THE EXPERIENCES OF INTERPRETERS IN MENTAL HEALTH ENCOUNTERS – A QUALITATIVE STUDY

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ABSTRACT

It has been recognized that high quality communication is required to help improve shared decision making between clinicians and patients. This makes the role of the interpreter all the more important to help LEP, or emerging English speakers in mental health encounters. While there are many studies on the clinician and patient experiences in cross-cultural mental health encounters, there are only a few qualitative studies that look at the interpreter experiences. As mental health issues in LEP or emerging English speakers increase, there is a gap in the literature as to how to successfully improve the quality of care using interpreters in mental health encounters.

Using qualitative methods, this study aims to address this gap by exploring the experiences of interpreters when interpreting for mental health encounters. Seventeen interpreters from the Philadelphia area were interviewed, representing 19 languages (8 Spanish only, 1 Nepali only, the rest interpret for multiple languages). They were asked about the following: 1) challenging experiences in the triadic relationship between interpreter, clinician and patient when discussing mental and emotional health, 2) their experiences in interpreting mental health concepts into another language, 3) their experiences in culture brokering and 4) their opinions on how to improve mental health encounters using interpreters

Findings include that mental health concepts and queries can be challenging to translate due to language differences (structure, limited vocabulary), cultural differences (including stigma), the interpreter is often called to cross professional boundaries by both patient and clinician, many interpreters desire mental health training, and feel that

clinicians need training on how to work with interpreters. The findings from this study should be further explored, in order to improve communication, and thus support the agency and autonomy of emerging English speakers in mental health encounters.

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CHAPTER 1: INTRODUCTION

Limited English Proficiency (LEP) is defined by the Department of Health and Human Services as difficulty in communicating effectively in English when English is not your primary language. Title VI of the Civil Rights Act of 1964 requires recipients of Federal financial assistance (including medical facilities that accept Medicaid and Medicare) to make interpretation services accessible to LEP persons.[1] In 2000 President Clinton signed a stipulation to Title VI of the Civil Rights Act that language be included in anti-discrimination in health care settings. Specifically, it states, "Persons with limited English proficiency must be afforded a meaningful opportunity to participate in programs that receive Federal funds. Policies and practices may not deny or have the effect of denying persons with limited English proficiency equal access to Federally-funded programs for which such persons qualify."[2]

In 2012, Brisset and Leanza undertook a meta-analysis of 61 qualitative studies on interpretation in health care settings in the US, Canada and the UK. These studies were equally weighed between clinician and interpreter. Among the issues they discuss are that trust, control and power are an integral part of the triangulated relationship between patient, interpreter and clinician. In addition, non-literal translation appears to be a prerequisite for effective and accurate communication. Finally, they conclude that researchers need to investigate how relational issues in interpreted interactions affect patient care and health, and this is the next step in improving the quality of care[3].

It has been recognized that high quality communication is required to help improve shared decision making between clinicians and patients[4]. This makes the role of the interpreter all the more important to help improve the patient-clinician experience.

Most qualitative studies investigate the clinician and/or the patients' point of view in general medical contexts. Factors affecting high quality communication included lack of appropriate interpretation, poor quality of interpretation, lack of time, and lack of cultural understanding by healthcare workers, which often resulted in inadequate and superficial health care and dissatisfaction and lack of adherence by patients[5]. For the healthcare providers the barriers also included communication barriers, difficulties finding interpreters, difficulties with interpretation of abstract concepts for patients with low health literacy[6].

The importance of interpreters as cultural brokers has been acknowledged, where, in addition to linguistic interpretation, the interpreter provides the clinician sociocultural context to the clinician. However, their opinions on their role in the encounter has not been well studied.

Studies that specifically look at the interpreter experience discuss the triadic relationship between clinician and patient, which is mediated by the interpreter. Raymond discusses many types of interpretation that occur, beyond linguistic, and how knowledge is transferred by the interpreter in both directions. This knowledge includes culture brokering to the clinician and knowledge brokering to the patient[7].

Another area that is not as well studied is the experiences of interpreters in mental health care. The COVID-19 pandemic brought to light the increase in long-standing health disparities, both physical and psychological, among minority and immigrant populations. Mental health needs in all populations have been well documented. A meta-analysis of 43 studies among the general US population showed a general lower psychological well-being and higher rates of anxiety and depression post-pandemic[8].

These disparities widened for LEP communities, who already have difficulties accessing quality mental health care[9].

