The Need for Gender-Sensitive Medical Interpreters for Victims with Limited English Proficiency in Sexual Assault Examinations

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ABSTRACT. The difficulties and trauma associated with sexual violence are exacerbated by language difficulties. Language difficulties pose particular barriers in accessing legal, social, medical and support services. This presents additional challenges for sexual assault response teams (SART). The SART members serve critical functions in supporting a victim of sexual violence from trauma to trial.

This paper addresses the need for trained gender-sensitive medical interpreters for adult female victims with limited English proficiency (LEP) in sexual assault examination, and thus the need for inclusion of trained medical interpreters in SART. Such needs were articulated from interviews with advocates and medical interpreters in the US, from literature reviews and conversations with women with LEP in the US. The paper closes with a set of specific recommendations that will promote comfortable accessible service to female victims of sexual violence with LEP.

KEYWORDS. Sexual assault examinations, sexual assault response team, limited English proficiency, medical interpreter, gender

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Journal of Immigrant & Refugee Services, Vol. 3(3/4) 2005
http://www.haworthpress.com/web/JIRS

doi:10.1300/J191v03n03_05

Sexual violence[1] affects every culture and race. As the diversity of the community grows, so do the needs of sexual assault victims.[2] The difficulties and trauma associated with sexual violence are exacerbated by language difficulties (Personal communications with Laura Zarate, March 16, 2002). Language difficulties pose particular barriers in accessing legal, social, medical and support services (Abraham, 2000; Asian Women's Shelter, 1999; Bauer, Rodriguez, Quiroga & Flores-Ortiz, 2000; Bonill-Santiago, 1996; Chang & Fortier, 1998; Lang & Brockway, 2001; MacLeod & Shin, 1993; Potocky-Tripodi, 2002; Randall & Haskell, 1995; Sockalingam et al., 2001; Song, 1996; Working Group of the Minnesota Interpreter Standards Advisory Committee, 1999). This is particularly true for immigrants and refugees (Potocky-Tripodi, 2002).

This problem presents additional challenges for sexual assault response teams (SART). The SART members serve all critical functions in supporting a victim of sexual violence from trauma to trial (Ledray, 1996, 2001; Little, 2001). In order to provide accessible service to all, a SART should include as members, all persons who come in contact with a victim. In addition, a SART should make sure that these individuals represent the communities being served.

This paper addresses the need for trained gender-sensitive medical interpreters for adult female victims with limited English proficiency (LEP) in sexual assault examination, and hence the need for inclusion of trained medical interpreters in SART. Such needs were articulated from interviews with advocates and medical interpreters in the US, from literature reviews and conversations with women with LEP in the US. The author presents an urgent need for interpreters in SART from various relevant backgrounds, since no comprehensive studies are available at this time. The paper closes with a set of specific recommendations that will promote comfortable accessible service to female victims of sexual violence with LEP.

BACKGROUND

Population with LEP and Health Disparity

In 1990, over 32 million US residents older than age 5, about 14% of population, do not speak English as primary language (Chang & Fortier, 1998). It is estimated that Hispanic and Asian population many of whom have LEP will increase by more than 100% each by year 2030

(Scott-Collins, Hall & Neuhaus, 1999). In Minnesota, at least 200,000 people or one out of every 20 Minnesotans have LEP (Working Group of Minnesota Interpreter standards Advisory Committee, 1999). These changing demographics provide richness of diversity in life, but they also present new challenges to existing health, legal and social service providers. Because of language barriers, millions of US residents cannot have access to health care (Baker, Parker, William, Coates & Pitkin, 1996; Bauer et al., 2000; Betancourt & Jacobs, 2000; Woloshin, Bickell, Schwartz, Gany & Welch, 1995). Language barrier contributes to high disparity in access to health services. The use of an interpreter is the standard solution to language barriers; however most hospitals do not have professional interpreters routinely available and they are forced to rely heavily on family members, hospital staff and other ad hoc interpreters (Baker et al., 1996).

