21

Collaboration

Sign language interpreters and clinicians working together in mental health settings

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Introduction

Dr Jones, a psychiatrist on contract with a school for the deaf, was working with a 12-year-old female consumer who was deaf. Over time, the psychiatrist became increasingly frustrated that she was unable to stabilise the young girl's mood. Even though Dr Jones used interpreters for each of her weekly sessions, she felt something was missing. The patient's chart indicated that their mood seemed to fluctuate significantly from week to week. Exasperated, she contacted Javier, a mental health counsellor who was deaf. After reviewing the chart and meeting briefly with the student, Javier asked Dr Jones about the interpreters. It turned out that two interpreters alternated weekly. The first interpreter was a very laid-back older female. The second was a young female with high energy. Javier asked whether the interpreters' personalities might be producing the variance rather than the patient herself.

The foregoing story highlights an example of what can occur when interpreting occurs in mental health settings. Clinical work has traditionally been viewed as a dyadic interaction where the relationship between the clinician and the consumer becomes the mechanism for treatment. In therapy, most of the symptoms are conveyed through communication and subsequently communication is one of the primary methods of treatment (Pollard & Dean, 2003). Without a shared language and cultural framework, the introduction of an interpreter becomes necessary. The challenge of interpreters and clinicians working together is that there are so many complexities and nuances at play, it is nearly impossible to address them all and to discuss them succinctly while considering any level of depth. This chapter will attempt to provide an overview of multiple considerations.

The authors are the founders of the Mental Health Interpreter Training (MHIT) Project (www.mhit.org), a programme that has pioneered and fostered the training and practice of interpreting in mental health since its inception in 2003. They have spent the better part of two decades looking deeply into the complex interplay of language, culture, and professional thought worlds that combine to make interpreted therapy challenging. The first author is the state director of the Alabama Department of Mental Health's Office of Deaf Services, which hires and trains sign-fluent clinicians and oversees systemic

programming related to Deaf mental health care including inpatient, residential homes, and outpatient services. The second is that programme's state coordinator, both a nationally certified interpreter and a trained clinician in the United States, who is responsible for ensuring communication access and the oversight of MHIT.

Throughout this chapter, the term deaf (with a lower case 'd') is used inclusively and unless otherwise specifically indicated, includes those who are, or who identify as, deaf or deafblind. When the Deaf community at large is indicated, or a specific reference to culturally Deaf people, that term will be capitalised.

Another choice the authors have made is how the participants in an interaction are labelled. The person providing therapy will usually be labelled the clinician. The person receiving the therapy will typically be called the consumer. We recognise that these labels may vary across settings. In some programmes, the person receiving services will be referred to as a patient, client, consumer, member, or recipient. The clinician may be a psychiatrist, psychologist, nurse, social worker, counsellor, or case manager. When germane to the discussion, distinctions will be made.

The term interpreter in this chapter generally refers to those interpreters who work between a sign language and a spoken language, specifically in the authors' experience, American Sign Language (ASL) and spoken English. Deaf interpreters, while addressed separately, should also be considered in terms of applicability to their work and training needs.

Another area this chapter will discuss is language deprivation, which is generally unknown to people who hear. Children who can hear will develop language as a natural course of interacting with family and community, while children who are deaf are more likely than not to be born into families where effective communication, most often through a form of visual language such as sign language, is inaccessible, thereby creating an immediate barrier to language acquisition (NIDCD, 2016). Language deprivation is of enormous consequence to psychosocial and neurological development, but it is nearly unknown to most clinicians who do not regularly work with consumers who are deaf (Glickman & Hall, 2018; Hall, 2017).

Overview

Counselling usually occurs in a dyadic format. The addition of an interpreter leads to shifts in alliances and competing professional demands and goals (Raval, 1996). The clinician may have an incomplete understanding of second languages and the interpreting process, which may unintentionally exacerbate problems with relationship building and successful communication. Clinicians may believe that the consumer initially bonds more easily with the interpreter and that sometimes the interpreter withholds or hinders communication (Cambridge, 2012). This can create feelings of being confused, scrutinised, distanced, inadequate, excluded, or competitive (Chatzidamianos et al., 2019; Cornes & Napier, 2005; Paone & Malott, 2008). It can also create situations where the clinician defers clinical authority and responsibility to the interpreter (Miller et al., 2005).

