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Intercultural mediation in mental health care

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Introduction

As healthcare systems are challenged to respond to the linguistic and cultural diversity that accompanies migrations, a common response is the deployment of the figure of the 'intercultural mediator' (ICM). This chapter will explore some of the key issues related to intercultural mediation in mental health care and will provide a background of the rationale for the existence of the ICM. We will also outline some of the serious factors, both conceptual and practical, that may confound matters, and, finally, we will explore the specific role possibilities that would appear to us to make sense 'given the givens' for the role and functioning of the ICM in mental health care.

It must be noted from the outset that the roles of the ICM are underdetermined there is little in the way of a common understanding as to what exactly this figure consists of, neither across countries nor professions, which inevitably compromises the ICM being an effective component of interculturally competent mental health care.

This chapter adopts a critical perspective on the very notion of ICM. We have had the opportunity to train intercultural mediators, supervise them, to work with them, and to engage in extensive conversations with all stakeholders involved in ICM, so, as mental health professionals working in a transcultural psychiatry program, we are well aware of the invaluable service ICMs provide. But, at the same time, we are concerned that healthcare systems, regardless of their political or other positioning, provide a lower standard of care for immigrant and refugee patients by using the figure of the intercultural mediator as metaphorical duct tape, that is, simply functioning as a patch in a system that is not equipped to truly overcome health disparities. We then face a paradox: on the one hand, there is an overall lack of institutional and individual intercultural competence in mental health care, and, on the other, in many cases there is no formalized mechanism by which to ensure sufficient levels of professional competence on the part of intercultural mediators.

Background

The current human displacement situation continues to challenge healthcare systems in general, and mental health care providers in particular. Various loci of 'difference', from linguistic to cultural to religious and beyond mean that delivery of services requires far more than a vague level of 'cultural sensitivity'. For a few decades now, commentators have indicated that effective work with patients from diverse cultures requires specific knowledge, skills, and attitudes—what is generally known as '(inter)cultural competence'—otherwise mental health professionals run a very serious risk of engaging in malpractice (1,2). Other chapters in this volume, along with an ample empirical and theoretical literature, demonstrate the serious dangers that exist at all levels of mental health care, from diagnosis to treatment, if clinicians cannot bridge the cultural and linguistic gaps. Despite the very clear need for something resembling 'intercultural competence', there are few training requirements and opportunities in this area in most medical schools and psychotherapy training programmes (3) or long-term integration of cultural issues into educational curricula (4). Even if there were (as is the case in counselling psychology in the USA), practitioners would still find themselves in situations for which their training has not prepared them, be it due to patients with whom they do not share a language or from cultures with which they, at best, have a passing familiarity (5).

Intercultural mediation and the need for intercultural competence

It cannot be emphasized enough that in most countries around the world there is a very serious risk of cultural malpractice (1,2,6), which at a basic level simply refers to culturally and linguistically incompetent treatment. Research supports this claim as what could be called intercultural miscommunication is one of the most frequent reasons of medical malpractice (7), and language and cultural barriers have been found to increase medical malpractice risks (8,9).

the position, the specific title or roles may vary based on sector or region of involvement.

Verrept and Coune's 'Guide for Intercultural Mediation in Health Care' (24) written under the auspices of the Belgian Federal Public Service Health, Safety of the Food Chain and Environment provides an excellent overview of all relevant aspects of this figure, essentially in health care, in which they define intercultural mediation as:

> All activities that aim to reduce the negative consequences of language barriers, socio-cultural differences and tensions between ethnic groups in health care settings. The final purpose is creating health care options that are equal for immigrants and native-born patients regarding accessibility and quality (out-come, patient satisfaction, respect for the patient's rights and so on). ICM is in fact a way to achieve this by improving communication and thus acting strategically on the care provider/patient relationship. In this manner especially the patient's position but also but also the care provider's position is strengthened so health care is better suited to patient needs and the care provider can work efficiently. Besides bridging the language and cultural barrier, an important dimension of intercultural mediation is also facilitating the therapeutic relationship between the care provider and the patient (24, pp. 5–6).[1]

