Translinguistic Practice with Chinese Immigrants in New York: My Social Work Experience in Mental Health

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Abstract: A second-generation Chinese American describes and analyzes her experience as a psychiatric social worker in New York City. Her two-year clinical experience as a licensed master social worker (LMSW) with an average caseload of 150 patients who primarily speak Chinese has provided her with four major reflective findings. First, mental illness is strongly connected to the clients' perception of guilt, shame, and/or perceived wrongdoing. Second, healing is a culturally defined process during the course of therapy, not a final product after therapy. Third, language barrier is a two-way challenge for both the social worker and an immigrant client. Fourth, Asian clients who are present and future-oriented may be less willing to share past experiences. These clinical reflections address the importance of two "translinguistic skills:" overcoming the clinician's own fear of speaking the patient's language and helping the clinician hear the patient's familiar language about life challenges.

Keywords: clinical practice, translinguistic skills, linguistic competency, self-reflection, Chinese immigrants

I consider myself a bilingual social worker because I speak both Chinese and English. I was born in the United States speaking English fluently, and grew up within a family of Chinese immigrants from Hong Kong, speaking Cantonese from early childhood. After taking Mandarin in high school and college, I also learned how to speak and read in Mandarin and write Chinese characters. However, doubts about my bilingual competency crept in, particularly during the first month of my career as a psychiatric social worker in New York City, because I often compared my L2 (second language) Mandarin to my native tongue: English. Fortunately, I later learned to accept my doubts. My transcultural skills are enriched through this process of stepping into the shoes of my non-English speaking clients. Since I worked in a hospital setting, I will use "patient" to represent the primary client and "clients" to represent the patient and the patient's family. This paper aims to analyze my clinical reflections on the experiences I have while working at an outpatient psychiatric unit of a major hospital in New York City with primarily Chinese immigrant clients.

Collecting Evidence in a Clinical World

The data collection method is based on direct observations and documentation, which is a self-reflection approach to gather thoughts and ideas to share with fellow practitioners and my supervisors who are Chinese-speaking psychiatrists. Swenson (1998) calls this self-reflection approach a practitioner's privilege. My experience is unique and more than a privilege because I have gained a transcultural perspective, more specifically-a translinguistic approach, from receiving feedback from my clients. Added to McBeath, Briggs, and Aisenberg's (2010) definition of a transcultural approach-developing social work interventions that respond to the needs of clients across diverse cultural groups with proven clinical efficacy, the translinguistic approach which is built on the social worker's skill set aims to help both clients and the social worker break through their linguistic interaction awareness during the initial help-seeking stage.

To be linguistically aware, as an American-born Chinese practicing clinical social work with Chinese immigrants who do not speak English, I use a translation system with three languages, English, Cantonese and Mandarin to transition between each therapeutic moment. In other words, my clients hear me speak their language, but I am hearing, thinking, and feeling with different languages. Moving fluidly among these three languages is essential to strengthen the therapeutic relationship with the client.

In this experience, most of my patients were referred to my hospital by their primary physicians (58%) and from a psychiatric inpatient hospital (36%), to receive psychiatric outpatient treatment. The remaining (6%) are either self-referral or referred by another agency (e.g., Visiting Nurse Service of New

York). On a daily basis, I interviewed patients to assess their psychosocial functioning and then refer them to see a psychiatrist for their medication regimen. It is this hospital's policy that all psychiatric patients must see a social worker at least once a month while in treatment with a psychiatrist. In these past 20 months, the majority (90%) of my patients were Chinese immigrants from mainland China (Fujian and Wenzhou provinces), mostly from rural areas, and they spoke Mandarin and sometime with an ascent of their own dialect. Those who came from Hong Kong (6%), a special administration region (SAR) of China, spoke Cantonese and a little English. They saw me first before I arranged their psychiatric session with our Chinese-speaking psychiatrist. As their assigned psychotherapist, I monitored treatment progress on an average from six to twenty-four months.

Among my former patients, most (75%) were female who were employed in restaurants or other service business with low income eligibility for Medicaid. Seventy-seven percent were adults 18 to 69 years of age, 8 percent were 70 years and older, and 15 percent were children and adolescents below 18 of age. A typical female patient had been living in the U.S. for five years, married, and had children ages 3 to 6 years old. On the other hand, a typical male patient had either been divorced or never been married, and was referred by a psychiatric inpatient hospital facility. The male patients who were married had no or very little family support and disconnected from their children. Their illnesses included schizophrenia, adjustment disorder with either anxiety or depression, major depression, and schizoaffective disorder.

