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**Recommendations for practices and protocols for
interpreters to follow in mental health interactions**

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Preamble

Within health care, mental health interactions are different from those in which a patient requires treatment due to his/her general or physical health condition. In the first place, mental health interactions are reliant on spoken or signed communication from a patient, as well as other forms of behaviour in order for mental health professionals to work with patients: there are often no physical or visible symptoms of a patient's condition that facilitate a diagnosis and course of treatment.

The relationship between a mental health professional and a patient is, in many ways, different from the relationship that a patient has with other health professionals by the behavioural forms, verbal or signed communication that characterise mental health interactions.

Elicitation and demonstration of symptoms, initial diagnosis and further monitored testing, therapy, recovery and/or management of symptoms all occur via interactions where the ability to openly communicate, build rapport, gain the trust and confidence to have a working relationship are critical.

The work of the interpreter in facilitating this is critical. These recommendations for practices and protocols seek to guide the interpreter so that s/he can work optimally in mental health interactions with both mental health professional and patient.

1. Ethical considerations

In an overall sense, spoken language Interpreters are guided by the AUSIT Code of Ethics and Code of Conduct (2012) and sign language interpreters are guided by the ASLIA Code of Ethics and Guidelines for Professional Conduct (2007). Sign language interpreters are also advised to be familiar with the ASLIA (2011) Guidelines for Interpreting in Mental Health Settings.

The principles from these codes, especially confidentiality, competence, professional conduct, non-discrimination and professional accountability, are important notions that should be followed in all mental health interactions.

These recommendations recognise also that at times, interpreters may need to work in ways that differ from the specific intentions of the principles, as there can be features of mental health settings that may it difficult for interpreters to always follow these principles.

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For example, beyond the mental health interaction or when the interpreter, through whichever circumstances, may be alone with the patient, the interpreter may learn of information or circumstances of the patient causing harm to others or to him-/herself. It is important that the interpreter is aware of such a risk and the interpreter should consider breaking the principle of confidentiality and notify the mental health professional of the content expressed by the patient or his/her circumstances that indicate self-harm or harm to others.

The possibility of disclosure to an interpreter is higher than it is to others, and for this reason, mental health interpreters should avoid contact with patients outside the presence of mental health professionals.

2. Knowledge base

Interpreters need to acquire a knowledge base relevant to mental health interactions. These include: settings, mental health personnel, mental health illnesses, mental health symptoms and services, and treatment of mental health illnesses.

A. Settings.

Services in mental health care in Australia encompass, in broad terms, the following:

- Emergency services (acute mental health initial assessment and screening);
- Inpatient and ambulatory services;
- Outpatient services;
- Clinical health services;
- Disability rehabilitation and support services; and - Medico-legal services.

Health professionals attempt to achieve a variety of objectives in these different settings through the provision of a range of mental health services. These services are usually divided into child & adolescent services, adult services, aged person services, and specialist services. Support and specialist services include disability services, drug and alcohol services, housing and accommodation services, income support services, recreation, and carer programs. The following sections briefly describe these settings and their main features.

B. Mental Health Personnel

Professionals in the mental health sector work in a variety of areas, such as triage, ancillary healthcare staff, diagnosis, treatment, therapy, primary health and allied health. The most common professionals with whom patients and interpreters have contact with are: psychiatrists, general practitioners (GPs), mental health nurses, psychologists, social workers and counsellors.

C. Mental health illnesses (Including the terms 'mental conditions' and 'mental disorders')

In hospital and clinical mental health settings in Australia, there are two diagnostic manuals that are currently in use. The first is published by the American Psychiatric Association, the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5). The second is published by the World Health Organization (WHO), the International Classification of Diseases: Classification and Mental and Behavioural Disorders 10th Revision (ICD-10). The following information is taken from the WHO (2010) website on "Mental and Behavioural Disorders". The ICD-10 groups mental and behavioural disorders into ten categories. These are given here, together with common illnesses:

- Organic, including symptomatic, mental disorders

Mental disorders grouped together on the basis of their having in common a demonstrable aetiology in cerebral disease, brain injury, or other insult leading to cerebral dysfunction. The dysfunction may be primary, as in diseases or injuries.

