment

Many mental health professionals today are faced with the challenge of appropriately assessing individuals who are linguistically and culturally different from themselves. There are some major obstacles in assessment that stem from the different perspectives that the clinician and the refugee patient bring to the mental health setting. Furthermore, there are problems with using psychological tests with a cultural group that is different from the one for which the test was developed. However, the benefits of having psychological test data outweigh the problems of adapting a test for use with refugee groups. To date, a relatively wide range of psychological assessment procedures have been developed or adapted for use with culturally diverse populations. Many psychological procedures, such as the Eysenck Personality Inventory, the MMPI and the SCL-90, have been used extensively in cross-cultural assessment and have both adaptable formats and a substantial validation base which supports their use. With an appropriate adaptation work period with cautious and responsible clinical use, psychological tests can provide useful information for developing treatment or intervention strategies for refugee patients.

Suggested Guidelines for Post Video Discussion Groups

This video provides an overview of psychological testing of refugee patients. For purposes of training, it may be more constructive to show this 44 minute videotape in sections since there is a great deal of information presented within a relatively short period of time. This format also provides opportunities to discuss the material immediately after it is presented. The depth of the discussion following the videotape will be shaped by the needs of the trainees and by time limitations of the training sessions.

Listed below are the major sections of the videotape with suggestions for further discussion. The length of each section is included in parentheses.

1) Introduction and the misuse of psychological testing

9 minutes

The instructor can lead a discussion on mistakes that Goddard made when testing immigrants. Discussion of his mistakes can lead to identification of other errors which the participants may have made themselves, or may have seen others make when testing minority or refugee patients. Participants can also offer suggestions on how these errors can be avoided or corrected.

2) Issues in cross-cultural assessment

7 minutes

This section includes a brief introduction to scale development and test adaptation and related problems and issues. The instructor can clarify or elaborate on technical points mentioned in the videotape. The contents of the discussion, particularly the psychometric aspect of the discussion, would depend upon the level and interest of the participants in the training session. Participants who have adapted psychological tests themselves or whose agency has undertaken this task can describe their endeavor.

Problems with translating test materials “on the spot” during test administration can be discussed. It should be emphasized that when adapting a test for use with refugees, it is crucial to have an appropriate translation of the test material using expert bilingual translators. As a way to check on the accuracy and appropriatenss of the translation, the translated material should be backtranslated into the original language. The content can be altered as necessary to assure that it is appropriately adapted for the target culture.

3) Procedures for adapting psychological tests to refugee patients

12 minutes

Our experts have commented on a number points related to the psychological testing of refugees. The participants can share their own experiences with testing refugees. They can also raise additional points which they see as relevant for gathering valid and useful test-based information. The applicability of some of these issues may vary according to specific refugee groups. Participants can select an ethnic group that is common in their community and discuss the relevancy of these issues for that group.

4) The MMPI and the case illustration

15 minutes

Because some of the participants may not be familiar with the MMPI, this would be a good opportunity for them to learn about this widely used psychological instrument. The applicability of the MMPI to refugee patients is illustrated through as case study of a Vietnamese woman. The discussion can focus on the MMPI profile and its interpretation. The profile is included in the handouts.

Recommended Handouts

Psychological Testing: Goddard's Results

Goddard's famous Kallikak study in the early 1900's is a good example of the misuse of psychological testing with immigrants. Goddard administered the Stanford-Binet almost immediately after the immigrants arrived from their long journey across the Atlantic Ocean. Although many did not speak English, the testing was conducted in English. Not surprisingly, many of the immigrants who took the test did not do well.

Goddard's original data indicated that very few of the immigrants were normal and most were feebleminded:

Immigrant Group*	% Normal	% Feebleminded
Jews	10%	83%
Hungarians	0%	80%
Italians	7%	79%
Russians	0%	87%

Points to Remember:

- Goddard's testing procedure was seriously flawed. The administration of the test was not in the immigrant's native language and the test had not been adapted for use with immigrant populations.