My reflections were recorded based on my clinical observations, peer reviews through weekly reflections, and supervision sessions. My direct supervisor was one of two Chinese-speaking psychiatrists in this hospital who provided me with guidance, mostly in areas of how to use the patient's cultural information to build rapport, work with patient's families, and pronounce medical terms that I have not learned in my Chinese classes, or my DSM courses. He also role played with me to help me understand how difficult expressing the symptoms in English were. The supervisory process involved case reviews, testing of theoretical assumptions, and case management reports. I also joined a weekly staffing meeting to report case progresses and identified skills used with the patients that had shown effectiveness. During these two years of practice, I used open-ended therapeutic questions focused for immigrant clients that were effective when counseling my Chinese clients, including factors associated with immigration decisions, cultural adjustments, securing work, accessing services, obtaining housing, and understanding the transportation system. There are four groups of clinical reflections I used, which can serve as helpful hints for clinicians who with immigrant clients from various ethnic backgrounds. These include validating the positive aspects of mental health, treating the clients as the expert, maintaining transcultural understanding, and focusing on future-oriented language.

REFLECTIONS

In line with the social work ethics to protect client confidentiality (Bennett, 2011), my clinical reflections are reported without any specific demographic information about these patients, such as age and gender of the patient when the patient's specific disorder is described. Direct quotes are used only when the disclosure of information would not be linked to the patient's identity. Quotations from my patients, if used in supporting these reflections, were translated from Chinese. Treatment consents signed by these patients including use of information for publications and professional presentations were obtained at intake.

Reflection 1: Validating the Positive Aspects of Mental Health

Although I was uncertain about my linguistic competency at the beginning of my career development, I learned from my clients that a clinician's competency is more than knowing the client's language. Competency must include genuinely appreciating the patient's culture, understanding the difficulties of using the language to express emotions and life issues, and providing a two-way means of communication for both the patient and the social worker or clinician to process concerns and solutions. Spano, Koenig, Judson, and Leiste (2010) report that this competency is an integrative and nonlinear perspective of cultural harmony, especially when both clients and clinicians

stand together at the "east meets west" juncture. During my first twelve months of intensively working with Chinese immigrant patients and their families in this outpatient psychiatric unit, my practice skill was enriched by the therapeutic connections made with these patients during as many as 50 one-on-one sessions per week. My patients found it difficult to attend group therapy, fearing that their issues would be publicly disclosed. This fear was exacerbated by the perception that the Chinese community is small, although the New York metropolitan area had the largest Chinese population – 695,000 – in the United States (U.S. Census, 2012).

Setting up a therapeutic goal that focuses on positive aspects of therapy has helped my patients disclose their concerns. For example, a male patient from mainland China who moved to the United States to re-unite with his son was reluctant to disclose his problem. I first highlighted his courage to seek medical help. After sensing that he became more comfortable with talking to me, I then encouraged him to share anything that would come to his mind. He said, "The United States does not seem to recognize my marriage nor believe that I am married to [my wife]." She was still living in China and was waiting to join the family in the United States. After having an opportunity to express his anger toward his current immigration issues, he opened up by expressing emotionally, "I feel interrogated like I am a communist even though I say nothing but the truth." Helping him focus on the positive goal of maintaining good mental health, he responded and ventilated his feelings. After I used a positive strategy to stress my patient's strength, over 80 percent of my patients began sharing their personal issues within the first two sessions.

Reflection 2: Healing is a Culturally Relevant Process-based Outcome

Healing is culturally defined as a journey, not solely a final product or expectation. The word "healing" in Chinese means the return to nature through reduction of worries and external dependencies. When my Chinese patients heard the word healing, they told me they automatically thought their physicians could recommend natural supplements or herbs to cure their illness. Prior to psychiatric treatment, many had been taking supplements that did not seem to work. These patients tended to seek medication for a quick-fix. However, they might have had a misconception that medication dosage could be a personal choice. Although the psychiatrists' recommendations were set for specific dosages, patients often asked how they could reduce their medication, especially at the start of treatment. More often than not, patients decided on their own to alter their medication dosage by cutting the pill in half or taking the pill only when they wanted to. As a result, many faced a higher chance of decomposition that brought them into the emergency room or psychiatric inpatient unit.