Dementia is a syndrome due to disease of the brain, usually of a chronic or progressive nature, in which there is disturbance of functions, including memory, thinking, orientation, comprehension, calculation, learning capacity, language, and judgement. This syndrome occurs in Alzheimer's disease, in cerebrovascular disease, and in other conditions primarily or secondarily affecting the brain.

- Mental and behavioural disorders due to psychoactive substance use

Disorders that differ in severity and clinical form but that are all attributable to the use of one or more psychoactive substances, which may or may not have been medically prescribed. Identification should be based on as many sources of information as possible.

These include self-report data, analysis of blood and other body fluids, characteristic physical and psychological symptoms, clinical signs and behaviour, and other evidence such as a drugs being in the patient's possession or reports from informed third parties. Many drug users take more than one type of psychoactive substance.

- Schizophrenia, schizotypal and delusional disorders

This includes schizophrenia, as the most important member of the group, persistent delusional disorders, and a larger group of acute and transient psychotic disorders. Schizoaffective disorders have been retained in spite of their controversial nature.

- Mood [affective] disorders

This block contains disorders in which the fundamental disturbance is a change in affect or mood to depression (with or without associated anxiety) or to elation. Most of these disorders tend to be recurrent and the onset of individual episodes can often be related to stressful events or situations.

- *Neurotic, stress-related and somatoform disorders*

A group of disorders in which anxiety is evoked only, or predominantly, in certain welldefined situations that are not currently dangerous. The patient's concern may be focused on individual symptoms like palpitations or feeling faint and is often associated with secondary fears of dying, losing control, or going mad. Contemplating entry to the phobic situation usually generates anticipatory anxiety. Phobic anxiety and depression often coexist.

- *Behavioural syndromes associated with physiological disturbances and physical factors*

The behavioural syndromes and mental disorders included in this classification are associated with physiological dysfunction and hormonal changes in the body. They include eating disorders and non-organic sleep disorders.

- *Disorders of adult personality and behaviour*

This block includes a variety of conditions and behaviour patterns of clinical significance which tend to be persistent and appear to be the expression of the individual's characteristic lifestyle and mode of relating to himself or herself and others.

Specific personality disorders, mixed and other personality disorders, and enduring personality changes are deeply ingrained and enduring behaviour patterns, manifesting as inflexible responses to a broad range of personal and social situations. They represent extreme or significant deviations from the way in which the average individual in a given culture perceives, thinks, feels and, particularly, relates to others.

- *Mental retardation*

A condition of arrested or incomplete development of the mind, which is especially characterized by impairment of skills manifested during the developmental period, skills which contribute to the overall level of intelligence, i.e. cognitive, language, motor, and social abilities. Retardation can occur with or without any other mental or physical condition.

- *Disorders of psychological development*

The disorders included in this block have in common: (a) onset invariably during infancy or childhood; (b) impairment or delay in development of functions that are strongly related to biological maturation of the central nervous system; and (c) a steady course without remissions and relapses. In most cases, the functions affected include language, visuospatial skills, and motor coordination.

- *Behavioural and emotional disorders with onset usually occurring in childhood and adolescence*

A group of disorders characterized by an early onset (usually in the first five years of life), lack of persistence in activities that require cognitive involvement, and a tendency to move

from one activity to another without completing any one, together with disorganized, illregulated, and excessive activity.

Hyperkinetic children are often reckless and impulsive, prone to accidents, and find themselves in disciplinary trouble because of unthinking breaches of rules rather than deliberate defiance. Their relationships with adults are often socially disinhibited, with a lack of normal caution and reserve. They are unpopular with other children and may become isolated.