- Goddard relied on abstract scores and ignored contrary data from the "real world" when interpreting test results. For example, if the immigrant functioned well in his/her daily life and spoke two languages fluently, this information was not integrated into Goddard's assessment of the person's intellectual functioning.

* Table adapted from Goddard, H.H. (1917). Mental tests and the immigrant. Journal of Delinquency, 2, 243-277 and Smith, J.D. (1985). Minds made feeble: The myth and legacy of the Kallikaks. Austin, Texas: Pro-Ed, Inc.

Psychological Scales

A scale of measurement provides a standard of comparison for quantifying objects or qualities. Scales are groups of items measuring a symptom cluster or trait and are commonly used in psychological inventories. Scale construction and validation is a challenging task; the general steps involved in this process are outlined below.

- The psychological attribute of interest must first be defined so that it can be studied. The range of the hypothetical behavior is explored and the behaviors making up the attribute delineated. For example, to measure the construct "dominance", we should initially define the construct and detail potential behaviors compromising it.
- Appropriate items that would be relevant to the attribute must then be written or selected. If a subject endorses that item, it would indicate a degree of that quality or attribute. For "dominance", such behaviors as "speaks up in a group" or "gives advice to strangers" that are relevant to the trait might be identified.
- The typical level of performance within a group is used to establish a norm for the behaviors in question. Through a careful investigation of the trait scores, a distribution of the scores for that trait can be constructed. A norm enables the researcher to compare an individual's score to those of others and is necessary for interpreting the meaning of the score.
- It is important to establish that high and low scoring individuals behave as expected. Such comparisons are necessary to establish the validity of the scale. If an individual should display "dominant" behaviors in the real world more often than the individual who scored low on that scale.
- The new scale can then be used to compare new subjects on the behaviors being assessed.

Points to remember:

- Measuring psychological qualities is more difficult than measuring physical qualities because psychological qualities are more variable and the scales which measure them are less direct.
- Assessing characteristics of a person from a cultural group which differs in background and language requires different assumptions and considerable care.
- If task relevance, content validity, and norm appropriateness of a psychological quality can be assured, the psychological attribute can be measured with a satisfactory degree of accuracy for making many practical decisions.

Cross-cultural psychological assessment: Adaptational Issues

Some of the assumptions underlying cross-cultural psychological assessment are:

- That the constructs or characteristics are similarly distributed, in each culture.
- That there is test equivalency, which means that the tasks or items are appropriate for the new cultural group.
- That there is sufficient test generalizability and validity for the new cultural group.

When using a test with a person from a different culture, the validity of the test should be evaluated in the target culture. Validities of interest include:

- Content validity: The content of the measurement instrument is relevant to the trait or behavior being assessed in the second culture.
- Internal validity: The correlational structure of items is similar across both groups.
- External validity: The scale measures the trait or behaviors equally well in both cultural groups.

Some difficulties with cross-cultural assessment include:

- Language: Psychological characteristics are assessed through language; therefore the standard English version of the test cannot be used in its original form.
- Task relevance: Psychological testing is often done in a self-report format which requites the use of paper and pencil. Some refugees have not had experience with this type of task.

Despite some of these difficulties, tests can be adapted for use with refugee patients if extra care is taken during adaptation. Some major points include the following:

- One must always be careful to choose relevant and appropriate test materials when testing refugees.
- Test materials must be appropriately translated using expert bilingual translators. Back-translation from the target language into the original language can be done to check for the accuracy of the translation. The content can be altered as necessary to assure that it is appropriately adapted for the target culture.
- Test instructions and administration procedures can be adapted to increase the refugee patient's understanding of the task.
- It is important to identify deviations from standard test administration procedures when administering a test to a refugee patient. Such deviations must be taken into account when interpreting the test results.

Projective Personality Testing with Refugee Patients

Projective personality testing involves the administration of relatively vague or ambiguous stimuli which may elicit a wide variety of responses. Despite the popularity of projective techniques in clinical settings, clinicians must exercise caution when using these techniques with refugee patients.