Psychoeducation around medicine management is important for immigrants who have been focusing on how they can "heal" faster. My finding is similar to another medical study about Chinese patients' medical noncompliance, which reported that older patients tend to have a higher level of medication compliance if their medication is covered by insurance or Medicaid and their illness contains chronic comorbidities. Meanwhile, younger patients tend to switch and discontinue their medication when they do not "feel" improvement (Lin, Jiang, Wang, & Luo, 2012).

Reflection 3: Accepting the Clinician's Own Language Barrier

Although speaking Chinese in daily conversations comes naturally to me, especially when I talked to my parents who were first-generation immigrants, I found that expressing my thoughts in a therapeutic setting with my Chinese clients was more difficult than expected. I experienced six major challenges:

First, Chinese is my second language. Because of my Chinese ethnicity, my Chinese patients make an assumption that I can speak fluently in Mandarin. As a result, my clients usually spoke very fast without thinking that I might not understand what they tried to convey. Nevertheless, since I grew up hearing my parents' Cantonese conversations, I found myself at ease when listening to my Cantonese-speaking patients.

Second, social workers are expected to show a full understanding of cultural diversity. However, my experience has shown me that I do not know all of

the cultural elements within the Chinese context since there are 56 Chinese ethnicities and over 2,000 distinctive languages, dialects and sub-dialects (Feng & Cheung, 2008; Gao, 2012). Chinese clients come from many regions of China. I respect cultural diversity, and I thought that I *must* use my emerging Mandarin skills in addition to my active listening skills. I thought I could receive and process sensitive information before responding to my clients' thinking pattern. However, when they used unique idioms or slang terms to illustrate their points, they could be lost in translation. As I am improving my language skills, I continue to appreciate how difficult it is for my Chinese-speaking patients to learn English as a second language during their adulthood. I learned that it is not shameful to disclose the fact that I have difficulty understanding my clients' conversations. With this disclosure, they often speak slower for me.

Third, I experienced barriers validating feelings in Chinese – whether in Cantonese or Mandarin. Throughout my childhood I learned to use academic or proper words in conversations; rarely do I express emotions in Chinese. Thus, as a clinician, I understand my clients also have difficulty expressing how they feel, especially when they tried to use English in a counseling session. When the question about feelings is asked, such as "What are some emotions/feelings you have after you shared your story with me?" my Chinese-speaking clients usually gave me a blank stare and did not know how to answer. The typical response was, "I'm good." To encourage their feelings, I created a feelings chart translated into the Chinese language: first, I asked my patient to engage in a matching game that involved matching facial and verbal expressions together, and then connecting that matched pair with their recent experiences or current emotions. The purpose of this game was to help patients understand the various emotions they might have. Give that many patients are not familiar with expressing their inner emotions with others, these game strategies have frequently eased my patients into opening up and expressing their emotions with me.

Fourth, many of my immigrant clients look for something quick and solution-focused. They would respond to me when I could provide them with concrete examples or goals. In order for my patients to "solve" their problems, I communicate with them that they must take smaller steps to achieve a long-term goal. The therapist would ask the patients to provide examples of how they achieved accomplished goals in the past. Specifically with working with Chinese immigrants, many would say "I want my (or my relative's) mental illness to go away now." Many times my patients' goals, especially patients with severe mental illness, are unattainable within a short time frame. Being honest and informing them about a more reasonable goal, and that the illness may never completely go away but can be stabilized, is a message I convey to my patients. At this stage, the clinician must develop working hypotheses to understand the patient's thinking and preference. After I have tested that my patients want to establish certain concrete goals (such as cutting down on medication use) during the first meeting, I work with them to design a plan of their cultural and individual strengths (such as emphasizing self-actualization through the immersion of their cultural beliefs) without forcing them to immediately disclose their problems.

Fifth, psychotherapy is not within the vocabularies used by my immigrant clients. When speaking about their problems, my clients usually avoided using terms that describe a mental illness. In Chinese, many translated terms have negative connotations such as *bing mo* (devil's illness) and *zhi bi zhen* ("mind shut-down disorder" referring to autism). Beyond modifying these translations, it is also important to educate the patients about being mentally healthy.