D. Mental health symptoms and services

In Australia, there are a number of public organisations or services that provide information to a general, non-specific audience about mental health conditions. These include the following:

- Anxiety conditions: anxiety; generalised anxiety disorder; social anxiety; agoraphobia; obsessive compulsive disorder; post-traumatic stress disorder; panic disorder
(mindhealthconnect - <http://www.mindhealthconnect.org.au/>) (beyondblue - <https://www.beyondblue.org.au/>)
- Personality disorders: personality disorder; borderline personality disorder; narcissistic personality disorder
(mindhealthconnect - <http://www.mindhealthconnect.org.au/>)
- Mood disorders: depression; bi-polar
(mindhealthconnect - <http://www.mindhealthconnect.org.au/>)
- Psychotic disorders: schizophrenia; psychosis; paranoia
(mindhealthconnect - <http://www.mindhealthconnect.org.au/>)
- Eating disorders: bulimia; anorexia nervosa; disordered eating
(mindhealthconnect - <http://www.mindhealthconnect.org.au/>)
- Depression; suicide prevention; supporting others; self-harm and self-injury; pregnancy and early parenthood; grief and loss; drugs, alcohol and mental health.
(beyondblue - <https://www.beyondblue.org.au/>)
- Dementia, memory loss and Alzheimer's disease
(Alzheimer's Australia - (<https://www.fightdementia.org.au/>))

In addition, there are other services that are intended for age-specific groups, e.g. KidsMatter (<http://www.kidsmatter.edu.au/>) for children of primary school age, and headspace (<https://www.ehespace.org.au/>) for young people aged 12-25 or for their family for them to contact a qualified youth mental health professional.

E. Treatment or mental health illnesses

When interviewing for specific disorders, e.g. depression or manic behaviour, a mental health professional will ask the patient to describe his/her mood, thoughts about the future, sleeping and eating patterns, thoughts about self-harm or harm to others.

When the focus is on substance abuse, for example, the questions will explore the types of substances, exact quantities and situations when the substances are used. Questions focusing on anxieties and phobias will elicit descriptions of physical symptoms, and those relating to psychoses on descriptions of hallucinations and delusions experienced by the patient (Pollard, 1998).

The initial mental health diagnostic interview provides a benchmark against which information obtained in follow-up interviews or reviews during treatment are measured. Reviews focus on the patient's description of changes to the mental health and/or physical symptoms, specifically whether there has been an improvement, a deterioration or no change.

The mental health professional may also follow up on the general questions regarding the patient's current life situation, to find out if the treatment has had an impact on the patient's everyday life. It is clear, therefore, that in an interpreted mental health diagnostic interview and for making a correct diagnosis and monitoring the effects of the treatment plan, the mental health professional will rely on the interpreter for an accurate and complete translation of the patient's language and ideas.

A mental health treatment plan can include a combination of therapies. These will depend on the diagnosis. Some mental health disorders require the use of medication (pharmacotherapy). Some commonly used medications include anticonvulsants (mood stabilisers), antidepressants, and antipsychotics. Medication may be prescribed to be taken orally (tablets), as patches, or in the form of injections.

Another type of treatment is talk therapy. There are many types of talk therapy, and they all focus, in different ways, on helping the patient understand how their symptoms are affecting their everyday life and empowering them to make positive changes. Some forms of talk therapy are conducted in one-on-one sessions, while others may be conducted in the form of group therapy.

Some of the more common types of talk therapy are psychodynamic therapy, Cognitive Behavioural Therapy (CBT), Dialectical Behavioural Therapy (DBT), gestalt therapy, relationship counselling, grief counselling, and addiction counselling are described below:

- Psychodynamic therapy (also known as classic psychotherapy) focuses on the patient's past to determine the origin of the mental health problems.
- In CBT the focus is on understanding how thought can influence behaviour, and how changing one's thoughts can change behaviour. CBT is frequently used to treat phobias, anxiety, depression and addictions.
- DBT teaches stress and emotion management and coping mechanisms, and improving relationships. DBT involves skills training, acknowledging thoughts which are usually avoided, as well as cognitive therapy and behaviour changes.
- Gestalt therapy is a humanistic and existential therapy that focuses more so on process (what is happening) over content (what is being talked about). The main

goal of gestalt therapy is change through self-awareness, with emphasis on what is current being experienced somatically.

- Relationship counselling is offered for problems involving families, marriages and partnerships. Family therapy (also known as Family and Systemic Psychotherapy) engages the whole family system as a functioning unit. Social context, communication and relationships have given primary importance in this therapy.
- Grief counselling is indicated following a loss, change or death.
- Addiction counselling addresses various types of addiction, e.g. internet addiction, gambling, or substance abuse.
- Electroconvulsive treatment (ECT) is a medical procedure which is used to treat various mental illnesses, such as severe depression, catatonia and some forms of mania and schizophrenia. The procedure, performed under general anaesthetic, involves inducing a controlled seizure with a series of brief, low-frequency electrical pulses to one or both hemispheres of the brain. ECT is performed under the supervision of a consultant psychiatrist and the patient is required to give informed consent. A Mental Health Tribunal may be asked to decide whether to approve ECT if a patient is unable to give informed consent.