People with LEP are not likely to seek health care services unless the providers meet their linguistic needs (Bauer et al., 2000; Betancourt & Jacobs, 2000; Chang & Fortier, 1998; Sockalingam, Brown & Jones, 2001; Wolosin et al., 1995). Difficulty in speaking and understanding English added to their isolation and created impediments to health care. To cope with language barrier, many women minimize their interaction with others in order to avoid the humiliation, embarrassment and frustration of not speaking the language (MacLeod & Shin, 1993). MacLeod and Shin (p. 37) further introduce LEP women's voice that they lost patience with themselves and others, and felt angry at times when talking to English-speaking social service providers. Matched with interviews from social service providers in Minnesota, women seem to feel powerless when facing language barrier in health services (Personal communication with B. Clairmont, July 18, 2003).

When patients are dissatisfied with the service, they may avoid follow-up care (Brown, 2001; Personal communication with N. Thao, April 3, 2002). Since many of LEP communities depend on word-of-mouth communications among themselves, one patient's dissatisfaction will be conveyed within the entire community; thus possible patients may delay seeking care until their conditions become critical (Riddick, 1998).

The Case of Women's Health

Language barrier is especially problematic in women's health where there are many sensitive components to care (Potocky-Tripodi, 2002). Woloshin et al. (1995) indicated that women with LEP were less likely to receive mammograms, breast examinations, and Pap smears than

their English-speaking counterparts. Betancourt and Jacobs (2000) introduced the case of a woman compromising the medical care without professional interpreter; where medical resident had to give up providing Pap smear to woman since she had LEP and her young son was interpreting for her.

Second language competency may decrease dramatically in times of crisis or in traumatic or emotionally charged situations (Personal communication with K. Moacheupao, February 5, 2002). A person's ability to comprehend and communicate can become limited in stressful circumstances including the case of sexual violence. This can occur even when a person is normally quite confident and fluent in English.

Language barrier not only influences direct quality of care, but it also impacts on informed consent (Betancourt & Jacobs, 2000). Even when done in English with native English speaker, obtaining informed consent for preventive test and emergency hysterectomy or cholecystectomy, or end-of-life decision making can be difficult and time consuming. Explaining such procedure to women with LEP can be complicated without professionally trained interpreter.

Use of ad hoc interpreter undermines confidentiality of patients. Particularly, in the case of sexual violence, when members of the community or family commit violence, use of family member to interpret compromise the safety of patients. Using children as an interpreter may potentially expose them to sensitive information and invert family dynamics.

Prevalence of Sexual Violence

Sexual violence impacts all women (Randall & Haskell, 1995). In the US, it is estimated that one in five women will be raped in their lifetime (Koss, Gidycz & Wisniewski, 1987). Women annually reported about 500,000 sexual violence (Bachman & Saltzman, 1995). Including non-reported case, statistics increased to 683,000 women being victims of sexual violence (Kilpatrick, Edmunds & Seymour, 1992).

Since sexual violence is considered the hardest crime to name (Abraham, 1999), we cannot rely solely on criminal justice statistics. For instance, non-criminal setting study found that only between 10 and 30% of victims who had experienced sexual violence actually reported the incidence to the police (Ringel, 1997; Russell, 1982). Especially for women with LEP, language barrier and historical relationship with law enforcement in this country and country of origin make it even more

difficult to feel comfortable in reporting crimes (Asian Women's Shelter, 1999; Feldman-Summers & Ashworth, 1981; MacLeod & Shin, 1993; MN Casa, n.d.). Furthermore, for refugee and immigrant women who have experienced sexual violence from the legal authority such as police in the country of origin or refugee camp, distrust for the law enforcement actually triggers some trauma when they interact with such authority (Potocky-Tripodi, 2002). In this regard, we can assume that there are more cases of sexual violence than reported cases, particularly in the LEP communities.