Sixth, language barrier affects not only the client, but also the clinician. I initially learned Chinese through my parents. I spoke Cantonese, not Mandarin, at home. When talking with my Mandarin-speaking patients, I have a translating process that goes through my mind. Initially, I translate the Mandarin spoken into Cantonese. These two languages are similar, except that Mandarin has five tones and Cantonese has nine, meaning that speaking a different tone changes the entire meaning of the word. Immediately after, I search for phrases in Cantonese because this language is more comforting for me. Within a second, I translate the Cantonese to English. Since I learned my clinical skills in English, it comes more naturally for me to reflect, validate and paraphrase in English. Once this translation process is complete, I can quickly gather

my thoughts in English, translate them back to Cantonese, and then to Mandarin so my clients can understand me. I call this an L3 (three-language) translation process. I do not use it in conversations with my Mandarin-speaking friends because casual talks do not require professional translations. Nevertheless, I learned how this language barrier has affected my confidence in my role as a bilingual psychotherapist. As I excel in my bilingual skills, I must also learn from my clients about what they have gone through as new immigrants so that I can become their bridge for analyzing their life stressors. In translinguistic counseling, I become more aware of using transference skills to fulfill my role as a therapist who speaks the client's language, or the "transitional object," and helps the client explore the link between the past and the present, or between the past and the future (Kitron, 1992, p. 235). Through this process, I have been learning more about a culturally sensitive meaning of empathy; a client's language adaptation can guide a clinician in understanding more about a professional's own limitations and strengths. This challenge has helped me refine my clinical skills.

Reflection 4: Focusing on Future-Oriented Language

Narrative techniques have been proven as effective when they are used to assist clients to disclosing their past, specifically unresolved issues that have carried guilt and shame and have affected their current behaviors (Miller, Cardona, & Hardin, 2006). By sharing their past stories or rewriting the past to lead to a hopeful future, many clients begin to gain insight on resolving their current difficulties (Hester, 2004). When I was a graduate student learning clinical skills, I learned from research-based literature that supports the act of revealing childhood experiences, such as the use of interpersonal intervention described in Lemma, Target and Fonagy (2011) and the time-limited intermittent therapy described in Smith (2005). My English-speaking patients are usually ready to share their childhood experiences and happy or sad moments with their families, friends or schoolmates. However, I found that most of my Chinese immigrant clients do not respond to this technique starting with "tell me about your childhood." Patients born and raised in the United States could usually describe their relationships with family members, their feelings toward their caretakers, experiences in school, or other traumatic experiences such as the death of a primary caretaker. These disclosures seem to come naturally as the content is culturally or contextually relevant to them. However, in my psychiatric unit, using this past-present transmission technique or any childhood-focused technique has not been viewed as an effective ice-breaker tool. For example, my immigrant patients were reluctant to disclose anything about their lifestyle in China, fearing that I might judge them in a negative way. Although they might hold the belief that their past is irrelevant to their present or future, many of them are ready to share recent changes to their lives, such as transitioning into a new country and voicing their concerns about the difficulties of their immigration journey. A middle-age patient who was diagnosed with major depressive disorder reported in a follow-up session, "I didn't want to talk about my childhood because it was sad. *Shuan la* (Just forget it)! I don't want to remember those horrific times." Instead of discussing the past, which might have caused too much pain, this patient expressed that addressing her current immigration situation was much more helpful.

In my experience, some Chinese immigrants refused to go into detail about their past, particularly those who went through cultural revolution in China due to unwanted memory or trauma related to their migration experiences. Although it's not uncommon for patients with traumatic experiences to refuse or even dissociate from their memories, my patients' pasts were compounded by social, political and economic injustice, in addition to their current family problems. It is more important to establish rapport with a focus on emotional security, as this grounding work helps patients understand their habitual use of "emotional reactivity and maladaptive coping strategies" to deal with memories that may cause further trauma (Regambal & Alden, 2009, p. 155). When my patients saw their past as irrelevant to current problems, or when they said that their health had been affected mainly by post-immigration issues such as cultural shock and their double-identity between being Chinese and American, I could help them find a way to reestablish their emotional stability. The past-oriented technique may generate a resistant response, such as "I don't know what you want me

to say," or "I have nothing to say about my childhood," or even "I don't want to talk about my childhood, just let me see my psychiatrist." Relating to these responses, my focus could not be on exploring their past, but instead on asking about their present issues or challenges that have been perceived negatively by others. Combining this present-future focus with a strength-based approach, I have gained trust from my clients while they were finding ways to reach a concrete and achievable therapeutic goal.

