Chapter 11
Interpreting and the Mental Status Exam

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ABSTRACT

The necessity of engaging qualified interpreters to work in partnership with mental health clinicians when serving patients with a limited English proficiency (LEP) is gaining widespread support. Numerous research studies have documented improved patient health and satisfaction outcomes in this regard. Psychiatric practice often involves complexities of thought, language, and communication that clinicians and interpreters must appreciate. One such topic is engaging LEP patients in the mental status examination (MSE). This chapter describes the nature of the MSE, challenges when interpreting for the MSE, strategies for handling such challenges, and approaches for effective collaboration between interpreters and mental health clinicians regarding the MSE and cross-linguistic mental health care more broadly. The current state of scholarship in the field of mental health interpreting and training opportunities for interpreters who seek to improve their knowledge and skills in the mental health arena also are discussed.

INTRODUCTION

There is growing evidence that individuals with limited English proficiency (LEP) experience obstacles to safe and high-quality healthcare (Wu & Rawal, 2017). Language barriers between patients and medical clinicians are common, and are associated with poorer quality of care, misdiagnosis, medical errors, and lower patient satisfaction (Flores, 2005; Divi, Koss, Schmaltz, Loeb, 2007; Ku & Flores, 2005; Ngo-Metzger et al., 2007; Woloshin, Schwartz, Katz, Welch, 1997). Language assistance provided by qualified interpreters has been shown to increase healthcare utilization as well as improve clinical outcomes and patient satisfaction (Flores, 2005; Jacobs, Shepard, Suaya, & Stone, 2004; Karliner, Jacobs, Chen, & Mutha, 2007). Generally LEP patients view the availability and quality of interpreting services as crucial;

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the use of interpreters and the perceived quality of interpreters' translations are strongly associated with the quality of care overall (Baker, Hayes, & Fortier, 1998; Dang et al., 2010; Green et al., 2005; Kline, Acosta, Austin, & Johnson, 1980; Kuo & Fagan, 1999; Lee, Batal, Maselli, & Kutner, 2002; Moreno & Morales, 2010; Ngo-Metzger et al., 2007).

Many oversight bodies recommend that healthcare clinicians working with LEP patients engage the services of professional interpreters to safeguard quality of care, patient safety, informed consent, and appropriate patient participation in healthcare decisions (Joint Commission, 2009; Registry of Interpreters for the Deaf (RID, 2007a). The use of interpreting services also is gaining advocacy within healthcare systems (Sleptsova, Hofer, Morina, & Langewitz, 2014). An interpreter provides an important linguistic and cultural link between the patient, clinician, and the healthcare system itself.

The use of qualified interpreters early in the sequence of *mental health* service interventions also is associated with better clinical practice and has been shown to be more cost-effective in light of the potential fiscal consequences of inadequate diagnosis and poor referral decisions (Bischoff et al., 2003). As healthcare systems develop and increasingly adopt policies regarding LEP patients and interpreters, it is important that interpreters and clinicians alike understand key issues in psychiatric practice that impact the nature and quality of interpreting work, such as how clinical interviews are optimally mediated by interpreters, including the mental status examination (MSE). The remainder of this chapter describes the MSE (and its variants), common challenges when interpreting for the MSE, tips for managing such challenges, strategies for effective collaboration with medical clinicians, and concludes with information regarding the current state of scholarship in the field of mental health interpreting and training opportunities for interpreters who seek to improve their knowledge and skills in the mental health arena.

BACKGROUND

What is the Mental Status Exam? The MSE is an important component of many clinical interviews. Its results can inform the patient's history, diagnosis, and treatment plan (Barnhill, 2014). All medical clinicians are trained to do the MSE, but it is most often used by clinicians in the mental health field. Its frequent use and value are comparable to taking a patient's vital signs in other fields of medicine. So why does this matter for interpreters? A patient's preferred language and culture must be taken into account when conducting and interpreting the results of the MSE. Linguistically and culturally, the patient must be able to understand the MSE questions and communicate their answers, while the clinician must be able to interpret the patient's responses in light of potential linguistic and cultural differences between clinician and patient (Pollard, 1998a; Norris, Clark & Shipley, 2016). Interpreters play a crucial role in ensuring that these linguistic and cultural elements are accurately conveyed and considered in this important phase of a patient's clinical assessment and care.