Clinicians may view the interpreter as providing a word-for-word transliteration between two languages rather than as an independently functioning co-professional that makes decisions on the interpretation of the message and influences the clinician–consumer relationship (Tribe & Lane, 2009). The interpreter may view themselves as a conduit, rather than being intimately involved in a triadic therapeutic relationship. An

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interpreter not trained or familiar with clinical work may struggle with the goals and process of therapy and not understand the impact they may have on the session, which can create alliances and goals counter to treatment efficacy. When the interpreter and clinician are not able to work effectively together, this can have a negative effect on the consumer's experience (Costa & Briggs, 2014). An approach in which the interpreter and clinician view each other as colleagues and members of a multi-disciplinary team can enhance the efficacy of clinical work (Tribe & Lane, 2009).

A consumer who is deaf introduces issues related to language and culture. In some instances, there will also be challenges such as fund of information differences and language dysfluency (Crump & Glickman, 2011). The consumer arrives to therapy with their own perspective of what a clinician and an interpreter should do and what mental health services entail. Individuals who are deaf often underutilise mental health services due to difficulties related to negative experiences including inadequate interpreting, poor communication, and fear of being misunderstood, being misdiagnosed, or having their diagnosis ignored (Landsberger & Diaz 2010; Mueller, 2006; O'Hearn & Pollard, 2008; Cabral et al., 2013; Critchfield, 2002).

The consumer who is deaf may view the interpreter as an ally and advocate, which may not be a significant issue in other community-based settings. However, it is meaningful when interpreters act in ways that thwart the clinician–consumer relationship. The interpreter in mental health settings performs or should perform a much different role, and this misperception by the consumer can potentially be harmful to treatment when the interpreter doesn't respond as expected.

The emergence of a specialty

In the United States, the concept of the speciality of mental health interpreting in the field of deafness dates at least as far back as the 1980s when psychiatrist Bernard Gerber (1980) published an article titled 'Interpreting for Hearing-Impaired Patients in Mental Health Settings', which in retrospect, seemed to address issues that arose when interpreters, following practice conventions of the time, inadvertently confounded treatment. He offered suggestions for improving outcomes, many of which are still applicable today and are addressed in this work.

Millie Stansfield (1981), working as an interpreter at the University of California at San Francisco's Center on Deafness, published 'Psychological Issues in Mental Health Interpreting', which addressed issues similar to those raised by Gerber, but from the interpreter's perspective, suggesting that mental health interpreting should be a speciality field. This article's appearance in the first issue of the *Journal of Interpreting* sparked some interest and awareness of the matter. The work of moulding this specialisation, however, remained relatively dormant through most of the 1990s.

Alabama became the first state to define a qualified mental health interpreter when standards were adopted into state code and incorporated a formal training programme (ADMH, 2003). The MHIT programme was developed which incorporated a 40-hour training, a supervised practicum, a comprehensive examination, and the requirement of annual continuing education. This ongoing annual training and considerations for the work of sign language interpreters and clinicians working together are explored by Crump (2012).

It became apparent that training interpreters without a parallel effort to train clinicians would only be partially effective. As Gerber (1980) maintained, interpreted therapy would be most effective when the clinician understood what was happening, a point that Hamerdinger and Karlin (2003) would expand on in their work. Costa (2017) discussed a 'relational training for counsellors who work with interpreters' (p. 1) delineating the need to examine how clinicians and interpreters can collaborate effectively. Miller et al. (2005) recommended that interpreters and clinicians receive training specifically related to working collaboratively.

Critical issues and topics

The clinician and the interpreter enter an appointment with their own perspectives of what the work entails. They also typically have varied viewpoints of what it means to be deaf, use sign language, utilise an interpreter, and provide therapy. Dean and Pollard (2005) point out that neither the clinician nor the consumer who is deaf typically understands what is happening in an interpreted transaction. The interpreter must decide as to what communicants mean based on the interpreter's understanding of their intent. The clinician and consumer are often unaware of the choices that an interpreter makes, choices that can have a profound impact on how each person understands the other (Fox & Pollard, 2020; Dean & Pollard, 2005).

Clinicians are routinely taught cultural sensitivity as part of their clinical education, yet they rarely develop an in-depth understanding of any particular culture or language differences (Benuto et al., 2019). Nor are clinicians taught with any degree of proficiency how to secure, utilise, or vet interpreting services. Vetting an interpreter should ensure that the interpreter's qualifications include national interpreter certification, training and experience working in mental health settings (Morere et al., 2019), and credentialing in mental health interpreting.