There are only a few qualitative studies that look at the interpreter experiences in a mental health context, which have small number of participants. These studies found similar themes: the importance of a pre- and post-briefing with the clinician to improve the triadic relationship, the desire for more acknowledgement and respect for the interpreter's role on the clinician side, and the need for more training in mental health for the interpreter. As mental health issues in LEP, or emerging English speakers increase, there is a gap in the literature as to how to successfully improve the quality of care.

Using qualitative methods, this study aims to address overlapping gaps in the literature by exploring the experiences of interpreters when interpreting for mental health encounters. The objectives of this study were to 1) investigate the perceptions from interpreters of their experiences in the triadic relationship between interpreter, clinician and patient when discussing mental and emotional health, 2) elicit their experiences in interpreting mental health concepts into another language, 3) elicit their experiences in culture brokering and 4) query their opinions on how their role may help improve the encounter.

Methods

17 semi-structured, open-ended interviews were conducted between January and March 2022. The interviews focused on interpreters' challenges during mental health encounters, including cultural and linguistic based challenges, and their opinion of how to improve mental health encounters using interpreters. The interview guide was written by

the principle investigator, after a review of literature, and in consult with the research advisor. The guide was revised after receiving feedback initial practice two professional interpreters (not included in the study). One-on-one interviews were conducted following a semi-structured interview guide. Interviews were conducted over Zoom, and recorded and transcribed by Otter. The principal investigator then reviewed the recordings and corrected the transcripts. Recordings and transcripts were deidentified and store securely on Teams.

Recruitment

This study was approved by the Lewis Katz School of Medicine at Temple University IRB. Participants were recruited using purposive and snowballing methods. Interpreters from local large academic hospitals with in-house interpreters and local language service agencies were queried on their interest in the study via email.

Description of Setting

Philadelphia a large urban area in the Northeast United States with multiple academic and community hospitals, and a wide variety of mental health inpatient and outpatient providers. The immigrant population is predominantly from Spanish speaking countries, but there are also large numbers of immigrants and refugees from the Middle East, Africa, and Asia.

Reflexivity

The principle investigator is a primary care pediatrician with 20 years of experience in Philadelphia, and works in a neighborhood with a high number of immigrants and refugees. She also has extensive experience working abroad and has been

working at her hospital's refugee clinic for the past 11 years. She also has done additional training in mental health and is involved in teaching in a mental health training program for primary care providers at her hospital.

Description of Participants

Participants interpreted for a variety of languages, predominantly Spanish (8). Most (10) were bilingual, interpreting for one language, the remaining 7 participants interpret for many languages, representing the multilingual nature of their home country as well as their immigrant and refugee experience Languages interpreted by participants were Spanish (8), Arabic (2), Nepali (2), French (2), Bengali, Burmese, Cantonese, Dari, Farsi, Fur, Hindi, Italian, Karen, Kinyarwanda, Kinyamurenge, Kirundi, Mandarin, Swahili, Urdu (1).

Three were born in the US, one in Puerto Rico, and the rest outside of the US. Seven participants came to the US as refugees, and seven were immigrants. Eleven became interpreters to fill a community need, 4 to help family and 3 became interpreters as a primary career goal.

Their average age was 48, median 45. They had an average of 17 years of education, ranging from 13 to 23 years. The participants reported a range of experience in interpreting for mental health, including behavioral and mental health settings (16), general medicine/pediatrics/subspecialty (11), court and legal settings (ie: involuntary admissions) (5), and emergency department (4). Four had received official mental health training for interpreters.

Data Analysis

Interviews were coded by the principle investigator and advisor until themes were agreed upon and concurrence in coding was achieved. See Appendix A for the interview guide and Appendix B for the codebook. The principle investigator then coded the interviews in NVIVO 12.

Results

Question: Walk me through the last time you interpreted for a mental health or discussion of emotions?

Was there anything challenging about this experience? (in terms of patient understanding mental health terms, and clinician understanding patient's expectations)

Was there anything unexpected?

Table 1 presents both the number of interviews the themes appeared in as well as the number of instances of coded text.

Experience	**# respondents**	**# references**
Boundary Crossing (community encounters, asked for opinion, privacy)	13	24
Difficult to interpret due to stigma	9	15
Not in person (telephone, video)	6	7
Interpreter affected by patient's experience	5	7
Mental health is more difficult to interpret than medical	4	4
Safety	4	4
Not interpreter's first language	3	5
US centerism	3	6
Time	1	1

Table 1: Challenging Experiences

The most common challenge noted was boundary crossing.