The MSE can be thought of as a broad cross-sectional assessment of a patient's cognitive and emotional state and capacities. While the MSE most frequently is conducted with patients being served in mental health settings, MSEs also may be conducted in primary care and other medical settings – whenever a patient's cognitive and emotional state and capacities are in question or simply must be documented. The MSE will most certainly be conducted during a mental health clinician's first contact with a patient and may be repeated frequently with the same patient, particularly in emergency or inpatient psychiatric settings. The interaction that comprises the MSE can vary considerably in length – being briefer when the MSE is repeated with a patient whose previous MSE results already have been documented or when

a clinician has little question that a patient's basic cognitive and emotional state are intact and unremarkable. An effective MSE can provide crucial data for immediate diagnostic and treatment decisions and inform more longitudinal mental health perspectives (Barnhill, 2014).

The assessment of mental status begins the moment the clinician meets the patient – at least it has begun in the *thought world* (Dean & Pollard, 2013) of the clinician. While some aspects of the MSE may include specific questions posed to the patient, for the most part, MSE data is gathered through observation and seemingly casual conversation, where the clinician is attuned to listening for key MSE information as the patient relays their story or answers broad questions (Robinson, 2008).

Though at times seemingly informal, the MSE nevertheless is a multifaceted clinical tool that involves a set of standardized observations and inquiries that reveal information regarding multiple domains: sensorium and cognitive functions, perception, thinking, feeling, and behavior (Robinson, 2008). Table 1, based, in part, on Robinson (2008), lists specific topic areas that are assessed under each of these domains. Almost always, a clinician's formal MSE documentation will address each of the topics listed, via the data gathered through observation, informal dialogue, and formal questions.

While clinicians will document most or all of the above topics in the patient's medical record after conducting the MSE, to an untrained observer (including many interpreters) the interview that yields MSE data may not appear to be an "examination" at all. If open-ended questions do not yield some of the desired MSE data, the clinician will usually ask more specific questions that focus on key MSE topics. Sometimes, patients will be asked to respond to specific MSE-related questions (e.g., "What is today's

Table 1. Domains and topics assessed via the mental status exam

Domain	Topics Assessed
Sensorium & Cognitive Functions	• Level of consciousness • Attention • Concentration • Orientation to person, place, date, and situation • Memory (short and long-term) • Fund of knowledge • Intelligence • Capacity for abstract thinking • Reality testing
Perceptual Anomalies	• Hallucinations • Delusions • Illusions • Depersonalization or derealization
Thought and Language	• Quality of speech • Thought content • Thought form • Suicidal and/or homicidal ideation • Insight • Judgment
Emotional Status	• Affect (shorter-term emotional states) • Mood (longer-term emotional states)
Behavior	• Appearance (e.g., hygiene) • Posture and gait • Motor activity • Degree of openness regarding the interview • Attitude toward the examiner

date?") or perform certain tasks (e.g., copy a drawing or follow a written command). (More on this topic in the next section.) Some clinicians use MSE checklists to gather key data in a more structured manner.

MAIN FOCUS OF THE CHAPTER: INTERPRETING FOR AN MSE

Assuming that interpreters are familiar with the complications and nuances of working in a bilingual-bicultural environment and working in mental health settings in particular (Pollard, 1998a; Tribe & Lane, 2009; RID, 2007c, Vernon & Miller, 2001), interpreting for the MSE when it is conducted in a conversational manner should not be particularly difficult. Of course, any time a translation challenge or relevant cultural issue arises, one should inform or educate the clinician about that challenge or issue. Asking a clinician to rephrase a question that was difficult to translate or explaining why a translation is difficult or noting how a question or topic bears particular cultural relevance are common choices an interpreter might make in such situations. But bear in mind each of the topics presented in Table 1 since the clinician will desire specific data regarding them.

For example, communication regarding, emotions, mood, unusual thoughts or sensory experiences, are particularly important to convey because they are not easily observed. Also not easily recognized by the clinician will be relevant characteristics of *how* the LEP individual is communicating. Is their speech (or sign language) unusually fast or slow or odd in other ways (see the section on "dysfluency" below)? Are the thoughts expressed by the patient (e.g., communications with the spirit world) possibly considered unusual in the clinician's culture but common in the patient's culture? Anticipating these important possibilities before they arise is the best preparation for interpreting during the MSE.

