A Partnership in Communication: A Qualitative Study on the Experiences Of Punjabi Clients as Users of Interpreters

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ABSTRACT

Health care practitioners are constantly challenged when providing services to culturally diverse communities. Communication barriers such as differences in culture and language, lack of education about health care services, cultural insensitivity on the part of the practitioner and system ineffectiveness prevent access to health care services by Punjabis and visible ethnic communities as a whole. In this practicum thesis, I present my personal and professional insights, research and client perspectives on how interpreters can help culturally diverse communities to access health care services. I discuss my qualitative study where participant observations and semi-structured interviews were conducted with Punjabi clients to explore their experiences of using interpreters. The focus is specifically on Punjabi clients. Since South Asians (which includes Punjabis) are the fifth largest single ethnic community in Canada and the third largest in British Columbia, it is important to understand their experiences. The findings suggest that many Punjabi clients are satisfied with their use of an interpreter. They appreciate having an interpreter take the time to explain different cultural beliefs and difficult concepts, translating from one language to another, and catching missed material This study has implications for health care practitioners in working with interpreters to develop a health care service delivery system that is accountable to all culturally diverse communities.

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INTRODUCTION

During my practicum work for the Masters of Social Work program, I came into contact with a large number of health care practitioners and Punjabi people in a hospital and a mental health center in British Columbia. Punjabi people are essentially "South Asian" from the Indian State of Punjab. The term "South Asian" refers to people with cultural origins in the Indian subcontinent, including Pakistan, India, Sri Lanka, Bangladesh, and Nepal (Johnston, 1984). Punjabi immigrants with higher education are already proficient in English when they come to Canada but there are many who have had no formal education and little or no knowledge of English. Punjabi men and children tend to acquire English more quickly than women and the elderly because of their daily exposure to work and school environments. Most Punjabi women tend not to acquire English unless it is required for employment or citizenship (Waxler-Morrison, Anderson, & Richardson, 1990).

In my discussions with health care practitioners, many expressed difficulties working with Punjabi people who speak little or no English. These clients are expected to communicate their thoughts in a relatively unfamiliar language (English) and this often misleads some practitioners attempting to assess just how active clients' symptoms are. As a result, there may be distortions and inaccuracies in evaluating clients' behaviour, clients may be misdiagnosed and receive inappropriate treatment because practitioners do not understand their cultural and linguistic dynamics. Punjabi clients' belief that practitioners may not understand their cultural and linguistic dynamics often results in them preferring to seek help from family members and friends and possibly traditional

healers and religious leaders before seeking the services of professionals.

Practitioners recognize that communication barriers exist when trying to understand different ethnic cultures. Since South Asians (which includes Punjabis) are the fifth largest single ethnic community in Canada and the third largest in British Columbia (about 103,545 people in particular, according to the 1991 Canada Census), practitioners also recognize that it is important to understand their experiences (Statistics Canada, 1991:20-21). In my own experience, members of the Punjabi community also recognize that communication barriers discourage them from accessing health care services. According to the literature, differences in culture and language, lack of education about maintaining optimum health and health care services, cultural insensitivity on the part of the service-provider, and system ineffectiveness are the leading barriers in accessing health care services by Punjabis and visible ethnic communities as a whole (Schott & Henley, 1996). Given the all of the barriers in accessing the services, practitioners are now looking at how the use of interpreters may help them reach out to Punjabis who are in need of service,

While all of the research to date on interpreters has been informative (Kline, Acosta, Austin & Johnson, 1980; Marcos, 1979; Mirdal, 1988 & Freed, 1988), all of it is done outside Canada, the majority of the studies are outdated, they do not involve qualitative data, and the cultural experiences of Punjabi people are not reported. To date, I have not found a study in which the researcher asks Punjabi clients how health care services can be more accessible to them. Therefore, based on my past experiences as a Punjabi immigrant woman, a social worker and interpreter, I decided to carry out a

qualitative study on the experiences of Punjabi clients as users of interpreters. While carrying out this study, I also began to write this practicum thesis, in hopes of lessening some of the gaps in cross-cultural research. In the midst of writing this practicum thesis, I attended an international conference on community interpreting. There was an enormous amount of current information available on the trends in community interpreting. I have included information gathered from the conference in Appendix I so that readers can become aware of some of the training programs, services, publications and key players in the broad area of community interpreting.

The purpose of a thesis is to document original research, to render in text a graduate student's competency in gathering data, carrying out an analysis of the information and pointing the way for further inquiry. The intent of a practicum thesis is to give equal value to the importance of research and practice. Taken one step further, it suggests the inseparability of theory from its application. In a practice-oriented discipline such as social work, it appears particularly important that graduate level research foster the ability to unite theory and practice. The creation of 'usuable knowledge' (Lindblom & Cohen, 1979) is central to praxis, whereby theory is utilized in order to guide practice and generate new thought. Therefore, I used my experiences from my practicum settings and research skills to write this practicum thesis.

The need for changes in our health care system is evident given all of the barriers that culturally diverse communities such as Punjabis have to face in accessing services. It is my aim in this practicum thesis to put forward many ideas, experiences, knowledge and insights in areas such as health care, interpreting and Punjabi clients. But I ask my

readers to keep in mind that my research, inquiry and reflection are far from complete. This practicum thesis is just the beginning of my endless search to find ways of improving access to health care services for all culturally diverse communities

In ***CHAPTER ONE*** of this practicum thesis, I offer my personal and professional reasons for doing research on Punjabis. I present small vignettes of clients who have faced difficulties in accessing health care services, and I define community interpreting as a profession. In ***CHAPTER TWO***, I focus on the Punjabi community in Canada with respect to its historical background, characteristics, beliefs about illness and ways of providing health care to Punjabis. ***CHAPTER THREE*** is a discussion of language, communication and intercultural communication theories that guide social workers and all health care practitioners in clinical practice. Some research on interpreters is also presented. ***CHAPTER FOUR*** describes my research process in detail. I conclude my practicum thesis in ***CHAPTER FIVE***, with my final thoughts, implications for practitioners, interpreters, clients, hospital administrations and social workers as well as plans for the future.

CHAPTER ONE

PURPOSE: WHY THIS RESEARCH?

Personal/Professional Reasons for Studying the Experiences of Punjabi Clients as Users of Interpreters

My personal and professional interest in conducting research around interpreters stems from my ultimate goal of suggesting an ethnically sensitive approach to health care. As a Punjabi immigrant woman, I often interpreted for my parents and I see risks in using family, especially young children as interpreters. Family members have a valid and important role in providing patient support, however, they are not appropriate interpreters. In my experiences as a social worker and interpreter at a hospital, I have witnessed family members often edit the patient's message heavily, add their own opinions, answer for the patient and take over the interaction between the practitioner and patient. I have seen patients reluctant to discuss certain problems in front of a family member because confidentiality is a concern. Many family members are untrained and often are unfamiliar with medical terminology. Withholding information, protecting patients from bad news or keeping practitioners from learning embarassing or damaging facts about their family are all reasons why family members should be discouraged from interpreting.

When young children must interpret for their parents, an inversion of power relations in the family is created. I recall treating my own mother as a child while I was interpreting for her. If she became upset with me, I would threaten to not escort her to any more medical appointments. She would then take on a humble and child-like role by

listening and cooperating with me. In retrospect, I feel badly about this but I use this as an example to illustrate how children can become in control. I was often exposed to sensitive, potentially disturbing conversations as a child interpreter. I am sure my mother wished to spare me from any trauma or embarrassing discussions with her family doctor, but as a non-English speaking immigrant, she felt she had no choice but to use me as her interpreter. Like me, many children must interpret for their parents. They are often required to pass on bad news or are held responsible for negative outcomes (Cross Cultural Health Care Program, 1998). I feel that these experiences and insight have added to my thesis topic.

I have also had direct involvement in the area of mental health. In Toronto, I coordinated a series of mental health workshops focussing on ethno-racial issues. My work with a South Asian seniors' group demonstrated the need for interpreters to go out into the community and accompany seniors to medical appointments and organizations where language is a barrier to effective communication. Having also worked as an interpreter in the mental health department of a large hospital in Toronto, I saw lots of areas for improvement such as the duration of the interpreter training, facilitators' knowledge of ethno-racial issues and participation of trainees. When I was actually interpreting, I often questioned my role as an interpreter, my relationship with the client and worker, the relationship between the worker and client, and the client in between. Therefore, I brought my own personal and professional experiences into my study which helped guide and inform my research.

Miscommunication in Health Care:

In my research efforts, I came across a large number of situations where miscommunication between the practitioner and client lead to misunderstandings, wrong diagnoses, failure of non-English speaking clients to return for medical appointments because they felt mistreated and so on. Here are a few vignettes to illustrate the complexities of intercultural communication in health care settings:

Manpreet:

After delivering her baby, this Punjabi woman spends a night at a hospital due to complications. In the middle of the night, she tries to articulate (in broken English) that she needs a glass of water. The nurse on duty tells her to get it herself. Manpreet tries to explain that she has stomach and leg cramps and is unable to get out of bed. The nurse does not understand what she is saying and ignores her. Manpreet falls asleep thirsty, frustrated and in pain (Case taken from Author's Practicum Experience).

Iqbal:

"This Birmingham woman, originally from a remote village in Pakistan, killed her husband by striking him over the head several times with an iron bar after years of physical abuse and after she claimed that he had threatened to kill two of her children. At her trial in 1981, she was assigned an interpreter who did not speak her dialect. Not understanding what had gone on at her trial, she uttered a phrase containing the following word in Miripuri dialect: "Ghultee." She was deemed to have entered a plea of guilty to murder and was sentenced to life imprisonment. "Ghultee" actually means "mistake."

She appealed the sentence four years later when her trial was declared a nullity on the grounds that she had not understood what was said there. Iqbal was released in 1985, but her family disowned her and she was often to be found walking the streets, talking to herself. In 1991 she committed suicide. Nobody had realised that Iqbal had not understood anything of what was happening to her"(Fowler, 1998:1).

Phuong

"Phuong, a 65-year-old man originally from Vietnam, was diagnosed with terminal cancer. Phuong's physician wanted to admit him to the hospital, where he could be given care that would alleviate his pain and enable him to be as comfortable as possible. Phuong was advised to go to the hospital immediately, but to his physician's surprise, he spent the next few days at a temple. Considering the pain Phuong was experiencing, his physician could not imagine postponing treatment. Phuong's daughter explained through an interpreter that her father needed to get prepared for what lay beyond his present life – to get his spiritual affairs in order. Only after Phuong spent the time he felt necessary to nurture his soul was he ready to enter the hospital"(Harvard Pilgrim Health Care, 1997:14).

Carlos

"Carlos, a 55-year-old native of Mexico, recently went to the local hospital's emergency unit for a routine medical problem. Although Carlos felt that his condition was not that serious and that he could wait to make an appointment to see his own physician, his

family rushed him to the hospital. Later, Carlos' physician told him that, for routine care, he should not go to the emergency unit but call ahead for an appointment in the health center. Carlos did not disagree with his physician's advice, yet just one week later ended up in the emergency unit again. His physician did not understand why, especially after he had explicitly explained to Carlos about the appropriate use of emergency services. What the physician failed to realize was that in traditional Hispanic societies, the entire family participates in decision-making. Carlos' family was managing his care and made the decision to take him to the hospital"(Harvard Pilgrim Health Care, 1997:12).

What can we learn from this?

I hope that the above vignettes illustrate the need for interpreters in a variety of languages as well as research around interpreters. The more interpreters and translators we can access, the less time these people will spend being silent about their stories. Offering services in the client's own language also helps break down communication barriers. We also need to learn that culture to culture, health care decisions are made differently. In some cultures, the family participates in the decision-making, not the individual. People's responses to illness and their approach to seeking health care is influenced by their culture. Many ethnic communities prefer to consult a spiritual healer from their own culture while receiving care from a Western-trained practitioner. It is my aim in this thesis to bring light to these types of distinct cultural differences.

What is Community Interpreting?

Before going any further, I would like to distinguish community interpreting from other types of interpreting, such as conference or escort interpreting, in that the services are provided to residents of the community in which the interpreting takes place, and not to conference delegates, diplomats, or professionals traveling abroad for business (Mikkelson, 1998). Community interpreting is performed by practitioners with some formal training in medical, legal or social service interpreting. I will use the definition used in the First International Conference on Interpreting in Legal, Health, and Social Service Settings: "Community Interpreting enables people who are not fluent speakers of the official languages (s) of the country to communicate with the providers of public services so as to facilitate full and equal access to legal, health, education, government, and social services"(Carr, Roberts, Dufour & Steyn, 1995:36).

Roberts (1994:127-138) makes some other distinctions that sets community interpreting apart from conference interpreting. Roberts identifies the following:

"1) community interpreters primarily serve to ensure access to public services, and are therefore likely to work in institutional settings;

2) they are more apt to be interpreting dialogue-like interactions than speeches;

3) they routinely interpret into and out of both or all of their working languages;

4) the presence of the community interpreter is much more noticeable in the communication process than is that of the conference interpreter;

5) a great many languages, many of them minority languages that are not the language of government in any country, are interpreted at the community level,

unlike the limited number of languages of international diplomacy and commerce handled by conference and escort interpreters ; and

6) community interpreters are often viewed as advocates or "cultural brokers" who go beyond the traditional neutral role of the interpreter."

With these concepts in mind, I now focus on the Punjabi community, with regards to their historical background, characteristics of this ethnic community, their health care beliefs and finally what to consider when providing health care to Punjabis, in Chapter Two.

CHAPTER TWO

A LOOK AT THE PUNJABI COMMUNITY IN CANADA

Historical Background on the Punjabi Community in Canada

South Asians in Canada immigrated from other parts of the world, including the South Pacific (Fiji) and East Africa. All South Asians share a common British colonial heritage and many have knowledge of English prior to coming to Canada. Sikh men from Punjab seeking better economic opportunities were predominantly the early immigrants to British Columbia, Canada in 1900 . Many found jobs in sawmills in the forest industry but in 1909, South Asian immigration was banned due to heightening racial tensions between them and Anglo-Canadians. But by 1947, the ban was lifted and South Asian immigration increased dramatically after 1961 as a result of changes in immigration (Waxler-Morrison et. al., 1990).

Between 1961 and 1971 the South Asian population increased from 7,000 to 68,000 (Buchignani, Indra & Srivastava, 1995). During the 1960's, South Asian men were allowed to bring their immediate and extended families to Canada. They were also allowed to enter professional, technical, clerical, and commercial occupations but due to discriminatory and racist practices of the dominant society, many chose to remain in the logging, mining and farming occupations (Johnston, 1984). Although many South Asians came to Canada for economic opportunities and better education, they also suffered great losses. Loss of Indian culture and extended family support, acceptance of low paying jobs that did not reflect their high level of education plus the negative

attitudes of Canadians caused stress for many South Asians.

Characteristics of the Punjabi Community in Canada

Despite initial losses upon immigration to Canada, Punjabi people have come a long way. After working long, punishing hours, many immigrants have made financial contributions to their families in the Punjab, bought their own homes, put their children through higher levels of education, opened their own businesses and invested in their retirements. The Punjabi Market on Main Street in Vancouver, British Columbia is a great example of economic cooperation and prosperity for Punjabis as a whole. It is a market that began with one Punjabi store in 1970 and now, there are over 100 stores on the street, serving the Punjabi community. In Canada, Punjabi communities have developed in which people share kinship, village and caste affiliations with each other as well as with people who still live in Punjab. "These communities actively maintain religious, political, economic and marital links with each other and these links play a significant role in the maintenance of kinship networks and moral values" (Sanghera, 1991:6).

Punjabis belong to Sikh and Hindu religions and are further sub-divided into various sub-castes. For the 50, 000 or more Sikhs in British Columbia, belief in a single God, equality of all people and a strong sense of community are important. While most speak Punjabi, some speak other South Asian languages such as Hindi, Gujarati and Urdu. Culturally, the extended family unit plays an important role in the daily lives of Punjabis. Family loyalty, obedience and respect, especially for elders (Assanand, Dias, Richardson & Waxler-Morrison, 1990) are commonly held values. The extended family

is close-knit, interdependent and earnings are pooled together so that the entire family prospers. Traditionally, parents do not live with a married daughter and her family unless she has sponsored them to Canada. The parents tend to live with all or their eldest son and their families. Putting elderly parents and grandparents into nursing homes is prohibited and discouraged. Instead, the elders are taken care of and consulted for financial advice, childrearing practices and major family decisions. The majority of Punjabi elderly people spend their lives babysitting. In my experience, many Punjabi elderly complain about being bored and depressed at home because all they do is cook, clean and babysit their grandchildren. Since the family structure is hierarchical and patriarchal in nature, elderly Punjabi men tend to involve themselves in recreational activities but the women tend to stay within their homes.