According to the US Department of Justice (1988), rates of violent crime reported to the police are highest for people who live in the inner city, are of lower socioeconomic status, and are members of ethnic minority groups. Sexual assaults reported to the police follow the pattern cited above. The studies have not examined the reason for reluctance to report sexual violence, how lower rates of report reflect protective mechanism within the culture and different understandings of what constitutes sexual violence within specific ethnic groups. Other reported rates of intimate partner violence found that all racial minorities experience more intimate partner violence than do whites (Tjaden & Thoennes, 1998). However, with regard to post-sexual assault services utilization, reporting of such violence varies among women of diverse backgrounds. African-American and American Indian women report significantly higher rates of intimate violence than women do from other ethnic backgrounds (Tjaden & Thoennes, 1998). Again, reasons for reporting disparities are not well studied. However, the author thinks that language barriers other ethnic groups have, compared with African-American and American Indian, may be one reason for the reporting disparity. Researchers also have noted that sexual violence has a special location in time and culture–its definition, structure and social response to it (Abraham, 1999; Bonilla-Santiago, 1996; Pierce-Baker, 1998; Song, 1994).

Existing Research and Services on Sexual Violence

Theories and intervention against sexual violence have been shaped in response to the experiences and needs of White, middle-class women. Western middle-class values are embedded in both research and service provided for the victim (Holzman, 1996). Only within the last 10 years, researchers and practitioners have begun to address the concerns of the experience of sexual assault among women with LEP, particularly within the context of domestic violence (Abraham, 1999; Asian Women's

Shelter, 1999; Bonilla-Santiago, 1996; Ho, 1990; Song, 1994). Among such studies, language barriers have been addressed as the primary factor for women with LEP for not seeking medical assistance.

Utilization of Health Care by Victim of Sexual Violence and Development of SART

Although most of sexual assault survivors do not sustain serious physical injuries as a result of the assault, many survivors still access the medical system for sexual assault examination which includes forensic evidence collection, medical care, sexually transmitted disease treatment, HIV/AIDS testing and emergency contraception (Kilpatrick et al., 1992). Several research studies indicate that abused women constitute a significant proportion of female patients seeking emergency medical service, obstetric care and primary need care (Gin, Rucker & Frayene, 1991; Glander, Moore, Michielutte & Parsons, 1998; Hamberger, Saunders & Hovey, 1992; McFarlane, Parker, Soeken & Bullock, 1992). Among Latina (mostly Mexican) seeking prenatal care, 14% reported some form of sexual violence during pregnancy (McFarlane et al., 1992). Given the fact that health care facilities are a common point of entry for survivors of sexual violence, the experience at the medical system plays an important role in victim's recovery (Cohen, Donohue & Kovener, 1996; Ledray, 1996, 2001; Little, 2001).

In reaction to the inadequacy of the traditional model for sexual assault medical evidentiary exams, in 1997 the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) first required health care facilities to have protocols on rape, sexual molestation and domestic violence (Ledray, 2001). While JCAHO does not require specifically trained Sexual Assault Nurse Examiner (SANE) to be present at evaluation, such requirement means that all medical facilities must identify and provide appropriate and complete services to victims of rape and abuse (Ledray, 2001). Before initiation of SANE programs, untrained emergency department staff (EDS) provided medical care and collected forensic evidence. It took at least 4-10 hours for EDS to provide necessary care, while SANE does for a maximum of 3 hours (Little, 2001). This was due to (1) lack of special training on the EDS and (2) EDS's perspective that needs of victims of sexual violence are less urgent than those of other patients because the majority of these victims do not sustain severe physical injuries (Little, 2001). Through the traditional model, victims are often re-traumatized when they come into contact with hospital emergency departments for medical care and

follow-up service with law enforcement (Little, 2001). To be most effective and to ensure victim-centered approach, it is essential that SANE or any other medical care provider works within a coordinated SART to prevent further victimization (Brown, 2001; Ledray, 1996, 2001; Little, 2001). In existing studies, they have the required SANE or medical care provider, advocate, law enforcement officer and a prosecutor in the SART (Brown, 2001; Ledray, 2001; Little, 2001; MN Casa, n.d.). However, none has mentioned the interpreter as a possible SART member. Ledray (1996) very briefly mentions how to work with interpreter in sexual assault exam. No other academic studies or practice manuals on sexual violence intervention or prevention mention the role of interpreter in medical, legal or general advocacy setting in depth.