In some cases, there were privacy concerns due to the interpreter being known in the community:

When I was working at (Agency), we had an incident when one of the Swahili interpreters. A client came back complaining, so we didn't know where was that coming from. But also I understood that when an interpreter lives in the same community, in the same neighborhood with patient or clients, neighbors can say something (private) and then they will be like, "oh I know so and so was in the room when I said it, maybe they want to spread the word." And sometimes they forget that actually the neighborhood is very small and people in their community can talk to each other and stuff like that. So that I took it at heart as a lesson just telling them that everything is safe to me. It's just going to stay here. Even if we meet outside. I am not going to say anything. Because I find myself like interpreting for so many languages and all these people live here in Philadelphia. And sometimes I meet them when I'm helping them with like financial aid

for their children. So I just want to make sure that I'm putting myself in a place where they feel respected and they can continue to trust me regardless.

Another common challenge was being asked to work outside their defined roles:

Another thing that's a little bit hard is that sometimes in different facilities or hospitals, they expect you to go in the bedrooms and sit with the patients and they you're there to interact with the patient. It's like you're their interpreter. You're the only one that speaks Spanish. You're the one that's supposed to be having a conversation with them and talking and then they come and ask you "Hey, what do you think about this? Do you think that he's coherent? Do you think this?" I don't know. I'm an interpreter, and I'm not here to evaluate your patients or let you know how it's going. You can ask the questions and I will respond and I will interpret but I'm not the one to give an opinion.

Some interpreters mentioned that patients had difficulty answering standardized mental health questions, commonly used in the United States:

Most of us (interpreters) do not like mental health encounters. Because the kinds of questioning that they do is very centered in US culture. And I hesitate to say that because the culture of the US is very eclectic, really. But for the most part, it's very white Anglo focused. And so it doesn't translate well when you're working with a patient, who is from a different culture, and who really is far removed.

The English the standard intake form or the standard intake language that is there, I think that has been created with so much thought , so much of discussion and refined language. So, that is that is really crisp.. But you know, and that has come in a cultural setting, you know, like, for, say it that was developed here in America, so, that has to do with American culture, you know, how American way of life. A lot of time people in the community in the Bhutanese Nepali community, if you want to be specific, do not understand the concept. They totally do not understand. Because this is not something that is talked about in a family setting, in a community setting. So, like, if you feel when a question is something like, you know ...in the last seven days, how do you rate your, you know, mood or something like that, right? How, how do you say like, in a scale of zero to 10? How do you say, like, if you say you are sad, what was the degree of sadness, like from the scale of zero to 10? In the first place, you know, they cannot say, like, in that specific seven days, you know, how often...like, "do you call it often?" "the usual?", you know, these kind of things. So, they won't be able to really pinpoint, you know. And the degree of zero to 10 scale is absolutely, you know, it does not make sense.

Many patients have low level of education and low health literacy, which makes the mentalhealth encounter difficult, even if their language has mental health terms:

Most of my of my patients, they come from countryside. Some of them even never go to school. They cannot read and write in Chinese even, you know. So it's very difficult to communicate with them. Especially at a doctor's office, you know, even talking to them like a daily conversation is hard. No saying like medical terms or medical diagnosis, you know, or treatments. They just cannot understand. And sometimes the children didn't come with the parent. So it leaves everything on us to explain to the patient what is going on. And so by the end of the visit, what I usually do is I write down everything on a sheet...on the paper on the after visit summary. I would translate it into Chinese, like with just a simple summary of like the diagnosis, the next visit, the medication, you know, things like that. And it happened a couple of times that the patient just told me, "Oh, I cannot read Chinese". And I don't know what to do, you know..."okay, you don't understand what I'm trying to explain to you in Chinese and you cannot read Chinese. What am I going to do?" So I have to have the patient , "call your son or your daughter put him or her on the phone. I have to talk to them. What is going on today and what they need to do after you go home," you know. So it's very stressful, very frustrate for me, for me, you know, because I felt like I have the burden I have to take care of the patient. But I don't know how you know, it's like you you're facing the person who's deaf or who's blind and who's, you know, even dementia.

The stigma of mental health was also a commonly mentioned challenge by the interpreters:

...culturally, they don't want to admit that they have somebody who is mentally ill. They don't want that. You don't say that he has a mental issue. They say "he's in a bad mood". They use always figurative words, which are not directly interpreted that this guy has a mental issue and should be treated in another way. Because the family, the family feel offended.

It's like, don't talk about it. You absolutely don't talk about it and it manifests, depression manifests...