Punjabi Beliefs about Illness

Punjabi views about illness are rooted in the Ayurvedic system of medicine. This system contrasts with the Western system of medicine in that it looks at illness as a result of imbalance in the body humours, bile, wind and phlegm; thus, treatment with foods and herbs is required to re-establish the balance (Waxler-Morrison et.al., 1990). For example, in Balasubramanian and Radhika's (1989:16-17) book on local health traditions, a list of Punjabi beliefs around foods and their properties and actions on the body is provided:

1. "Moong daal" - Green gram. Somewhat cold, moist and light. Good for digestive system and blood formation.
2. "Karela" - Bitter gourd. Hot, dry and heavy. Good for blood purification, diabetes, paralysis, rheumatism and kidney troubles. Restricted use in stomach disorders and

fever.

3. "Mooli" - Radish. Cold, moist and light. Good for piles, jaundice, good for liver and spleen disorders, restricted use in mental and stomach disorders.
4. "Kela" - Banana. Neutral and heavy. Good for blood formation, stopping nocturnal emissions, easy menstrual flow when taken with honey and milk. Restricted in common cold, cough, diabetes and in those having poor digestion.
5. "Angoor" - Grapes. Neutral and light. Good for blood formation, brain, eye sight and is a good appetizer. Restricted use in diarrhea and dysentry.
6. "Ber" - Jujube. Neutral and heavy. Good appetizer, good for eye sight and formation of blood. Restricted use in stomach ailments, cold and cough.
7. "Khopa" - Coconut. Hot, dry and heavy. Good for liver and kidney disorders. Restricted use in diarrhea and dysentry, cold, cough and asthma.
8. "Shehad" - Honey. Good for digestion, eye sight, gums, teeth and skin, helps in curing fever, cough, tuberculosis, jaundice, renal stone. Excessive intake of honey should be avoided for it can cause stomach disorders.

All of these foods combined with one's behaviour and medication are offered as a treatment regime. Besides these, there are other treatment alternatives. These are discussed next.

Herbal decoctions, teas made by grinding and boiling herbs and spices, bathing, massaging and rubbing almond oil on the body are also helpful. In the case of mental illness, many Punjabis believe possession by a demon or the "evil eye" of a jealous relative or neighbor can be treated through ritualistic chanting and praying performed by

an exorcist or priest. Tying a protective black thread around a sick person's finger, wrist or neck, wearing a metal cylinder with a protective verse in it around the neck, or promises of gifts to a temple or shrine upon recovery are all traditional treatments (Waxler-Morrison et. al., 1990).

At this point, it is important to note that "mental illness is sometimes believed to have supernatural causes, particularly spells or curses cast by jealous relatives or acquaintances"(Waxler-Morrison et.al., 1990:166). Since mental illness is stigmatized, it is often hidden within the family and may remain untreated for a long period of time. Only when families are unable to obtain help from temples and shrines, astrologers or home remedies do they report the illness to a physician. But even then, symptoms of mental illness are usually described in somatic form, such as headaches, stomach aches and burning bodily sensations rather than anxiety or depression.

Providing Health Care to Punjabis in Canada

When providing appropriate health care to Punjabi clients, mental health practitioners need to take into account what clients believe the problem to be, how they define the problem and how they define positive mental health. Kleinman (1980:106) suggests that clients and their families should be questioned about their views on illness and disease in order to understand their explanatory models of sickness and health. Kleinman presents eight questions that clients should be asked in order to understand their explanatory models:

1) What do you call your problem?

2) What do you think has caused your problem?

3) Why do you think it started when it did?

4) What does your sickness do to you? How does it work?

5) How severe is it? Will it have a short or long course?

6) What do you fear most about your sickness?

7) What are the chief problems your sickness has caused for you?

8) What kind of treatment do you think you should receive? What are the most important results you hope to receive from the treatment?

In addition to this, practitioners need to be aware that sick clients encounter different medical languages as they move between the health care system's sectors. They are forced to translate from one language to another. Kleinman (1980) believes that clinical miscommunication is based on distinct medical idioms. A Punjabi client may interpret his/her complaint as it is popularly characterized in India but not be aware of how to interpret it in Western medical vocabulary. A Western doctor may respond by translating the complaint into what he or she believes is its Western medical equivalent. Although the client may not agree with the doctor's reasoning, he/she may feel too intimidated to contradict the doctor. The physician's failure to translate biomedical concepts into idioms that the client can comprehend may result in the client not returning or following the treatment regimen.

Schott & Henley (1996) report that Western medical and health care terminology cause difficulties when there is no equivalent in the client's language. For example, a wide range of terms such as 'stress', 'schizophrenia' and 'depression' have no equivalent in Punjabi and are not generally understood. These concepts are often untranslatable. In

my experience I have found that even trained interpreters have no exact Punjabi words for these terms and they tend to use the English word for them.

Let us consider a Punjabi family suffering from stomach aches during a period of mourning a deceased family member. Each member experiences the symptom of stomach ache but not one member complains or obtains medical help because firstly, they do not obtain an interpreter, and secondly, they all attribute the pain as a signal of communication from the deceased family member. In their eyes, the deceased family member is communicating that he or she will always remain inside each of them and that is why they all have temporary stomach aches. This example is similar to Kleinman's (1980) example of a culturally constituted coping mechanism. Kleinman (1980:158) insists that "the shared somatization experience which some might view as an instance of group hysteria serves as a culturally constituted coping mechanism for the family as a whole, providing a legitimated medium for communicating and handling extremely distressing emotions." For many Punjabis, somatized illness behavior is an adaptive mechanism, whereas mental illness is stigmatized and hidden.

Health care practitioners also need to understand that many of the mental or emotional difficulties experienced by Punjabi clients may result from a drop in their socio-economic status upon immigration to Canada, their inability to speak the language of their new host country, their inability to find adequate employment and separation from extended family members and so forth. But sometimes, trying to understand the cultural context of each client is not an easy task. It might even mean involving somebody of the same cultural context into the helping relationship. This is where the

need for interpreters is evident.

The next chapter provides a conceptual context around language, communication and intercultural communication. Research on interpreters is also presented.

CHAPTER THREE

CONCEPTUAL CONTEXT

Although many health care practitioners and other service-providers recognize and talk about the need for interpreters, very little current research is reported on the subject by Canadians. Instead, most of the research is carried out around language and communication. Communication theory (Nelsen, 1978 & Durst, 1994) establishes that communication is occurring at all times. Any human behavior observed by other people conveys something to them and with an awareness of this theory, practitioners can sharpen their understanding of just what information a client's words and actions convey. As a theory, it is concerned with individuals' receipt of various forms of information and their responses to it. Responses include individuals' memories of past experiences, their current bodily sensations, needs, feelings and thoughts and occurrences in the human environment.

Theories around language (Durst, 1994; Sands, 1988 & Cormican, 1978) also address issues of working with culturally-diverse clients. For instance, Durst (1994) stresses practitioners need to be sensitive to the communication exchanges they engage in with clients. According to him, clients bring into their relationship with practitioners a lifetime of socialization experiences, so practitioners need to develop a level of understanding and appreciation of different cultures. But often, practitioners dismiss the difficulties they experience as simply a "culture gap" and this reflects poorly on the health care profession as a whole. With clients of a different ethnic or cultural

background, trust is difficult or even impossible to develop due to communication gaps.

Durst (1994) believes "problems in communication are frequently the result when one group does not trust the truthfulness or accuracy of the other (p.34)." He uses the example of refugees who believe that any form of trust could be used against them; hence, formal exchanges with practitioners are viewed with suspicion and caution. Based on my personal experience, I feel that Punjabis' relationships with outsiders must be viewed with guarded tolerance. From Punjabis' perspectives, health care practitioners represent authority, so disclosure of information that is private and sensitive in nature is done extra carefully.

Practitioners will often talk about illness in a sector-specific language or biological functions and behaviors, whereas clients talk about it in a culture-wide language of experience (Sanghera, 1991). As a cultural product, language embodies many of a person's cultural assumptions about life (Parekh, 1974). Words having culturally different connotations makes interpretation a difficult process. The language of culturally diverse people involves metaphors, unique perceptions and underlying themes of different conditions and often, directly interpreting these into English may not be possible. In many instances, practitioners are unaware of the meaning ethnic clients attach to spirits and supernatural phenomena. Disagreements over the nature of magic and rituals also exist. Crick's (1976) exploration of language and meaning suggests people's cultural beliefs should be taken at "face value" rather than considered false. Belief in spirits embody a cultural dogma and the nature of magic and ritual should be seen as responses to purely intellectual problems with rich symbolic and expressive

elements.

In this discussion around language and communication, it should be pointed out that communication also involves non-verbal discourse and varies across cultures. Unconscious norms and expectations manifest themselves in a variety of behaviors, including social distance, gestures and touch, degree of eye contact, and posture (Karim, 1997). Lishman (1994) adds to this by suggesting that non-verbal communication may be divided into two forms: social distance and kinetics such as gestures, eye contact, and expression. Significant cultural differences in perceptions of appropriate client-practitioner proximity also exist and this is directly affected by one's gender, social class and the nature of the relationship between the client and practitioner. It is also important to note that proximity may also indicate such factors as orientation, posture and touch (Karim, 1997).

Palmer & Barnett (1984) use a Cultural Convergence model to explain communication. This model or theory of communication establishes that communication is a continuous process in which information is shared between individuals, groups or communities. The process is cyclical with no clear beginning or ending and the goal is mutual understanding. As long as the communicators perceive differences in their understanding of each other or in the content of their communication, they continue to exchange information. Individuals, groups or communities make judgements of these differences based on the information being received. They must have an awareness of their own worldview, transmit information based on this and compare the feedback to their original message content. Mutual understanding will arise in the process as changes

occur. Thus, the result of convergence or the state at which there is notable similarity between the language of the participants is called understanding.

According to other research around communication, in a flexible communication relationship, obvious content is conveyed, there is an exchange of context messages, symmetrical or complementary definitions of mutual relationships are established, and mutual operating rules are negotiated (Nelson, 1978). But when practitioners interact with culturally diverse clients, the relationship tends to be based on difference, rather than on equality. Difficulties with the processing of information occur and this results in poor communication. Practitioners depend on clients' speech in gathering history of the problem, in making diagnoses and in assessing levels of development and indications of social dysfunction. Language differences between the practitioner and client and the client's lack of ability to articulate certain kinds of problems in a language that is relatively unfamiliar to them (i.e. English), leaves both parties feeling helpless. Since health care treatment is conducted primarily by oral means (Cormican, 1978), the practitioner needs to become familiar with the particular client's language or otherwise communicate through an interpreter.

The excuse of a "culture gap" and apparent distrust in intercultural communication may stem from practitioners' lack of awareness of ethnic meaning structures. Sands (1988) stresses that each client brings his or her own frame of reference to a helping situation. Each client engages in the construction of a context and interpretation of meanings very differently. Ethnic communities perceive reality in their own way and it is important for practitioners to know where their clients are coming

from:

> "The therapeutic interview depends largely on the expression, comprehension and exchange of linguistic symbols in a social context. Linguistic symbols have particular meanings to the practitioner and client, and the two may or may not share the same meaning structure. The content and form of linguistic expression reveal feelings, attitudes and thinking about the message and the interview situation. Unless the practitioner is sensitive to the client's language and the context in which it is uttered, valuable data will be lost"(Sands, 1988:149).

In Gudykunst & Kim's (1984) book, Sapir and Whorf (1956) warn us not to consider language as merely a medium through which we express our thoughts and feelings. Acquiring language also means acquiring culture which in turn conditions our perception, thinking, and behaviour. Language ties us to a speech community where we develop a sense of identification and distinctiveness from other speech communities. Language is a product of culture as each culture has a system of language which people use to communicate with one another. Culturally induced language reflects the values of culture. For example, a little child perceives people behave in a certain way. He or she sees people employ special linguistic patterns and begins to imitate them.

Gudykunst & Kim (1984) offer a theoretical perspective that includes the following ideas: When two people from different cultural contexts interact, experiencing reality in terms of shared meaning is likely to be minimal. Differences in linguistic systems tend to be considerable. In their book, they write about Boas (1911), who first described the relationship between language and culture by analyzing the lexicons of two languages, revealing distinctions. The classic example of the Inuit language having many terms for the word 'snow' is discussed by Boas. Since then, several anthropologists have

offered insight into the relationship between language and culture.

Whorf (1956) believes that people's perceptual worlds are molded through the language used. For instance, a language may involve jargon, hidden implicit cues and it could also be telegraphic. Suppose you are with a close friend from the same cultural or societal context. You find yourself making a brief reference to something yet each of you can understand one another clearly because of a wealth of shared experiences. This type of language may be seen as vague to an outsider but between members of the same culture, it is highly understandable.

Gudykunst & Kim (1984) add to the literature around communication with their popular book Communicating with strangers: An approach to intercultural communication. Although this book is quite old, it contains relevant theories around intercultural communication. It looks back at the days when human beings were born, lived and died in one geographical area, never having to make contact with someone from a culture different than theirs. But now, in a world of mass communications and a global village where events in one area can be transmitted to hundreds of other countries within minutes, the need to understand other cultures and patterns of communication is mandatory.

These authors believe culture is transmitted from one generation to another through communication. They refer to Edward T. Hall who in 1959 established that "culture is communication and communication is culture"(Gudykunst & Kim, 1984:4). That is to say that being raised in a particular culture, we learn the language, rules and norms by a very early age. It is that culture that shapes our behavior and communication. When

communicating with people from another culture, we are confronted with differences in language, rules and norms. But these differences should not be seen as barriers. Instead, understanding the behavior of others in the context of their culture can facilitate communication. Gudykunst & Kim label this approach 'cultural relativism"(1984:5). They see communication as a process that allows for recognition of its continuity, complexity, unrepeatability and irreversibility.

Intercultural communication refers to a phenomena of communication in which there is a direct or indirect contact between participants who are different in ethnic backgrounds (Kim, 1984). An underlying assumption in this practicum thesis is that ethnic differences between communicators (i.e. Punjabi clients and non-Punjabi practitioners) contribute to the inherent problematic nature of the human communication process. Communication becomes problematic when practitioners are unable to understand the culture (here, defined as ethnic background) of their clients. Kim (1984:17) identifies culture this way: "Commonly speaking, culture includes world regions (such as Eastern and Western culture), world subregions (such as North American culture and Southeast Asian culture), national culture (such as French culture and Japanese culture), ethnic-racial groups within a nation (such as Black American culture and Mexican American culture), and various sociological subgroups categorized by sex, social class, geographic regions, and countercultural groups (such as Hippie culture, prison culture and street culture), among others."

The area of intercultural communication developed its own identity in the 1960s and 1970s. Pioneers in the area were interested in meeting practical intercultural

problems and strived to be accepted in the broad field of communication. The growth in publications, research activities and conferences on intercultural communication reflect efforts to advance intercultural communication as a significant part of the social-behavioral-human sciences. But despite publications such as Intercultural Communication Theory, International and Intercultural Communication and the Handbook of Intercultural Communication, as well as the Speech Communication Association and the International Communication Association, Kim (1984) reported that there have yet to emerge coherent conceptual paradigms of intercultural communication. Lots of research has been devoted to what we mean by intercultural communication and other related labels such as interracial, interethnic, international, cross-cultural and contracultural communication. Also, there have been attempts to develop theories and models that describe, explain and/or predict intercultural communication in a number of contexts such as immigrant acculturation, adjustment of sojourners and diffusion of ideas across cultures, among others. But generally, inquiry into intercultural communication has been scattered with reports on personal experiences, observations of limited aspects of communication patterns in different cultures, primarily descriptive and atheoretical empirical research. In fact, "much of the work has relied on the formulation of other disciplines such as anthropology, psychology and sociology, divided in their theoretical, conceptual, and methodological orientations"(Kim, 1984:14).

Some of the fragmentation can be attributed to the relatively short disciplinary history of culture and communication. Communication itself is an extensive and complicated phenomena so naturally, it cuts across many other disciplines. For example,

Kim (1984:15) states: "Interpersonal, organizational and mass communication have been used to categorize communication phenomena in terms of number of interactants involved, degree of mediation, potential for privacy, and/or clarity of distinction between message sender and receiver roles. Other labels such as instructional, health and therapeutic communication refer to specific social contexts in which communication occurs." What differentiates intercultural communication from the rest of the field is the relatively high degree of difference in the experiential backgrounds of the communicators due to cultural differences. Problems in the human communication process naturally arise due to cultural differences as well as individual, personality, age and physical appearance differences between communicators. Intercultural communication as a phenomena of communication deals with cultural similarities and differences among communicators.

We can divide intercultural communication further into the social context in which it occurs. Social context can include business-organizational, educational, immigrant acculturation, political, sojourner adjustment, technology transfer-developmental, and therapeutic-counseling contexts. In these and other social contexts, intercultural communication has similarities in the transmitting, receiving and processing of messages. The cultural and experiential backgrounds of the intercultural communicators determine the style of perception, thinking, use of verbal and nonverbal messages and the interrelationships among them. For instance, the communication between a Punjabi client and a Western-trained doctor would differ from the communication between two Canadian business partners. In other words, specific role

relationships, expectations and behavioral norms and rules between two communicators depend on the social context in which the intercultural communication takes place.