ICMs are called upon in general and in contrast to medical interpreters, because of the need for someone who has specific cultural expertise, awareness of the functioning of the healthcare system, and knowledge of the interaction of culture and health, in addition to linguistic competence in the relevant languages. Frequently, but not necessarily, ICMs are required to bridge the linguistic gap. Thus, the issue of cultural fluency is, indeed, the bedrock of ICM as is said by many, 'much more than just translation' (although we consider this to be a misguided view; especially in mental health care there is no such thing as 'just translate'). To that end, the roles of medical interpreters are examined in meta-analysis by Brisset et al. (25), who analysed 61 studies on the topic in the USA, the UK, Canada, Sweden, Switzerland, Australia, South Africa, France, Ireland, Italy, and New Zealand, and found that roles of interpreters in health care vary from passive 'voice box' in the USA (26) to informant, culture broker, and advocate in Canada (27) and to more active roles of covert co-diagnostician (28) and therapy conduit in the USA (29).

The central task, then, for the intercultural mediator, beyond those functions standard to a medical interpreter (see Chapter 39) is that of cultural clarification, cultural contextualization, and facilitation of the relationship or connection between the patient and the provider/mental health care system. We consider the delimitations of this definition to be imperative, especially in mental health care.

The issue of the ICM's role is complex. Although the standard model has been that of an unobtrusive 'absent presence', especially in mental health care, the presence of a third party inevitably alters the dynamics of the therapeutic process (19,30–33). The impact of the ICM on the therapeutic process is further complicated by those who advocate for roles such as advocacy for the patient or one-on-one information provision and gathering (34). We will take this issue up further later.

[1] Reproduced with permission from Verpert, H., and Coune, I. (2016). *Guide for Intercultural Mediation in Health Care*. Brussels, Belgium: FPS Health, Safety of the Food Chain and Environment.

For practical purposes, in our opinion, differences between ICM and medical interpreting in mental health care are not necessarily significant, although this is a point of debate (35). For example, the Belgian Intercultural Mediation Ethical Guidelines draw heavily on medical interpreting associations (24). Our interest here, however, is not to belabour this point. Indeed, as there is a chapter specifically focusing on medical interpretation in this volume (see Chapter 39), our focus will be on the cultural focus of the ICM.

For the most part, in the wake of recognition of health disparities in the treatment of newly arrived immigrants and refugees, healthcare systems looked to ICM to be what we believe was—and unfortunately in many cases continues to be—a stop-gap measure, and as such we fear that there is a serious danger that rather than solving the problem at hand the presence of the ICM may exacerbate it. Our wish here is by no means to disparage the excellent work provided by dedicated ICMs, but rather represents our concern that their incorporation into the healthcare system represents cultural disqualification. Rather than demand that mental health professionals are prepared to work with all patients we compensate for their lack of cultural competence with the ICM who (through no fault of their own), are generally not well trained nor highly educated and, as such, ill prepared to take on the rather taxing and complex job required.

Cultural knowledge

The centrality of culture in mental health care has been amply elaborated upon in other chapters in this volume and elsewhere. From our perspective, culture is of importance in the context of the experience, expression, and explanation of distress, on the one hand, and, on the other, the expectations concerning the course, treatment, and engagement with the mental health professional (36). For the mental health professional making sense of what the patient presents and communicates and to be able to then communicate back to the patient is central. It is precisely in the negotiation of meaning, the interpretive process, that the intercultural mediator has a central role (19).