Some interpreters try to help the patients overcome stigma by comparing it to medical issues:

So when you said that it's mental, they say, "Oh, I'm not crazy!". You say like that. It's like are we have in our language? It's a very, like, few (words in our) language. Or not able to translate the thing. So you have to describe. "Okay, you're not, you're not crazy, you not fool. You are, you need help. Like the body we have to see the doctor. For our mind, our think, they like need help. So both of them, body and mind, we need like a help. Not only the body. So that's why for your heart for your mind. For your thinking is like, you need happy." So yeah, I have to explain in different ways

.

Another interpreter worked on a project to develop a glossary for mental health terms:

...it was a group of interpreters, we worked on a glossary in different languages. So we did in Swahili. So for me since then, I have been able to use this Swahili word and try to get meaning in other languages. Because that's easy that way, so that at least I can. It can be appropriate and they understand that actually, we're not saying that you're crazy. You are sick. It's, it's an illness, it has a name. You are not crazy. Just like from that glossary I have been able to just like write some word that I use frequently. In other languages, and now I have been really using it. And the more I use it I find that actually, things are getting even more easier.

Question: Did you interpret word for word, or did you have to reword responses from either side?

Table 2 presents both the number of interviews the themes appeared in as well as the number of instances of coded text.

Response	**# respondents**	**# references**
Yes	6	7
No, meaning for meaning, because no equivalent words (vocabulary)	9	14
No, meaning for meaning, due to patient's limited awareness or education	2	3
No, different language structure	5	7
No, interpreter needs to explain intent of question	4	5
No, role of body language	5	9
Use of idioms	1	1

Table 2: Did you interpret word for word?

Most interpreters reported that they do not interpret word-for-word, for a variety of reasons:

Some languages do not have many words in general:

It's a very like few (words in our) language. Oh no, not able to translate the thing. So you have to describe… Actually it's the emotion. Emotion, like in America, they have like many things, happy or excited or as many things right. But in our language we don't have like that.

Other languages do not have many words used in English for mental health:

Because we don't have enough word about mental health in our language...they just literally translated as being crazy or losing your mind

Even if the word like let me say, like stigmatization, we don't have it, PTSD, we do not have it.

Many interpreters talked about interpreting meaning for meaning:

I like to interpret mainly the meaning. Because if I if I interpret word by word, you know, I would be like Google interpretation.

What makes tricky about that is you're not only interpreting, but you're sort of intuiting what the intent is of the question, "what's behind this? What is it trying to get at? " So that when you interpret, you're interpreting meaning versus words… Sometimes I'll give it a little bit more than what she's given it in terms of expanding on, not the question, but you have to use a few more words, to explain what what the intent of the question is, what's that? What is the underlying meaning of the question?

Interpreting meaning for meaning takes longer, which can frustrate the clinician:

A sentence might take might become a paragraph when you're trying to interpret it, because, you know, if you just say that transliterated or you just try to say as much as it is trying to, like, in as many words or as much time, then it will not convey the message, you'll have to explain what that particular phrase or what that particular sentence is trying to convey. Bringing that into the cultural context of the person.

Because we don't have like a targeted word that the doctor is speaking in our language. Like we cannot interpret directly. So you have to go around to explain to the people where the doctor will feel like weird, like "why you talk so much? I just talked few words, and why you talk so much?"

One interpreter felt that word-for-word helps convey the state of mind of the patient:

If someone is having a manic, or you know, someone it's like talking 100 miles an hour blah, blah, blah. You know, and "Superman and and then "I'm in the computer, and I play another"...You just keep on going, because if I change anything, I'm disturbing the diagnosis. You can't do that.

Sometimes the interpreter needs to interrupt when the patient does not understand the clinician's question:

So on that time, we are like kind of asking the doctors, I need to like we need more clarification for this point. Can you make it more clear this question? Or can you give me permission to make clear and their own language concepts are such a small example for the patient? For example, if this happens, what do you gonna do? Or something like that?

Sometimes the clinician understands the language and feels that the interpreter is getting it wrong:

I've been scolded by therapists, saying, you're not saying what I'm saying. Because they speak some Spanish and they're literally listening to what you're saying. And that's not literally what they said, but I'm not interpreting literally, I'm interpreting meaning. And so meaning ... you can have two interpreters interpreting the same person, but their word selections may be different, right? They're both correct.

Some interpreters mentioned the importance of body language:

If the patient is looking down instead of answering you need to interpret that. Are they being shy? Are they just not feeling safe to interpret it or it's just like culturally not appropriate for another person to say specific things to a young person. So if you can break it down without offending the patient and you let them know, okay, you're safe. Don't feel shy because I'm here.