June Ock Yum (1984) sees intercultural communication as a process of constructing new networks and/or restructuring existing networks. It is a process of creating and maintaining cultural boundaries, or bridging the boundaries between diverse cultural communities. In Yum's discussion of network analysis, she talks about how one would expect recent immigrant communities to be attracted initially to their own ethnic social networks but eventually there would be less rigidity of ethnic boundaries as immigrant communities live longer in the host country. Members of certain ethnic communities tend to seek each other's company and support, creating strong ethnic boundaries. In fact, Yum & Wang (1984) found that even after a relatively long residency in the host country, some ethnic communities continue to maintain rather strong ethnic boundaries and keep unique ethnic network patterns.

Others such as Korzenny & Korzenny (1984) view intercultural communication as the field of study that focuses upon the interaction and/or message diffusion that involves individuals, groups or communities of people from different cultures. These authors believe research in intercultural communication emerged in the 1960s under the leadership of Edward T. Hall, an anthropologist and Everett M. Rogers, a rural sociologist.

Gudykunst & Kim (1984:15) establish that "we are communicating with strangers anytime we communicate with people who are unknown and unfamiliar and those people are in an environment unfamiliar to them."

Communication becomes a symbolic process involving the attribution of meaning and intercultural communication is communication between people from different societal cultures. The term stranger is somewhat ambiguous in that it is often used to refer to aliens, intruders, foreigners, outsiders, newcomers and immigrants as well as any person who is unknown and unfamiliar. The German sociologist Georg Simmel (1950:402) came up with the concept of the stranger. He viewed strangers as simultaneously being near and far:"The unity of nearness and remoteness in every human relation is organized in the phenomenon of the stranger, in a way which may be most briefly formulated by saying that in the relationship to him, distance means that he, who is also far, is actually near...the stranger...is an element of the group itself. His position as a full-fledged member involves being both outside it and confronting it."

That is to say that strangers are both near and remote because they may be physically close but have different values and ways of doing things. They are physically present and participating in a situation but are also outside the situation because they are from a different place. Wood (1934:43-44) presents a broader conceptualization of the stranger:

> "We shall describe the stranger as one who has come into face-to-face contact with the group for the first time. For us the stranger may be, as with Simmel, a potential wanderer who comes today and goes tomorrow, or he may come today and remain with us permanently. The condition of being a stranger is not...dependent upon the future duration of the contact, but it is determined by the fact that it was the first face-to-face meeting of individuals who have not known one another before."

Obviously not everyone we meet for the first time is unknown and unfamiliar. Often we

are familiar or know something about people we meet for the first time. Therefore, we can say that our social interactions vary with respect to the degree of strangeness or familiarity present in the interaction.

Shack (1979:2) believes this concept "remains one of the most powerful sociological tools for analyzing social processes of individuals and groups." Furthermore, Edward T.Hall (1959) believed we must never assume we are fully aware of what others communicate to us. There is a great deal of distortion in meaning in the world when we try to communicate with one another. Trying to understand the mental processes of others is much serious than most of us care to admit. We need terms such as the concept of the 'stranger' to understand one another.

When communicating with strangers, we make predictions about the outcome of our communication behaviour. We make predictions to reduce the uncertainty present when communicating with strangers. Miller & Sunnafrank (1982) believe people experience a sense of uneasiness and perceived lack of control when thrust into an unfamiliar culture. These feelings arise due to a lack of information about the individuals with whom they must interact as well as cultural information concerning language, norms and values. Since cultural information helps in making communicative predictions, it is helpful to have knowledge about a person's culture with respect to its languages, dominant values, beliefs and prevailing ideologies. Accuracy in our predictions will only be achieved if we know a lot about a stranger's culture. Errors in prediction occur when we are not aware of the stranger's cultural experiences or because we try to predict behavior on the basis of our own cultural experiences. But if we assume that strangers'

language system is the same as ours, misunderstandings or inaccurate predictions arise.

There may be misunderstandings and problems in the development of intimate relationships with strangers we meet due to differences in the degree of personalness or impersonalness in role expectations. For example, consider a North American physician with an impersonal orientation discussing medication with a client (stranger) who has a personal orientation. The physician expects to meet the client briefly, getting down to business right away while the client expects to get to know the physician as a person before getting down to business. This may lead to misunderstanding because of the different role expectations.

Role relationships vary significantly depending on the degree of formality expected in a relationship. For example, in the Punjabi culture, using first names may be perceived as overly casual or overly stiff. There is also a degree of hierarchy in the sense that the doctor-patient relationship is hierarchical. Punjabi patients really look up to doctors, value them with the utmost importance and really trust doctors' every word.

The written Punjabi language is a highly restricted language in the sense that one must understand the implicit meaning and significance of the characters and Punjabi history. Understanding Punjabi as a linguistic system also means being sensitive to the specific social context in which a particular communication transaction occurs. For instance, being sensitive to the social status of the addressee is important. Using certain words have respectful or derogatory implications, certain nouns or verbs can only be used when speaking to a superior, inferior or equal, and certain words can imply both positive and negative feelings.

Silence can be used in expressing seriousness, thoughtfulness, respect etc., sending clear messages without verbalization. Therefore, recognition and conscious use of silence becomes an important mode of communicating in Punjabi. There are also distinct cultural norms in the Punjabi culture. For example, a lot of hand gestures are evident, close proximity is desired between two communicators, and Punjabi women tend to cover their mouth when laughing. Even eye behaviour is different from the Western culture. Traditionally, Punjabi women are not expected to look straight into the eyes of men, especially strangers. The up and down movement of eyebrows is discouraged in both Punjabi men and women because it implies flirtation. Wolfson & Norden (1984, p.156) describe East Asian cultures as sharing certain norms such as "1) deference to others, 2) verbal devaluation of self and family, 3) absence of verbal aggression, 4) absence of direct expression of feelings, 5) avoidance of confrontation, and 6) lack of assertiveness." These same cultural norms exist in the Punjabi culture.

Sometimes, the use of a third party person in social intercourse is customary. The indirectness involved in having a third party person is sometimes necessary when attempting to resolve conflicts between spouses, arranging marriages etc. The use of a third person party allows both sides to communicate with one another or withdraw without losing face. Thus, in encounters where interpreters are used, the North American may see the interpreter "as a window pane that transmits the message from one language to another; but in the Punjabi culture where a third person role is customary, the interpreter's role may become a much more active one, to the consternation of the American who is likely to interpret it as inefficiency or perhaps disloyalty"(Stewart,

1972:53).

As you can see, there are distinct language and communication styles in cultures such as the Punjabi culture. Practitioners need to be aware of and appreciate these different styles. James Downs asserts that "one of the greatest stumbling blocks to understanding other people within or without a particular culture is the tendency to judge others' behaviour by our own standards"(Gudykunst & Kim, 1984:83). This leads to misunderstanding.

Misunderstanding in intercultural communication occurs when different meanings are attached to the same message. Practitioners look at ways to minimize misunderstanding so that they can communicate effectively. One way is by becoming "culturally relativistic"(Gudykunst & Kim, 1984). Cultural relativism contends that the only way we can understand the behavior of others is in the context of their culture. Communication effectiveness means minimizing misunderstandings. No two people will attach exactly the same meaning to a particular message because of our differing experiential backgrounds. Our ability to speak the other language and knowledge about the stranger's culture influences our effectiveness in communicating. Gudykunst & Kim (1984:193) insist, "knowledge of the stranger's culture and of how it is different from and similar to our own has a direct impact on our interpretations and predictions of their behaviour. If we know nothing about the strangers' culture, it is highly probable we will make inaccurate predictions and interpretations of their behaviour."

But despite our differences, the commonality of humans binds us together. Thus, when communicating with strangers, we need not only to recognize the

differences existing between strangers and ourselves, but also to search for the commonalities we share with the strangers. Since all practitioners cannot speak the language of every client, they involve interpreters in the communication process. Interpreters help practitioners look for commonalities, minimize misunderstanding by explaining the cultural context of clients, and help practitioners understand the language of culturally diverse clients and thus, contribute to communication effectiveness. With this theoretical background, I began my own study to look at how interpreters may become more effective in minimizing misunderstandings in intercultural communication.

Research around Interpreters

Health care practitioners look toward theories of language and communication in order to understand their clients. More and more practitioners are also realizing that they need to involve interpreters in their work so that they can intervene effectively. From my research to date, I have combined the work of two authors (Freed, 1988 & Mirdal, 1988:315, 327) to generate a working definition of an interpreter: "An interpreter is the man or woman in the middle, between two cultures, between two persons, between two social levels (the client and practitioner) and between two loyalties. The interpreter has a relationship with both the patient and the practitioner. Appropriately interpreting the communication and helping to bridge cultural value differences between the client and practitioner means not only conveying words, but also meanings in the cultural context of the client."

Authors in the United States have published articles about the interpreter's role,

the assurance of confidentiality, the juxtaposition of the parties in the interview, cultural factors and the type of person to serve as an interpreter (Freed, 1988). Some have given guidelines for using an interpreter in social work (Glasser, 1983; Caple, Salcido & Di Cecco, 1995), the problems inherent in working through an interpreter (Durst, 1994 and Baker, 1981), and the importance of interpreters in cross-cultural therapy (Mirdal, 1988).

In Kline, et. al.'s (1980) study of Spanish-speaking patients, it was generally found that there was better satisfaction among psychiatric patients interviewed through an interpreter than there was among patients interviewed directly in English. Interpreters can often serve as consultants and teachers for practitioners. Practitioners may have a hard time understanding a Punjabi client's view of ethics, roles, family life, interpersonal relationships and other basic aspects of life but through an interpreter, the practitioner can understand some of these cultural elements, at times steering the practitioner away from wrong actions and serious mistakes. "If the worker misunderstands the client, asks an inappropriate question or offends the client, a sensitive interpreter can prevent problems by asking, "Are you sure you want to ask that question? Have you thought about ____?"(Baker, 1981:394). Caple et. al. (1995) also see benefits in using an interpreter as a cultural guide to help the practitioner place clients' behavior in a cultural context. Understanding the norms, expectations and values of let's say the Punjabi culture, can help a practitioner assess a Punjabi client's functioning in his or her ethnic community.

But just as there are benefits in using an interpreter, several authors identify risks as well. One of the well-known risks is that working through an interpreter can be a slow, time-consuming process (Baker, 1981). Instead of going through the standard interview

procedure of question/answer/question, the interpreter interaction involves question (from the interviewer)/question (from the interpreter)/answer (from the interviewee)/answer (from the interpreter) and so on. The interviewer may even forget the question by the time an answer from the interpreter is given!

In addition to this, the practitioner may sometimes feel "left out' of the interaction or unclear about the appropriateness or effectiveness of their work. A practitioner may experience uncertainty and mistrust when he or she hears a client utter the practitioner's name several times in a lengthy response but the interpreter says only, "The answer is yes." Kline et. al. (1980) also believe that working through an interpreter takes twice as long to gather and convey information. These authors use an example of watching television without sound and then hearing the sound later. In other words, the practitioner can only watch a client speak but not hear the sounds made by the client until later when the sounds are heard through an interpreter.

Other problems inherent in working through an interpreter include the unwillingness of some interpreters to divulge certain information that might show the client's community in an unfavorable light, role reversals where the interpreter may begin to dominate the interview, juxtaposition of the parties involved (for instance how should each party be seated in a clinical interview), and issues of confidentiality when a third party (the interpreter) is involved (Freed, 1988). Another highly dangerous problem is when the interpreter selectively underestimates a client's emotional suffering and despair in the process of interpretation. For instance, a psychiatric client's struggle with a mental health problem may not be accurately communicated by the interpreter and it may lead

the client to commit suicide, as reported in Marco's (1979) study of the effects of interpreters on the evaluation of psychopathology in non-English-speaking patients.

Interviewing through interpreters can become an easier process when interpreters are selected based on certain qualities. For example, it is common that an interpreter is an immigrant as well (Mirdal, 1988) so that the cultural context of clients can be conveyed accurately. Adequate command of both the English language and the client's language is important if the interpreter is called on to translate written documents. Compassion for people from their own country, sensitivity and an intuitive understanding of others are essential for interpreters (Baker, 1981). In addition, interpreters' knowledge of clinical psychiatry could be helpful in diminishing errors in translation such as omissions, additions, substitutions and condensations (Marcos, 1979; Freed, 1988). The interpreter should not add or subtract from what the practitioner and client communicate to each other. Instead, "the interpreter must have the capacity to act exactly as the interviewer acts - express the same feelings, use the same intonations to the extent possible in another language, and through verbal and nonverbal means convey what the interviewer expresses on several levels"(Freed, 1988:316).

In order for interpreters to work effectively, they need to receive appropriate training and preparation. A community worker sums it up best: "You wouldn't be given an amateur doctor or nurse if you were ill. So why an amateur interpreter? It's just not the same"(Schott & Henley, 1996:102). A briefing of the interview process is important in order to ensure that "interpreters are sensitive to the emotional issues in the interview, understand their role, interpret the cultural content to the practitioner and achieve

accuracy"(Freed, 1988:315).

Marcos (1979) also advises practitioners to meet with interpreters before the interview to discuss goals, focal areas to be assessed, particularly sensitive topic areas that may need to be explored, the interpreter's attitudes, importance of confidentiality and encouragement for the interpreter to ask questions and get clarification from the client and practitioner at any stage of the interview. "Orienting the interpreter as to the interview's purpose and preparing him/her for content that may be sexual, graphic or emotionally laden would be helpful"(Caple et. al., 1995:167). From a mental health perspective, Schott & Henley (1996) also advise interpreters to not ignore a client's mental distress by continuing to translate. They suggest that the interpreter concentrate on listening, supporting the client and summarizing what has been said to both the client and practitioner at the end.

In Glasser's (1983) report on guidelines for using an interpreter in social work, it is suggested that the interpreter interpret small amounts of information so that much is not lost in translation. The interpreter needs to be aware of feelings and emotions, not just facts; the client should be asked for feedback to ensure true communication is occurring; the practitioner needs to be alert for body language and facial expressions that are not congruent with the spoken word, and the practitioner and interpreter should develop a close, trusting relationship so that power imbalances and miscommunication are avoided. Caple et. al. (1995), Freed (1988) and Marcos (1979) all suggest that a briefing should occur after each interview for the interpreter to 1) discuss information about the client that may not have emerged in the interview 2) reveal any confusion or ambivalence regarding

the interview process 3) review the content of the interview to allow clarifications, deeper understanding, descriptions of cultural dictates and explanations of specific behaviors and 4) assess other dynamics of the interview.

CHAPTER FOUR

THE RESEARCH PROCESS

Methodology

Qualitative research methods were selected for this study in order to generate data rich in detail and embedded in context (Maxwell, 1996), and because "Qualitative approaches to intercultural communication research are boundless"(Ting-Toomey, 1984:182). Qualitative inquiry calls for patience, hard work and imagination and often is a continual process of unending search and discovery. To reduce the risk that the conclusions would reflect only the systematic biases or limitations of a specific method, information was collected using a variety of methods. This triangulation of data collection methods (Maxwell, 1996) allowed me to gain a thorough understanding of the clients' experiences.

Using the methods of participant observation, which involves observing individuals in natural settings (Creswell, 1998), and semi-structured interviews, which allows one to obtain qualitative descriptions of the participants' life world with respect to interpretation of their meanings (Kvale, 1996), gave the conclusions far more credibility than if I were to limit myself to one source or method. Thus, I collected multiple forms of data, summarized my findings and spent adequate time in the field. The research was participant-centered in that it depended on the individual clients to share their stories in an interview and to demonstrate their experiences through participant observation by the researcher.

Sampling Design

I interviewed 10 Punjabi clients from a hospital in British Columbia where I completed my practicum for the Masters in Social Work program at the University of British Columbia. Recognizing that clients can be valid, reliable and useful evaluators of the value of interpreters, I decided to interview them only, rather than the interpreters and the practitioners as well. Since 20 per cent of the clients served at this hospital were South Asian (which included a greater percentage of Punjabis), I chose to focus on the perspectives of only Punjabi clients for my study. A letter of initial contact translated into Punjabi describing the case study and inviting those that were interested to contact me through the phone number provided was used to recruit participants. The participants were recruited based on the following criteria:

1) Had to be 19 years of age or over.

2) Had to be Punjabi-speaking and spoke little or no English.

3) Had to be in the care of a health practitioner.

Because a small sample was used, I tried to make it homogeneous by recruiting only Punjabi clients. However, participants were not recruited based on age or gender because I wanted to hear the experiences of Punjabi clients that are diverse in terms of their age and gender. Masking the names of each participant ensured the anonymity of each client. The number of individual interviews conducted depended on the number of clients available and willing to participate in this case study.