What makes a qualified interpreter?

Clinicians may assume that bilingual staff can provide needed interpretation. However, bilingual staff can struggle with understanding language outside of their own experiences and may not comprehend the complexities of the interpreting process (Bot, 2005; Raval, 2005). They may also overestimate their own linguistic and cultural proficiencies. A similar phenomenon, sometimes referred to as the Dunning-Kruger effect, relates to difficulties in recognising one's own incompetence (Kruger & Dunning, 1999).

Clinicians may assume that a family member or friend of the consumer can function as the interpreter, wishing to avail themselves the of benefit of convenience and cost-savings. The clinician who takes this route may not understand the harm that this arrangement can cause the consumer and the potential increased distortion of the therapeutic process (Tribe & Lane, 2009; Leanza et al., 2010). The ability to maintain a casual and familiar level of conversation in a language does not equate to the ability to interpret between two languages, particularly when the environment requires a high degree of technical jargon, knowledge, and skill.

In addition to concerns about linguistic abilities, family members and friends have a pre-established relationship that may supersede the alliance that should exist between the clinician and consumer (Critchfield, 2002). As a result of their own personal motivation or emotional investment, they may take on the role of rescuer to protect the consumer or,

conversely, may obfuscate or eliminate information that they perceive as reflecting badly on their family unit or that they feel is inappropriate (Friend & Dentino, 1991). The clinician has an obligation to protect the consumer's confidentiality, which is not assured when family members or friends are utilised (Juckett, 2005). As such, regardless of the language competency of the family member or friend, they should not be utilised as the session interpreter; however, they may be encouraged instead to take on other supportive roles, such as an advocate, when appropriate.

The introduction of a professionally trained interpreter has its own challenges (Cabral et al, 2013). Historically, interpreter training pays only cursory attention to unique issues present in mental health settings. The programmes also typically do not focus in-depth training on language dysfluency or atypical use of language within the deaf community, leaving interpreters poorly equipped to handle dysfluencies that they may encounter in mental health settings.

Mental health work can be complex. Effective strategies, including techniques and approaches commonly used by qualified mental health interpreters, may seem to be at odds with initial education received in interpreter programmes. Codes of ethics or guidelines of professional conduct may be taught or viewed in ways that are considered absolute. This type of concrete thinking further complicates the development of an effective therapeutic triad which requires the development and use of practice profession thought processes and solutions (Dean & Pollard, 2005).

Individuals who desire to learn a language will be most effective when they associate with members of that language community. The same is true for sign language interpreters where developing linguistic and cultural competence is greatly facilitated by assimilation into the Deaf community. As deaf people are members of a low-incidence population (Fellinger et al., 2012; Mitchell, 2006), the communities of shared language users can be small, creating situations where interpreters and consumers who are deaf may know each other, or share common acquaintances. Familiarity and consanguinity require constant exploration of boundaries, transparency, and diligent self-awareness.

Boundaries and alliances

As professionals who are hearing, the clinician and the interpreter often share a similar language and may share similar cultural values. As such, they may be perceived by the consumer who is deaf as having a privileged relationship, which can exacerbate perceptions of power differentials and inequities. Interpreters may perceive themselves as needing to mitigate those power differentials as well as unintended oppression from members of the hearing community (Critchfield, 2002; Cabral et al., 2013). The shared cultural and linguistic framework which exists between the interpreter and the consumer, as well as an expectation that the interpreter is there to support the person who is deaf, can set the stage to derail therapeutic alliances and treatment.

Some practices can be helpful to mitigate the impact of alliance formation and role confusion. A clinician typically does not have a dual relationship with a consumer outside of therapy. That may not be the case for the interpreter and consumer. Efforts should be made to reduce or eliminate contact between the interpreter and consumer outside of the therapy session including consideration of community-based appointments, sitting together in the waiting room, etc. (Williams & Crump, 2019; Fox & Pollard, 2020). Additionally, taking time at the onset of treatment to clarify the roles and responsibilities of the clinician

345

and the interpreter, including addressing confidentiality and boundaries, takes on a new level of importance (Tribe & Sanders, 2003). Providing training related to mental health systems, diagnoses, issues, processes, and clinical and interpreter roles and responsibilities to the Deaf community at large, can also help to assuage misunderstandings and alleviate concerns (Costa et al., 2014).