In my personal experience working as a concerned person for victims of sexual violence with LEP and an advocate for victims of sexual violence with LEP, none of the EDS members or any SANE asked my friends or clients of their need for interpreter at sexual assault examination in Fairview University Hospital. Similar cases were discussed at an interview with K. Mouacheupao. Often we as a bilingual or multilingual person present at the hospital are used as an ad hoc interpreter without consent of clients or person present (Personal communication with K. Mouacheupao, February 5, 2002).

General Lack of Trained Medical Interpreter

Despite the federal mandate, the Title VI of Civil Rights Act of 1964, which requires all federal agencies and federal-funded services to provide meaningful access to LEP persons, many health care services still fail to provide linguistically appropriate service to people with LEP (Baker et al., 1996; Bauer et al., 1996; Woloshin et al., 1995).

Most American physicians are probably not sufficiently bilingual to practice in a language other than English (Woloshin et al., 1995; Working Group of Minnesota Interpreter standards Advisory Committee, 1999). For instance, there are nearly 50,000 Hmong people living in Minnesota, the state has only 6 Hmong speaking physicians (Working Group of Minnesota Interpreter standards Advisory Committee, 1999). While commonly available in other environments such as diplomacy, international business and legal setting, professional interpreters are rarely available in health care (Woloshin et al., 1995). In Minnesota, Hennepin County Medical Center's 46 interpreters served over 54,000 individual patient visits in 1997 (Working Group of Minnesota Interpreter standards Advisory Committee, 1999). When interpreters are

not available, medical providers utilize (1) their own language skills, (2) family or friends or (3) other ad hoc interpreters such as bilingual strangers from the waiting room or other hospital employees such as clerks or custodians called away from their regular job responsibilities (Bauer et al., 1996; Woloshin et al., 1995; Working Group of Minnesota Interpreter standards Advisory Committee, 1999). Furthermore, Baker et al. (1996) stated that interpreters are often not called even when language barriers are present. Interpreters are often called upon only at the discretion of health care workers, not from the requests of clients. For instance, among Spanish-speaking sample, Baker et al. (1996) found that 87% of patients who did not have an interpreter thought one should have been used.

Even when it is advertised that multilingual service is available, adequate interpreters seem to be difficult to obtain and prolonged the waiting time for the patients (Bauer et al., 2000; Warrier, n.d.).

The lack of professionally trained interpreters compromises on information transfer. It impairs the evaluation of the symptoms by the physicians and results in misdiagnosis. This can prove to be expensive since unnecessary tests may be ordered. This can also create frustration in both medical service provider and clients.

When ad hoc interpreters (be it family or stranger) are used, they may lack sufficiently good language skills to interpret which can affect medical care. In one study, ad hoc interpreter demonstrated 23-52% of words and phrases interpreted incorrectly (Ebden, Bhatt, Carey, & Harrison, 1998).

Maintaining confidentiality will be very difficult when ad hoc interpreters are used. Not only will it endanger confidentiality of the patients, but it will also endanger the trusting relationship between medical provider and clients. Such a case may inhibit the patients from disclosing necessary information.

Medical service provider's lack of professionally trained interpreter usage could miss important underlying psychosocial problem such as domestic violence. Patients with LEP may want to further explore their condition and want to tell more about their condition to physicians, but without trained interpreter, such further commitment with medical providers are limited.

Not having an interpreter greatly influences patients' perceived knowledge of their diagnoses and treatments. Only 38% of patients who did not have an interpreter when one thought it was necessary to have interpreter said that their understanding of their condition was good to excellent (Baker et al., 1996). Baker et al. (1996) also suggested that

there were better compliance with follow-up when interpreter existed in their first appointment.

Need for Gender-Sensitive Interpreter for Victims of Sexual Violence

It is strongly recommended that service providers arrange for trained female interpreters to be engaged for an assignment involving female victims of sexual violence (Asian Women's Shelter, 1999; Lang & Brockway, 2001; MacLeod & Shin, 1993; Mulvihill, Mailloux & Atkin, 2001). Victims of sexual violence prefer to have female professionals as they are most often raped by a man and experience the same generalized fear and anger towards men (Ledray, 1996). There is no comprehensive statistics on the gender of professional interpreter to date. However, Hmong interpreters in Minnesota indicated that there are more Hmong male interpreters than female interpreters especially as court interpreters (Personal communication with N. Thao, April 3, 2002).