3. Features of interpreted interactions in mental health

There are a number of features that interpreters should attempt to be clear about before the interpreted interaction commences. The first is:

A. Pre-interaction information.

Information about the interpreting assignment that can be gained before the interaction, e.g. Address, name of institution, name of clinic or hospital area / ward that give general information about the site / place of the interaction.

B. Briefing

In order for interpreters to work effectively with mental health professionals, it is important that they request and have a briefing with the mental health professional for both to work effectively with each other.

For the interpreter, this briefing is an opportunity to gain information on the general purpose of the interaction, or what the mental health professional seeks to 'achieve', in a general sense, in the interaction.

This information allows the interpreter to be informed of the mental health professional's perspective and intentions towards the interaction. The interpreter is thereupon able to anticipate the way the mental health professional will communicate with the client and the likely type of language to be used.

There are a number of points that can be touched on in the briefing with the mental health professional. Below is a non-exhaustive list from which the interpreter may consider which are relevant to the interaction:

- Previous experience working with interpreters
- Role of interpreter in facilitating communication between speakers/users of different languages
- Ethical codes by which the interpreter works, including the principle of confidentiality
- General format or purpose of interaction
- Is this the mental health professional's first interaction with the patient
- Any relevant information about the patient's speech/signing, e.g. aphasia, strokerelated language problems.
- Safety concerns. If so, the possibility of using a code word (e.g. "flag") for the interpreter to signal that s/he feels that his/her physical safety is threatened
- If the mental health professional has questions about the language itself of the patient, whether s/he will bring this up in the interaction itself or in a de-briefing after the interaction.
- Use of 1st person "I" by interpreter in rendering the speech/signing of the patient and of the mental health professional. Where the patient appears unsure about the role of the interpreter and appears to view him/her as the mental health professional, the interpreter may consider switching to 3rd person singular in rendering what the mental health professional has said/signed.
- Whether introduction of the interpreter includes (self-)identification of the interpreter with full name, first name or whether the interpreter prefers not to identify him-/herself.

The above are only an example of the issues that may be brought up in the briefing. A recommended practice is that at least 10 minutes should be allocated for the briefing and that the briefing time is recognised as working time for the interpreter and is thus remunerated. For family therapy sessions, it is recommended that the briefing time is between 15 and 30 minutes.

C. Outlining of interpreter's role and negotiation of role-relationship

The briefing serves the purpose of an exchange of information between the interpreter and the mental health professional, so that both are in a position to perform their tasks in the interaction itself and to know how to work together within the interaction. The interpreter should, in the briefing, outline his/her formal role as interpreter for the interaction.

The outlining of the interpreter's role is a negotiated practice: the interpreter and mental health professional negotiate and check that they know, in general terms, how the interaction may be structured, if the interpreter would like to introduce him-/herself or allow the mental

health professional to introduce him/her and for the interpreter to then outline his/her role to the patient.

Further, the briefing allows both interpreter and mental health professional to touch on issues such features of the patient's speech or signing, the patient's possible use of spoken English or code-switching, how the interpreter will render not only the content of a patient's speech or signing, but also its form, particularly where this may be incoherent, repetitive, highly figurative or metaphoric and so on.

In addition, the interpreter should enquire whether it is possible or advisable to take notes and/or which mode (consecutive/simultaneous) of interpreting can or should be used.

D. Primary contact with patient

As stated, the interpreter should discuss in the briefing with the mental health professional, issues to do with introduction (of both parties), use of names or forms of address, and explanation of role to the patient. The interpreter should either be introduced, or introduce him-/herself.

