Working with Monolingual

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Tailoring a therapeutic approach to the patient's needs is always balanced against the importance of grounding one's clinical work in sound theory. Working with a specialized population is no exception. However, selecting an applicable theory and making adaptations is a challenge for the clinician.

The setting is an intermediate care hospital at South Beach Psychiatric Center where eight beds, designated for monolingual Chinese patients from Brooklyn, Manhattan, and Staten Island, have been set aside within the Bensonhurst unit. These patients are transferred to a state facility after a period at an acute hospital when patients need further stabilization or placement.

The Chinese patients speak one or several of the following languages: Mandarin (the national language), Cantonese, Fuzhounese, Toisanese, and, less frequently, Hakka, Wenchounese, or Shanghainese. In the past, such patients were scattered across various state hospitals where staff was forced to scramble to find translators, or, by default, use untrained and possibly

unreliable sources, such as cleaning and kitchen staff or friends and family of the patient. Clinicians who spoke the language were occasionally called in, but the patient's progress could not be monitored day-to-day, even for mental status.

The need for such a specialized language unit evolved from experiences such as the incident in Illinois, many years ago, when a Chinese man was hospitalized for years for Schizophrenia. The case gained notoriety when it was discovered, after finally being interviewed in Chinese, that the patient was not psychotic.

Over time, events such as the suicide of a Chinese patient, who seemed stable and without complaint, at a state hospital, were a wake-up call for serious changes in service provision to those whose primary language is not English.

While it may not be practical to create units for all possible smaller populations, the Spanish-speaking community led the way in the fight for a language-specific unit. The Asian community followed and New York State was responsive, as it provided language-specific care for Chinese- and Korean-speaking patients. Since then, an unofficial unit serving Russian-speaking patients has also come into being.

An intermediate care setting is somewhat different than an acute ward. Acute hospitals serve patients who are in the crisis phase of their illness. By the time patients becomes "state-bound" for intermediate care, they have spent a month, or possibly several months, in the acute hospital. Reasons for transfer include further stabilization, placement, or forensic status requiring long-term observation. In the case of the Chinese unit, patients also are transferred for treatment in the patient's language.

The Advantages of Having a Similarly Cultured Staff

Providing treatment in the patient's language is critical in the day-to-day evaluation of the patient's progress, particularly for suicidal patients and psychotic patients who have unstable periods. Immediate interventions in the patient's language are crucial to decrease misunderstandings and increase intended communication.

In settings without translation, communication occurs (and good treatment can be provided), but it is hard to assess whether the communication is what is intended. Projection occurs whether or not communication is in the patient's own language, but much more room is left for the imagination if it is not. Reduction of ambiguous communication is a vital part of the patient's grasp of reality, control, and clarity.

Most recently, an English-speaking nurse coordinator was trying to prevent a Chinese patient from eating too quickly and choking. Because the

Chinese-speaking patients

patient was not responsive, the nurse spoke louder (saying the same well-intended words) during the second and third requests. The patient thought the nurse did not like her. The nurse thought the patient could not manage eating at the cafeteria (a privilege for those with improved mental status) and should eat on the unit because she was not listening to instruction. A meeting was called for the patient, nurse, and therapist (who spoke Chinese). When the patient realized that the nurse was trying to prevent her from choking, the patient agreed to "eat more gently." She also realized the nurse cared about her. Since then, their relationship has improved to the point of affection.

Another advantage is that staff members from the same culture are familiar with the context from which the patient comes, thereby providing some understanding of the cultural expressions (normal vs. abnormal) and particular needs of the patient. Young men from China often hold hands with each other, but sometimes patients can also engage in "inappropriate" touching. Staff from the same culture can differentiate culturally normal from abnormal behavior more easily, and they can explain to staff from other cultures how they can differentiate normal from abnormal behavior.

Fresh observations from staff outside of the culture, however, can also be helpful, as they view behavior through a different cultural lens. Questions asked about the culture can stimulate active thinking about the culture at-hand. As the staff talks to each other about their own observations, both sides contribute to the greater understanding of the cultural situation at hand.

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Aside from having communication become more intended, patients are discharged better prepared for their return to the community. Heavy emphasis has been placed on psychoeducation, discharge readiness, and medication education.