Acknowledging sexual violence as largely male perpetrated, many social services for victims of sexual violence have women-only policy (Asian Women's Shelter, 1999; Asian Women's United of Minnesota, 2000). This gender exclusivity rejects male help and simultaneously rejects the notion of men as experts and authorities over women, and rescuers and protectors of women. This exclusivity for women does not limit itself to its clients, but also for its workers and volunteers. Whalen (1992) points out that traditional approach of male help has been largely found in many medical models.

RECOMMENDATIONS FOR PRACTICE CHANGE

From reviewing existing studies, practice, interviews and personal experience, the author found that there is no comprehensive study about interpreters in sexual assault examination or SART despite growing number of women with LEP visiting medical care. Although increased attention has started to focus on development of professionally trained medical interpreter (Bauer et al., 1996; Chang & Fortier, 1998; Woloshin et al., 1995), the need for trained medical interpreter with specialization has not been discussed. In this part of the paper, the author recommends practice changes in sexual assault examination and SART to expand and enhance services for victims/survivors of sexual violence with LEP. The following recommendations require flexibility and creativity to

expand and enhance services for victim-survivors of sexual violence with LEP. In each recommendation, involvements of survivors' opinions are indispensable to reflect real needs and voices of service recipients.

Research and Data Development

Research is needed to bolster anecdotal evidence of the extent of need for interpreter in sexual assault examination (Baker et al., 1996; Bauer et al., 2000; Betancourt & Jacobs, 2000; Chang & Fortier, 1998). This research should be inclusive of all groups that comprise women with LEP and highlight the differences as well as the similarities of the groups. Specific research on the sexual violence among women with LEP is urgently needed to evaluate the need for interpreters in its intervention program. Gender based analysis and diversity analyses are needed at all levels of research. Research can help identify and/or develop models, best practices, training, program development, service delivery and policy development.

Collaboration/Coordination of Services

Existing members of SART, former service recipients, bilingual advocates, ad hoc medical interpreters, trained medical interpreters, and trainers for interpreters should work together to define the needs, roles, duties and responsibilities of trained medical interpreters in responding to sexual violence. The group may need to consult the community members for its cultural competency and understanding. Through open dialogue, interpreters and their trainers should learn the basic terminology needed to provide comprehensive interpretation services. This would form the foundation of all cooperation, coordination and collaboration. Extended SART members should also work together to provide outreach programs to communities with LEP about sexual violence and availability of sexual assault examination programs in local hospitals. Collaboration should be able to refer victims to other direct service programs when necessary.

Development of Trained Medical Interpreter

National Council on Interpreting in Health Care, together with institutions developing medical interpreter must urgently develop national standards for medical interpreter to provide consistent interpreting services (Chang & Fortier, 1998; Downing & Roat, 2002). Development

of courses on both general and specific areas of medical interpretation is needed to serve the clients better (Downing & Roat, 2002). Training should be conducted on both academic and non-academic settings. Health care providers should also learn how to work with medical interpreters in the process of setting up the multilingual services. Communities with LEP population should help development of professional interpreters by recruiting possible interpreters reflecting specific population. Visibility of interpreters in the community will also serve as part of the outreach services. To develop gender sensitive interpreter, aggressive recruitment of women should be done within the communities.

Outreach Program

Standards for accurate and appropriate translation must be developed to widely distribute information on sexual violence and sexual assault examination programs. Existing programs need to be better publicized in appropriate language, and with cultural sensitivity which reflects the all levels of the communities. Usages of ethnic radio, TV programs and ethnic newspapers are a few examples of such outreach programs (Asian Women's Shelter, 1999; MacLeod & Shin, 1993). Appropriately translated materials about sexual violence and sexual assault examination should be published and distributed through religious institutions, health care services, schools, restaurants, beauty salons, grocery stores and day care services. Development of clearing houses (web based) to promote sharing of appropriately translated materials will enable wider distribution of the materials to the underserved communities and service providers who have just begun to provide services.