Specific Questions and Procedures Sometimes Used During the MSE

Beyond what may appear to be typical conversation about a patient's emotions, life difficulties, etc., there are many specific questions and procedures that may come up during the MSE. Each of these questions or procedures relates to one or more of the topics listed in Table 1. Interpreters should be prepared to encounter these questions and procedures, some of which may seem unfamiliar or strange. Some patients express surprise or even annoyance that these questions or tasks are asked of them, especially when they feel that the clinician is digressing from addressing the concerns that brought them to the facility. It is usually sufficient for the interpreter (or better yet, the clinician) to explain that these questions or tasks are presented "to everyone" or otherwise convey that, in mental health settings, these questions or tasks are common.

Regarding the topic of orientation, clinicians may ask the patient to state who they are, where they are, the day and date, or even ask questions that should involve common knowledge such as who the president of the United States is.

Regarding attention and concentration, clinicians may ask patients to do arithmetic problems in their head (not on paper) such as a task known as *serial 7s* (Teng, 2018). Here, a patient is usually asked to subtract 7 from 100 (the correct answer is 93) but then continue subtracting by 7s (e.g., 93 – 7 = 86, 86 – 7 = 79, etc.) for a short while. Another common technique is to ask the patient to spell a familiar word backwards. Often, the clinician will choose the word "world" (where the correct answer would be d-l-r-o-w). However, if one has translated the word "world" into the patient's preferred language (e.g., "mundo" in Spanish), the task would be problematic or not make sense at all unless the clinician was

informed that the word "world" was changed to another word via the translation. In the video accompanying *Mental Health Interpreting: A Mentored Curriculum* (Pollard, 1998a), a Spanish language interpreter encounters this problem and asks the clinician if he wants the patient to spell *world* or *mundo* backwards.

Regarding short-term memory, clinicians may ask patients to remember a short list of words, then recall them perhaps 20 minutes later. In some cases, when a patient has difficulty recalling one or more of the words, the clinician may give them a hint (e.g., "It was a color.") or even offer multiple choices (e.g., "Was it red, blue, or green?")

Other procedures are intended to investigate the patient's language functioning. One such strategy is asking the patient to comply with a sequence of verbal commands (spoken or written) beginning with one-step commands (e.g., "Close your eyes") and progressing to more complex commands with multiple steps (e.g., "Point to the ceiling, then point to the door, and then to the main source of light in this room"). Another technique may involve asking a patient to read aloud from a paragraph or from a list of single words. Patients may be asked to spontaneously generate a written sentence. When these language-based MSE tasks are administered, especially involving reading or writing, LEP patients may not be able to respond or respond inappropriately which could be mistaken for symptoms of cognitive impairment. Interpreters should immediately discuss with the clinician any potential challenges in assessing patients using these language-based techniques, including how translation of spoken instructions (or responses) might affect the results.

Other MSE tasks may involve writing, drawing, or other motor functions. Patients are sometimes asked to copy a drawing that is shown to them, using another piece of paper. These drawings are usually geometric figures such as two oblong hexagons that intersect. Sometimes, patients are asked to perform an imaginary motor function such as threading a needle. A common procedure is to ask patients to draw a clock (that is, an analog clock face, not a digital clock) and set the hands of the clock at "ten past eleven". This specific wording, in English, is critical to the task; saying "ten minutes past eleven o-clock" would disrupt the information the clinician is looking for. This part of the clock drawing command presents translation difficulties in many languages and the clinician should be informed of this.

Finally, in assessing abstract reasoning, it is common for clinicians to ask patients to explain the meaning of a proverb. English language proverbs such as "people who live in glass houses shouldn't throw stones" or "a rolling stone gathers no moss" might be presented. Here, the clinician is looking for an abstract versus a concrete explanation of the proverb's meaning. While some LEP individuals may be familiar with the proverb(s) presented or be able to figure out an abstract explanation even if they are not familiar with the proverb, it is typical for LEP individuals to be unfamiliar with proverbs in a language in which they are not fluent. Again, clinicians should be alerted to this problem if a proverb inquiry is made during the MSE.