Concerns with interpreter certification

While national certification bodies such as the Registry of Interpreters for the Deaf (RID) offer generalist certifications that offer verification of the interpreter's ability to provide interpreting services in a variety of settings (RID, n.d.), the process is not intended to validate interpreters' qualifications for work needed in specialised settings such as mental health.

The Americans with Disabilities Act (ADA) defines a qualified interpreter as one that is 'able to interpret effectively, accurately, and impartially, both, expressively and receptively, using any necessary specialized vocabulary' (ADA, 2011, p. 1). Standards have been published by multiple entities serving individuals who are deaf, including RID (2007) and the National Association for the Deaf (NAD, 2013). Despite these laws and standards, individuals who are deaf identify healthcare, including mental health, as the most challenging settings to receive qualified interpreting (NCIEC, 2009).

Mental health interpreting requires a high level of competency in a host of areas. The notion of accepting work in highly complex settings without appropriate and in-depth training has become an ethical concern. Yet too often, interpreters participate in basic training without consideration to the harm that can be perpetuated when they complete a training event and believe they understand what mental health interpreting encompasses. Unfortunately, to continue to mire oneself in the basics and consider it sufficient causes harm to the consumers served and ultimately to the interpreting profession (Crump, 2018).

While generalist interpreters may not think of themselves as practitioners working in mental health, many community-based assignments can have an inherent element of mental health. Seemingly innocuous appointments can become, without warning or foreknowledge, mental health assignments, leaving the interpreter feeling overwhelmed or ill-prepared. A medical appointment can become one in which the consumer discloses a mental illness or suddenly has to deal with devastating news, leading to a mental health crisis. An educational assignment can consist of developmental issues but may also involve students relating instances of trauma or abuse, misuse of substances, or the first evidence of a mental illness.

Even when it is identified as a mental health appointment, agencies may view national general certification sufficient indication of competence. Competing demands sometimes exist between the requirements of a mental health appointment and the lack of available interpreters. This can lead to an interpreter being assigned or choosing to accept mental health appointments without the requisite knowledge base or skills needed to effectively perform the work required in that setting (Fox & Pollard, 2020). The interpreter may not realise the complexity of the situation in which they are working and the reasons for varied perspectives and choices within mental health. This can lead the interpreter to subsequently minimise their inadequacies in this setting.

Exploring qualifications of a mental health interpreter

A skilled interpreter working in mental health settings must also have competencies beyond those that are language-based (Glickman et al., 2020). Interpreters should have

346

a fundamental working knowledge of clinical areas such as childhood development in children who are deaf, clinical disciplines and their areas of focus, treatment approaches and settings, mental disorder symptomologies, language dysfluencies, and deafness aetiologies.

Additionally, it is recommended that mental health interpreters possess personal characteristics such as resiliency, responsiveness, adaptability, insight, the ability to maintain appropriate boundaries, successful self-care strategies, and the ability to participate in clinical supervision (Harvey, 2003; Olson & Swabey, 2017; Dean & Pollard, 2009). They must also be willing to take inventory of their own history, trauma, and mental health, and consider the impact it might have on their work.

Thought worlds

One area to consider is the differences of thought worlds that exist between the clinical and interpreting professions (Dean & Pollard, 2009). Namy (1978) states, 'Interpreting, therefore, is not merely transposing from one language to another. It is, rather, throwing a semantic bridge between two different cultures, two different thought worlds' (p. 1). Dean and Pollard (2013) describe thought worlds as a 'sophisticated understanding of communication that takes into account the roles and other characteristics of the individuals who are communicating' (p. 3). An individual's work is impacted by their thought world and each must consider not only their thought world but that of the other.

Examples of thought world considerations can include an interpreter seeing unusual language and possibly over-attributing this to a consequence of language development, specifically deprivation or communication isolation (Humphries et al., 2016, Hall, 2017), that exists within the deaf population. As such, their resulting interpreting choices may be to normalise the language output, which can give rise to missing clinical data (Fox & Pollard, 2020). A clinician, by contrast, is apt to attribute unusual language patterns to pathology, while not recognising that atypical language may have many sources.