Question: Give me an example of when you were culturally aligned with a patient.

Give me an example of when you were not culturally aligned with a patient?

Table 3 presents both the number of interviews the themes appeared in as well as the number of instances of coded text.

Response	# **respondents**	# **references**
Culturally aligned	12	21
Shared refugee experience	3	6
Not culturally aligned	12	17
Not culturally aligned, understand	3	4
Religion	5	6
Role of Gender	5	6

Table 3: Cultural alignment

Culturally aligned: One interpreter related an incident where they were able to give a clinician some cultural context about a patient which was important for her therapy:

So the son gets everything, all the privilege in the family. The girl has nothing, Especially this poor girl. She's the second daughter. She's not the older one. So she is in a very bad situation that nobody ever pay attention to her, you know, or listen to her. And on top of that, she has epilepsy. So both her siblings in her parents kind of abuse her, you know, verbally or mentally, you know, not physically though. So in that case, after a couple of sessions with their family, I realized because the girl was so upset after each session, she doesn't want her mother and her siblings to come you know. She wants just talk to her individually. So I have to ...after the second session finish, I have to talk to the therapist separately, privately and gave her the background information of how difficult it is to be in a girl in a family. The second daughter, not a son, who everybody wants, you know, and with the life of epilepsy. And so I talked to the therapist about it and talked to her about how the mother, at least in my eyes, I can tell that she's abusing the daughter, you know, with her words and her facial expression and her tone, you know. And so, the therapist appreciate very much about my input, you know, like I gave her the background of the cultural differences you know, in in the United States, you never think as a lot of parents, they never realized they would treat their daughter and son differently. But in

China, that is a completely different story, you know? So that's what I mean. If you just interpret by word by word, you'll never get that.

Not culturally aligned:

I think that the Caribbean, the Caribbean, the Caribbean islands in general, they are so diverse. That I have had those situations and for example, with Dominican Republic, not so much as Puerto Rico or anything like that. But Dominican Republic in itself, I think is so rich in culture. Yes, I've had situations like yeah, that could have been way more smooth if I would have known a lot more.

Question: Do you think it's important to have the same cultural background as a patient? Why or why not?

Table 4 presents both the number of interviews the themes appeared in as well as the number of instances of coded text.

Response	**# respondents**	**# references**
Yes	11	20
Yes (answered for clinician)	2	2
No	4	6

Table 4: Is it important for interpreter to have same cultural background as patient?

Most respondents felt that it was important for the interpreter to share the same culture as the patient in mental health encounters.

I think it's very helpful, especially when it's, especially with mental health and behavioral health, like, it's just you talking about some delicate things, and you don't want to be stopping every five minutes, interpreter needs clarification or back and forth. I would say depending, like, if it's something that's very, it's going to be very serious.

I've had situations when they look at you sometimes like the angel in the room, you know, like the, the peace of mind. So yeah, for sure. It is important.

Even if there is language concordance, some interpreters discussed the importance of being aware of cultural differences:

And honestly, I think it's important because a lot of things can be missed in translation and you may be lost as an interpreter because you just don't understand.

...even you speak the language. If you are not from the same culture you might not understand. There's some views from community to community you see, those change. Which other people cannot understand only those who live in the same community. And they have that same culture. So the cultural barriers and the cultural scene is a very big issue.

Question: What areas of improvement do you see in mental health conversations using an interpreter?

Table 5 presents both the number of interviews the themes appeared in as well as the number of instances of coded text.

Response	# **respondents**	# **references**
Desire for pre- and post-sessions	9	10
Know therapist, collaboration, make interpreter part of team	4	6
More time	6	6
Answered for CLINICIAN improvement	4	8
Answered for PATIENT improvement	1	1

Table 5: Areas of improvement

Pre- and Post- sessions:

A little bit more info for the interpreter helps interpreter make ready or set their mind to that appointment, that okay, I'm going to be in this appointment. "The patient is going to be...", "This is the third session of therapy that he or she is taking". Or what is

the questions is going to be, especially the names of medication you're asking because that medications or the doctors are prescribing it and you're not aware of what medications he or she takes, what stage that patient is So, general help for the interpreter mixed interpretation more effective between the parties I can say.