Other Potential Complications When Interpreting for the MSE

The Bilingual, Bicultural Environment and Fund of Information

Interpreters know that, frequently, differences between two languages cannot easily be bridged, especially in a word-for-word way. Unfortunately, clinicians who are monolingual may not understand this and erroneously presume that whatever is said in one language can be mapped, in a direct fashion, to words that have similar meaning in the other language. Dean and Pollard (2005) offer useful guidance to read-

ers who do not fully understand the nature of interpreting work which sometimes requires translation strategies that are unknown, even unexpected, by monolinguals.

Interpreters also make translation and behavioral decisions based on cultural and contextual variables in the service environment, as well as their own experiences as members of an LEP community (since most interpreters' first language is the non-English language with which they were raised). Interpreters are usually the only person in the room who truly understand the bilingual, bicultural factors at play. This information could directly impact a clinician's ability to achieve the objectives of a MSE and/or other evaluation and treatment goals and must be openly discussed (Raval, 2003). Differentiating between bilingual, bicultural factors that are truly relevant to the situation from those that may reflect the interpreter's own personal themes, biases and assumptions – especially in mental health settings – is a valuable outcome of such frank discussions (Tribe & Lane, 2009).

LEP individuals may be immigrants, refugees, or deaf persons who have had difficulty acquiring a spoken/written language such as English (which is common in the deaf population). One consequence of limited proficiency in a majority culture's language, or less familiarity with that culture itself (as is often the case with immigrants and refugees) is a lower "fund of information" (Pollard, 1998b) regarding the country or culture in which they now live, regardless of one's intelligence or educational attainment. Fund of information deficits are the result of multiple factors that impede access to information in the majority language (e.g., radio, television, magazines, overheard conversations, etc.). When LEP or deaf patients "don't know things" that a clinician assumes are common knowledge, errors in MSE conclusions can result. Deficits in fund of information also can hinder a patient's understanding of, and cooperation with evaluation and treatment in mental health and other medical settings. Gathering information about communication and learning history in both family and school contexts can help to differentiate between fund of information gaps, limited intellect, and mental health symptoms.

Dysfluency

It is not unusual in psychiatric settings to encounter patients whose primary language is not fluent or even proficient (i.e., their language is "dysfluent"). Certain mental illnesses and neurological conditions can interfere with individuals' thought processes, language abilities, or both. For example, psychotic illnesses, mania, strokes, dementia, drug or alcohol intoxication, and certain developmental disorders all may cause language dysfluency symptoms. Dysfluency generally takes one of three forms: (1) a general lack of language proficiency that significantly impairs communication with the individual or (2) specific, disruptive errors in language use that are atypical of average users of that language, but which do not significantly impair communication, or (3) language articulation problems that are not suggestive of a thought disorder per se (e.g., slurred speech). All of these forms of dysfluency are important to notice and convey to clinicians – the interpreter is typically the only person in the room who has the ability to notice such language problems.

Since virtually all (hearing) persons are proficient, if not fluent, in their preferred language, even seemingly minor dysfluent language events *might* be indicative of important psychiatric or neurological impairments. For this reason, mental health clinicians are taught to attend to even the subtlest of language dysfluency events. Andreasen (1980) describes no fewer than 20 specific types of language dysfluency that may be observed in psychiatric settings, giving examples of each type (as manifested by native English speakers with psychiatric disorders).

Here is an example of obvious, general dysfluency, directly quoted from a native English-speaking patient with schizophrenia who was responding to a psychiatric interview captured on film in a training video series for mental health clinicians (Wohl & Csernansky, 1994):

Well there the before on the clock, that's the 6, 7, 8, 9, 10, 11, 12, 1, 2, 3. They go by those numbers of the clock. And when you do the 25 after that's the after side of the clock. We go by the 1, 2, 3, 4 and 5 of the clock and the 5 you go right left to 7 number on the clock is the 5 number. You go right left to that number. That's what the 25 is. If you don't do something they tell you to do and Jesus makes the shotgun sound and then phone rang not to answer the phone or the doorbell.