In terms of demographic data on the 10 clients interviewed, respondents are referred to as respondent #1, respondent #2 etc. and profiled in categories such as age and

gender, below:

	Gender	Age
Respondent #1	Male	63
Respondent #2	Female	29
Respondent #3	Female	32
Respondent #4	Female	70
Respondent #5	Female	62
Respondent #6	Male	31
Respondent #7	Female	68
Respondent #8	Female	48
Respondent #9	Female	56
Respondent #10	Female	35

As you can see, the sample is diverse in terms of gender and age. Eight females and two males were interviewed, ranging in age from 29 to 70. With respect to their language capabilities, all except respondents #4, #5, and #7 said they could understand some words in English and could answer back in 'yes' or 'no.' Respondents #4, #5 and #7 did not understand any English whatsoever and did not attempt to answer any questions without an interpreter's assistance. Only respondent #6 seemed to understand a lot of English but like all of the other respondents, he could not speak enough English to communicate his thoughts clearly without an interpreter.

Data Collection Methods

Participant observation enabled me to draw inferences about client meanings and perspectives that may not have been obtained by relying exclusively on interview data. Participants may have been reluctant to state their perspectives directly in an interview but I feel I obtained a better sense of their perspectives through actually observing them in their interaction with the practitioner and interpreter. This meant sitting in on a

counseling session alongside the client, practitioner, and interpreter for one hour to gather material. Traditionally, participant observation is desired by those who believe any type of involvement in a natural progression of the contact between cultures can only benefit the individuals involved. An 'active' approach means the researcher needs to become a member of the group studied, and to 'know' the culture as its members know it (Creswell, 1998).

Robert Shuter (1984) speaks extensively about the benefits of naturalistic field research. He states that social scientists in the past have had a huge interest in examining people in their natural habitats. Attempting to record spontaneous interaction and behavior in the research participant's habitat – the workplace, family, street corner or any location where individuals interact and behave spontaneously is the essence of naturalistic research. It can be conducted by participant observation, ethnomethodology and phenomenology. According to Shuter (1984), being culturally immersed provides information and insights that are necessary for understanding social patterns. Unlike experimental research which attempts to systematically control and manipulate variables traditionally in a laboratory, naturalistic field research witnesses behavior as it unfolds in natural settings: "In a laboratory, the surroundings are artificial, subjects are susceptible to experimenter bias and the results may not be generalizable beyond the laboratory setting. The field offers natural communication patterns in action – people interacting in their own natural settings"(Shuter, 1984:202).

Anthropologists, sociologists, ethnologists, social psychologists and communication researchers have conducted many naturalistic studies. The

communication field has been interested in the impact of context on communication. Social contexts such as the family, health institutions, political organizations and religion have been researched. Hospital settings have been examined to assess nurse-patient interaction and to observe, interview and analyze cross-cultural styles of expressing pain. In such studies, contextual communication patterns can be identified, described and contrasted across cultures.

Opponents of this view insist that overinvolvement may taint the culture and/or distort the objectivity of the researcher(s) involved: "The moment one becomes involved one overtly mixes personal values with research and objectivity suffers"(Tafoya, 1984:56). A potential limitation that stems from this type of research is that a certain degree of scientific objectivity is compromised. Cause-effect relationships cannot be identified because of the inability to control numerous intervening variables in the natural environment and consequently, reliability gets abandoned. In addition, critics feel that the researcher relies too heavily on subjective impressions in collecting data by being immersed in social context.

If the researcher uses such a subjective research approach, cultural assumptions and expectations may unduly influence the collection and interpretation of data. Ting-Toomey (1984) also believes it is difficult to record observations in naturalistic settings without some form of intrusion. But this criticism can be addressed by stressing the partnership of several research strategies to maintain objectivity, including triangulation of information, in-depth interviews and so on.

One can also argue that any human interaction in any sense, will affect both the

researcher and participants, regardless of either's attempt to remain distant or removed. Exposure to each other will affect both parties and the benefits tend to outweigh any potential harm from the interaction. Harm becomes an issue only when the researcher extends his or her role from 'data gatherer' to an 'activist' of policy or issues beyond the research. Yum (1984) insists that participant observation is advantageous over direct questioning in that the researcher in the field can often directly verify it.

Changing my role from that of an outsider to an insider allowed me to observe and record events in the process without becoming an active participant in the counseling session or activity. My role as an active learner was to report my findings based on the participants' views rather than as an "expert" in the field (Creswell, 1998). Extensive field notes were taken while observing. Field notes included: 1) observations around context, mood, setting and body language; 2) insights; 3) speculations, 4) new/unanswered questions and 5) my own feelings and values.

Individual interviews were valuable in checking the accuracy of the observations and providing additional information that may have been missed in observation. The interviews were conducted in Punjabi, semi-structured, open-ended and incorporated questions generated from the observations and previous practice and experiences. The interview format allowed me to acquire more specific information about the clients' experiences but unstructured enough to allow clients to tell their own stories (Kline, et. al, 1980).

Before beginning the interview process, an interview protocol was designed, similar to the one illustrated by Creswell (1998:127). It was a page in length with

approximately five open-ended questions and ample space between the questions to write responses to the interviewees' comments (see Appendix H). I tried to generate questions that were culturally sensitive in nature rather than technical. The interviews lasted about 1 hour in length and began with an open-ended question. Subsequent questions were conversational in an attempt to gather more information. The questions were geared around around things observed and these questions did confirm my observations of the interactions between the clients, practitioners and interpreters. At the end of each interview, a debriefing period occurred in which participants were asked if there were any questions I did not ask, how might the interview be improved and how the interview process was for them.

Each interview was audiotaped and the tapes were transcribed to compare and retain the context of the data. They were coded for confidentiality and no identifying information is presented in this report on my study. A copy of the transcription of the data was offered to the corresponding client to review and edit.

Ethical Issues

In gathering the data, I needed to strike a balance between the risks and benefits to the participants. Making certain that the participants were not damaged in any way meant they needed to know enough about the research. The letter of initial contact and the letter of consent were translated into Punjabi so that the participants could make knowledgeable consent. Upon meeting the participants, I explained that they will benefit from this study by speaking about the experiences of using interpreters in a safe environment with someone (the researcher) who speaks and understands their language and cultural context.

The fact that I speak the same language and have a similar ethnic background to the participants meant that I already brought tacit knowledge into the study. I was familiar with many aspects of their lives and this may have lead to acceptance and trust.

Based on my experiences as a social worker and interpreter, I did not see any potential for harm to the participants. In fact, I believe that the possible benefits in terms of empowerment and support were far more significant. The participants may however have felt the study was somewhat intrusive, personal and emotionally sensitive. Thus, a debriefing and clarification period was offered. Participants also had access to their primary health care practitioner throughout the duration of this study. In turn, I offered the participants meaningful feedback and an overview of my findings.

While my relationship with the participants was professional enough that it enabled me to ethically learn the things I needed to in order to validly answer my research question, it was also open enough that it encouraged participants to openly express their feelings. In terms of self-disclosure, I let them know that I am also Punjabi and an M.S.W. student doing my placement at the hospital. When sharing my personal experiences with participants, I kept in mind the effects of doing so, which may have included less information sharing or too much information sharing by participants. The study posed no serious ethical problems because the participants remained anonymous and I took measures to minimize the possible effects of my own authority or similarity to participants.

Methods of Data Analysis

My analysis was ongoing and inductive in order to identify emergent themes, patterns and questions. It was also an attempt to break the data into "meaningful units" which resulted in a higher level of synthesis (Creswell, 1998). Like other researchers (Marshall & Rossman, 1995), I tried to bring order, structure and meaning to the collected data. Reading the transcripts in their entirety several times to try and get a coherent sense of the interviews as a whole helped me break down the data into manageable parts.

I generally reviewed all of the information gathered in the form of reading through it to obtain a sense of the overall data. Analysis of each participant's comments individually and then categorization of data and the assigning of data bits to themes and codes (Coffey & Atkinson, 1996) occurred. Looking at words used by participants, extracting meanings and metaphors, categorical aggregation (Creswell, 1998) in which I sought a collection of instances from the data so that issue-relevant meanings are extracted were all part of the analysis. Generally speaking, a cross-case analysis was performed in which I examined themes across the cases and brought out themes that were common to all cases.

In the Findings section of this thesis, I describe what I saw in the data within the context of the setting of the participant observations and interviews. Quotes and paraphrasing are used to look at categories or identification of general themes as part of the classification process. I tried to make sense of the data by interpreting it based on my own hunches, insights and intuition. An attempt to establish patterns and naturalistic generalizations came out of the interpretation process.

Finally, in making sense of the data and providing an interpretation of what I learned, I used my personal views or theories in the literature to make assertions. In my analysis, I suggest that if this study was continued and extended to include other ethnic groups, perhaps a common theme(s) may begin to emerge. This research may add to the findings already in the literature and provide new answers or extend the body of knowledge already available around interpreters. The next section focuses on the limitations related to the design. It is intended to help other researchers address their own limitations in research.

Limitations Related to the Design

In terms of data collection methods, Sarbaugh (1984) advises the researcher to realize that some members of a cultural community may provide data to outsiders while others may not. Some members speak for their cultural community, claiming to have special insights but in fact may not. In some communities, one may never admit to not knowing the response to a question because admitting lack of knowledge may be a threat to status while other communities may prescribe that members are 'expected to know' the response to a question. There may also be culturally constituted norms about who to talk to and who not to. In addition, the awareness of the presence of the observer will certainly alter the behavior being recorded, by whatever means.

Interviews certainly helped me to understand the experiences of Punjabi clients but I must recognize that the verbal reports of their experiences may be limited by their ability to describe and conceptualize. In Morse (1994:292), Dreher writes: "Given that verbal expression is subject to individual variation, it is important that the investigator

take precautions to ensure that the interpretation is truly a reflection of differences in experiences and not simply differences in the capacity to use language and discourse." To allow for the examination of competing explanations, the issues of reliability, validity and generalizability are discussed next.

> "A scale or instrument that consistently measures some phenomenon with accuracy is said to be reliable. The instrument is dependable and has a certain amount of predictability associated with it. If an instrument is reliable, then administrating it to similar groups under comparable conditions should yield similar results"(Royse, 1995:106).

In this study, the interview questions and participant observations might not be reliable because the experiences of Punjabi people as users of interpreters may be measured inaccurately. They may not be dependable and if administered to a similar group of clients under similar conditions, the results may be quite different. The researcher must address questions such as: "How might he or she be wrong?" "What are the plausible alternative explanations?" "How does the data support or challenge the researcher's ideas about what's going on?" "Why should anyone believe the results?"

"An instrument is said to be valid when it measures what it was designed to measure"(Royse, 1995:109). Maxwell (1996) states that validity depends on the relationship of the researcher's conclusions to the real world. The researcher needs to consider the validity threats to the potential conclusions of the study and how these will be dealt with. The threat to valid description in the sense of inaccuracy or incompleteness of the data (i.e. describing what was seen or heard) can be solved by audio recording of interviews and verbatim description of observations (Maxwell, 1996). Perhaps I could have also video recorded and transcribed my observations. But as

Maxwell (1996:89) points out, "For observation, video recording is both more difficult to do and more trouble to transcribe." Since I did not videotape, I did try to make my observational notes as detailed and concrete as possible.

There is also the threat to valid interpretation which is "imposing one's own framework or meaning, rather than understanding the perspective of the people studied and the meanings they attach to their words and actions"(Maxwell, 1996:89-90). Asking open, non-leading questions may give clients the chance to reveal their own perspectives, but not considering alternative explanations or understandings of the phenomena studied or not collecting or being unaware of discrepant data can cause a serious threat to the theoretical validity of an account (Maxwell, 1996). Therefore, consideration of what could disprove the conclusions, such as being vague, too general etc. is important.

The other type of problem raised about qualitative studies is reactivity, which is the influence of the researcher on the setting or individuals studied (Maxwell, 1996). It is impossible to eliminate the influence of the researcher so it is important to just understand it and use it productively. In my participant observations, I believe reactivity was as serious a validity threat. In the foreign setting of a hospital, I think that as an observer, I had a lot of influence on clients' behaviour. In the interviews, reactivity was also a powerful and inescapable influence because what the clients said was a function of the interviewer and the interview situation itself. For instance, the setting was foreign and I was an authority figure in that setting. Therefore, this may have influenced the clients' responses and behaviour.

There are a number of validity tests that can rule out validity threats and increase

the credibility of conclusions. Sometimes, just reporting any discrepant evidence and allowing readers to evaluate this and draw their own conclusions can be a validity test. "The strategy of triangulation, that is, collecting information from a diverse range of individuals and settings, using a variety of methods can reduce the risk of chance associations and of systematic biases due to a specific method and allows a better assessment of the generality of the explanations that you develop"(Maxwell, 1996:93-94). But sometimes, the methods that are triangulated may have the same biases and sources of invalidity and the researcher may select methods that tend to support the preferred conclusions. Therefore, it is important to recognize the fallibility of any particular method whether it be individual interviews, participant observations, questionnaires, surveys etc.

Another effective strategy for identifying validity threats, the researcher's biases, assumptions and flaws in the method is feedback. Getting feedback from a diverse range of people who were both familiar and unfamiliar with my study may have yielded valuable and different comments. Getting feedback about the data and conclusions from the people studied (Punjabi clients) is a process known as member checks (Maxwell, 1996). This way, any misinterpretations of their meanings and perspectives can be ruled out. In addition, providing "rich data"(Maxwell, 1996:95) that is detailed and complete can provide a clearer picture of what is going on.

"Generalizability means how well the findings from a specific study fit another situation"(Royse, 1995:38). I need to also consider whether or not my conclusions are generalizable within the setting or group studied as a whole and whether or not my

conclusions are generalizable beyond that setting or group. For example, my account of the experiences of Punjabi clients as a whole is seriously jeopardized because I have selectively focused on particular clients and on particular kinds of interactions (i.e. Punjabi clients who are accessing health care services), ignoring other types of clients and other types of interactions. Thus, I need to consider whether my conclusions are generalizable beyond the setting and participants studied in the sense of being representative of a larger population, that is, all Punjabi clients. It is quite possible that those who agreed to the interview may not be representative of the larger population. They volunteered when most other Punjabi clients may not have. They may have some traits or characteristics (i.e. more outspoken) that make them less representative and therefore, this could affect the generalizability of the study.

Increasing my sample size may make my conclusions more generalizable and increase the credibility of my research findings. My sample size of 10 may be judged too small to achieve maximum variation of a complex phenomenon or to develop theory. By not describing the setting of my study more fully, I cannot support the generalizability of my results. For example, I could have discussed the percentage of Punjabi clients accessing services at the hospital setting, the percentage in terms demographics, and a breakdown of the number of Punjabi males and females accessing health care services etc.

In dealing with some plausible threats to the validity of my results, I need to ask myself, did I interview enough Punjabi clients? Did I bias the data by who I interviewed? I cannot rule out the possibility that clients may have felt intimidated by the hospital

setting or by me as a researcher. I do not know whether what the clients said is true and not just what they thought I wanted to hear. I tried to deal with this by assuring each client of anonymity. I interviewed them privately, after they had received health care treatment so that they did not feel threatened or think that their treatment may be in jeopardy.

It may also have been a good idea to interview each client in a location distant from the hospital. This way, clients may not have held back from sharing their feelings, positive or negative. It is quite possible that clients did not relate well to me because I represented authority, the hospital, the institution. I am certain that client responses would have been different if they were interviewed elsewhere, such as in the privacy of their own homes. I also think that some of the responses would vary if I had interviewed clients at another time or on another day, rather than immediately after the clients' encounter with the practitioner and interpreter. I noticed that many clients seemed tired after receiving treatment. Many may have been too tired to carefully think about my interview questions. They may have answered my questions quickly, in order to go home. There was one instance where I requested a pregnant client to come another day for the interview because she was just so exhausted after her health care appointment. Looking back, I believe this client's responses were more thoughtful and reflective, compared to the other clients I interviewed. In order to increase my confidence in the validity of my work, I attempted to collaborate with each client by discussing my observations and my conclusions.

My color and ethnicity, class, culture, gender, age, affectional orientation,

education, functional ability, and any other influences may have influenced the participants' responses. For example, I predicted that Punjabi clients may perhaps reveal too much or too little about themselves simply because I am of the same ethnic background as them. In my previous experience, I have noticed that Punjabi clients who are older than me tend to share a great deal because they see me as a young, educated woman who is eager to listen and learn from them. But sometimes, too much information is shared; thus, a limitation may be that I had to work through a tremendous amount of data in a relatively short period of time in order to report my findings. Not enough time may have limited my attempt to generalize my findings to other ethnic groups. By the same token, I may have been treated as an insider with assumptions of shared values, experiences and knowledge. Hence, Punjabi participants may not have told me everything because they might have assumed that I already knew.