Points to Remember:

- The task may not be understandable to refugees. It may be puzzling to the refugee patient why it is necessary to respond to ambiguous stimuli. Without an appreciation of the purpose of projective testing, it may be difficult to get full cooperation from them.
- Scoring is often subjective and not reliable. In recent years, scoring systems such as Exner's comprehensive system for the Rorschach and Holtzman's scoring system for the Holtzman's Inkblot Test have been developed. These can help prevent the subjectivity of scoring. However, most other projective techniques have no such standardized scoring system.
- Extensive training is needed to administer and interpret the projective test results. Interpretation is demanding even under normal circumstances. However, interpreting test results of refugee patients is further complicated by the paucity of normative data and the dissimilarity of the cultural context surrounding the refugee patient's response. This dissimilarity can be exemplified by associations given to the color red in different cultures. In China red is associated with happiness whereas in the United States there is no such association.
- Clinicians should not assume that refugee clients, both adults and children, can do such "common and easy" task as drawing (for techniques such as House-Tree-Person or Draw-a-Person). Asking them to draw may be more stressful and non-informative than is anticipated and, therefore, the results would be subject to misinterpretation.

Requirements for Cross-Cultural Application of the MMPI

Before administering the MMPI to refugee patients, the following requirements must be met.

- Literacy: Individuals taking the MMPI must be able to read the items. Without this basic requirement, it is difficult for the patient to take a self-report psychological inventory.
- Equivalent translation: Prior to a broad usage with refugee patients, the translated instrument must be evaluated for its equivalency to the original instrument.
- Cultural adaptation: The MMPI needs to be tailored to fit the new cultural groups with which it is to be used. This would entail adapting items which are culturally specific, such as those that make reference to specific books or childhood games.
- Factorial invariance: Scales must display similar inter-correlations across cultures. This would assure that the constructs being measured in the two cultures are similar and that there is test equivalency. (For further information, please see a paper entitled Cross-cultural assessment of personality: The case for replicatory factor analysis by Y.S. Ben-Porath)
- External validation: The test must be validated for the new culture by relating scale scores to extra test correlates.

Psychiatric Rating Scales

There are currently a number of psychiatric self-rating scales that have been translated for use with refugee patients. A listing of such scales can be found in the Cross-cultural psychological assessment: Issues and procedures for psychological appraisal of refugee patients (Butcher, 1986). The following is a selected reference list of rating scales which have been used with refugee patients.

Cornell Medical Index

Brodman, K., Erdmann, A.J., Lorge, L., et al. (1949). The Cornell Medical Index: Adjunct to medical interview. JAMA, 140, 530-534.

Lin, K.M., Tazuma, L., & Masuda, M. (1979). Adaptational problems of the Vietnamese refugees. Archives of General Psychiatry, 36, 655-961.

Hamilton Anxiety Scale

Hamilton, M. (1959). The assessment of anxiety states by rating. British Journal of Medical Psychology, 32, 50-55.

Hamilton Depression Scale

Hamilton, M. (1960). A rating scale for depression. Journal of Neurology, Neurosurgery and Psychiatry, 23, 56-62.

Hopkins Symptom Checklist-25 Indochinese Version (HSCL-25)

Mollica, R.F., Wyshak, G., de Marneffe, D., Tu, B., Yang, T., Khuon, F., Coelho, R., & Lavelle, J. (1985). Hopkins Symptom Checklist-25 manual. Cambodian, Laotian, and Vietnamese versions. Washington D.C.: U.S. Office of Refugee Resettlement.

Symptom Check List-90 (SCL-90)

Derogatis, L.R., Lipman, R.S., & Covi, L. (1973). SCL-90: An outpatient psychiatric rating scale – Preliminary report. Psychopharmacology Bulletin, 9, 13-18.

Piasecki, J., Heegaard, W., Holtan, N., & Jaranson, J. (1985). Interviewer manual for rating the Hopkins Symptom Checklist-90 (SCL-90). St. Paul Ramsey Foundation, Grant Number 8387.