Although at first glance this might make sense, there are complications in the very notion of 'cultural knowledge' itself. Back in 1987, Sue and Zane (37) noted that cultural knowledge was 'distal' from interactions with clients, that is to say, any knowledge a clinician may have about a patient is abstracted from the actual interaction, and the application of said knowledge is complex (37). But this begs an even more important question, one that is particularly germane in this increasingly globalized world as 'culture' is a complex and overdetermined construct. From the multiple definitions of Kroeber and Kluckhohn (38) to the anthropologist Brightman's call to 'forget culture' (39), it is clear that what exactly it is that is meant by 'culture' is rather elusive. As Lakes et al. (40) point out, in many of the conceptualizations of cultural knowledge as applied to mental health it is implied that it is in some capacity meaningful to talk about discrete 'cultural groups'. Yet at the same time in this globalized world in which exogamy is increasingly common, the specific demarcation of a given culture for a particular person is inevitably fuzzy. Many commentators, for example, suggest that urban middle-class professionals across much of the world share similar cultures perhaps to an even greater extent than they do with their much poorer, rural country mates. Similarly, some black Americans

advocacy to patient medical education. We have some serious doubts about any role beyond those described by Verrept and Coune (24). What should be avoided is that the ICM is used, in some capacity, to compensate for a deficit of the healthcare system or the mental health professional. In our professional practice we have seen ICMs be asked to function as babysitters, as companions, as agents to explain treatment regimens, or even to convince patients to follow said regimens. For the most part, each medical professional has a specific role to fill, and although there is some overlap, the roles are clearly delineated, and it is never optimal if a nurse has to do the work of a doctor or a doctor of a social worker. Above all, competence is key for any role that is carried out (48). From this perspective we have a hard time understanding why an ICM would, for example, take a patient history or explain a treatment regimen, as these functions are under the purview of the professional practice of psychiatrists, mental health nurses, and psychologists. We have serious doubts about ICMs filling these roles as all nuances are relevant in the specific medical field and all details must be clearly and professionally explained in order not to compromise the treatment (for instance, failing to specify clearly the combination of medication, hours to take medication, etc.)

The need for professionalization and credentialing

To our knowledge no health care system requires specific university-level training and credentialing for ICMs, as is the case for other mental health professionals. Although there are initiatives at some local and regional levels (e.g. Train Intercultural mediators for a Multicultural Europe (TIME) in the European Union; MA in Sociology Intercultural Mediation programme by The University of Wrocław; MS in Intercultural Mediation by Leuven University; and some others), in few cases are they required by national healthcare systems (34). In part, this is because in the context of health care there is no institutionalization of this figure. Without a formalized job description registered with the labour department, anyone can assert they are an ICM, and any health authority or municipal administration can agree. There is no formal mechanism by which to ensure that training provided to ICMs adhere to any sort of minimum hours, content, quality, or otherwise. Indeed, it can happen that the primary qualification for becoming an ICM is being of a given 'other' culture and being linguistically competent in the relevant languages. What this means is a considerable inconsistency and instability, to the extent that many highly competent ICMs leave the profession owing to the precariousness of the employment situation.

Considering the role of the intercultural mediator

Given the complexity of the role of the ICM combined with the inconsistent training and lack of credentialing, along with the very real risk of cultural malpractice without the participation of an ICM, we would like to propose a role that we feel can be realistic and effective.

Because of the centrality of the therapeutic relationship and non-verbal communication in the clinical process, the presence of the ICM in the therapeutic dyad is not merely additive, but fundamentally impacts almost every aspect of the therapeutic process. This presents a fundamental challenge: should the goal be to minimize the intrusion of the ICM? Or should it be to fully acknowledge it and, indeed, make use of this figure in a therapeutic manner?

Elsewhere we proposed the idea of the ICM as a sort of junior co-therapist out of the recognition that in the context of mental health care the 'absent presence' is all but impossible (19). As time has passed since then, we agree that although this might be an ideal, it requires more resources than perhaps are available. How, then could an ICM function effectively and avoid impeding or complicating the therapeutic process? In what remains of the chapter, we will make a specific proposal for the ICM in a mental health care system of restricted resources, that is, what might be 'realistic' rather than what is ideal. What we want to do is avoid ICM succumbing to be a tool of cultural disqualification, but rather serve to increase intercultural competence. We will then specify some issues relevant to work with specific populations.

