The main duty of the mental health interpreter is the faithful conveyance of a message via speech, albeit in a conscientious manner by helping clinicians and patients overcome communication obstacles caused by cultural differences. As James Whitney Hicks, a practicing psychiatrist in New York City and an instructor at New York University Medical Center, states: “Psychiatrists pay close attention to speech. It is through speech that we understand what is on a person’s mind. You tell a story about your concerns and how they developed, and psychiatrists extract from this a pattern of illness.” Since diagnosis will take place mainly from self-reported symptoms and descriptions, it is obvious that the use of an unknowledgeable interpreter may distort the clinician’s view of the patient’s mental status, since the words or thoughts that the clinician will hear can be unconsciously or consciously filtered by the interpreter. The following will explore briefly the external and internal processes involved in mental health interpreting, including an overview of some of the speech patterns that signify mental illness.

Diagnosis of Mental Illness through Speech

Mental illness is extremely common. A study published by Harvard Medical School’s Ronald Kessler indicated that 46% of Americans are at risk of developing a mental illness in their lifetime. Fortunately, for the most part, mental illness is very treatable.
In the U.S., mental disorders are diagnosed based on the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V)*. This manual is a compendium of diagnostic criteria for mental illnesses and a valuable resource that can be purchased by anyone who would like an in-depth knowledge of diagnoses, symptoms, and treatments.

When compiling a psychiatric assessment report and treatment plan, the clinician will first determine an initial diagnosis based on self-reported symptoms obtained during a client’s oral history. The types of information the clinician gathers from a client’s oral history include the presenting complaint (the reason for the visit), past psychiatric and medical history, family history, personal history, social circumstances, whether there is any drug and alcohol abuse, and forensic history. From this information, the clinician will then assess whether there are any co-occurring developmental or personality disorders (e.g., paranoid disorder). After that, the clinician will determine if there is a medical condition that is contributing to the continuance, development, or exacerbation of the diagnosis reached. For example, the use of corticosteroids in the treatment of a chronic illness could cause mania.) During the interview, the clinician should be able to detect conditions and life stressors within the environment of the client that might contribute to the illnesses reported. Some of the most common conditions and their associated symptoms include:

- **Anxiety:** Mild heart palpitations, dizziness, and excessive worry.

- **Bipolar Disorder:** Symptoms of depression that alternate with extreme euphoria, marked by excessive energy, reduced need for sleep, grandiose ideas, lack of impulse control, and a tendency to be easily distracted.

- **Depression:** Sadness, emptiness, hopelessness, reduced activity in pleasurable activities, sleep disturbance, low energy, difficulty in concentrating, and suicidal thoughts or attempts.

- **Panic Disorder:** Attacks of fear/anxiety, heart palpitations, shortness of breath (often described as “chest pain,” with the client thinking he or she is going to die or is having a heart attack).

- **Psychotic Disorder (Including Schizophrenia):** Delusions, hallucinations, and disorganized thinking, behavior, or speech.

During the final diagnostic stage, the clinician will determine a baseline for a high level of functionality, which will assist him or her in monitoring improvements or worsening symptoms and the effectiveness of treatment.

### Cultural Issues Related to Diagnosis

Mental health issues are universal, but their manifestations differ from person to person and from culture to culture. Therefore, the American Psychiatric Association warns clinicians:

Diagnostic assessment can be especially challenging when a clinician from one ethnic or cultural group uses the *DSM* Classification to evaluate an individual from a different ethnic or cultural group. A clinician who is unfamiliar with the nuances of an individual’s cultural frame of reference may incorrectly judge as psychopathology those normal variations in behavior, beliefs, or experience that are particular to the individual’s culture.

Although culture-bound syndromes and idioms of distress are mentioned briefly in commonly used resources such as the World Health Organization’s *International Classification of Diseases and DSM-V*, they have not been researched adequately. Therefore, the interpreter, with practice, time, immersion, and through continued dialogue with members of the population for which he or she interprets, must formulate a personal mental database from which to draw and infer if the descriptions proffered by a particular client are culturally bound.

What are idioms of stress and culture-bound syndromes? An excerpt from *Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General* offers the following definitions:

- **Idioms of Distress:** Idioms of distress are ways in which different cultures express, experience, and cope with feelings of distress. One example is somatization, or the expression of distress through physical symptoms. Stomach disturbances, excessive gas, palpitations, and chest pain are common forms of somatization in Puerto Ricans, Mexican Americans, and Caucasians. Some Asian groups express more cardiopulmonary and vestibular symptoms, such as dizziness, vertigo, and blurred vision. In Africa and South Asia, somatization sometimes takes the form of the person experiencing the sensation of burning hands and feet, or feeling worms in the head or ants crawling under the skin.

- **Culture-Bound Syndromes:** Culture-bound syndromes are clusters of symptoms much more common in some cultures than in others. For example, some Latino patients, especially women from the Caribbean, display *ataque*.
Mental health issues are universal, but their manifestations differ from person to person and from culture to culture.

Dealing with Unusual Speech

When a client’s mental functions are impaired sufficiently, his or her language may no longer make sense. Aphasia is an example of a condition that impairs language, where, because of a change in brain pathology, the patient becomes unable to use words as symbols. Extremely disorganized thinking that occurs during psychosis (loss of contact with reality) is immediately apparent because the speech is often nonsensical or illogical. For example, the question “How are you feeling today?” may elicit the response “I was okay and these green men in black cars. I was walking. The street and the movies, but the lights and they were flying okay.”