Westermeyer, J. (1986). Two self-rating scales for depression in Hmong refugees: Assessment in clinical and nonclinical samples. Journal of Psychiatric Research, 20, 103-113.

Vietnamese Depression Scale.

Kinzie, J.D., Manson, S.M., Vinh, D.T., Nguyen, T.T.L., Bui, A., & Than, N.P. (1982). Development and validation of a Vietnamese-language depression rating scale. American Journal of Psychiatry, 139, 1276-1281.

Zung Depression Scale.

Zung, W.W.K. (1965). A self-rating depression scale. Archives of General Psychiatry, 12, 63-70.

Westermeyer, J. (1986). Two self-rating scales for depression in Hmong refugees: Assessment in clinical and nonclinical samples. Journal of Psychiatric Research, 20, 103-113.

Transcripts of Experts

Elizabeth Gong-Guy, Ph.D.
"Probably one of the biggest problems that we have is that when refugees come in for a test is that they don't understand the nature of the test situation; even if they have been told that they are being evaluated, they do not have any kind of familiarity, many of them, with paper and pencil tests, they have not been through the same educational system and the idea of being evaluated at one sitting or several sittings on concepts and on tasks and abilities that are really unfamiliar to them is very difficult to inform them about. So, even if you think you are doing an informed test, typically we find that the refugee is very confused about the test situation overll."

Saly Pin-Riebe
"The barriers…the first thing is the language barrier; the second thing is, because they came here, is their social adjustment. They do not feel comfortable sharing, that is a cultural difference, they do not feel comfortable sharing their personal problem with a stranger. And also, the concept of mental health is different, that is a barrier too. And the trust issues that you are asking, that is a big problem. And also with the trust issue, they do not understand what you are going to say about their problem to somebody else. They do not understand the issue of confidentiality in the policy of mental health…At all! In the mental health policy of the facility…They do not know that you have that kind of policy. And also, they are passive. You need to remember that…they are very passive. And, the most important thing is that, with the effect of the trauma experience that they have, maybe this person has no concentration, maybe this person has a depression, and they just could not hear what you are asking. And the testing, with the trauma experience, if the testing by using the material, they were terrified by that, they thought that you were going to torture them or something like that"

"I think, they view it as an invasion of their privacy, that is the first thing, and the second thing, they are confused by your asking questions. For Cambodians, they expect you as the person they perceive that could help them to know their problems, what are their problems, and so they expect you know already, and why you ask questions? So you did not know anything about it? About helping them at all? How could you help them? Like the doctor, the same as a doctor who asks them about their problems, medical problems, like that, a doctor should know what disease they have and treat them and how come the doctor did not know and is asking the patient? And that is their expectations. It is a cultural expectation."

Olivia Martinez, M.S.W.
"Well, assuming first of all that the interviewer and interviewee both speak the same language, let's make that assumption, I think that when you are treating someone from a different culture or you are doing an assessment, the first thing you need to realize is how little you know and you have to be ready not to make assumptions, not to think you understand, etc., etc. When you know for a fact that the person is from a different culture than you and you ask certain questions, it becomes increasingly important to observe body language. In general, those areas that are sensitive to the dominant-culture person are also sensitive to a Cuban refugee or entrant, you know, sex, success, failure, these kinds of things I think a large portion of our populations aren't too comfortable talking about openly until they have established a strong trusting relationship, that principle is not any different."

Nguyen Nguyen, M.D.
"A lot of patience for the psychologist doing the test to help the patient understand the questions, a correct meaning of the questions, to answer the question. It required very well trained interpreter to translate questions to patient. So it required both, a well-trained interpreter and a lot of patience upon the psychologist doing the test."