More Time:

Time really giving the patient time and the interpreter time. I feel like time, most of the time, has been a challenging thing because I totally understand like providers has certain amount of minutes or an hour for patients. And sometimes if patients just want to talk about everything, and as an interpreter, there is just a certain way you don't want to just cutting short people. I rather take notes, or just memorize everything than interrupting them, because I know if I interrupt them to me not coming back to the same point. I think time is the most important things.

Some interpreters expressed a desire for more collaboration and team building:

(S)ometimes, when you know what therapist it's easier to work with that. If you've interpreted for them before. It allows you to have sort of a base with them.

And it is the relationship between the family and the therapist is very important. And so the more they can connect with them, is so important because there's a third person involved. And so they have to include that person. You can't ignore the interpreter there.

Some interpreters understood the question as areas of improvement for clinicians:

So being aware of cultural differences, being aware that the patient or the parent might or the patient might not be aware of how the system works here in the United States is important.

Question: Do you think there should be a mental health training for interpreters?

Table 6 presents both the number of interviews the themes appeared in as well as the number of instances of coded text.

Response	# respondents	# references
Yes	8	12
No	1	2

Table 6: Should there be a mental health training for interpreters?

Question: What should a mental health training for interpreters include?

Table 7 presents both the number of interviews the themes appeared in as well as the number of instances of coded text.

Response	# respondents	# references
Mental Health/Psychology	9	16
Mental Health Diagnosis	4	6
Giving bad news	1	1
How to interpret for different types of encounters	2	2
Mental Health vocabulary	4	4
Safety	3	3
How to engage the therapist	1	1

Table 7: What should be included in a mental health training for interpreters?

Many of the respondents felt that a better understanding of mental health diagnoses and treatment would help them with their job:

I think that interpreters have a vision of the symptoms or how, you know, how does the disease looks. We do our research in that. But I think it will be very interesting to see what is really the, the, either the doctor, the nurse, what are they looking for? A little bit more about understanding or filing that gap of having a more integration between us.

In my high school years, or even college years I never had a single class of psychology. Okay. I never even heard about psychology, the word of psychology. Everything I learned about psychology was after I came to United States in graduate school. I actually did take a couple of courses of psychology and therapy back in graduate school. So I think, I think people should, interpreters should probably, you know, have some background training of, of basic psychology and therapy courses, you know. Like, like counseling, at least, like counseling or therapy courses. Because if you don't...if there are a lot of words you never heard about, like, of course, depression, anxiety, that kind of thing.

The importance safety training in mental health encounters was also mentioned:

I think safety is a big one. Safety. I was trained as a nursing assistant in something called CPI just you know, crisis prevention, you know, and I've had a lot of situations when it's like, this person, as an interpreter because I've worked with a team right? They should have benefit from that. You know. You should have not placed yourself in this position of risk. Yeah, kind of empower sorts of interpreter because you get in the room and you know that you're in control, the idea not just depending on somebody else to tell you "don't do that". You know, right, right. It's important for us to understand what is happening and what is safe and what isn't. That is a big deal.

Discussion

Language and cultural barriers, as well as low health literacy, can negatively affect the quality of mental health care for patients with limited English proficiency. The interviews demonstrate that LEP patients face language barriers not only because they do not speak English, but often their native languages do not have a varied vocabulary towards mental health. These barriers impede on the therapeutic relationship, as well as the LEP patient's ability to participate in share decision making. Further studies on how language impacts stigma, and whether interventions such as a mental health glossary are effective would be helpful.

Clinicians would benefit from utilizing interprets for a better understanding these linguistic and cultural barriers, and tailor the encounter to provide culturally appropriate care. Efforts to strengthen interpreter-clinician collaboration by expanding the role of the Spanish and Chinese interpreters in New York showed improvement in assessments and the therapeutic alliance.[10]

Conclusion

Shared decision-making is supported when patients have not just autonomy, but agency in their care. For LEP patients receiving mental health care, increased agency comes from improved communication with the clinician. This includes improving and strengthening the role of the interpreter, through mental health training for interpreters, and training clinicians to better collaborate with interpreters to utilize them as cultural brokers, as well as tailor their assessment and care in a culturally appropriate way.

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APPENDIX A: INTERVIEW GUIDE

What are interpreters' perceptions of their experiences in the triadic relationship in discussing mental health and emotional issues.

Thank you for taking the time and meeting with me. I'm interested in hearing your experiences as an interpreter when discussing mental health. When discussing mental health interactions, I am referring to interpreting for mental health providers, such as psychiatrists or psychologists in a behavioral health clinic or hospital, dealing with a mental health crisis in the hospital, as well as discussions about mental health and emotions that would take in other places, such as primary care office.