Funding

Consistent and adequate funding is necessary for training and dialogue. Disadvantaged Minority Health Improvement Act of 1990 made additional funds available from Department of Health and Human Services and Bureau of Primary Health Care (Jackson, 1998). These funds should be readily available to develop programs to provide health care in the languages of the intended recipients. Additional encouragement to public institutions to allocate resources to ensure the health care access for people with LEP is needed.

Because patient's beliefs about health are largely culturally determined, confusion can occur even when interpretation is accurate. However, competent interpretation is the necessary first step in providing culturally

appropriate care (Beltran, 2001; Brown, 1992; Chang & Fortier, 1998; Downing & Roat, 2002). Increasing collaboration between mainstream services and ethnic communities will be the learning place for cultural health concepts for both parties, thus promoting cultural understanding if not cultural competency for future services.

Discussing sexual violence or violence against women within certain communities may become obstacles due to their belief in the traditional gender role (Asian Women's Shelter, 1999; MN Casa, n.d.; Immigrant, Refugee and Visible Minority Women of Saskatchewan, 2001). Also when perpetrators of such violence are from the community, the community may choose to protect its name over the safety of women in the community. However, to protect all citizens from violence, the advocates should communicate to all communities that violence on anyone should not be tolerated. Discussion with community leaders will be a key to the success for implementation of recommendations particularly with regard to outreach program and recruitment of possible interpreters.

Not addressing the issue of sexual violence within the ethnic community means continuing high rates of not reporting the case and silencing the victims, thus maintaining health care disparities among people with LEP. Fundamentally, it endangers the safety of all people within the ethnic communities.

CHALLENGES TO IMPLEMENTATION

Implementations of the above recommendations can be unstable with the political environment of the country. Weight of the opinion about immigrant shifts according to the dominant political model. Also support for policies about violence against women has always shifted through the political upheaval (Gordon, 1988). Current Bush administration has cut tremendous amount of funding for Office for Violence Against Women and changed the policy towards immigrants to more be conservative, especially after September 11, 2001. Constant and consistent lobbying from citizens' organizations will be vital to provide stable and consistent health care access for immigrant women or women with LEP. Such actions can be called for morality of the citizens, providing basic human rights to all.

Burdens of certain professional interpreters could be heavy. For instance, interpreters for certain languages could be in greater demand than interpreters for other languages. Long hours of working in sexual assault examination are stressful. However, it is professionally unethical

for more than one interpreter to provide interpretation for one patient at a time (Downing & Roat, 2002). In this sense, team support within SART or other interpreters will be necessary. Needs assessment of the community should prepare multiple interpreters of certain languages reflecting the size of the community.

CONCLUSION

The goal of this paper was to address the need for trained medical interpreter in sexual assault examination. Through open dialogue, themes identified here should serve to inform trained medical interpreter, medical and social service providers, educators, researchers and policy makers about intervention and prevention towards victims of sexual violence with LEP. Additionally, this study should be translated in languages other than English to increase awareness within the community with LEP and enhance their involvement in the discussion.

NOTES

1. In this paper, I have limited the use of the term sexual violence in its meaning to include rape, sexual assaults and manipulation of reproductive rights. I have no intention to exclude any unwanted sexual acts such as verbal sexual harassment and sexual control by using "sexual other." However, since I aim to explore need for medical interpreter in sexual assault examination, limited terminology is employed in this study.

2. For the purpose of this study, I use the term victim to reflect female. Thus, the victim is referred to as she and the perpetrator as he. This is supported by the wide understanding that men are typically the perpetrators of sexual violence (Koss et al., 1994; Tjaden & Thoennes, 1998). In addition, I use the term victim–survivor and victim interchangeably. In recent feminist argument, the term victim is avoided to take away the stigma that the victim is powerless; however, I argue that avoiding the term victim will depoliticize the act of violence and obscure the accountability of perpetrators. Hence I use the term victim to emphasize the accountability of perpetrators.

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