A perpetual challenge in mental health care is that there is much more to the process than simply the interchange of information. In mental health care, words and their relationship to non-verbal language really matter. Thus, the effective negotiation of the different roles identified earlier is of paramount importance. All of the above really leads us to the challenge of what exactly it is that the ICM should be up to in the therapeutic encounter.

Although different healthcare systems in some cases, and commentators in others, have proposed roles and functions for the intercultural mediators, in the context of this chapter we remain with few, if any, standards required in the training and accreditation of ICMs. One consequence of this is that, at worse, it can result in some serious complications in the therapeutic process (49), and at best provides opportunities for new, more therapeutic roles. In the middle lies what Bot terms 'boundary crossings' (50) and Pöchhacker calls 'modified rendition' (51). For Pöchhacker, the medical interpreter follows from the words of the first interlocutor ('first rendition') to the final rendition, which is what arrives at the second interlocutor. What the ICM does, however, is to deliver a 'modified rendition' (51). A boundary crossing for Bot (50) is when the ICM modifies the content or tone of the message, in effect 'taking charge' of it in order to soften the message, to render it more culturally appropriate and so forth. Reviewing much of the literature, it is not clear whether a 'modified rendition' or 'boundary crossing' is positive or antithetical to the clinical process, although as mental health professionals we are concerned that it may be that we are not receiving the full story. Davidson (52) expressed concern that ICMs may function as 'gatekeepers', as when linguistic interpretation is involved, they, in effect control the information at hand. Searight and Searight (53) suggest that ICMs be a 'central figure' in which they take charge of the therapeutic exchange. This, we believe, would only make sense with high levels of training, although in the context of mental health care the training necessary for this to take place would render the ICM competent to be a mental health care professional thus obviating the need for the ICM.

CASE STUDY 38.2 Cultural Clarification in Practice

A bright young woman explains that she is unhappy in her marriage, and would like her husband to be more attentive and romantic. At the same she insists that her husband is a good man. Here it can be

helpful to the ICM to underscore to the clinician that in the culture of the patient it is often the case that gender role expectations and dynamics often diverge from what is normative in Europe.

A clinician was conducting an interview with a Moroccan couple as the wife was showing symptoms of depression. When asked as to their perceptions of the cause, the wife indicated that it was her marriage. Before getting married, she explained, she was optimistic about her future and free to do what she liked. With her marriage, however, she now was required to take care of her husband and young children. As the therapist heard this he was concerned that the husband would become angry with the wife for in effect holding him responsible for her distress. To his surprise, the husband nodded in agreement as she explained. The ICM clarified to the therapist similar role expectations.

We suggest that the ICM's tasks stay close to linguistic and cultural interpretation and the facilitation of the therapeutic relationship. One of the key aspects of this work is helping the clinician make sense of what we often term 'cultural issues'. As with metaphors, the idea here is that the ICM always provides both the 'exact' version and the 'cultural' version. In both cases this information can help a clinician formulate strategies to develop treatment plans. At the same time, however, the ICM is not interpreting the behaviour of the patient nor providing a diagnosis, but rather providing information that the clinician will then have to apply in a culturally competent manner. In all of these cases, the ICM is merely conveying either contextual information or possible meanings. It is, we believe crucial that the ICM maintain a high level of 'cultural humility' and always acknowledge the limited and contingent nature of the information and interpretations provided.

The ICM can also have an important role in the reverse direction. Although we doubt that it makes sense for the ICM to provide cultural clarifications to the patient ('what she means is … ') we do think that the ICM can provide feedback to the clinician to help him or her communicate more effectively, especially around taboo and uncomfortable subjects. As it is never good idea to maintain lengthy sidebar conversations that exclude the patient (or conversely the clinician), the ICM can explain to the patient, 'I am telling the doctor I think it is hard to understand what she said', thus ensuring that all are engaged in the interaction.