This language sample is so disturbed that it would be nearly impossible to translate accurately. There is simply not enough logic or structure in the patient's language to convey sufficient meaning to the interpreter to allow her/him to form a coherent translation into the target language. (In the interpreting field, we denote that interpreters are receiving an utterance in one language, the "source language," and translating it into another language, the "target language"[1]). Dysfluent language of this severity is most certainly evidence of significant psychiatric or neurological impairment. If the interpreter translated only those parts of this utterance that she/he understood, in effect, "cleaning up" the language sample and failing to convey to the clinician the severe dysfluency that was otherwise evident, critical diagnostic information would be hidden from the clinician's awareness. The key here is to note that the patient's language, in large part, is not coherent. An interpreter's assumption of, or search for meaning in this language sample would be both fruitless and counter-productive. Below, we will address what an interpreter still can do to be helpful to the clinician, even when confronted with such severe language dysfluency.

Here is a different language sample demonstrating a much *less* severe degree of dysfluency that is nevertheless significant enough to have diagnostic relevance. It is also a direct quotation from a native English-speaking patient from the same diagnostic interview film series cited above. She is discussing the death of her mother. This patient was filmed during the manic phase of bipolar illness.

She had cancer of the spinal cord when I was 11-years-old and they had to take out her back, eight inches of her back out to kill the cancerous tumor. So that means she was paralyzed from her breast down for 21 years of her life. She died the age of the year I was born, '61. I believe everything has a purpose under heaven…I believe that's the time that God wrote down she is going to die before she hit her 62nd birthday. She was going to die and be my guardian angel at 61 of the year I was born.

Notice this patient's unusual phrasing involving numbers as well as her reference to her mother being paralyzed from "the breast down." Other portions of this interview revealed that the patient expressed a great deal of sexualized ideation. Native English speakers might say that a person was paralyzed from the "neck" down, the "waist" down, etc., but not the "breast" down. The several odd references to numbers in this language sample are even more noticeable. The severity of language dysfluency is subtler than in the earlier language sample and does not impair understanding as severely. Yet, even these language anomalies are diagnostically relevant. Again, ignoring such language anomalies or "cleaning up" the language in one's translation would hide important diagnostic information from the clinician.

While encountering language dysfluency is one of the most challenging aspects of interpreting in mental health settings, it is also one of the most important – where the interpreter's response to this challenge typically holds diagnostic and/or treatment significance. Most interpreters who work in com-

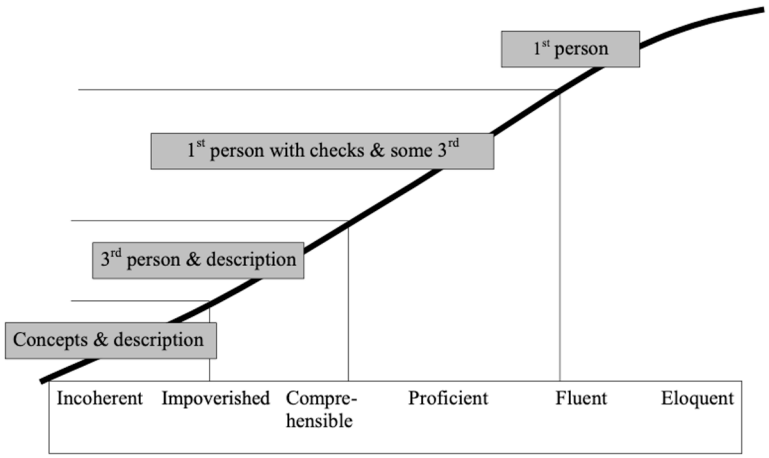
munity settings have not encountered language dysfluency associated with psychiatric or neurological disorders, but it is not unusual to encounter in mental health settings. Despite the challenges involved, there are still helpful ways the interpreter can respond.

Again, the first rule is to not "clean up" dysfluent language or otherwise speculate what the patient "probably means" and then provide the clinician with a fluent, coherent (and misleading) target language translation. While a verbatim translation may not be possible when a patient's language is seriously dysfluent, interpreters still have options.