This does not have to include use of full name or first name if the interpreter does not wish to identify him-/herself. (This should be outlined in the briefing.) In the primary contact with the patient at the start of the interaction, the interpreter should consider the following to check with the patient:

- Language for which the assignment is booked, certification/accreditation level of interpreter
- Previous experience communicating via interpreters
- Ethical principles: 'completeness' of interpretations, i.e. the interpreter will interpret all speech/signing from all parties; confidentiality of interaction, i.e. no content or details of the interaction will be passed on to others
- Physical configuration of the interaction
- Use of 1st person "I" in interpretation
- Mode of interpreting (consecutive and/or simultaneous)

In addition to the patient, the interpreter may be working with family members, friends or others associated with the patient. In multi-party group interactions, the interpreter should check the above features with all those with whom s/he will be working.

E. Discourse of the mental health interaction

A key aspect of interpreting the speech/signing of others is to focus on the overall meaning of the speaker's words/oral text, or the signer's signing. Interpreters align themselves to the *content* of what is said/signed and render this in the other language. However, in mental health interpreting, the *form* of speech or signing is usually important to the mental health professional.

Mental health professionals rely not only on the referential content of a patient's speech/signing, but on the *way* the patient speaks/signs with any of the following also contributing to a diagnosis or to forms of treatment: speed, flow, intonation, cadence, repetition of particular forms, discourse markers (*you know, like*), stuttering, incoherent speech, body language, conspicuous avoidance of forms or constructions (e.g. 1st person singular "I"), conspicuous over-use of constructions (e.g. passive voice) or unusual linguistic practices (e.g. using the 3rd person singular to refer to oneself, alliteration or rhyming sequences).

F. Patient Discourse

Interpreters need to convey the features of the form of a patient's speech or signing to the mental health professional so that these are apparent to him/her in diagnosing or working with a patient in a therapeutic setting. It is often very difficult to replicate the specific features of the linguistic forms used by a patient *in* the form of the interpretation.

Where interpreters are unable to do this, or where the features *cannot* reasonably be replicated in an interpretation (e.g. stuttering, alliteration, rhymes), the interpreter should convey to the mental health professional what *form* is being employed by the patient by way of description of this form. When working with a patient, mental health professionals rely on these features of a patient's behaviour, and not only the referential content of what they say/sign.

Interpreters need to have knowledge of how illness and pain are expressed not only linguistically via terms and statements of well-being, but through other linguistic forms such as euphemism, metaphor or reference to other concepts that index health or well-being.

A patient's descriptions of his/her disposition, comfort level and concept of self will reflect his/her personal circumstances and his/her world-view. As a result, for some patients, reference to colours, numbers, places, foods or other symbols (real or metaphoric), or use of analogy or figurative language, may, for example, be the way in which they describe themselves, their symptoms and/or (those in) their environment.

For Deaf patients who use Auslan, their language use may be non-standard or idiosyncratic due to their language acquisition history (i.e., that Auslan is not their first language).

As stated, the *form* of the patient's speech is important to the mental health professional and the interpreter's interpretation of the patient's speech/signing should contain these *forms* (e.g. references to colour, numbers, places and so on.). The interpreter is advised *not* to 'make meaning' out of these forms beyond the referential content that these forms relate to. It is up to the mental health professional to 'make meaning' out of the spoken/signed interpretation, and if he/she has questions about the meaning or other significance of the patient's speech/signing then he/she will ask these questions via the interpreter to the patient.

Where the interpreter is not able to readily interpret the patient's speech/signing to reflect these forms, for whatever reason, the interpreter should describe these forms and add that this is his/her [the interpreter's] description, and not what the patient said/signed. It is important in these instances that the interpreter renders the referential content in the way that it is spoken/signed to him/her, but that he/she does not take on the role of 'meaning maker'.

A patient's language may be affected by his/her mental and/or physical condition (e.g. a person suffering from dementia may have difficulty speaking because of the physical changes that occur in the brain). A bi- or multilingual patient (of any degree of language mastery) may use one or more languages to express him-/herself, or a mix of languages and/or dialects.

The linguistic, prosodic and paralinguistic features of a patient's communicative repertoire may be symptomatically remarkable or not. A trained interpreter is ideally placed to recognise significant variation from what might fall within culturally acceptable linguistic (including prosodic and paralinguistic) parameters

G. Mental Health Professional discourse

A mental health professional may use different registers in his/her communication with different interlocutors. In general, healthcare staff are trained to use everyday English and avoid technical language when communicating with patients.