Elizabeth Gong-Guy, Ph.D.
"One of the things that we find very valuable is to sit down with the refugee who is going to be tested and typically with a family member and explain to them exactly what is being done and for what purposes. And that really requires that the tester, the examiner, be very clear on the purpose of the examination as well. If the test is being done for the purposes of some kind of an educational placement, that has to be explained very clearly; if it is being done because of a court-ordered evaluation, that also has to be explained. And we also find that it is real important at the outset to cover issues of confidentiality and talk about how the test will be interpreted. A lot of that information can go over the refugee's head but in many cases we find that they ask very intelligent questions that given the opportunity…, not given the opportunity to ask, we would have simply missed."

"We modify the test administration typically to include a lot more explanation. We like to use tests where as a part of the standardized procedure there is a practice session built in."

"Well, first of all we allow probably three times the amount of time that we would in a feedback session to a native speaker of English. A lot of time we find that we have to go back through the test because the refugee is either confused or upset about a specific procedure that has been done. We do a lot of reassurance in explaining how we have interpreted the test results."

*Transcriptions are presented in order of appearance.

Guidelines for Working with Interpreters

Rosa E. Garcia-Peltoniemi, Ph.D.
Eric Egli, M.A.
Department of Psychology
University of Minnesota

The experience of working with an interpreter during the many different facets of patient care is usually new to most mental health professionals. Formal training in this special aspect of patient/professional communication has not been generally available. Thus, most mental health professionals have not been trained to use interpreters in performing tasks such as diagnostic interviews, counseling, psychotherapy, medication education, or psychological testing. Yet, since in most communities there are few, if any, bilingual mental health professionals, access to mental health care for a substantial segment of the population will depend largely on the availability of interpreters who can take on this important function and professionals who are willing and able to provide services in this manner.

Working through an interpreter brings in an added dimension of complexity to the activities performed by mental health professionals. The question of professional role boundaries is likely to arise in this situation and cannot be ignored. As a general rule, we think it is extremely important that mental health professionals do not relinquish responsibility for performing the tasks which are appropriate to their role when working with interpreters. Moreover, mental health professionals need to be conscious that the same professional standards and rules of conduct that apply to services provided through interpreters. Consequently, it is in the best interest of mental health professionals to work with interpreters who are not only competent to communicate across the language barrier but also capable of abiding by professional standards and ethical practices. By the same token, providing mental health professional and should be avoided whenever possible. Family members or friends of the patient should not be used as interpreters because they lack the appropriate training, and most importantly, because they lack the objectivity needed to perform the interpreting tasks without interfering in the assessment or treatment process.

We recognize, however, that there are situations in which either extremely scare resources and/or unexpected crises lead to a far less than optimal choice of individuals who can take on the role of interpreter. In our experience, it is precisely in these situations that is becomes most crucial for the clinician to have some knowledge about the tasks of the interpreter and how they should be performed. The step-by-step procedures offered below can be implemented in a variety of situations involving both trained and untrained interpreters. Issues of interpreter competencies and role responsibilities requite less attention when dealing with trained interpreters.

Before the session

1) Determine the interpreter's level of language sophistication, sensitivity to mental health issues, and general disposition for the task(s) to be performed.
    - What is their level of education in each language? How well do they speak each language?
    - Have they trained to do interpreting? Have they interpreted before?
    - Do they know anything about the mental health field? Have they interpreted in mental health settings?

2) Determine if interpreter is a "good match" with your client/patient.
    - Consider age, sex, country of origin, cultural background, personal maturity, etc.

3) Establish role guidelines and responsibilities.
    - Discuss confidentiality and the ethical guidelines that apply in the professional relationship with the client.
    - Ask the interpreter to interpret what the client says as accurately as possible, including slang, obscenities, and unusual speech patterns.
    - Ask interpreter not to screen the client's comments or messages for fear of offending you, or because they may reflect poorly in the patient of the refugee community.
    - Instruct the interpreter to ask for clarification immediately should he or she not understand wither you of the client.
    - Make clear that the function of the interpreter is to guarantee the right of the client to consult with you (the mental health professional) in as direct a manner as possible.

4) Plan for the tasks to be accomplished during the session.
    - Discuss the purpose of the session, your plans, goals and expectations.
    - Address potential areas of difficulty
    - Decide upon mode of interpreting, seating arrangements and introductions.