Figure 1 below portrays different options interpreters have when encountering dysfluent language. At the base of the figure is a scale of language dysfluency where fluent or even eloquent language is depicted on the right end of the scale. When language is of good quality, as depicted here, interpreters will normally translate in the first person and have little difficulty. Remember, here we are referring to the patient's preferred or best language. While most individuals are fluent in their preferred language some patients with psychiatric or neurological disorders are not. Thus, fluency (and logic) should never be presumed when interpreting in a mental health setting.

The middle portion of the scale is meant to depict language that is somewhat poorer in quality, such as proficient (but not fluent) language or language that is comprehensible (i.e., generally understandable, for the most part) but not even proficient in quality. Here, an interpreter will usually translate in the first person, when the language is good enough to allow this, but will often need to ask the patient to repeat or clarify what they said. Another option in this range of language dysfluency is to switch from first person translation to "third person" translation (e.g., "He was describing a physical fight he had with a friend, but it is not clear if this happened recently or long ago or which person punched which person first"). While a third person translation does not provide the clinician with the exact detail that the interpreter might desire, it still provides the "gist" of the language sample and further alerts the clinician that the interpreter is having difficulty translating the patient's language, therefore making the clinician aware that there is probably a degree of dysfluency being manifested by the patient. If the clinician truly cares about the unclear content, she/he can interrupt and ask the patient to clarify. But, more likely, the clinician may want to know (later) from the interpreter the nature of the translation difficulty she/he observed

Figure 1. Translation options when confronted with language dysfluency



when the switch to third person took place. Such information may well reveal the type of dysfluency the patient was manifesting (Andreasen, 1980).

At the left end of the scale at the bottom of Figure 1, are the terms "MLS" (meaning "minimally language skilled"), where very little of the patient's language is clear and/or logical and "incoherent," where virtually none of what the patient is communicating is understandable. Again, this certainly can happen when patients have severe psychiatric or neurological impairment, but interpreters still can be tremendously helpful in such situations. As shown in Figure 1, while first person translation in such situations is likely impossible, there might be segments of the patient's language that are sufficiently understandable for a third person translation. But even when that is not possible, interpreters can still *describe* what they are observing in the patient's language. Such description can be extremely helpful to clinicians who are trained in identifying different forms of language dysfluency.

For example, there is a dysfluency symptom known as "clanging" in which patients are drawn to the structure of the language they are using and not the logic of what they are attempting to say. With hearing patients who "clang" they may put together a sentence with words that rhyme or begin with the same sound but, together, the sentence does not make sense. Deaf patients who clang also are drawn to the structure of sign language (and lose sight of the logic of their communication) by putting together a sentence that uses several signs involving the same handshape but, again, which do not make sense as a complete utterance. Since clinicians working with interpreters will not recognize rhyming, sign language handshapes, etc., the only way they might suspect that a patient might be clanging is for the interpreter to inform them that these types of phenomena are occurring.

While clanging is only one example of the many language dysfluency symptoms one might encounter, two key points remain – interpreters should always explain to the clinician (either in the moment or afterward, as the situation warrants) unusual language events that they observe and, second, never insert clarity or logic in a patient's language utterances when such clarity or logic is weak or absent. Failure in either regard "hides" potentially crucial diagnostic and/or treatment information from the clinician that may well impede or curtail the treatment that the dysfluent patient deserves.

Interpreter-Clinician Partnership in Mental Health Interpreting

When interpreters and clinicians work together in providing access to care for patients whose first language is not English, there are multiple benefits for all, especially patients. The following section offers considerations in developing a collaborative relationship and environment for the interpreting of MSEs, others psychiatric interviews, and medical appointments generally.

Like other venues of interdisciplinary teamwork, in medical contexts, preparation helps clinicians and interpreters work together most effectively. Interpreters should be recognized as fellow "practice professionals" (Dean & Pollard, 2013, 2018) on the service team. Familiarizing oneself with local interpreting agencies, national interpreter organizations and their codes of ethics or professional conduct, and specific guidelines for working with interpreters in medical and mental health settings can be very useful (Tribe & Morrissey, 2004). Written guidelines and contracts about interpreters in medical settings can include specifics regarding confidentiality, roles and responsibilities, and other professional and ethical issues (Sills, 1997). Introducing interpreters to key hospital or office staff, inviting their participation in continuing education lectures or courses and relevant meetings helps integrate interpreters with the broader medical team and environment (Tribe & Sanders, 2003). Clinicians could also provide a dictionary of medical terms available for interpreters to consult (Tribe & Morrissey, 2003).