Language patterns related to mental disorders may be overlooked by a hearing, non-signing clinician who is overwhelmed with the experience of working with a consumer who is deaf, which can cause them to underutilise their own range of clinical expertise (Pollard, 1994). The clinician might not consider that the same clinical language indicators that can occur with consumers who are hearing may also occur with consumers who are deaf. However, these indicators frequently manifest differently. The clinician is dependent on the interpreter to help them understand not only the content that is being shared, but also how it is being expressed. Often the interpreter is the only person who is uniquely able to understand the languages and cultures of both the clinician and the consumer, as well as the complicating factors present when working between the two languages and cultures, yet they often enter the assignment without the benefit of clinical training. Exploration of emotions, mood, delusions, or sensory experiences are critical within mental health settings (Fox & Pollard, 2020), yet can be difficult to interpret, especially when the interpreter is not trained to recognise and understand what they are observing. A person who is deaf and exasperated, upset, or manic can be misunderstood to be hostile. A typical aspect of sign language depicting characterisation in which the signer shifts perspectives can potentially be misconstrued as responding to an external stimulus. The active nature of sign language may confound the clinical impressions related to depression (Leigh & Pollard, 2003). A sign-fluent clinician would be more likely to consider those potentialities.

347

Stephen H. Hamerdinger & Charlene J. Crump

Psycholinguistic errors and other language considerations

The interpreter may need to educate the clinician regarding the linguistic complexity of a question that may not have parallels in the original spoken language. It can be difficult at times to explain why an interpretation is not effective. The clinician is then placed in a situation where they, not completely understanding the predicament, may need to rephrase the question or comment. When dysfluency is present, it can be even more challenging to explain to the clinician why the information is difficult to interpret (Fox & Pollard, 2020).

Additionally, interpreters can make decisions in their work that impact treatment. Studies have attributed interpreter errors to omission, insertion, condensation, substitution, role exchange, change of form of questions to closed/open questioning, normalisation, and mistranslations (Farooq & Fear, 2003; Paone & Malott, 2008; Price, 1975). A question such as 'What is your mood today?' can become 'Are you feeling happy or sad?' These choices are common techniques that are utilised by interpreters (Napier, 2004, 2016). The challenge for the team becomes awareness and recognition of how interpreting techniques can influence treatment.

Not only do psycholinguistic errors among individuals with schizophrenia exist, but this is also further complicated by the fact that ASL and certain aspects of Deaf culture can emulate such errors typically seen in individuals with schizophrenia (Trumbetta et al., 2001; Thacker, 1994; Thacker, 1998). Further complicating treatment, people with language deprivation frequently use language in a way that is similar to individuals experiencing psychosis. Some examples of this include failure to use time markers, lack of referents, lack of clear transitions which can appear as topic derailment, poverty of content, tangentiality, incoherence, or illogical utterances. This may have attributed to the historical overdiagnosis of individuals who are deaf with schizophrenia (Kitson & Fry, 1990; Glickman, 2003; Landsberger & Diaz, 2011).

Interpreters working with individuals who have schizophrenia should also be aware that language considerations related to the disorder exist so that they don't over ascribe language dysfluencies to other causalities, such as language deprivation, and subsequently remove clinical information. Because the non-signing clinician is unaware that the language challenges are present, they often become dependent on the interpreter to make distinctions of causality, which can lead to inaccurate diagnoses or even role diffusion. In the case of schizophrenia, a few examples of language considerations are:

- Visual perception and recognition may be slowed and less accurate;
- Emotive facial expressions may be perceived differently (Kubota et al., 2003);
- Poor eye contact;
- Longer pauses;
- Blunted affect;
- Signing that is too slow or overly fast;
- Difficulty with complex grammatical structures;
- Decreased ability to utilise closure skills;
- Unclear referents and transitions;

Other language dysfluencies may be present due to the aetiology of deafness. The disease or trauma that caused the deafness also caused other comorbid neurological sequelae, which manifest in specific patterns of dysfluent language. Interpreters and clinicians need to learn how to discuss these anomalies collaboratively (Glickman & Crump, 2012).

348

Aetiological language patterns can result from a host of prenatal or postnatal causes of deafness. Examples of language abnormalities collected from communication skills assessments that may present in some individuals deafened by congenital rubella syndrome (CRS) are discussed in Crump & Hamerdinger (2017).

Other examples include diseases under the TORCH complex, as well as premature birth and foetal alcohol syndrome (FASD). Post-natal causes, such as traumatic brain injury (TBI), strokes, or bacterial meningitis, can also impact language use (Soren & Druzin, 2003; Crump & Hamerdinger, 2017).