During the session

1) Talk directly to the client and make sure interpreter speaks for you and to the patient in the first rather than the third person
    - <u>Good</u>: "How are you feeling today?"
    - <u>Poor:</u> "How is she feeling today?" or "Ask her how she is feeling today"

2) Use language that is within the ability or knowledge level of the interpreter.
    - Avoid using technical terms/jargon
    - Avoid obscure or ambiguous words.
    - Avoid idioms/slang.

3) Regulate the pace of the interview

   - Establish a reasonable pace to avoid taxing the interpreter
   - Keep sentences brief and concise.
   - Avoid chained questions
     - Good: "Do you smoke?"
     - Poor: "Do you smoke or drink alcohol?"

4) Do not exploit the language barrier to talk about patients in their presence.

   - If you have some understanding of the client's language, acknowledge this at the outset.
   - If you must consult with the interpreter on a technical point, explain to the client what you will be doing.

After the session

1) Discuss questions or concerns that emerged during the session:

   - Bring out for discussion any communication problems you or the interpreter noted.
   - Discuss cultural issues and the interpreter's impressions of the client's use of language.

2) Debrief interpreter carefully, particularly if the session was emotionally charged.

3) Make any necessary plans/arrangements for future sessions.

Additional Information for Working with Interpreters

A case example may help illustrate how the steps outlined above can be implemented in clinical practice. We will illustrate an unavoidable situation in which previous planning for language interpretation failed at the last minute and the clinician was faced with having to "make do." The patient in the original case on which the video vignette "Disturbed Speech" is based was a young make who had been released from jail for the purposes of psychiatric evaluation at a teaching facility in a nearby state several hours away. On the day of the evaluation, the staff interpreter at the clinic became ill and no other interpreter could be located. The patient came accompanied by a male cousin who, being a few years younger in age, was a lower status, and according to cultural norms obliged to show deference and respect for his older cousin. Given that it was not practical to reschedule the evaluation, the clinician decided to go ahead and use the patient's cousin in the role of interpreter. Recognizing the many possible pitfalls involved in this particular situation the clinician met with the young cousin separately and reviewed in detail the requirements of the interpreting task, the expectations being placed on him, and the problems that could arise. By showing an understanding of the difficulties involved in the task at hand, the clinician not only elicited the young cousin's cooperation but was able to give him some helpful guidelines on how to provide accurate interpretation that would allow appropriate diagnosis. Specifically, the young cousin was instructed to interpret everything the patient said no matter how irrelevant,

nonsensical, or embarrassing and he was alerted to the possibility of being embarrassed by the patient's behavior during the interview. As a result of these instructions, it was possible to determine that the patient's speech was extremely disorganized and in fact reflected a thought disturbance (flight of ideas). This was further confirmed by the patient's non-verbal behavior, which was best characterized as intrusive, disruptive, and highly inappropriate. Following the interview, the clinician again met with the young cousin separately and reviewed the session, giving special attention to the young cousin's feelings of embarrassment about the patient's behavior and his current family situation, which had changed significantly as a result of the patient's illness.

We must emphasize, lest this previous case example be misunderstood, that one cannot expect fully competent interpreting from inexperienced individuals after a brief pre-session orientation. In addition, there are other activities regularly performed in mental health settings, which requite high levels of proven interpreting competency and additional counseling/psychotherapy. There are a number of points that need careful consideration when administering psychological tests with the aid of an interpreter. First, psychological tests administered in this manner are likely to take two to three times longer than a standard administration. Considerable time and effort need to be devoted to training the interpreter so that the administration is as close to standard as possible; for example, it is very important that the interpreter know the test procedures thoroughly and be able to maintain a neutral stance throughout testing. Test instructions should be translated ahead of time (a task that a translator and not the interpreter may need to undertake) and not on the spot. Nonetheless, it remains a fact that interpreter-aided test administrations are never standard, and this should be taken into consideration when interpreting the test results and noted in any test reports. The same interpreter should be used throughout the administration of a lengthy test battery. Finally, there are certain test procedures which will be nearly impossible or highly impractical to administer with the aid of an interpreter; they include projective tests such as the Rorschach and the Thematic Apperception Test.