If there are questions that you are uncomfortable with or that you find upsetting, please let me know, and we will skip them. You are free to stop the interview at any time.

General Questions (quantitative): in RedCap, can be done before or after the interview

Where were you born?

What is your age?

What is your ethnicity?

What languages do you speak?

How many years of school did you complete?

Open ended:

How did you decide to become an interpreter?

What languages do you interpret for?

Are you certified to be an interpreter? What kind of certification do you have?

Do you have medical certification?

Do you work as an interpreter full time, or do you do other work as well?

Do you do more telephonic, video or (before COVID) in person interpreting?

Probe: how much of each?

Have you received any training for interpreting for mental health?

Tell me about range of places where you have interpreted for discussions about mental health or emotional issues? *For example: psychiatry visits, therapy, emergency room, primary care*	The purpose of this question is to level set-so I understand the experiences of the person I am speaking to.
Walk me through the last time you interpreted for a mental health or discussion of emotions? Probes: What was the setting? Was there anything challenging about this experience? (in terms of patient understanding mental health terms, and clinician understanding patient's expectations)	The purpose of this question is to get an idea of how a mental health interaction is conducted in the interpreter's experience?

Was there anything unexpected? Did you interpret word for word, or did you have to reword responses from either side?	
Was this last case representative of your experience? If not, why? Tell me about a more typical experience	
Give me an example of when you were culturally aligned with a patient. Probes: did you relate to their experience? Did you let the clinician know you have a similar background? Did you know the patient or did you live in the same community? Do you think it's important to have the same cultural background as a patient? Why or why not? When interpreting for a parent and child, have you ever noted a culture gap between them? How do you navigate that?	The purpose of this question is to find out how much an interpreter feels their own culture plays a role?

Give me an example of when you were not culturally aligned with a patient? Probes: Did you feel like you may have missed something about their point of view?	
What areas of improvement do you see in mental health conversations using an interpreter?	
Do you think there should be training for mental health encounters for interpreters? If so, what should be included in the training? If not, why not?	

APPENDIX B: CODEBOOK

CODE	DESCRIPTION	SUBTHEME	EXAMPLE
1.How became interpreter	Interpreter relates how they started on path to become interpreter	1.1 Primary career goal	-Spanish interpreter was sent to observe medical interpreters as a high school student due to her interest in languages
		1.2 Led to it by filling a need	
		1.2a Family need	-Nepali refugee who speaks English helps parents who at doctor's office and hospital
		1.2b Community need	-Native Spanish speaker was working at an international center in France and was asked to interpret for guests coming from Latin America

4 Received mental health training, NO		4.1 No 4.2 Yes-general-unofficial 4.3-Yes-general-official 4.4-Yes-for interpreters-unofficial/CME 4.5-Yes-for interpreters-official/certification	
5. Range of places		5.1 behavioral/mental health settings 5.2 general medicine/pediatrics or sub-specialty 5.3 emergency department 5.4 court/legal settings	
6. Interpreting experiences 6.1, 6.2 and 6.4 can be double coded	Description of their experiences interpreting in mental health settings	6.1 Positive-good clinician interaction, good patient interaction	-Spanish interpreter working with deaf/mute patient notes how well the clinician worked with patient -Clinician treats patient rudely

		6.2 Negative-explicitly say a negative word or comment to describe experience 6.3 Challenging 6.3.1-Safety 6.3.2 Boundary crossing (community encounters, privacy, asked for opinion) 6.3.3 US-centerism	-Clinician left Spanish interpreter alone in a locked room with a schizophrenic patient in an inpatient facility -Karen patient who knows interpreter from community asks them to answer questions for them because it is upsetting for them -Arabic interpreter finds questions to be based on the US experience, which the patient can't relate to -Nepali speaking patient has difficult answering questions about feelings, or degree of feelings.

			-Difficult when voices talk over each other -Mental health questions take a long time to answer
		6.3.4-Challenge-Not in-person (telephone, video)	-patient may have disrupted thoughts, in dementia state, or sedated
		6.3.5-Challenge-Time	
		6.3.6-Challenge-Difficult to interpret due to patient's condition	-In Nepal people with mental health issues are seen as "mad" and are isolated from society
		6.3.7-Challenge-Stigma	-Congolese children are afraid they will be taken from their parents -Karen interpreter acts out the feelings of the patient during