My focus on the experiences of Punjabi clients may be seen as a race/ethnicity bias. As stated earlier, I chose to focus on only this segment of the population because it is traditionally an under represented group in research. Furthermore, in an attempt to reduce researcher bias, I used the unstructured interview format and the use of open-ended questions. I recognize however that the interpretation of the data collected must be claimed as my own interpretation of the information received.

Perhaps if I had set up a focus group instead of individual interviews, I may have obtained more data. I remember four Punjabi women sitting and talking at the hospital one time. They were complaining about hospital services and the conversation became very intense, heated and interesting. Perhaps if I had held a focus group consisting of all

of the clients in my study (male and female), it may have yielded responses different from those collected through one-on-one interviews. Sometimes, a one-on-one interview may be intimidating for a client, but when sitting in a circle with people who are from the same ethnic community as him or her, the client may open up and engage in more sharing of feelings.

Just as my power as a researcher may influence the clients' responses, we also need to consider the power of both the interpreter and the practitioner. Firstly, considerable power rests with the practitioner. It is highly likely that the power of the practitioner in relationship to the institution, his/her age, culture and social class influenced clients' responses. For example, the clients' deference to authority, their tendency to regard the practitioner with utmost importance and their belief in the accuracy of the practitioner (i.e. "the doctor knows best") certainly would affect their responses. Many practitioners are aware that some ethnic communities (i.e. Punjabis) have a great deal of respect for them and a high degree of obedience towards them. As a result, there are practitioners who may take advantage of this and use their power and high status at its extreme.

It is the practitioner who diagnoses, counsels and treats the client. The practitioner organizes the discussion, directing it in a fashion that is suitable to him or her. He or she can mold clients' responses and determine which parts of the material are significant, and this decision is often made unilaterally, independent of the client's or interpreter's views.

> "The practitioner's dominance introduces an extraordinary bias which can lead to a unilateral and ethnocentric view of "what's wrong." The practitioner's views may be further

> biased by his or her personal background, values and social class. Clients may not question or criticize a practitioner's diagnosis or reasoning because the practitioner's formal training, education and certification in medical methodology creates a sense of correctness, authority and superiority. The circumstances can lead to a situation in which client and interpreter views are overlooked or excluded as invalid concerns" (Putsch & Joyce, 1990:1050).

One way of addressing this limitation may be to encode and decode the wording of each speaker, in order to find instances where there is practitioner dominance. For example, after observing and/or tape recording an interaction between the practitioner, client and interpreter, it may be interesting to dissect each speaker's wording and analyse it. Breaking up the language of each speaker and analyzing it may provide instances or examples of specific nuances, belittling of clients, sarcasm, power relations and so on. Monitoring the speech of the practitioner to see whether or not he or she was sensitive to the culture, how he or she asked questions (i.e. in a domineering or culturally sensitive manner) and how it impacted the client and interpreter may have been a good idea. Sometimes interpretation does not allow for this type of monitoring to occur, so the responsibility to monitor may rest on the researcher. As a researcher, I did not engage in this practice since it has been done in other cross cultural studies, but I do believe my analysis and conclusions would be stronger if this were done.

The interpreter is also in a position of power. Being entirely neutral and non partisan is difficult for interpreters. Since the interpreter is the sole processor of both the practitioner and client views, he or she is in the position to manipulate both the information exchange and the situation. The practitioner may have no idea that the interpreter is taking control of the interaction. This brings us to a central argument which

is, should interpreting be just interpreting, or should it involve more roles? While some people believe interpreters should only interpret, there are others that believe interpreters need to adopt different roles.

Interpreting requires varying levels of knowledge and skills. The interpreter's role becomes more stressful and complex when working with death and dying issues, patients in the intensive care unit, recovery room or social work department. Often, interpreters may have more difficult roles such as ombudsmen or counselors in personal and family situations (Putsch, 1985). Some interpreters have to explain biomedical concepts to clients and this is viewed as a basic "cultural broker" function of medical interpreters. Due to a lack of linguistic equivalency for words like "allergy", a number of interpreters have to explain this to clients, along with other difficult concepts.

The practitioner's diagnostic or therapeutic role must often be shared by the interpreter. For example, many interpreters provide therapeutic support to clients who are very sick and express difficulties not being able to speak English. There are many practitioners who treat interpreters as co-workers and colleagues, and not only as "word processors". Chang & Fortier (1998) also believe interpreters are called on to take different roles, including those of cultural mediator and advocate. But despite these views, many people at the interpreters' conference which I attended spoke about the harmful effects of involving interpreters too much in the practitioner-patient encounter. This model is not held up because they argue that the interpreter's overinvolvement may make clients overly dependent; the overlapping of interpreters' roles may confuse the definition of interpreting, and it may cost more to hire interpreters who also engage in

advocating, mediating and counselling relationships with their clients.

There are obvious benefits and liabilities to interpreting. An interpreter may feel a great sense of self-worth and pride, knowing that he or she made it possible for two people with two different languages to understand one another. The interpreter may also benefit because when interpreting, he or she becomes a team player in an important medical encounter. The interpreter gains access to the hospital settings and is often granted many of the privileges and rights of hospital staff. He or she is usually treated with respect, consulted on cross-cultural issues and greatly relied upon to bridge the gaps in intercultural communication. For many interpreters, the health care interpreting profession becomes a stepping stone towards establishing careers in other areas such as legal interpreting, medicine, social work and so on.

While the benefits to interpreting may be many, the liabilities are also plenty. If an interpreter fails to interpret accurately, the problems of misdiagnosis, mistreatment and misunderstandings arise. An interpreter may be blamed for misinterpreting and looked upon unfavorably. Trust does not always develop, even between the interpreter and client. The client may consider the interpreter very much like a stranger or outsider and therefore, not divulge any personal information. Since there is a great reliance on the interpreter, he or she may feel pressured to develop trust and deliver quality service or else, lose his or her job. On the other hand, the client may divulge too much personal information but ask the interpreter to keep it a secret. This puts the interpreter in a difficult position. The interpreter is instructed to interpret exactly what the client utters. But in doing so, the interpreter may feel disloyal to the client. As mentioned before,

interpreting can become a long, time-consuming process. It requires a substantial amount of patience, time and perseverence on the part of all parties involved. The communication process can be slow between two people, let alone a third party (the interpreter) entering the interaction.

Since the value of interpreters is examined from many points of view, I should not underestimate the potential for bias and error. Although I made efforts to decrease threats such as selection and sample bias, my search for accuracy may have been hindered due to multiple contradictory realities. The participants may not all have had alternative realities but nevertheless, there were some. Some may be deluded or simply in error and I need to be aware of these.

Assuming too much and going beyond what my data can support would be overgeneralizing my study. One way of making my findings fit another situation may have been to pilot test my interview questions with persons who are similar to those who were in my study. Making sure items are understood would have been established from the responses they made. This may have helped me pick out any confusing and vague questions. In this way, my interviews would consistently measure the phenomena I was studying with accuracy; thus, increasing the reliability of my findings.

Findings

A number of themes emerged from this study. From the sample, it seems more Punjabi females require an interpreter than Punjabi males. As a researcher, I did not choose the number of females or males for interviews. Instead, I conducted my study with whoever came for service, and it just so happened that more females were present

than males. However, the fact that more females showed up than males is significant. This supports my earlier statement that Punjabi women tend not to acquire English because many stay at home, whereas Punjabi men and children learn English by working outside the home and attending school. Therefore, more Punjabi women (than men) rely on an interpreter to help them understand English.

While many of the clients preferred family members to interpret for them, they appreciated interpreters and were satisfied with their work. Interpreters are viewed as necessary for explaining distinct cultural beliefs, explaining difficult concepts, translating from one language to another accurately, and catching material that might have been missed without an interpreter. Each of these themes are discussed below, using quotes from the clients in this study.

I chose quotes that suggested a common theme. For example, if one respondent said he or she appreciated having an interpreter, I sorted through the data to find more examples of this. In dealing with the data, I was looking for instances where respondents expressed a common experience or desire, such as preference for family members to serve as interpreters. Throughout my sorting process, I came up with clusters of quotes that had common themes or ideas, and it was difficult deciding which themes to focus on. I decided to focus on themes that:

1) had more than one quote to back it up;
2) were interesting or provided new information for me as a researcher;
3) offered some type of guidelines or suggestions for practitioners in providing quality health care.

Interpreters are necessary for explaining distinct cultural beliefs

In the case of mental illness, many of the clients believe it has supernatural causes such as spells or curses cast by jealous relatives or neighbors. These clients expressed difficulty in trying to explain this to practitioners without the help of an interpreter:

Respondent #7

> *"In our culture, we have many beliefs about mental illness. To someone who is not from our Punjabi culture, these may sound silly but to us, they are part of our lives. So that is why I like using an interpreter because the interpreter knows about these beliefs and can explain them better than me in English."*

Respondent #10

> *"I always have a hard time explaining to a doctor why I wear a black thread around my neck. The interpreter understands that I wear this to get rid of bad spells or curses put on me by jealous people and he can do a much better job of explaining this to the doctor."*

Interpreters are necessary for translating from one language to another

Having an interpreter enables clients to translate their complaints as they are popularly characterized in India into Western medical vocabulary:

Respondent #1

> *"I wanted to tell the doctor that some of my emotional difficulties are a result of immigration to Canada, my inability to speak English, not being able to find a decent job and separation from my family. But I could not have possibly translated all of this without the interpreter breaking it up into smaller sentences. The interpreter took every piece of what I wanted to say and translated it from Punjabi to English."*

Respondent #4

> *"I know how to describe my illness in Punjabi but I needed*

the interpreter to explain it in English to the doctor."

Respondent #8

"In India, there are a number of herbs and home remedies that can cure an illness. I think it is easier describing these to a Punjabi interpreter than to an English-speaking doctor. The interpreter can then find suitable words in English to describe the Indian system of medicine to the doctor."

Respondent #9

"Sometimes, there are Punjabi words that are hard to translate into English, so how is a doctor supposed to know how I am feeling? I remember a time when I told my daughter I had really bad cramps in my stomach. She did not know how to interpret this into English so the doctor had no idea what I was complaining about. A professional interpreter on the other hand can interpret something like 'cramps' quite easily because they know the medical language."

From my participant observations, I noticed that a wide range of terms such as 'stress', 'schizophrenia' and 'depression' have no equivalent in Punjabi and were not generally understood by clients. These concepts are virtually untranslatable. I observed that even the professionally trained interpreters had no exact Punjabi words for these terms and they tended to use the English word for them.

I also observed that many of the interpreters were extremely accurate in their translation from one language to another. For example, one interpreter did such a good job of interpreting a consent form for surgery. She read each sentence of the form to herself, thought about it and subsequently translated it in small parts to the client. She would then ask the client if clarification was needed.

Interpreters are necessary for catching missed material

Another significant finding was that interpreters are necessary for catching any material that may get missed in the interaction between the client and practitioner. Here are some poignant examples of this from my participant observations: a dietician asked the client (Respondent #3) whether or not she was taking any vitamins. The client responded *"no"* but the interpreter realized that she did not really understand the question so he asked the client the same question over again. This time, the client understood the question and said, *"Yes, I take Vitamin C."* In another situation the client (Respondent #2) kept on saying yes or no to virtually every question asked without letting the practitioner finish asking the entire question. Fearful that much may get lost in the interaction, the interpreter cautioned the client to relax, listen to the question in its entirety, let the interpreter translate it entirely, and then to respond.

There was also another client (Respondent #10) who admitted that she did not fully comprehend a question but nevertheless, replied yes or no:

Respondent #10

> *"At one point I was just answering yes or no to every question, not waiting for the interpreter to translate the question into Punjabi. I did not really understand all of the questions, so I was glad when the interpreter asked me to slow down and wait for her to interpret. Who knows, I may habe been given the wrong medicine if I continued answering questions without thinking about them!"*

Interpreters are necessary for explaining difficult concepts

Because many of the clients (Respondents #1, #3, #5, #8, #9 and #10) perceived practitioners' speech as fast-paced, it seems interpreters are necessary for explaining

concepts that are difficult to grasp:

Respondent#1

"Even though I can speak some English, I could not understand what the doctor was saying because she spoke so fast! The interpreter slowly explained what the surgical procedures would be like."

Respondent #5

"I think I would be able to understand English better if the doctors here did not speak so fast. Maybe then, I would not need so much help from the interpreter."

Respondent #9

"I find that the older I get, the harder it is for me to hear properly. What makes it even harder is that everyone (doctors) speaks English very fast. I am sure the interpreter was tired of repeating everything the doctor said because I could not hear or understand English that well."

In another situation, I observed that some of the language used by the practitioner was so difficult to understand that even the interpreter had a difficult time. The interpreter asked the practitioner to slow down, break it up into smaller parts and speak slowly. In my conversation with this practitioner later on, I learned that she was glad she was told to make herself more clear. In fact, a number of interpreters asked for clarification from the practitioners themselves, before interpreting the information to the clients.

Preference for family members

I found it quite striking that despite receiving what they labeled as 'much needed' service from the interpreters, some clients still prefer to bring family members with them for interpretation. Two of the clients (Respondents #2 and #4) said they appreciated

having a professionally trained interpreter when they were not able to bring a family member with them but if they were to choose between bringing a family member or having a professionally trained interpreter, they would choose a family member. I inquired further why this may be the case by asking each client, *"It seems to me by your response that you were pleased with the interpreter's work yet you would still like to bring a family member with you next time. Why is that so?"* The general response by clients was that coming for health care services is a private matter and it is not necessary to have outside interpreters know too much about their medical histories. In the clients' view, it is easier talking to a family member about personal issues:

Respondent #2

> *"The mental health of people is a very private and family-related issue. Most people like to keep it hidden and will only talk about it with an outsider in extreme emergencies."*

Respondent #4

> *"Speaking to a stranger (interpreter) about medical problems is already embarassing. It would be doubly embarassing to talk about mental health problems."*

Even a couple of female practitioners commented that they prefer talking to a family member about their clients' situations. In their departments of the hospital, most of the cases involve removal of the clients' clothing, so these practitioners felt embarrassed having a male interpreter present. Even in my participant observations, I found that some female clients (Respondents #5 and #9) felt uneasy lying on an examination table, half-dressed, with a male interpreter watching them. I raised this issue with some of the interpreters in the study and their common response was that the sex of

the interpreter should be taken into consideration, especially when extremely private matters (i.e. removal of clothing) are at hand.

One client (Respondent #4) preferred having a family member interpret because she had very minimal command of the English language, despite being in Canada for the last 35 years:

Respondent #4

> *"Even though I have been in Canada for about 35 years, I speak little English. I have never worked outside the home a day in my life here in Canada. My husband has worked in a mill all of his life and he speaks very good English. I raised my children at home and once they were old enough, they always went everywhere with me. They were always around to interpret for me so I never had to learn English. Now that I am old, I have even more family who can interpret for me and I never leave home without somebody, wherever I go."*

There was one client (Respondent #6) who firmly believed that family members cannot interpret as effectively as professional interpreters:

Respondent #6

> *"My experience has been that although my wife speaks good English, there are some things that she can't understand. The interpreter understands well and can explain it in good terms. If I bring somebody else with me, they might not understand as well. The other thing is that the interpreter has a responsibility to explain things properly. Family just can't explain as well. Family may tell you some things but also leave out a lot of what the doctor says, or miss some things. This is very serious, especially when it is medicine. Because if you do not understand well, this may lead to more serious medical problems."*

It is significant to note that out of all the clients interviewed, this was the only client who had used an interpreter before. Every other client had never used an interpreter before but this client had used an interpreter about 15 other times for immigration, workers' compensation and medical issues. He seemed very comfortable using an interpreter, perhaps because he has used one so many times and realized the benefits of doing so. It is quite possible that many of the other clients would prefer using professional interpreters rather than family members once they become used to this idea over time.