Much has been written of the complexities of a third person in the therapeutic encounter, and concerns that the therapeutic relationship can be negatively affected (19,32). This does, indeed, raise a conundrum and speaks to role-related issues. A worst-case scenario is one in which the patient develops his or her primary bond to the ICM—what was termed a boundary crossing above—to the detriment of the therapist. Such a situation detracts from the capacity of the clinician to be effective and situates the ICM in a position which would only make sense were he or she to be a psychiatrist or psychologist, and so on. To that end it remains imperative that the clinician and ICM take all steps necessary, including positioning in the treatment triad such that the primary contact is between the mental health professional and the patient.

Clinical intercultural competence includes knowing how to work with intercultural mediators

As a starting point, we echo Hunt and Swartz (54) as they call on clinicians to be sufficiently competent to work effectively with ICMs. What is most definitely not part of their job description is to compensate for the lack of cultural competence of health professionals. That is to say, 'cultural disqualification' emerges when mental health professionals disavow taking full responsibility for ensuring they have sufficient competence to work with their patients. Thus, our starting point is that ICM only is functional in the hands of a clinician with the necessary competence to work with patients from other cultures and with ICMs. In large part this means that there is a shared understanding of the role and function of the ICM. On this basis, then, it will require healthcare professionals to know how to communicate with a patient via the ICM, and how to avoid depositing in the ICM the responsibility for the communicative process. We shall take up this point further later.

As is well known, a tool, no matter of how high quality, is of little use if the user is uninformed and unskilled in its use and is unfamiliar with its functions. As Hunt and Swartz note:

> it is only if we are aware of the importance of the therapist's communicative competence that we begin to recognise the need to conceive of communicative competence more broadly when training therapists: the goal of therapists working with interpreters should be to attain communicative competence which includes an ability to work with an interpreter without losing focus or containment in therapy, as opposed to simply having the capacity to communicate effectively in a dyadic interaction (54, p. 101).[2]

Notwithstanding the need for competent ICMs, whatever their specific functions may be, mental health professionals must be prepared and competent to make effective use of what the ICM brings to the encounter. Thus, to begin with, the mental health professional will need to have some foundation in intercultural competence; as much as an ICM can facilitate communication, contextualize and clarify cultural dynamics, and provide linguistic interpretation, as noted, it never makes sense for the clinician to rely on the ICM alone to manage the cultural dynamics as these are far more complex than a simple 'this means that' sort of approach.

ICM competencies

See Box 38.1.

Given the precariousness of the specific roles/functions, training, and competence of different ICMs in different sites, countries, and so on, the mental health care professional needs to be cognizant of what the specific ICM she or he works with is competent to carry out. Further, and this is especially the case of psychotherapy, it is imperative that the clinician have a presession meeting with the ICM to outline the plan of action and review the methodology (predicated in large part by the competencies of the ICM) to be used. In addition to the ICM's competencies, it is also the mental health professional that must delineate how she or he would like to develop the mediated session, as per the requirements of the treatment being provided and the preferences of psychiatrist, psychologist, and so on. The onus, then, is first and foremost on the mental health care professional to determine how the work with be carried out. We reiterate the idea that the ICM is a 'tool' to be used by the practitioner; we do not believe that the ICM should have a protagonist role; for that to be the case they should then be a psychiatrist, psychologist, mental health social worker, or psychiatric nurse.

[2] Reproduced with permission from Hunt X, Swartz L. Psychotherapy with a language interpreter: considerations and cautions for practice. *South African Journal of Psychology*, 47(1):97–109. Copyright © 2017, SAGE Publications. https://doi.org/10.1177/0081246316650840.

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