Many clinicians are not aware that the aetiology of deafness may, in some cases, have also caused damage to other parts of the brain, which can create language dysfluencies. Subsequently, the clinician may misattribute the language dysfluencies to psychosis (Glickman, 2008; Crump & Hamerdinger, 2017). Interpreters may also be unaware of this phenomenon and may over-normalise or over-pathologise what they are seeing as typical in some members of the Deaf community. Diagnosis is the domain of the clinician, not the interpreter. However, the clinician cannot make an appropriate diagnosis or provide adequate treatment without accurate information. The conveyance of accurate linguistic information is the domain of the interpreter.

Rich linguistic and clinical information can be present in many forms. A deaf person who is signing in a way that does not cross the mid-line may be exhibiting a clinical or neurological disorder. These can occur in individuals deafened by FASD, TBI, stroke, or an individual who is exhibiting psychosis and having difficulty with visual-spatial or paraphrastic parameters of sign language. Conversely, it could be that the person has developed an idiosyncratic manner of signing due to language isolation. It is critical that the interpreter has the level of discourse with the clinician conducive to exploring these variances. Much of this is beyond the training and experience of either the clinician or the interpreter, highlighting how critical cross-training is.

Neutrality, secondary trauma, and self care

The interpreter needs to be emotionally prepared to enter the clinical milieu in which sensitive or highly emotionally charged discussions may occur. The interpreting field has often touted that interpreters should be neutral. Neutrality does not exist, especially in environments where parties are potentially emotionally vulnerable or reactive (Harvey, 2003).

Clinicians are trained to deal with potential emotional extremes or volatile material. Clinicians may enter an appointment with some idea of where the discussion will lead. When the clinician and interpreter have not prepared themselves in a pre-session, the interpreter is more likely to be taken unawares and react emotionally to what is occurring during the session. This can have a deleterious effect on the work product and existing alliances.

When a clinician does not respond in the way that the interpreter expects, the interpreter may perceive the clinician as unqualified, uncaring, or unknowledgeable. When this occurs, the interpreter may respond using compensations, such as word choices, tone, or facial expressions meant to express the empathy that they feel is lacking, thus leading to role exchange (Costa & Briggs, 2014).

Interpreter programmes rarely train students to deal with the potential for emotionally volatile material or vicarious trauma. Therefore, they lack the professional preparation for issues such as the projection or negative emotions, which clinical programmes routinely

Stephen H. Hamerdinger & Charlene J. Crump

provide. Being the object of transference without clinical awareness of this phenomenon and how to deal with it can create high levels of anxiety for the interpreter and can even create distrust between the interpreter and the clinician.

The interpreter may experience unconscious feelings directed at either the clinician or the consumer. It becomes important that those feelings are acknowledged, and attempts are made to explore the context of the situation together. Conscientious clinicians will seek supervision to process traumatic material encountered in the session. Interpreters generally do not, either believing that it is unethical, unnecessary, or they are unaware that such an option exists (Chatzidamianos et al., 2019).

Emerging debates

Consecutive interpreting

Interpreting between two spoken languages is often done in a consecutive format especially in settings where a high degree of accuracy is valued (Estafani, 2020). Interpreting between sign and spoken languages, however, is usually produced in a simultaneous manner. Research has found that consecutive interpreting allows for more processing time, which increases the accuracy of the resulting interpretation and reduces fatigue (Gile, 2001; Russell, 2005).

While many issues can be addressed by participating in pre and post sessions, the interpreter and clinician must also work together to address how they will handle issues that arise in the moment that can change the course of the discussion during the session (Miletic et al., 2006). Interpreters often struggle with having conversations about the consumer who is deaf with the clinician. They also struggle with the consumer who is deaf knowing that they are having these conversations. Yet without the information the interpreter holds during the session, clinically significant items can easily be overlooked or omitted. A benefit of consecutive interpreting in mental health work is that it can allow the interpreter to include nuances or clarify points of confusion within their interpretation that would not come through if simply interpreting the content simultaneously (see Chapter 13 for a further discussion of consecutive interpreting).

Confidentiality, collegiality, and collaboration

Interpreters historically have viewed the concept of confidentiality as a rigid code of silence where information cannot be shared (Dean et al., 2011) while clinicians practice confidentiality as information that is shared in confidence with members of the treatment team. The interpreting field has been evolving to understand that interpreters can share information within professional teams, including treatment teams, yet the individual interpreter may lag in their understanding of this concept, which may create a barrier to collaboration.