Appreciation for interpreters

But while Punjabi clients still prefer family members to serve as interpreters, family members are not always around so professionally trained interpreters are appreciated:

Respondent #4

> *"It is not easy being old and unable to speak English. My family is quite large so I always have a daughter in-law or grandchild around to bring me to medical appointments. But I remember a one time when nobody was home and I came through emergency. Thank God I had a professional interpreter. Otherwise, I would have been helpless."*

Respondent #5

> *"When my daughter interprets, she knows all about me because she lives with me but an outside interpreter does not know how I am feeling. But sometimes, my daughter cannot come with me so I really like having an outside interpreter."*

Respondent #7

> *"We definitely need more interpreters in different agencies. There are so many Punjabi people who cannot always bring family members to interpret for them. That is why so many of them appreciate having someone professional and from the same culture as them do the interpreting."*

Satisfaction with interpreters

One client (Respondent #2) felt guilty for wasting the interpreters' time and did not suggest any ways of increasing the effectiveness of interpreters:

Respondent #2

> *"I did not want an interpreter because I do not like to waste their (interpreters') time. I feel like he (the interpreter) went through all this trouble for me by spending two hours in the interview, driving all this way and I feel bad for him. It just seems too much of a bother. But I like when my sister comes with me because she is free in the afternoons so that is why I like having her do the interpreting."*

Another client (respondent #1) was so thankful to get an interpreter that he hesitated to suggest ways of improving the use of interpreters. I would ask whether the clients felt the use of interpreters was effective or ineffective or what they like or disliked about using an interpreter and common responses were:

Respondent #2

> *"Oh, the interpreter was just fine. He did a great job and I am just glad he was there for me, otherwise I would not have understood a single thing."*

One client (Respondent #9) did not suggest how interpreters might be used more effectively other than requesting interpreters to arrive on time. She even challenged me by asking:

Respondent #9

> *"Isn't it just good enough for the interpreter to come and help me? Why should I have any complaints when they (interpreters) do such a good job of interpreting?"*

From my participant observations, I noticed that many clients (Respondents #2,

#3, #4, #7, #9 and #10) continuously nodded their heads in agreement with the interpreters. All of these clients smiled a lot; they repeatedly thanked the interpreters, and used other non-verbal cues such as eye gestures and hand movements to express their satisfaction with the interpreters. For example, I noticed that the older respondents (#4, #5 and #9) kept looking at the interpreters in admiration; sometimes used their hands to pat the interpreters on their shoulders, and often told the interpreters how helpful they were. All of this suggests to me that these clients were extremely satisfied with the interpreters' work.

Discussion

The findings suggest that overall, regardless of their age or gender, Punjabi clients are satisfied with the use of interpreters. For them, it seems it is a privilege to have an interpreter available so they were hesitant to discuss how interpreters can become more effective. But from their responses and from my own observations, I was able to extract ways in which interpreters can become more effective in helping practitioners and their clients to understand one another more clearly. The need for interpreters to remind practitioners about monitoring the speed of their speech and to make sure they (the interpreters) have prior knowledge of medical terminology are evident in this study. The need for interpreters to clarify their roles in the interview situation is also evident. It seems it might be necessary for interpreters to make it clear that clients are not bothering them (the interpreters) but that it is their job to interpret. This might encourage more Punjabi clients to use an interpreter and not feel bad about it.

But while themes such as using interpreters to translate difficult concepts, to

convince practitioners to speak more slowly and to identify material that may get lost did emerge, there were a number of more interesting, deeper themes that also emerged. Some of this 'latent' content is obvious in the quotes used by clients such as 'privilege', 'outsiders', 'private matters', 'hidden', speaking to a 'stranger', 'doubly embarassing', do not like to 'waste interpreter's time' and so on. In this section of my thesis, I would like to analyse the significance of the findings and emergent themes in relation to theories around language, communication and intercultural communication.

The use of interpreters in the translation of material from one language to another relates to Kleinman's (1980) theory regarding explanatory models. As discussed earlier, when talking about health and illness, Kleinman's explanatory models are a useful framework for looking at these issues. The client (patient) usually has one model based on his or her culture; the health provider has another model, usually based on Western ideas of medicine and the interpreter may have either or both of these models or more interestingly, have an entirely different model. Thus, understanding the explanatory models of each interactant is key to minimizing misunderstandings in intercultural communication. Using an interpreter to explain a client's explanatory model to a health provider is necessary, as the findings suggest in my study.

Some of the words chosen by clients suggest deeper themes of low self-esteem, low expectations, clients' sense of entitlement to services and how clients construct their experiences. For example, one client did not want to waste the interpreter's time; he or she did not want the interpreter to go through any trouble for him or her and he or she felt bad, and saw it as too much of a bother for the interpreter. All of this suggests to me that

the client lacks a strong sense of self and does not feel worthy of service.

Many other clients were just so thankful to have an interpreter, considering it a privilege. This reveals much about clients' sense of entitlement to services. Perhaps Punjabi clients feel that it is too much to ask for or have an interpreter. Their lowered expectations may be that they do not have a right to service. I know from traveling to India that medical services are very limited in India. Very few people are able to afford adequate medical treatment and when these people come to Canada, they receive it free of charge. Perhaps they are just so grateful to receive such service that any additional support (such as an interpreter) is viewed as a privilege or a special bonus. In any case, these examples prove that it is crucial to involve interpreters in the provision of health care services. As I mentioned earlier, Punjabi clients must feel completely entitled to adequate services, not see it as a privilege but rather, a right. I believe interpreters are trained to fill this role.

The examples given above support Wright's (1984) notion that there are differences in the way people live and see the world. This author believes that these differences have always been part of intercultural communication. In other words, intercultural communication takes place in a world of different role relationships, expectations, behavioural norms and rules between communicators. Sands (1988), also establishes that clients bring their own frame of references to a helping situation. Just as the Punjabi clients in my study perceive reality in their own way, Sands urges practitioners to know where their clients are coming from. Once again, I believe this can be accomplished through the help of interpreters.

Gudykunst & Kim's (1984) concept of the 'stranger' relates very succinctly to the Punjabi clients' beliefs in my study. In fact, many of the Punjabi clients referred to practitioners as 'strangers' or 'outsiders'. This confirms Gudykunst & Kim's belief that when people are unknown and unfamiliar, we are essentially communicating with 'strangers.' Simmel's (1950) opinion that some of us are 'strangers' to one another, still holds today because as this study shows, we may be physically close, but have entirely different beliefs and ways of doing things. The Punjabi clients and practitioners were essentially 'strangers' because although they were close in proximity, some of their values and beliefs differed.

In addition, just as Miller & Sunnafrank (1982) assert that a sense of uneasiness and lack of control surfaces in a strange communication encounter, I also could feel that sense of uneasiness and lack of control in both the practitioner and Punjabi clients in my study. But the positive side to this is that interpreters were available to ease some of the discomfort and they brought a sense of empowerment (especially to the Punjabi clients). The interpreters were instrumental in helping both the practitioners and clients understand each other's frame of references, share cultural information and ultimately minimize misunderstandings. As discussed earlier in my thesis, all of these factors are key in establishing effective intercultural communication.

At this point, I wish to address the finding that Punjabi clients still prefer family members to serve as interpreters. Quotes used by clients such as "It's a family matter"... "private matter"... "prefer to keep it hidden" etc. reflect Punjabi people's strong belief in the value of family. Individuals have in their cultural societies significant groups such as

family, co-workers and friends. These groups provide individuals with emotional support and a sense of security. They also espouse in their members a respect for authority, acceptance of standards, a tendency to behave in accord with established norms, and a desire to cooperate to achieve group goals.

While Western cultures stress the individual as the primary point of reference, many non-Western cultures stress a great degree of submission of individual identity. By an early age, Western culture encourages children to be autonomous and self-directed. Children are encouraged to decide for themselves, develop their own opinions, solve their own problems, have their own things etc. Any serious misconduct brings shame just to the individual and little to the family. There tends to be a big emphasis on "me", not "we." Many North Americans value ambition, aim, individual centeredness and self-reliance, not mutual dependence.

Non-Western cultures on the other hand (such as Punjabi people) value emotional dependency on other members of their primary groups. Members of a family are supposed to submerse their personal interests and desires in favor of those of the total group. They should behave in a manner that will not disgrace the honor of the family or company. There is a collective sense of responsibility. Instead of saying, "If you do that, people will laugh at you," they say, "If you are laughed at, you are bringing shame to your family"(Gudykunst & Kim, 1984:127). Many of the Punjabi clients in my study spoke about their attachment to family, how personal matters need to be kept within the family and so on. Perhaps that is why family members are the preferred choice as interpreters. But like I mentioned earlier, perhaps these clients also need to get used to

using professional interpreters over a period of time.

I was not surprised at the client (Respondent #4) who has been in Canada for the last 35 years but cannot speak any English. This elderly woman is characteristic of the large number of Punjabi people who have chosen to rely entirely on family members to function effectively in every facet of their lives. In my experience, I have come across many Punjabi women who have spent several years in Canada as homemakers, using family, friends and relatives to interpret for them. Many Punjabi women are content with staying at home. Many shop at Punjabi stores, they visit Punjabi-speaking doctors and their support systems are comprised entirely of Punjabis. Responsibilities such as paying the household bills, visiting lawyers or accountants, or making any business transactions are usually handled by their spouses or older children.

Therefore, many Punjabi women seem to function effectively in Canadian society, never mastering any English. I raise this issue because so many of us assume that only newly arrived immigrants are unable to speak or understand English. But in reality, there are a significant number of people (from various ethnic cultures) who never acquire English due to their cultural life patterns and preferences. Reliance or preference for family members to interpret and manage virtually every area of their lives is common, and practitioners ought to be aware of this.

This study was worthwhile in bringing out the need to educate clients about the inherent differences between using professionally trained interpreters versus family members. There still seems to be an immediate desire for some Punjabi clients to have family members serve as interpreters even when they know that family members do not

have the required medical knowledge to interpret accurately. Unless family members can be trained to interpret accurately and in confidence, interpreters must continue to play a leadership role in educating clients to accept the help of professional interpreters, to not see it as an invasion of privacy, and to not see the use of interpreters as a privilege but rather, a necessity.

Just as many of the interpreters in this study did, other interpreters also need to play an educational role with clients. There were several instances where clients directly asked their interpreters about health, nutrition, illnesses etc. It was great observing interpreters provide educational information to the clients but what I really liked was how the interpreters would consult the practitioner if they too were uncertain about a client's question. In a sense, the interpreters were really delivering health care services as well. This supports the idea of partnership between practitioners and interpreters to provide high-quality, professional health care services.

In carrying out other studies around the use of interpreters, I suggest extending the participant-observation and interviews to various other ethnic communities in order to hear how they feel interpreters can be used more effectively. As stated earlier, I chose to focus on only this segment of the population because it is traditionally an underrepresented group in research. It would also be interesting to conduct another study and observe the interpretation styles of interpreters from various training institutions. It just so happened (by coincidence) that all of the interpreters in this study were professionally trained at the same college in British Columbia, offering an extensive interpreter training program. But the reality is that not all interpreters are trained equally

and it would be good to look at the different interpretation styles.

Furthermore, examining whether there are differences in the language of interpreters who were originally from the villages in India versus the cities in India would add to the current research. I am aware that interpreters who grew up in the cities in India speak a far more sophisticated dialect of the same language versus those interpreters from small villages who speak very simplistically. I assume there would be problems if a client from a village had an interpreter from the city because there would be dialectical differences. Further areas of study may also include interviewing interpreters and practitioners in separate studies to hear their voices on how to health care services can become more culturally and linguistically accessible.

CHAPTER FIVE

CONCLUSION

In this practicum thesis, my journey towards exploring the broad area of community health care interpreting was multi-directional. I began my journey by providing personal and professional reasons for writing this thesis, presenting vignettes describing some cultural and linguistic barriers as well as a definition of community interpreting and why it needs to be studied. I extended this discussion to a particular ethnic community that is, Punjabi clients accessing health care services. I am hoping that my overview of the historical background, characteristics and health care needs of the Punjabi community was adequate in bringing out the need for professional, trained interpreters in this ethnic community. Without professional interpreters, the consequences of medical miscommunication can be severe. Risks such as Punjabi clients becoming sicker because they fail to stick to treatment regimens that they do not understand, missed appointments, incorrect diagnoses and worse, avoidance of the health care system altogether can be eliminated provided that interpreters are present.

I presented a number of theories around language, communication and the broader field of intercultural communication. My aim was to shed light on how these theories evolved and how they make their way into the area of health care. I then directed my readers' attention to a small qualitative study on the experiences of Punjabi clients as users of interpreters. My involvement as the researcher for this study created a space for me to investigate how an underrepresented ethnic community (Punjabis) in academic

research construct their experiences in the Canadian health care system. Conducting this research enabled me to draw some conclusions. As the results and discussion of my research study suggest, the need for qualified, professionally trained interpreters is immense.

There are large volumes of culturally diverse people (newly arrived immigrants as well as long-settled residents) who filter through our health care system, unable to speak or understand English accurately. Many of these people have distinct beliefs and values about illness and as my study suggests, are unable to translate these beliefs and values into English, without the help of a professional interpreter. I have presented several examples and client quotes to illustrate the effectiveness of professional interpreters in translating from one language to another, explaining distinct cultural beliefs and catching important material that may get lost in intercultural communication.

I am concerned about the large number of Punjabi people who continue to rely on family members for interpretation. As this study has found, many Punjabi people are satisfied with and appreciate professional interpreters but there are some who would still bring family members to interpret for them in the future. Hopefully over time, these people will get accustomed to using professional interpreters and not consider family members as a suitable alternative. This situation can improve as the number of professional interpreters increase in all health care settings. But to increase the number of professional interpreters means increasing administrative costs – an issue to which I now turn.

The costs of hiring professional interpreters or using interpretation services such

as the AT & T Language Line are high. At the hospital where I did my practicum, there are about 100 calls per month, requiring interpretation. The hospital is only provided with a budget of $1000 per month for hiring interpreters or using other interpretation services. A low budget such as this does not allow for any extra training or development programs and often, funds from other department budgets in the hospital are used because the demand for interpretation is so high. Like other hospitals, this hospital tries to save money by providing community volunteers with 12 hours of interpreter training and providing staff with four hours of training, so that professional interpreters do not need to be called in. There are other hospitals that hire students as interns to interpret for people. In return, these students obtain credits for academic courses.

While these cost-saving techniques do seem like viable alternatives, I come back to my argument that there is absolutely no suitable alternative to hiring quality, professionally-trained and experienced interpreters. There are many pitfalls associated with using staff, students, family and volunteers as interpreters such as breach of confidentiality, valuable time lost from a staff member's own job and an inversion of power relations in the family. These pitfalls can be avoided when using professional interpreters.

One way to perhaps save money might include hiring a full-time, professional interpreter who would remain at the interpretation site, rather than calling in an interpreter and paying for this service by the hour. This way, a professional interpreter would always be on hand; thus, eliminating the need to call in staff, students, family or volunteers. Another way to save money might include not paying interpreters who show

up late for an interpretation. Throughout my study, I noticed that many professional interpreters showed up late or did not show up at all but were still paid their hourly rate. In my discussions with health care practitioners, it was agreed that lots of money is wasted in this way. Therefore, the financial situation can improve, so long as the people involved become more accountable and aware.

Implications for Clients

Recognizing the worth of interpreters in helping to explain distinct cultural beliefs, difficult concepts, medical terminology and jargon is important for clients. They need to be encouraged to use the services offered to them and not consider these as a special bonus or privilege. The example in my findings of the client who has used an interpreter about 15 other times and feels completely comfortable with it could be presented as a case example to other clients. This way, other clients may be convinced that over time, they can also get accustomed to using an interpreter, and not feel bad or think that they are wasting the interpreter's time.

The findings may help clients to understand some of the harmful effects of not using interpreters such as misdiagnosis, inappropriate treatment, longer delays and waiting time etc. In addition, it may suggest to them that if they are uncomfortable with the opposite sex interpreter, they can request a same sex interpreter. If they do not understand the dialect of the interpreter's language, they must make the interpreter and practitioner aware of this. If anything is unclear, clients must make sure they ask the interpreter. It may take time for clients to become more assertive, but it will definitely happen.

Implications for Interpreters

Being thoroughly involved with both the practitioner and clients during an interview is important for interpreters. If they suspect a problem or get a negative response, interpreters must come back to an issue. Since rumors, jealousy, privacy and reputation are present in close-knit communities (Putsch, 1985), interpreters must acknowledge this problem and assure clients of confidentiality. They must prepare and plan ahead if clients ask them to secretly keep details from the practitioner. Interpreters must realize that they have an important role to play. They must ensure accuracy in interpretation in order to meet both client and practitioner needs.

Interpreters also need to monitor the practitioner's speech to ensure that the practitioner asks questions in a culturally sensitive manner, and does not use his or her power and authority to silence the client or make the client feel uncomfortable or insignificant. Interpreters also need to watch for how their own power in relationship to their age, class or status impacts the client. For instance, a client who has no education and grew up in a rural village may not feel comfortable with an interpreter who is college-trained and raised in the city. Similarly, an elderly Punjabi client may not feel at ease with a young interpreter. Interpreters must be aware of these issues and respect differences in clients.

Implications for Practitioners

Practitioners must use an interpreter unless they are thoroughly effective and fluent in the client's language. They must avoid using family members, friends, neighbors and staff as interpreters and they must learn basic words and sentences in the

client's language. At the hospital where I did my practicum, Punjabi classes are held for staff members to learn basic words such as "hello", "how are you?", as well as specific health food and behaviours in Punjabi so that clients can feel practitioners have an interest in their language and issues. In addition, practitioners should become familiar with specific beliefs, practices and traditions even when an interpreter is present, because this provides a solid grounding in beginning to understand their clients' concerns.

On a broader level, practitioners should have translated health-related materials available to pass onto clients and these materials should be checked for quality by having them back-translated. Meeting with interpreters on a regular basis is crucial so that practitioners can evaluate the interpreter's style and approach to clients and provide them with constructive feedback. Often, matching the interpreter to the task or matching a client to the same sex interpreter is the practitioner's responsibility. Practitioners can usually request a particular interpreter, depending on availability.