Hiring qualified interpreters who have experience, training, and are comfortable in mental health and/or medical settings is valuable for many reasons, but is especially important when initial diagnostic (e.g., MSE) and treatment planning decisions are being made. Determining the client's preferred language, including dialect, and finding an appropriate interpreter with a background in both the patient's preferred language and mental health work is often a challenge that can be streamlined when interpreter referral agencies and clinicians work together. If possible, interpreters and patients should be matched for gender, age and religion, particularly if this is relevant to the meeting or consultation (e.g., in cases of sexual assault or intimate partner violence) (Patel, 2003; Nijad, 2003). If multiple appointments are anticipated and the patient and interpreters agree, then the same interpreter should be requested for ongoing appointments whenever possible. When that is not possible, interpreters should be encouraged to pass along key information about the assignment (e.g., key names and relationships that are discussed, important facts that have been established, etc.) to new interpreters who will be involved so that continuity of communication can be maximized between the clinician(s) and multiple interpreters.

Interpreted appointments almost always take more time than appointments where clinicians and patients speak the same language and schedules should be planned to accommodate that extra time. A 10-15 minute "pre-session" before the appointment begins, in order to explain the purpose of the meeting and clarify any technical concepts, vocabulary or jargon, cultural issues, and nonverbal communication norms that may arise should take place whenever possible. If using technical vocabulary or procedures other than discussion is anticipated, familiarizing the interpreter with these terms or procedures beforehand can allow for smoother communication during the appointment (Tribe & Morrissey, 2004). Even planning the physical arrangement of the environment, so that it is conducive to a three-way conversation is helpful (Tribe & Morrissey, 2004).

The value in taking the time to prepare in advance for interpreter-clinician collaborations cannot be overstated. Beyond the interpreters and clinicians themselves, interpreter service agencies, office managers, and human resources personnel also can be helpful in this preparatory stage.

If pre-appointment preparation is done well, this maximizes the likelihood that the clinician and interpreter can concentrate effectively on their respective duties during the appointment itself. Ultimately, when the appointment begins, the clinician, interpreter, and patient should all feel comfortable; it should be obvious to the patient that these fellow practice professionals "know what they're doing." Leading off with an open discussion, where all involved acknowledge that interpreted conversations present unique challenges is fundamental (Tribe & Morrissey, 2004). This can be achieved by first clarifying the interpreter's professional role and addressing confidentiality boundaries (Tribe & Sanders, 2003).

Being mindful of pacing and turn-taking is especially important when working with interpreters. They cannot interpret for more than one person speaking at a time and, as noted, words or concepts in one language do not always have exact equivalents in another language, sometimes requiring extra time for an effective bilingual, bicultural translation. Clinicians and interpreters should not discuss anything in front of the patient that is not intended for the patient to understand. That is, all communication conducted in the patient's presence should be translated. If issues arise which require private discussion between the interpreter and clinician, the interpreter can explain this to the patient and a break can be taken so that the interpreter and clinician can confer or, better yet, these things can be discussed in private before or after the meeting (Razban, 2003; Baylav, 2003). Particularly in mental health settings, it also is advised that interpreters not be alone with the patient/family without the clinician present (e.g., in a waiting room) to maximize confidentiality and professional boundary-keeping.

The collaboration between clinicians and interpreters should continue after the appointment as well. The appointment experience is often rich with communication dynamics, curiosities, and ideas for feedback that can be discussed during a short debriefing session. Any translation, cross-cultural or other challenges the interpreter noticed should be shared with the clinician. Debriefing on how well the clinician and interpreter worked together as a team is another important topic which may involve questions or even constructive criticism regarding their working partnership. Discussing arrangements for future communications and appointments also can occur at this point. This "post-session" is a wonderful opportunity for these practice professionals to share information and resources that may help one-another continue to develop their skills in bilingual, bicultural mental health work.