		6.3.8-Challenge-Difficulty opening up (lack of trust, or fear 6.3.9-Challenge-interpreter affected by patient's experience 6.3.10-Challenge-Patient does not understand what the clinician is saying 6.3.11-Challenge-Mental Health is more difficult to interpreter than. Medical	interpretation, and feels them too -interpreter asks the clinician to rephrase the question -Patient acts like they understand, but then asks the interpreter after clinician leaves, or in the community -Spanish interpreter says that a mental health encounter is much more complicated than an encounter for constipation where they give a laxative Afghan interpreter that it is more difficult to interpret mental health visits in her 2nd and 3rd language

		6.3.12- Challenge-not interpreters first language 6.4-Interpret for parent / child encounter 6.5- Can't recall	-Therapist speaks directly to the patient and interpreter interprets the interaction for parents Interpreter not able to recall last time they interpreted for mental health
7. Do you interpret word for word?		7.1-Yes 7.2-No - Meaning for meaning because no equivalent words (vocabulary)	-Limited words in Karen

		7.3 - No-Meaning for meaning because of patient's limited awareness/education	-Although Chinese has the words in vocabulary, many patients are not familiar with the concepts
		7.4-No-Different language structure	-Arabic is very grammatically different from English, so impossible to interpret word for word
		7.5-No-Use of idioms	-No "if's, ands or buts" does not make sense in Italian, but there is an equivalent
		7.6-No-Interpreter needs to explain intent of question or answer	-Spanish interpreter has to add extra explanation to explain intent of questions in an eating disorder visit -Body language plays a large role in the Kinyarwanda

		7.7-No-Role of body language	language, which is difficult to interpret
8. Cultural Aspects	8	8.1-Shared refugee experience	-Karen interpreter shares the experience of fleeing from violence into the jungle
		8.2-Shared culture	-Mandarin interpreter observes that a girl is being verbally abused by her mother due to her gender -Bolivian interpreter has done research and had experience with other Hispanic cultures
		8.3-Not shared,	-Congolese interpreter speaks to a Burundian friend to understand what she was missing in an interaction

		8.4- religion 8.5-role of gender	-Arabic interpreter from Egypt feels culturally aligned with patient from another Islamic country due to their shared religion -Sudanese Arabic interpreter sees cultural differences from Arabic speakers from the Middles East and Sub-Saharan Africa, despite shared religion and language -Female patients from Middle East prefer female provider
9. Do you think it's important for interpreter to		9.1-Yes Why?	

have the same cultural background?		9.2-No Why?	
10. Areas of improvement		10.1 Pre/Post session 10.2 Knows therapist/collaboration/make part of team 10.3-Time 10.4-In person for MH	-Nepali interpreter tries to meet with clinician for a few minutes before for a pre-session -Chinese interpreter worked with same patient with therapist for a few years -Congolese interpreter thinks mental encounters using interpreters should be given more time -Congolese interpreter feels that mental health encounters

			should be in person , to help read body language
11. Do you think there should be training for interpreters in mental health encounters?		11.1-Yes -Why? 11.2-No -Why not?	 -
12. What should a mental health training for interpreters include?		12.1-Safety 12.2-Engage Therapist 12.3-Mental health/psychology 12.3a-Diagnoses	-Should include how interpreters can assure their safety -Should include training on how the interpreter can engage therapist, to make interpreter part of team

		12.3b-Vocabulary 12. 3c-how to interpret for different types of encounters 12.4-Giving bad news	-Should familiarize interpreters with different mental health diagnoses -Should include review of vocabulary for mental health cases -Should include how to interpret for individual, couples and family therapy, suicidal cases -Interpreter should be warned privately if they will be giving bad news
13. Do you think there should mental health training for interpreters?		13. Skills clinicians need working with interpreters- 13a. General best practices	

Interpreter answers "Yes, for clinicians"		13b—Patient considerations 13c-Team building	--Make sure interpreter sit s behind clinician, maintain eye contact, read body language -Avoid stigma, understand cultural diversity within a language group -The clinician sees therapist part of the team.

Miscellaneous/Interesting

20. Different type of Interpretations		**20a.** Interpretation for deaf patient	-Nepali interpreter had to use parents to interpret for deaf patient, with ASL interpreter on hand
GEM	Interview 9, lines 281-288	Swahili interpreter worked on glossary of mental health terms, which she	

		uses for the other languages she interprets for	
	Interview 9, lines 501-504	Swahili interpreter is called back into a case with 3 hours sleep, and goes in because she does not want anything to go wrong	
	Interview 13, lines 214-219	Spanish interpreter feels that English is more abstract, she's not sure that even she understands what she is interpreting	