In addition, practitioners must realize what it means to be in a dominant role. Realizing that their power in relationship to their age, culture and social class can serve to impede rather than improve communication is essential. Failure to recognize this issue may block practitioners' ability to provide quality medical services. Medical interpreting often requires long, explanatory phrases, so practitioners must learn to accept this and allocate more time for medical encounters where interpreting must take place.

Implications for Hospital Administrations

Hospital administration needs to play a crucial role in linking clients and language services at each stage of the client visit to ensure access and continuity of care. Each

interpreter should be checked for uniform quality and standards should be established to ensure quality. Orienting new interpreters on institutional and administrative policies and procedures, evaluating interpreter services by observing interpreter-client encounters and testing interpreter language skills are all part of the hospital administration's responsibilities.

Improving service by tracking data on the cost, use and quality of each interpretation is also necessary. Linking clients with quality interpreters requires hospital administration to identify client needs whenever the client makes contact with the organization. Assessing the demand of each client is important because a client may be able to complete an intake form but require considerable interpreter assistance to understand a medical problem. Hospital administration is also responsible for scheduling language services, ensuring availability of interpreters, covering any language at any time and avoiding unreasonable delays. Hospital administration needs to ensure continuity of care at each stage of the client visit, including outreach, appointment, registration, examination, diagnosis, treatment and follow-up.

Hospital administration is also responsible for checking for uniform quality and issues around screening and training for interpreters and practitioners alike. Training practitioners and interpreters together ensures the uniform quality of each interpretation. Interpreter training should include skills development and knowledge acquisition so that the interpreter can serve both the practitioner and the client. Knowledge of technical terms and professional jargon, plus language proficiency and interpersonal communication skills need to be part of the interpreter training. From an organizational

policy perspective, a focus on the interpreter's role regarding issues such as confidentiality, medical/legal issues and ethics is also important and should be part of the training.

In addition, measuring and improving language services means tracking costs and using data collected from performance appraisals and satisfaction surveys. These practices help establish the true costs of interpreter services and provide insight into the cost-effectiveness and quality of the services. Finally, hospital administration should consider whether or not medical interpreting needs to be certified, and if so, by whom? "Interpreter certification implies a uniform set of skills and a minimum standard of competency, tied both to training and professional licensing" (Chang & Fortier, 1998:14). Hospital administration needs to look at other certification models and consider who should establish standards, and what standards should cover.

Implications for Social Workers

I feel it is extremely important to join other social workers and health care providers in advocating and empowering clients to become participatory members in demanding culturally and linguistically appropriate health care. The fact remains: many non-English speaking newcomers to Canada will learn English quickly and settle successfully within a few years of arrival. Others however, will face a much longer process of adaptation and English language acquisition. The make-up of immigrants has and will include people from countries with languages that have nothing in common with English; immigrants from impoverished countries where repressive governments and forces have prevented them from getting an education; people who have spent their lives

in factories, construction, or homes where their native language is not English as well as elderly immigrants sponsored by family members in a community where English is not required.

As social workers, we need to teach people that as long as there is no disruption or crisis in their lives, many non-English speaking people manage fine. But when illness, hospitalization, unemployment, domestic violence, family breakdown and death occur, these non-English speakers do not know where to turn for help and cannot ask for help in the service-provider's language. That is when adult family members, young children, relatives, friends and neighbours are called in to interpret for them. But as this thesis has shown, the dangers of using untrained interpreters are enormous. The results of this include inaccurate communication, which wastes time and money, but more importantly, harms the client. As service-providers, enablers and advocates, social workers have the responsibility of ensuring their clients optimum health and stability. This means: "collaborating with ethnic communities toward the realization of full community participation in the health care system, providing relevant, innovative and professional training for medical interpreters, providing cultural competency training for health care providers and administrators, collaborating with institutions in outreach to increase ethnic community members' participation in health careers, providing leadership in the management of effective interpreter services within institutional settings, empowering under-served communities through support, advocacy, education and community development, to achieve self-directed access to, and efficacious use of health care resources and to undertake and support community-based research and model

development projects to improve and set standards for cross-cultural health care"(Cross Cultural Health Care Program, 1996:3).

I make the connection to social work because the effective use of interpreters has implications for social work practice, policy and education. These issues are particularly relevant to social workers because so many of us work with clients that are different from ourselves, both linguistically and culturally. As social workers, we need to come to the realization that we must take a leadership role in ensuring all health care providers, clients, and interpreters fulfill their respective roles of providing, receiving, and facilitating access to culturally and linguistically sensitive health care services. That realization time has come now.

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APPENDIX F:

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ਇਜਾਜ਼ਤ ਦੇਣਾ ਫਾਰਮ

ਪੰਜਾਬੀ ਤਰਜਮੇਂ ਵਿੱਚ ਸੇਵਾ ਵਰਤਣ ਬਾਰੇ ਪੰਜਾਬੀ ਮਰੀਜ਼ਾਂ ਦੇ ਤਜਰਬੇ- ਕੇਸ ਦੀ ਪੜਤਾਲ-ਖੋਜ

ਮੁਖ ਖੋਜੀ - ਪਰੋਫੈਸਰ ਫਰੈਂਕ ਟੈਸਟਰ, ਸੋਸ਼ਲ ਵਰਕ ਸਕੂਲ, ਟੈਲੀਫੂਨ 822-2100
ਸਹਾਇਕ ਖੋਜੀ - ਅਮਰਿਤਪਾਲ (ਪਾਲੀ) ਢੈਂਸ - ਬੀ.ਏ. ਬੀ.ਐਸ. ਡਬਲਯੂ, ਗਰੈਜੂਏਟ ਸਟੂਡੈਂਟ ਅਤੇ
ਐਮ. ਐਸ. ਡਬਲਯੂ ਕੈਂਡੀਡੇਟ ਸੋਸ਼ਲ ਵਰਕ ਸਕੂਲ, ਟੈਲੀਫੂਨ 822-2100

ਉਦੇਸ਼ (ਮਕਸਦ) - ਇਸ ਦੀਆ ਪੜਤਾਲ ਦਾ ਮਕਸਦ ਪੰਜਾਬੀ ਮਰੀਜ਼ਾਂ ਦੇ ਪੰਜਾਬੀ ਬੋਲੀ ਵਿੱਚ ਤਰਜਮੇ ਕਰਨ ਵਾਲਿਆਂ ਨਾਲ ਸਹੀ ਮੈਡੀਕਲ ਟਰੀਟਮੈਂਟ ਵਿੱਚ ਤਜਰਬੇ ਜਾਨਣਾ ਹੈ। ਇਹ ਛੋਟੀ ਖੋਜ ਤਰਜਮੇਂ ਕਰਨ ਵਾਲਿਆਂ ਦੇ ਗੁਣਾਂ ਦੀ ਖੋਜ ਅਤੇ ਸਮਾਜ ਦੀ ਚੰਗੀ ਜਾਣਕਾਰੀ ਦੇਵੇਗੀ ਜੋ ਪੰਜਾਬੀ ਮਰੀਜ਼ ਦੇਖਦੇ ਹਨ। ਸਹਾਇਕ ਖੋਜੀ ਸਮਝ ਸਕਦਾ/ਸਕਦੀ ਹੈ ਕਿ ਕਿਵੇਂ ਕਨੇਡਾ ਦੇ ਸੇਹਤ ਦੇ ਮਹਿਕਮੇ ਦੇ ਬਾਰੇ ਆਪਣੇ ਆਪ ਮਹਿਸੂਸ ਕਰਦੇ ਸਮਾਜਕ ਅਤੇ ਧਾਰਮਕ ਵਿਚਾਰਾਂ ਰੱਖਣ ਵਾਲਿਆਂ ਮਰੀਜ਼ਾਂ ਨਾਲ ਸੇਹਤ ਦੀਆਂ ਸੇਵਾਵਾਂ ਦਾ ਤਰੀਕਾ ਪਹਿਚਾਨ ਕਰਦੇ ਹਨ। ਜੇਹੜਾ ਕਿ ਇਹਨਾਂ ਮਰੀਜ਼ਾਂ ਦੀ ਚੰਗੀ ਤਰਾਂ ਸੇਵਾ ਕਰ ਸਕੇ।

ਪੜਤਾਲ ਦਾ ਤਰੀਕਾ - ਇਹ ਕੇਸ ਦੀ ਪੜਤਾਲ ਤਜਰਬੇ ਦਾ ਹਿੱਸਾ ਹੈ ਜਿਸ ਵਿੱਚ ਸਹਾਇਕ ਖੋਜੀ ਦੁਭਾਸ਼ੀਏ ਅਤੇ ਖੋਜ ਵਿੱਚ ਭਾਗ ਲਵੇਗਾ/ਲਵੇਗੀ। ਅਤੇ ਦੇਖੇਗਾ ਕਿ ਪੰਜਾਬੀ ਮਰੀਜ਼, ਸੇਵਾ ਕਰਨ ਵਾਲਾ ਡਾਕਟਰਾਂ ਅਤੇ ਤਰਜਮਾਂ ਕਰਨ ਵਾਲੇ ਆਪਸ ਵਿੱਚ ਕਿਵੇਂ ਕੰਮ ਕਰਦੇ ਹਨ। ਇਹ ਖੋਜ ਦਾ ਦੁਭਾਸ਼ੀਆ, ਪੜਤਾਲ ਹਰ ਇੱਕ ਮਰੀਜ਼ ਨਾਲ ਇੱਕ ਘੰਟੇ ਦਾ ਹੋਵੇਗਾ। ਸਹਾਇਕ ਖੋਜੀ ਇਸ ਪੜਤਾਲ ਅਤੇ ਦੁਭਾਸ਼ੀਏ ਦੇ ਨੋਟ ਲਿਖੇਗਾ/ਲਿਖੇਗੀ। ਇਸ ਮਗਰੋਂ ਸਹਾਇਕ ਖੋਜੀ ਹਰ ਇੱਕ ਮਰੀਜ਼ ਨਾਲ ਫੇਰ ਪਹਿਲਾ ਮੁਲਾਕਾਤ ਕਰੇਗਾ/ਕਰੇਗੀ। ਖੁੱਲੇ ਸਵਾਲ ਪੁੱਛੇ ਜਾਣਗੇ। ਹਰ ਇੱਕ ਮੁਲਾਕਾਤ ਟੇਪ ਕੀਤੀ ਜਾਵੇਗੀ ਅਤੇ ਲਿਖੀ ਜਾਵੇਗੀ। ਹਰ ਇੱਕ ਮਰੀਜ਼ ਨਾਲ ਦੂਜੀ ਮੁਲਾਕਾਤ ਰੱਖੀ ਜਾਵੇਗੀ ਜਿਸ ਵਿੱਚ ਉਸ ਨਾਲ ਲਿਖੀ ਹੋਈ ਰੀਪੋਰਟ ਦੀ ਜਾਣਕਾਰੀ ਦਿੱਤੀ ਜਾਵੇਗੀ ਅਤੇ ਦਰੁਸਤ ਕੀਤੀ ਜਾਵੇਗੀ। ਇਹ ਮਰੀਜ਼ ਵਾਸਤੇ ਮੌਕਾ ਹੈ ਕਿ ਉਹ ਦੁਭਾਸ਼ੀਏ ਅਤੇ ਮੁਲਾਕਾਤ ਨਾਲ ਹੋਇਆਂ ਗੱਲਾਂ ਦੀ ਸਹੀ ਜਾਣਕਾਰੀ ਅਤੇ ਖੋਜ ਜਾਣ ਸਕਣ। ਅਤੇ ਪੁੱਛ ਗਿੱਛ ਕਰ ਸਕਣ।

ਗੁਪਤ ਭੇਦ ਰੱਖਣਾ - ਇਸ ਖੋਜ ਨਾਲ ਕੀਤੀ ਗਈ ਕੋਈ ਵੀ ਜਾਣਕਾਰੀ ਜਿੰਦਰਾ ਲੱਗੇ ਥਾਂ ਅਤੇ ਛੁਪਾਕੇ ਰੱਖੀ ਜਾਵੇਗੀ। ਸਾਰੇ ਕਾਗਜ਼ਾਂ ਨੂੰ ਕੋਡ ਨੰਬਰ ਦਿੱਤਾ ਜਾਵੇਗਾ। ਅਤੇ ਕਿਸੇ ਤਾਲਾ ਅਲਮਾਰੀ ਵਿੱਚ ਰੱਖੇ ਜਾਣਗੇ। ਇਸ ਸਬੰਧ ਖੋਜ ਵਿੱਚ ਹਿੱਸਾ ਲੈਣ ਵਾਲਿਆਂ ਦੇ ਨਾਮ ਕਿਸੇ ਵੀ ਰੀਪੋਰਟ ਵਿੱਚ ਦੱਸੇ ਨਹੀਂ ਜਾਣਗੇ।

THE UNIVERSITY OF BRITISH COLUMBIA

APPENDIX H

INTERVIEW PROTOCOL

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Project: The Experiences of Punjabi Clients as Users of Interpreters
Date:
Time of Interview:
Place:
Interviewer:
Interviewee: (masked name)
Questions:

1) "How long have you been using an interpreter?"

2) "What has been your experience using an interpreter?"

3) "How do you feel the use of an interpreter is effective/ineffective?"

4) "What did you like/dislike about using an interpreter?"

5) "How do you feel the use of interpreters could be improved?"

Participant Observation Period

A one-hour observation period will be spent with each client in their counseling session with the practitioner and interpreter. Extensive field notes will be taken during and after this time. The purpose of this experiential component is to fully capture the client's experience of using an interpreter.

PERSONAL RECOLLECTIONS OF AN INTERPRETERS CONFERENCE

I had the opportunity to attend a conference that came at a very timely moment for me, just as I was writing my thesis. The 2nd Critical Link Conference on Interpreters in the Community was instrumental in bringing together about 304 delegates from around 23 countries to address issues around interpreting. Held in Vancouver, British Columbia, the conference included plenaries and sessions around community interpreting, interpreter roles, interpreting in health care and court settings, training, standards and testing, mental processes in interpreting as well as special issues such as legal liability for interpreters, setting public service interpreting equivalencies and so on.

The mayor of Vancouver, British Columbia, Philip Owen and the Canadian federal minister of state for multiculturalism, Dr. Hedy Fry, welcomed the delegates. Dr. Hedy Fry spoke about Canada being an "integrated method" or a "Stir Fry" where people come together with strong values. She proclaimed that it is possible to be diverse and united at the same time. She also stressed three important initiatives in multiculturalism:

1) People should have a sense of identity and belonging;
2) there needs to be integration. We need to help people integrate into the social, political and economic life in Canada;
3) there should be access to social justice. When we interpret, we facilitate people to have access to health care, education, anything that helps people to integrate into the community.

Several exhibitors were on site from organizations such as AT & T Language Line Services, Cross Cultural Health Care Program, John Benjamins Publishing, Language Today, Rausch Companies, and Vancouver Community College. A huge number of

people took an active interest in language issues. Many people expressed their desire to see more publications around interpreting and language.

Delegates from as far away as South Africa, Australia and Hong Kong brought multiple perspectives to issues such as the challenges of sign language interpreting, trends and prospects of community interpreting, interpreting models in the health care sector, interpreter education and training, national certification system for community interpreters and the challenges of over-the-phone interpretation versus face-to-face. As a whole, the conference allowed for the presentation and discussion of similarities and differences between Canada, the United States and other countries' styles of community interpreting.

There was a tremendous amount of information for my own thesis research on the experiences of Punjabi clients as users of interpreters. Conference delegates were able to share their knowledge about the interpreter programs in various health care settings as well as understand from other delegates some of the complexities associated with community interpreting.

Many of the delegates left the conference feeling extremely proud for being interpreters. They learned that when they interpret, they facilitate people's access to health care, education, and legal systems – anything that helps people integrate into their community. Many recalled being new immigrants themselves trying to integrate into an unfamiliar and strange community. Realizing the impact of legal, social, and economic barriers due to language differences was part of the learning at the conference.

After the conference many delegates regarded the term interpreting differently.

They encouraged one another to see it as just that – interpreting. It does not need to be qualified or labeled as cultural interpreting, legal interpreting or the myriad other qualifiers used because these extra qualifiers simply attach confusion to the word interpreting. Of course there are different types of interpreting but if interpreters wish to advance as a profession, we need to simplify our language and come to a common understanding of what interpreting is. In addition, interpreters need to work in partnerships to establish standards of quality and training for interpreters, as well as set a minimum standard of education.

Many of the delegates also came out of the conference with an increased awareness of the costs involved in not using interpreters. While the vast majority of conference delegates agreed that the cost of using an interpreter is high in their respective countries, many also agreed that the costs of not using an interpreter are substantially greater. Problems in miscommunication, misdiagnosis, missed appointments, missed operating room time and so forth need to be examined as costs that arise due to the absence of an interpreter.