Activities such as counseling and psychotherapy, which involve regular contact throughout a number of sessions, are also best carried out with the aid of the same interpreter. Special effort should be devoted to familiarizing the interpreter with these tasks and developing the working relationship between clinician and interpreter. Personal characteristics of the interpreter may play an even more crucial role in these activities which invariable involve going over emotionally loaded material. Two characteristics appear to be very important and should be taken into consideration when selecting interpreters for these tasks; these are the interpreter's level of maturity and his/her own mental health. The latter characteristic, in particular, may be of prime importance when providing mental health services to refugees, given the traumatic nature of most refugees' experiences. Exposure (or re-exposure if the interpreter is also a refugee) to accounts of highly traumatic events is not only emotionally draining but can in some cases have deleterious effects on the mental health of an individual. Mental health professionals need to recognize and be prepared to deal with the impact of traumatic or upsetting issues on the interpreter.

Finally, we would like to recognize that most mental health professionals currently face working within increasingly cost-conscious service delivery systems. Decisions about resources are often made by administrators and not by the clinicians performing the services. We have repeatedly emphasized the need for extra time and effort involved in all facets of working with interpreters. It is our belief that thorough knowledge of what is involved in delivering mental health services

through interpreters will help clinicians both involved in delivering mental health services through interpreters will help clinicians both lobby for the availability of language interpretation and negotiate reasonable and realistic working conditions for serving refugees. The Civil Rights Act guarantees the right to equal access to services regardless of national origin. Admonitions based on civil rights, however, are not likely to result in much change unless they are also accompanied by workable recommendations for providing quality mental health services to refugee clients.

Original References*

Refugee Mental Health: Psychological Testing

Al-Issa, I. (Ed.). (1982). *Culture and Psychopathology*. Baltimore: University Park.

Ben-Porath, Y.S. (In press). Cross-culture assessment of personality: The Case for Replicatory Factor Analysis. In J. N. Butcher and C. Spielberger (Eds.), *Recent Advances in Personality Assessment*, Vol 8. New Jersey: Lawrence Erlbaum and Associates.

Berry, J.W., & Blondel, T. (1982). Psychological adaption of Vietnamese refugees in Canada, *Canadian Journal of Community Mental Health*, 1. 81-88.

Brislin, R.W. Lonner, W., & Thorndike, R. (1973). *Cross-Cultural Research Methods*. New York: Wiley.

Brislin, R. W. (1970). Back Translation for Cross-Cultural Research. *Journal of Cross-Cultural Research, 1*. 185-216.

Butcher, J.N. (1986). Current Developments in MMPI use: An International Perspective. In J. N. Butcher, & C. D. Spielberger (Eds.), *Advances In Personality Assessment*. Vol. 4. Hillsdale, N. J. : Lawrence Erlbaum Press.

Butcher, J. N., & Pancheri, P. (1976). *A Handbook of Cross-Cultural MMPI Research*. Minneapolis: University of Minnesota Press.

Cheung, F. M. (1985). Cross-Cultural Considerations for the Translation and Adaptation of the Chinese MMPI in Hong Kong. In J.N. Butcher & C. D. Spielberger (Eds.), *Advances in Personality Assessment*. Vol. 4. Hillsdale, N. J.: Lawrence Erlbaum Press.

Dahlstrom, W. G., Lachar. D., & Dahlstrom, L. E. (1986). *MMPI Patterns of American Minorities*. Minneapolis: University of Minnesota Press.

Egli, E. A. (1987). *The Role of Bilingual Workers Without Professional Mental Health Training in Mental Health Services for Refugees*. (Contract No. 278-85-0024 CH). Rockville, MD: National Institute of Mental Health.

Exner, J. (1974). *The Rorschach: A Comprehensive System*. Vol. 1. New York: Wiley.