Since patients in an intermediate setting tend to be more stable than those in an acute hospital, they are in a better position to absorb the necessary information that will help prolong their stay in the community after discharge. While there will always remain a portion of patients who have limited to little insight due to the particular nature of their illness, those who are able to take in information leave the hospital better able to comply with treatment.

This seems especially true for the young undocumented patients from China who suffered a breakdown due to their difficulty in adapting to the United States. Treating psychotic patients earlier, rather than later, appears to have a more promising outcome. The theory held is that psychoeducation increases the patient's ability to help him/herself participate and cooperate in his/her own treatment. From observation, some Chinese patients have not received sufficient psychoeducation in past hospitalizations. While this may not completely transform the patient the first time around, repeated education (especially when they return to the unit) is necessary and eventually makes for a better consumer.

At times, more than medication and psychological education and treatment compliance are addressed. In the case of a patient who returned quickly to the unit, a great deal of time was spent helping him become aware of how his obsessive behavior and inability to stay away from his victim led that person to call the police and obtain an order of protection. He is currently doing better after the second discharge from the unit. He may return, but the hope is that this patient will learn again and again until he grasps how to help himself stay in the community.

Cultural Competence: A Challenge Over Time

It is not safe, however,

Continued on page 31

Working with Monolingual Chinese

Continued from page 29

to assume that a staff member who comes from the same culture is necessarily an expert about the culture, despite the advantages mentioned above. Blending cultural issues with clinical practice requires the prerequisite training in mental health, as well as the study of one's own culture, the current culture, and the integration of the two. From observation, staff that are immigrants, especially new ones, work comfortably with patients as language fluency, cultural familiarity, and similarity in past experience helps with daily conversation and sharing of experiences during group therapy.

A beautiful example during group is the discovery that some of the common songs everybody knew were Communist revolutionary songs that all were required to learn during the Cultural Revolution. Singing them with staff from the People's Republic became a nostalgic experience far distanced from politics.

The disadvantage of Chinese-speaking staff, especially new immigrants, is seen in the adjustment struggle with everyday function on the unit. While interpersonal relationships with American staff may not be hampered, comprehension of social rules and communication sometimes requires "extra work" for staff to fully understand the intended communication. Recent examples include Chinese staff handling patient problems privately, without documenting them in the logbook, because face-saving is important in the culture. In a psychiatric unit, however, much of the communication between shifts occurs through the logbook. Failure to document information about patient problems occurred, not so much because staff tried to hide it, but because they handled it in a way that would not cause someone to lose face.

Also, many new immigrants do not study their own culture academically and from a perspective outside the culture. Unless one is trained in university classes or has attended conferences and seminars on cross-cultural issues, immigrants are often oblivious that cultural issues exist while, ironically, they run into cultural misunderstanding daily. However, when cross-cultural issues are pointed out, many immigrant staff readily comprehend, identify, and agree that they exist. A primary reason for the lack of identification of cross-cultural issues is that new immigrants have not had to think about being from a different culture until they have arrived in the United States. To reflect on their personal cultural adjustments to the new culture is immediately relevant, but time is needed before one can fully be in the position to comment about one's own culture in the context of another culture, as immigrants have so much to integrate.

The parallel process between patient and staff member, in terms of cultural adjustment, is ongoing. The monolingual Chinese unit is an interesting context in which to study such a process. The current observations are by no means exhaustive or complete. The staff (both English- and Chinese-speaking) continues to learn about working with monolingual Chinese patients.

What Happened To Emotions

Continued from page 30

macy. However, other male traits can be utilized to facilitate therapy, such as the male predilection for cognition, and men's willingness to take action.

At the NYSPA Convention, we discussed how the male role socialization process impacts many men's ability to identify and discuss their emotions, introducing the idea of "normative male alexithymia", a milder form of alexithymia (which means literally, "without words for emotions") which is fairly widespread.

I offered some guidelines for the assessment of normative alexithymia in male patients, then presented a psychoeducational program for improving men's ability to identify and discuss emotional states and to find the vulnerable emotions underneath their anger. This program is useful at the beginning stages of therapy for many men, because it enables them to develop the skills of emotional self-awareness and emotional expressivity that will empower them to wrestle with the deeper issues.

I welcome your thoughts on these issues (Rlevant@aol.com).

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