As part of a multidisciplinary team, however, an interpreter may be exposed to a wide variety of registers, including specialist and technical ones. The same applies to the communicative repertoires of patients, which may show wide variation across register and formality, as well as coherence and coherence.

A mental health professional's language may also be guided by the interpreter's linguistic choices in the rendition, as he/she may reasonably expect this to be a mirror of the LEP patient's language.

Interpreters are required to learn the most common terms, such as anxiety, Alzheimer's disease, anorexia, Asperger's syndrome, attention deficit hyperactivity disorder (ADHD), autism, bipolar disorder, bulimia, dementia, depression (including major depression), neurosis, obsessive compulsive disorder (OCD), panic attack, paranoia, phobia (agoraphobia, claustrophobia), post-traumatic stress disorder (PTSD), psychosis, and schizophrenia.

It is important to note that some common terms, e.g. dementia and autism, are not mental health disorders *per se* but can affect thinking, behaviour and mood.

Each term has its definition, symptoms and treatments. Terminology is a part of an interpreter skill repertoire, and interpreters are encouraged not only to know the translation of the various terms, but also learn about the various conditions and the types of medication most commonly used to treat them.

Understanding how a condition, disorder or illness presents is important for knowing how an interpreter can recognise signs of potentially dangerous behaviour. This recommendation includes symptoms that are not only mental ones, but physical ones as well.

The physical behaviour of a patient, which includes verbal/signing as well as non-verbal/nonmanual behaviour, are very often reflective of the mental health condition that a patient has. It is recommended that interpreters learn about the typical physical symptoms that patients with common mental health conditions often display.

This knowledge serves the purpose of allowing the interpreter to focus more on the verbal/signed behaviour and to not needlessly be distracted by behaviour that may be unusual but nonetheless common amongst patients with particular conditions.

Nonetheless, the significance of body language and other paralinguistic or prosodic features are as important as words or signs. Where patients repeat the same things, these repetitions should be interpreted into English by the interpreter.

4. Self-care in mental health interpreting

Briefings and de-briefings are practices that are recommended and that interpreters find helpful, but that are not always provided. Briefings and de-briefings should be viewed as part of the interpreted session.

De-briefings allow the interpreter to bring up issues that relate to the interpreted interaction. These may include the speech/signing of the patient that the interpreter may have difficulty understanding or rendering this into spoken English. These may also include re-visiting difficult situations in which the patient was distressed or appeared to be traumatised.

Discussion and reflection on these can assist an interpreter in dealing with and managing an interaction that was upsetting or highly stressful.

Mental health interpreters, like mental health professionals, are exposed to stressful situations on a regular basis through the nature of their work. The cumulative effect of their work can have a negative effect on their own mental health.

Interpreters, like mental health professionals, are exposed to the same risks of developing secondary traumatic stress (STS), vicarious trauma (VT) and burnout. The symptoms of STS are intrusion, avoidance and hyper-arousal. Intrusion is the inability to keep memories of an event from returning.

There are 'conventional' ways to deal with work-related stress, such as engaging in activities that are removed from work, and that distract or stimulate a person in other ways, e.g. listening to music, physical exercise and meditation. These strategies can often deal with stress encountered and lead to a management of the stress so that the interpreter is still able to work and not suffer an uncomfortably high level of discomfort.

However, a cumulative effect of working in distressing and stressful situations from the behaviour of others is STS, which can lead to burnout. Burnout is associated with emotional exhaustion (e.g. low energy levels, depleted emotional resources), depersonalisation (e.g. detachment in response to some aspects of employment), and reduced personal accomplishment (e.g. negative self-evaluation).

Where interpreters experience STS that may then develop to VT or even burnout, they should consider professional counselling services, for example via the Employee Assistance Program (EAP). The EAP is available in public healthcare facilities across Australia and is available to in-house interpreters working at these.

Freelance interpreters who accept contracted assignments have, at present, variable access to EAP, depending on the Language Services Providers with whom they are contracted. Having a self-care pathway identifying the types of assistance available for the different issues that arise is an important feature for interpreter self-care and well-being.

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