Gong, Y-X. (1986). The Chinese Revision of the Halstead-Reitan Neuropsychological Test Battery for Adults. *Acta Psychological Sinica*. 18, 433-422.

Graham, J. R. (1977). *The MMPI: A Practical Guide*. New York: Oxford University Press.

Greene, R. L. (1987). Ethnicity and MMPI Performance: A Review. *Journal of Consulting and Clinical Psychology*, No. 55, 497-512.

Greene, R. L. (1980). *The MMPI: An Interpretive Manual.* New York: Grune and Stratton.

Holtzman, W. H. (1968). Holtsman Inkblot Technique. In A. I. Rabin (Ed.), *Projective Techniques in Personality Assessment*. New York: Springer, 136-170.

Irvine, S.H., & Carroll, W. K. (1980). Testing and Assessment Across Cultures. In H. C. Triandis &J.W. Berry (Eds.), *Handbook of Cross Cultural Psychology: Methodology, Volume 2*. Boston: Allyn & Bacon.

Irwin, D. A., & Madden, C. (1986). A Psychoeducational Assessment Procedure for Southeastern Asian Refugee Students. In C. L. Williams, & J. Westermeyer (Eds.), *Refugee Mental Health in Resettlement Countries*. Washington, D. C.: Hemisphere.

Lindzey, G. (1961). *Projective Techniques in Cross Cultural Research*. New York: Appleton-Century-Croft.

Lopez, S. (1988). "The Empirical Basis of Ethnocultural and Linguistic Bias in Mental Health Evaluations of Hispanics". *American Psychologist*, 43, 1097.

Malagady, R. G., Rogler, L. H., & Constantino, G. (1988). Reply to "The Ethnocultural and Linguistic Bias in Mental Health Evaluations of Hispanics. *American Psychologist*, 42, 228-234.

Marcos, L. R. (1979). Effects of Interpreters on the Evaluation of Psychopathology in Non-English Speaking Patients. American Journal of Psychiatry, 136, 171-174.

Murphy, J. M. (1976). Psychiatric Labeling in Cross-Cultural Perspective. Science, 191, 1019-1028.

National Coordination Group of MMPI (1982). The Revision, Employment Evaluation of MMPI in China. *Acta Psychologica Sinica*, 4, 449-458.

Sechrest, L. Fay, T., &Zaidi, S. (1972). Problems of Translation in Cross-Cultural Research. *Journal of Cross-Cultural Psychology*, 1, 41-56.

Strand, P.J., & Jones, W. (1985). *Indochinese Refugees in America*. Durham, N. C.: Duke University Press.

Triandis, H. C., & Berry, J. (1980). *Handbook of Cross-Cultural Psychology*. Boston: Allyn &Bacon.

Werner, O., & Campbell, D. (1970). Translating, working Through Interpreters and The Problem of Decentering. In R. Naroll & R. Cohen, (eds.), A Handbook of Methods in Cultural Anthropology. New York: American Museum of Natural History.

Williams, C. L. (1987). Issues Surrounding Psychological Testing of Minority Patients. *Hospital and Community Psychiatry*, 38, 184-189.

Williams, C. L. (1986). Mental Health Assessment of Refugees. In C.L. Williams & J. Westermeyer (Eds.), Refugee Mental Health in Health Resettlement Countries. Washington, D. C.: Hemisphere Publishing Corporation.

Williams, C. L. (1985). The Southeast Asian Refugees and Community Mental Health. *Journal of Community Psychology*, 13, 258-269.

Williams, C. L. & Westermeyer, J. (Eds.). (1986). *Refugees Mental Health in Resettlement Countries*. Washington, D. C.: Hemisphere Publishing Corporation.

Xu, Y., Gong, Y-X., Mathews, J. R. (1987). The Luria-Nebraska Neuropsychological Battery Revised in China. *The International Journal of Clinical Neuropsychology*, 9, 97-101.

*** Updated resources are currently being collected by the Refugee Health Program at the Minnesota Department of Health and will be added to the workbook when available.**