Interpreters should never try to edit or logically reconstruct nonsensical speech (or explicit or offensive speech, for that matter), since this could hamper the clinician’s assessment of true mental health status. Instead, if the interpreter understands the distinct words utilized, he or she should try to repeat the utterances verbatim. If the speech is so disjointed and incoherent so as to make verbatim interpreting impossible, the interpreter can switch to a descriptive mode. For example, the interpreter could interpret the response in the paragraph above this way: “He is speaking very rapidly and is saying something about ‘I was okay’ … green men, black cars … walking … street … movies … lights … flying … okay.”

In severe cases, the words may be completely unrelated to each other, or a client may speak to a hallucination or be delusional. In these situations, the interpreter should not dispute what the client holds to be true or attempt to correct the words,

de nervios, a condition that includes screaming uncontrollably, attacks of crying, trembling, and verbal or physical aggression. Fainting or seizure-like episodes and suicidal gestures may sometimes accompany these symptoms. A culture-bound syndrome from Japan is tajin jyufusho, an intense fear that one’s body or bodily functions give offense to others.6

At this point, it might help to provide an example of interpreting an idiom of distress. Spanish-speaking clients from Mexico may attribute their symptoms to aire. This can be translated loosely as “wind” or “air,” but is used to describe any strange and sudden unknown ailment in which the spirit is knocked or dislodged from the body by a sudden fright, trauma, or illness. An interpreter would not be able to translate the phrase Me dio aire literally as “I was invaded by wind,” since this rendition might cause the clinician to believe that the client was speaking irrationally. If what the client says is in any way unclear, the interpreter should ask the client directly for an explanation (after letting the clinician know) and then interpret the response. The client’s own definition or description of the phrase in question can usually provide either the interpreter or clinician with a clue as to whether or not the client’s speech pattern could be attributed to a psychological condition.

If the interpreter does not know what a term means, he or she could preface the interpretation with a brief explanation of the culture-bound term and its significance. The interpreter should always let both parties know of such terms and their relevance to the communication process. However, interpreters should be careful not to assume that the term or description utilized by one person means the same thing for each individual. If there is doubt, the interpreter should request clarification, or follow the lead of the clinician, who will often ask a follow-up question such as “When you said ‘this,’ what did you mean?” or “What does this mean to you?”

Also, the interpreter should never assume that he or she knows what the client is thinking and convert a culture-bound syndrome automatically into a textbook one (e.g., by interpreting ataque de nervios as “panic attack” or “nervous breakdown”). Instead, the interpreter should allow the clinician to determine whether the described symptoms fit the diagnostic criteria of a certain psychological syndrome.

The goal of every interpreter should be to educate clinicians and other health professionals as much as possible regarding frequently encountered cultural symptoms and descriptions, so as to foster trust building between the client and health professional. This education should preferably take place outside of the clinician’s encounter with the client, so as not to hamper the communication process.

To this end, interpreters should try to locate information that takes into consideration the symptoms and descriptions utilized by the populations for which they will be interpreting. They can also compile a list of resources and glossaries for themselves and the health professionals with whom they work. However, interpreters must never forget that although their job is to promote good outcomes and diagnosis by interpreting the client’s thoughts accurately, once they have helped the clinician overcome any obstacles related to language or culture, the ultimate responsibility of the diagnosis and outcome is the clinician’s, not the interpreter’s.
since the client is unaware that he or she is not making sense and is probably frustrated that others cannot understand. Instead, the interpreter should work with the treatment team by being supportive and clear in all communication with the client. If the client becomes louder or more insistent or does not understand the interpreter, the interpreter should request a break rather than continuing. During this time, the interpreter can apologize to the client for being unable to understand and acknowledge that this must be causing the client distress. As James Hicks recommends in *Fifty Signs of Mental Illness*:

You may find it helpful to tell him what you think he is saying, so that he can tell you if you have understood him more or less. He may be able to say yes or no even if he has difficulty putting together more complicated answers. I find that a psychotic patient is often greatly relieved to realize that someone has understood him, since the world has otherwise become such a lonely, frightening, and confusing place.8

There are other speech patterns or observations that an interpreter should describe to the treatment team. For example, a clinician who does not understand a language will not be able to detect stuttering, low affect (a flat or situationally inappropriate tone with reduced range of emotion that is not indicative of the person’s culture), or rapid speech. Sometimes clients will simply immediately repeat back what is being said to them (referred to as echolalia), make up words, use actual words in unusual ways, or believe they are speaking in tongues or foreign languages. Another speech disorder interpreters may encounter is referred to as clanging, where the client clumps words together that begin or end with the same sound. This may include compulsive rhyming or alliteration without an apparent logical connection between words. (Here, the interpreter might be able to notice a distinct speech pattern; for example, the client is speaking in nursery rhymes from his or her country.) In all of these cases, the interpreter must not only interpret the decipherable aspects of the speech, but describe the speech for the clinician.

**A Crucial Role**

There are still many mental health interpreting issues that remain to be explored and verified by the medical and interpreting community. However, the role of the interpreter in mental health cannot be disputed. It is an all encompassing and crucial one, since the interpreter holds the key to helping the clinician unlock the door to the mental status of the client. In the absence of comprehensive education resources and official opinions, mental health interpreters must educate themselves on the external and internal processes of mental health interpreting in order to foster quality of care and proper diagnosis. They must also do this while balancing professionalism, safety, and consumer welfare.

**Notes**

2. “Mental Health: Overcoming the Stigma of Mental Illness” (Mayo Clinic Foundation for Medical Education and Research, 2009), www.mayoclinic.com/health/mental-health/MH00076.
6. Ibid.

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**Reminder: Beware of Scams**

If it is too good to be true, it is probably a scam. A number of e-mail and online scams have specifically targeted translators and interpreters. Stay vigilant!

ATA Members and Internet Scams
www.atanet.org/membership/internet_scams.php

National White Collar Crime Center
www.nw3c.org