Continuing Education and Mental Health Interpreting

The lack of well-regulated training for interpreters is an issue in many countries (Dean & Pollard, 2001; Tribe & Sanders, 2003; Hwa-Froelich & Westby, 2003). Interpreter qualifications, training, and other professional and even legal requirements vary widely (Tribe & Morrissey, 2003). The effectiveness of interpreter preparedness and on-the-job judgement, whether regarding translation, behavioral, or ethical decisions depend a great deal on their familiarity with the setting in which they are working (Dean & Pollard, 2013). Unfortunately, interpreters often function or are trained as "generalists" – as if their bilingualism and cross-cultural knowledge prepares them to work with equal effectiveness in any setting. This is quite inaccurate. Medical and mental health settings, legal settings, and educational settings, especially post-secondary ones, present particular challenges regarding the requisite knowledge, vocabulary, and experience to perform competently as an interpreter (Pollard, 1998a, RID 2007a, 2007b, 2007c).

An interpreter's role is complex and demanding. Their work requires a variety of skills, including knowledge of specialist terminology, ability to reflect on meaning, memory skills and the ability to convey accurately the meaning of the content expressed (Tribe & Morrissey, 2003). Interpreters benefit greatly from continuing education, support, and supervision (Dean & Pollard, 2009, 2013). Interpreters who work in mental health settings also may need supervision and consultation resources around matters such as therapeutic boundaries, confidentiality, therapeutic practice, and the consequences of communicating traumatic material (e.g., vicarious trauma). Interpreter organizations should consider how to incorporate mentoring, consultation, and supervision into continuing education programs for all interpreters, especially those working in mental health and medical specialties.

Two organizations have created certification processes for medical interpreters: the Certification Commission for Healthcare Interpreters (CCHI) and the International Medical Interpreters Association (IMIA). The CCHI exam assesses healthcare terminology, interactions with other healthcare professionals, interpreting encounters, and cultural responsiveness and includes consecutive and simultaneous interpretation in addition to sight translations. The IMIA Certified Medical Interpreter status is available for Spanish and nearly 30 other languages and requires successful completion of written and oral exams (VanderWielen, 2014).

The United States presents a mix of state legislation and individual organization policies regarding medical interpreting. Even though the above two national organizations provide certification processes for medical interpreters, various state certification programs also exist. Pollard (1998a) developed a popular mental health interpreting training curriculum conducive to various interpreter training environments (e.g., small group, large group, individual, etc.) Other notable resources for mental health interpreter training include the Alabama Department of Mental Health's Mental Health Interpreter Training (MHIT)

program, the CATIE Center's mental health interpreter training program at St. Catherine's University, Cambridge College's Mental Health Interpreter Certificate program, the Cross Cultural Communication Institute (CCCI) Mental Health Interpreter Certificate, the University of Minnesota's Interpreting in Refugee Mental Health Settings training, a program run by the National Latino Behavioral Health Association (NLBHA), and the National Asian American Pacific Islander Mental Health Association (NAAPIMHA) Mental Health Interpreter Training Program (MHITP). In 1978, the U.S. Congress passed the Federal Court Interpreters Act, mandating that the U.S. courts establish a program to facilitate the use of certified and otherwise qualified interpreters in judicial proceedings instituted by the United States (VanderWielen, 2014).

CONCLUSION

The presence of qualified interpreters in mental health settings is gaining popularity. The benefits to patient access and satisfaction in healthcare, diagnosis, and treatment are many. The MSE is a central component of assessment in mental health settings that is used to examine and document various aspects of a patient's cognitive and emotional functioning. Some elements that impact interpreting for the MSE lie in the assessment techniques utilized by clinicians and some in the challenges that LEP patients may present (e.g., dysfluency, fund of information gaps). A collaborative and open relationship between clinicians and interpreters is the key to conducting a proficient MSE and bridging the gaps between the clinician, patient, and interpreter. Utilizing cooperative guidelines helps to organize interpreter and clinician roles and responsibilities before, during and after interpreter-mediated appointments. Supporting the progress of mental health interpreter training and certification programs is essential to promoting the vital role of interpreters in mental health care.

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ENDNOTE

[1] In the interpreting field, we denote that interpreters are receiving an utterance in one language (the "source language") and translating it into another language (the "target language")