The conference impacted several delegates to act as stronger advocates for professionally trained interpreters. They learned that there is no good replacement for a professional interpreter. Young children, adult family members, relatives, friends, neighbors or co-workers are not suitable substitutes. A professional interpreter has the ability to interpret accurately, not just literally. He or she adopts an unobtrusive position, uses first-person speech, offers cultural insights but not direct opinions or advice and renders the message of each speaker truthfully and faithfully, always conveying the

content and spirit of each speaker.

Just as interpreters should convey the content and spirit of each speaker, this conference conveyed the content and spirit of each conference delegate's involvement with interpretation. A great deal of cultural insights were shared, lots of learning took place and the attendance at the conference reflected the magnitude of interpreting as a profession worldwide. As a result, I eagerly await the next Critical Link Conference on Interpreters in the Community. Below, I share some of my findings from the Conference about specific interpreter programs and services around the world.

The Translation of Documents Demonstration Project – British Columbia

In Vancouver, British Columbia, 15 hospitals and 4 community agencies have come together to develop consistent standards for medical translation, to develop qualifications for translators, to co-ordinate and translate at least 5 documents in 4 target languages, to review existing translated materials, to develop a databank of translated materials, and to explore the sustainability of joint translation efforts. The overall goal of this Demonstration Project is to improve the standards and procedures for translating patient education and instructional materials. It is also an effort to allow community agencies currently having sophisticated processes in place for translations to share their knowledge and assist in the standard development and identification of translators. Focus groups will be held with translators and community members of 4 target language groups. Ultimately, translated materials will be provided to all community members (patients and families) accessing health care services.

Worldwide Interpretation and Translation Services - Manitoba

Based in Winnipeg, Manitoba, Worldwide Interpretation and Translation Services (WITS) promotes and provides high quality and affordable translation and interpretation services. Corporate initiatives include the training and ongoing mentorship of multilingual translators and interpreters in over 35 languages as well as consumer education activities throughout the community. In addition to providing interpreters in various settings this agency provides document translation services to individuals and businesses. In its efforts to promote standardized practices and continued professionalization in interpretation and translation services, WITS also delivers a career development lecture series for interpreters and translators from the major immigrant language communities in Manitoba. Topics include different techniques in the interpretation and translation fields; ethical and professional challenges; the legal, medical and educational systems as well as other settings; the marketplace and the general knowledge needed to be successful in both fields. Services are offered in a number of languages such as Punjabi, Russian, Polish, Portuguese, Tagalog, Chinese, German, Serbo-Croatian and Ukrainian.

Across Languages Interpreter Program - Ontario

In London, Ontario there are about 72,000 immigrants who are in need of experienced interpreters. Across Languages is a non-profit charitable organization which has provided interpreters for nearly 10,000 non-English speakers and 1500 service providers since 1989 (Across Languages, 1998). This organization provides trained interpreters to community agencies, government, professionals and businesses to help

non-English speaking clients to become more independent and self-confident when accessing health, education, legal, government and social services. Approximately 40 distinct languages and dialects are covered by interpreters who are trained in the role of the cultural interpreter, ethics of interpretation, cross cultural communication and interpreting skills for eight to ten weeks.

The Language Bank Interpreter Program - Alberta

In Calgary, Alberta the Calgary Immigrant Aid Society administers a community program called The Language Bank. Through the provision of high quality language services the program aims to advocate and facilitate equal access for immigrants to community services and programs. Some of the services provided include translation of written documents from another language into English or vice versa and interpretation to facilitate understanding between speakers of English and speakers of other languages for newcomers to Canada. The languages covered include Punjabi, Cantonese, Vietnamese, Albanian, Tamil, Turkish, and about 50 others.

The Yale-New Haven Hospital Interpreters Project – New Haven

In keeping with their mission of providing the very best care possible and enhancing the communication between health care providers, patients and family members throughout the hospital, the Yale-New Haven Hospital offers interpretation services 24 hours a day. Although priority is given to medical interpretation, interpreters may fill other roles such as supporting patients and families experiencing the stresses of hospitalization and illness, reducing isolation, alerting staff to unmet needs and allowing communication to initiate from the patient. Other functions include translating patient

information, letters, medical reports, discharge information and other incidental documents for patients and providers. In protecting patient rights and confidentiality, the hospital does not use the patient's family or children for medical interpreting, it does not ask patients to bring their own interpreters and it does not ask untrained individuals to interpret. Instead, the responsibility of finding an interpreter is taken by the hospital to ensure quality patient care.

The Stanford Hospital Interpretation Program - California

Realizing that communication can be difficult and slow, inaccurate and misunderstood between people who do not speak the same language, the Stanford Hospital in California provides Spanish and Russian interpreters 24 hours a day as well as sign language interpreting. Interns, community residents, Stanford students and employees make up a Language Bank that covers 20 other languages with over 60 qualified volunteers. Telephone interpretation is available, translation of medical materials is provided and medical interpretation workshops and training sessions are offered on a regular basis. These include awareness of cultural issues and how to effectively work with an interpreter.

The Monterey Institute of International Studies Interpreter Courses - California

The Monterey Institute of International Studies in California offers a popular Medical Interpreting Course designed to prepare students to enter the challenging and exciting field of medical interpreting. Students are introduced to the complexities of medical interpreting with an emphasis on professional ethics, intercultural communication and interpersonal skills. In small groups, instructors and students work in

consecutive interpreting (doctor-patient interviews) and sight translation (medical reports and questionnaires). This is a 2 week intensive, 30 hours per week, 60 total hours of instruction course which prepares students to provide effective medical interpreting so that non-English speakers have equal access to vital health care services.

The Monterey Institute of International Studies was one of the first schools to offer courses in court and medical interpreting. Long known for its graduate program in conference interpreting and translation, it now focuses greater attention on community interpreting as a specialized field of interpretation. It seeks to fulfill its mission to enhance the prestige of community interpreting as a profession ands to encourage talented bilinguals to consider careers in community interpreting.

The California Health Care Interpreters Association - California

The California Health Care Interpreters Association in Stanford, California supports and promotes the health care interpreting profession. It does this by: establishing standards of practice, adopting a code of ethics, creating a certification program, sponsoring internships and scholarships, and advocating for cross-cultural awareness through education of health care professionals. Encouraging the development of advanced level training in health care interpretation and institutions of higher education, promoting the networking of institutions that provide interpretation services and making recommendations on existing or new policies affecting patients with limited or no English proficiency are also part of this association's goals.

Resources for Cross Cultural Health - Maryland

In Silver Spring, MD a national network called Resources for Cross Cultural Health Care offers information and assistance on cultural competence in health care. Comprised of individuals and organizations in ethnic communities, the network provides expertise on medical interpretations, program design and training, cross cultural assessments and training and the design and delivery of health services for culturally diverse communities. It is also involved in policy research and development, information dissemination via a comprehensive website, onsite and telephone technical assistance and consultation services, and interactive forums and conferences for policy makers, medical interpreters and anyone interested in sharing information on how best to provide culturally appropriate health care.

The Cross Cultural Health Care Program - Washington

Another successful training program for medical interpreters is based in Seattle, Washington. The Cross Cultural Health Care Program in Washington offers a forty hour course called "Bridging the Gap" which prepares bilingual individuals to work as medical interpreters in hospital and clinic settings. The course offers basic interpreting skills; information on health care systems such as how doctors think, anatomy, basic medical procedures; culture in interpreting with regards to self-awareness, characteristics of specific cultures, as well as communication skills such as listening skills, communication styles, appropriate advocacy and professional development. Participants receive an extensive interpreter handbook, medical glossaries available in a number of different languages, culture specific materials such as traditional healing methods and an

interpreter's guide to medications. Based on the success of the program, the Cross Cultural Health Care Program's Institute in now providing participants with the skills and expertise to organize their own training programs in their home cities. This way, anyone can train to become an effective medical interpreter regardless of where they reside.

The National Language Project – South Africa

In an effort to recognize all of the South African languages as official languages, The National Language Project in Cape Town, South Africa has in place a Community Health Interpreters and Training and Employment Program. This program aims to facilitate communication between Xhosa speaking patients and non-Xhosa speaking health care providers by offering an interpreting. The program also hopes to ensure that Xhosa speaking patients obtain appropriate health care services. As a two-year pilot project funded by the Flemish government in Belgium, Canada Foundation for Development and Peace, Levis Strauss, Anglo American and Liberty Life, the program offers a training program for interpreters. The training lasts for two months – one month theory and the other month practical. So far, the program has received a lot of support and it looks like a health interpreting training model that can be replicable in other regions.

The Institute of Linguists – United Kingdom

As a multilingual society, Britain has many people living there who do no speak English well enough to access public and voluntary services (Institute of Linguists, 1997). Therefore, the Institute of Linguists, which is a leading professional language body in the United Kingdom offers a Bilingual Skills Certificate that provides language

competence in English and another language in the context of the U.K. public services. The examination for this certificate includes role plays in English and in the other language, sight translation from English, writing letters and so on, all based on real life situations. This type of examination would benefit anyone living in a bilingual community and who would like to communicate effectively or would like training to become a public service interpreter.

The Victorian Interpreting and Translating Service – Australia

Established in 1994, the Victorian Interpreting and Translating Service (VITS) in Melbourne, Australia offers specialist interpreting services in the legal, health, education and commercial fields in over 80 languages, 24 hours a day, seven days a week. Specialized services include Mental Health Interpreting Service for client interviews, psychological assessments, psycho-geriatric assessments, family therapy etc. as well as education and legal interpreting services.

The National Accreditation Authority for Translators and Interpreters is the only authority in Australia authorized to provide testing and accreditation for interpreters and translators. All of VITS' interpreters and translators hold accreditation with this authority and each interpreter receives intensive training and development to provide efficient, high quality, professional service.

Other significant services offered by VITS include a fully computerized booking system designed to assess each client's specific needs; state of the art Multilingual Desktop Publishing System that produces any format of translation; telecommunications technology which offers clients access to a qualified interpreter in under four minutes, as

well as expertise in the production of multilingual audio-visual material. Quality control, monitoring and evaluation for service provision is ongoing at VITS.

The Netherlands Model

In the Netherlands, a network of 6 Interpreter Centres offers nation-wide coverage for free interpretation and translation services for health and social services. As one of the oldest, broadest and most intensive interpreter programs, I use the Netherlands as a unique model of interpretation.

It was back in 1977 that the Dutch authorities decided to create an interpreters' service. Just like in every other geographic area, there are a large number of immigrants who speak a language that the Dutch are unable to understand. Since 1977, a large influx of people from all over the world have sought asylum in the Netherlands. For the 6 Interpreter Centres, this meant increasing their services. In 1977 the 6 Interpreter Centres provided more than 420 thousand hours of interpreting service and approximately seventy five percent of these were for asylum seekers. The Interpreter Centres offer a diverse range of products and services such as personal interpreting assistance, 24 hours a day telephone interpreting, group interpreting and consultation and translation sessions. There are now more than 700 interpreters working in more than 85 different languages and dialects. We have to wonder, what makes the Netherlands model so successful? Much of the success is directly a result of professional interpreter training, correct interpreter attitudes and a thorough complaint procedure. Let us now turn to these issues.

Professional Interpreter Training

Very stringent recruitment and selection procedures are necessary for interpreters

at any of the six Interpreter Centres. An interpreter must be at least 23 years of age, a resident in the Netherlands for a minimum of three years and must have completed general secondary education. In addition, extensive knowledge of both the Dutch and other culture is required, good expressive skills in both languages and training and refresher courses need to be followed regularly. He or she must also complete extensive tests in which not only language skills are assessed but also the correct interpreter attitude.

Correct Interpreter Attitudes

As professionals trained to listen carefully and translate accurately, interpreters need to have the right attitude to work under difficult circumstances. Often, culturally diverse people have complicated and unclear problems that need consideration. Interpreters need to remain absolutely impartial and independent and treat all information as confidential. The Netherlands interpreters are trained to possess an extensive knowledge of technical jargon and terminology over a wide range of subjects. Familiarity with important cultural differences requires an open and friendly attitude and that is what a Netherlands' interpreter adheres to upon joining one of the six Interpreter Centres.

Complaint Procedure

Complaints related to interpreter attitudes, confidentiality requirements, correct translation, interpreter intelligibility, impartiality etc. are handled by the manager or deputy manager of the Interpreter Centres. Complaints can be submitted by telephone or in writing. The Netherlands model is prompt and efficient in handling all complaints,

regardless of the nature of the complaints.

AT & T Language Line Services

Another innovative approach to dealing with the challenges of language barriers is the AT & T Language Line Services. This over-the-phone interpreting service seems to be internationally recognized and judged as the highest quality service of its kind. It is available 24 hours a day, seven days a week from any phone in the world. Highly skilled professionals can interpret form English into 140 languages and connecting to an interpreter can take just 45 seconds or less. In critical communication situations, this short connection time allows for Language Line interpreters to listen to the speaker, analyse the message and accurately convey the true meaning rapidly and efficiently. These interpreters have been trained in over-the-phone interpretation skills and are a more cost-efficient alternative to hiring full time interpreters because Language Line is paid for on an as-need basis. This service has experienced millions of calls and is considered accurate, objective and confidential.

While over-the-phone interpretation may seem attractive, several of the attendees at the Critical Link 2 Conference had questions about it. In an open forum, many of the conference attendees recognized that over-the-phone interpretation has become a viable alternative to in-person interpretation around the world. Many of the attendees also addressed questions of what constitutes community interpretation in a phone environment and how the phone setting impacts service quality, modes of interpretation and customer expectations. AT & T Language Line service representatives provided useful information about the service and training of interpreters. A quality specialist spoke about the

promptness of the phone connection being incredible, the training of phone interpreters as highly strict and so forth.

Audience members raised important points such as the impediments of over-the-phone interpretation. Some people believed there is a lack of visual cues with over-the-phone interpretation while others argued that interpretation is usually oral, so visual cues are not always required. Other comments were that over-the-phone interpretation does not give one a chance to do any advocacy work; bonding is automatic in face-to-face interpretation but limited and not as strong in over-the-phone interpretation; there is more confidentiality over the phone, and it is easier getting people to use a phone versus other audio-visual technologies. Others think that the system has some flaws. Some practitioners complain that the quality of the interpretation is spotty. One newspaper reports that "many patients, especially older immigrants find it disconcerting to communicate with a disembodied voice, on a speaker phone"(Fein, 1997:40).

In terms of costs, there is a one time set-up fee and a monthly fee for this service. There are three types of service fee rates. Some of the rates are as follows:

Subscribed Interpretation

This is designed for organizations that communicate with non-English speakers on a frequent and regular basis. It costs $250(Canadian), with a $70(Canadian) monthly fee. Each call costs $4.00 - $6.25/minute.

Membership Interpretation

This is mainly for organizations or individuals that have an intermittent, predictable language interpretation need. It costs $100(Canadian), with a $50(Canadian) annual renewal fee. Each call costs about $5.25 - $6.75/minute.

Personal Interpretation

This is a service ideal for individuals who occasionally need interpretation. This costs about $4.15 - $7.25/minute, and a $2.50 service charge for each completed call.

Many of the conference delegates believed that the AT & T Language Line is costly. Often, the use of an interpreter is a slow, time-consuming process and when an individual or organization pays a per minute rate for interpretation, the cost can become quite high. But AT & T continuously offers cheap, promotional rates in its efforts to attract customers. It is important to keep in mind that while the service may seem costly, the costs of not using an interpreter often exceed these service costs. For example, when fellow staff members are called in to interpret, they leave their own job and use up valuable time doing interpretation. In that sense, there is lots of money lost too. Therefore, one really needs to assess the long-term costs of not using a professional interpreter to the costs involved in using a service such as AT & T. Despite criticisms, the AT & T Language Line service continues to handle millions of interpretations. The benefits or losses of this service will need further consideration in the years to come.

I also learned about a diverse range of publications such as the 1998 Directory of Health Care Interpreter Training Programs in the United States and Canada, The Critical Link Newsletter for Interpreters in the Community across the World, The ATA Chronicle, which is a publication of the American Translators Association, Language Today, a British magazine dealing with language technology, multilingual documentation, translating and interpreting, as well as two excellent books titled Liaison Interpreting by Gentile, Ozolins & Vasilakakos (1998) and another called Interpreting

and Translating in Australia: Current Trends and International Comparisons, (1998) by Dr. Uldis Ozolins.

In an effort to disseminate information and make it as accessible as possible, there are a number of websites available. These include: Asian Health Services (www/ahschc.org/language.htm); Cross Cultural Health Care Program (www/xculture/org) Resources for Cross Cultural Health Care (www/DiversityRx/org) Professor Brian Harris at the School of Translation and Interpretation at the University of Ottawa (http:\\aix.1.uottawa.ca) and finally, a Bulletin Board that receives contributions on a code of best practice, ethical questions, horror stories on interpreting, requests for advice etc. (comminterp @web/apc/org).