CLINICAL IMPLICATIONS

Learning from Clients to Develop Clinical Skills

A recent study has tested that the effort to match the client with a same-ethnic clinician may not be the sole factor that makes treatment effective. Farsimadan, Draghi-Lorenz and Ellis (2007) found in a random assignment experiment of 100 ethnic minority clients that those who had expressed their matching preference showed better outcomes than those who did not express a preference. My supervisor shared with me that my reflections would help other clinicians learn to be a good listener, as my experiences have also led me to use better empathic skills. The act of helping my clients reveal their problems and strengths is a great way to reflect upon my own limitations. From this reflection, I have adjusted my clinical skills in six ways:

1) Focus on present and future instead of the past: Instead of "Tell me about your childhood," ask, "Tell me what made you decide to move to this country," or "Who made this decision?" "What influenced your decision to move here?" "What did you do to prepare for this immigration journey?"

2) Identify the clinician's own language strengths and limitations: I have asked the clients to speak slowly on numerous occasions. To validate the client because of our language barrier, I often say, "I too have an accent when I speak Chinese because I am an ABC (American-Born Chinese). Chinese is my second language so please let me know if you need me to repeat something for you."

3) Encourage clients to talk more: Social workers are good at talking, but when their clients are reticent, they must remember how to use skills to motivate clients to express feelings and thoughts at their own pace. Instead of asking more questions after an intake interview, for example, a competent worker may say, "I've been asking you some questions. Now, it is your turn." If the client remains silent, then use prompting techniques such as "tell me a word that comes to mind" or "describe yourself as a Chinese in a non-Chinese environment" or "name someone in your family who you would like to talk with."

4) Dispute negative associations to mental health: Frequently I provide psychoeducation to my patients around their illness. Many patients tend to feel stigmatized and negatively labeled when diagnosed with a mental health issue. By normalizing the situation and providing statistical evidence to my patients about the characteristics of people who have been affected by mental health issues, they begin to feel hopeful about treating their illness and not feel negatively labeled. Since many mental health diagnoses do have a negative connotation, social workers should ask their clients to reframe these terms into positive ones. These translated terms must be modified to relate to the "positive health" perspective. However, it is difficult to change the scientific terms even though they are negatively impacting my patients' psychological well-being. They may have a perception that seeing a psychotherapist means that they have been chi xian (insane in the mind). In this process, I usually say, "The Chinese translation of this illness is X. It actually means you are feeling Y or acting Z." Using concrete measures can help clients understand the illness and find ways to heal.

5) Remove labels: Hear the client's perspective first, analyze the situation, and contextualize the problem as it is related to the client's current situation, such as how an illness may be a response to adjustment or coping. Sometimes, I inform the clients that we may use a medical term to represent this adjustment issue simply for insurance purposes but we will focus on the solution, not putting a label on the problem.

6) Use creative means to make the client's

translation process easier: As I develop more skills to work with my patients, I find that when they do not feel like talking, they can write down thoughts in their own language, as the expression is therapeutic to them without external judgment. By means of these writing exercises, many patients disclose their difficulties and shame, and use culturally appropriate terms to translate the illness to fit their definition or experience of the situation.

CONCLUSION

As a bilingual social worker, I found that the so-called "language barrier" is labeled as a problem faced by new immigrants, which is only a one-sided view; the other side of this "barrier" is actually the social worker's main challenge. Language barriers are indeed a clinician's issue. There are key issues to keep in mind when working with the Chinese-speaking population, specifically with mental health illness. First, a clinician should be aware of the client's boundary limits relating to the past, and especially sensitive to the client who may not want to reveal their childhood or warfare experiences. Secondly, the clinician can address and normalize the difficulty of the language barrier so that the patient is not alone with having language difficulty, as the clinician may also be experiencing similar challenges. Lastly, since mental illness is a taboo subject among many Chinese-speaking patients, it is critical to provide psychoeducation to emphasize the positive aspects or the achievement of good mental health for these patients. It is also essential to validate and praise the patients for taking steps to seek help from mental health professionals. All of these findings point to the use of two translinguistic skills that bilingual clinicians must deal with: overcoming the clinician's own fear of speaking the patient's language and empowering the patient to use his/her own language to address life challenges.

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