Mental health agencies and clinicians may focus on the number of consumers seen and generating revenue. Time for the clinician and interpreter to meet before and after sessions is often not built into the schedule. Funding entities, such as insurance companies, often do not consider the complexities of mental health work with individuals who are deaf and the interpreting process. Therefore, they may not recognise the additional time needed for the same level of outcome in their services (Fox & Pollard, 2020; Kravitz et al., 2000; Razban, 2003).

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Use of deaf and native signing individuals in non-clinical roles

The use of deaf interpreters within mental health settings is an emerging practice. Deaf interpreters are themselves deaf and have native or near-native fluency and experience beyond those of bilingual hearing interpreters. They typically work between sign language to sign language or when an atypical use of sign language is present.

By necessity, the utilisation of deaf interpreters will introduce a consecutive model to the process. It also allows for rich information regarding language use to be conveyed to the clinician. The natural flow of communication between the hearing clinician, the hearing interpreter, and the deaf interpreter will allow for important back-channelling to occur across the therapeutic interaction.

Deaf interpreters are trained to break down complex or abstract concepts and present them to the consumer with dysfluent language in terms that person can comprehend. The process by which they do this often provides insight into not only the consumer's language development, or lack thereof, but also into the consumer's cognition. For the non-signing clinician to make the best use of the process, having the hearing interpreter narrate what the deaf interpreter is doing, including highlighting specific concepts that are proving difficult to convey to the consumer, has much potential.

Additionally, this introduces yet another person into the typical dyadic relationship who comes with their own training, background, biases, and understanding of people who are deaf. It is important to note that training deaf interpreters to work effectively in mental health has lagged significantly behind that of hearing interpreters. It is an area that needs to be addressed and researched in the future.

Another way that native users of sign language can make important contributions is by functioning as communication specialists who are distinct from deaf interpreters. A communication specialist is trained to assess and analyse existing communication skills a consumer brings to the setting and determine how best to utilise and augment those skills. The foundation for this work may include a structured communication assessment, such as the Communication Skills Assessment (CSA) (Williams & Crump, 2019; Glickman et al., 2020). This assessment will indicate areas where the consumer has language strengths that can be tapped and weaknesses that can be addressed. The communication specialist would then be able to assist the treatment team in developing strategies that can be used to make communication and treatment more effective.

An important aspect of utilising a CSA is language skills development. Much of the language and social development that can occur is what Glickman (2016) refers to as pre-therapy, a critical element to the treatment efficacy of some consumers who are deaf. Individuals who are language-deprived can lack the ability to label emotions they feel, which is critical to self-control and the ability to utilise coping skills. This process is covered in some detail in Black and Glickman (2006).

Training interpreters and clinicians collaboratively

The MHIT programme is covered in detail in Crump's (2018) study and includes mental disorders, language dysfluency, clinical disciplines, alliances, the treatment process, and vicarious trauma. Overarching each of these areas is the broader concepts of interpreting as a practice profession, the demand control schema, and a normative ethics context-based decision-making process, which delineates how ethical decision making can occur within these areas based on values, rather than a rules-based decision-making process.

These categories have implications for the interpreter's work in analysing the various factors and calculating which approach can most effectively support the goals of the therapeutic interaction (Dean & Pollard, 2013). Mental health work requires a conscious effort to ally with the goals of the therapy and a need for open discussions between the interpreter and clinician related to boundaries, which can help protect the integrity of the therapeutic process.

When treatment occurs over multiple sessions, the same interpreter should be used throughout treatment (Raval, 1996; Raval & Tribe, 2014). This not only allows the clinician to differentiate between the mood, language, and tendencies of the interpreter and the consumer, it allows the opportunity for collaboration to strengthen over time (Patel, 2003; Nijad, 2003) and is an indicator of clinical success (Hamerdinger & Karlin, 2003).

Pre- and post-conference become vital components in establishing and growing these skills. During pre-session conferencing, we posit that a useful discussion includes a consideration of how to work together, the goal of the session, previous issues that may be pertinent, current status, treatment approach, known language use, psychosocial history, the diagnosis and its potential impact on communication, possible conflicts and strategies, and how to handle emergent situations that may arise during the session.

In post sessions, the clinician and interpreter can utilise this time to explore difficulties, seek guidance, give feedback, clarify issues that arose during the session, and provide resources. This debrief can also provide a level of clinical supervision and help to mitigate issues of secondary trauma (Miller et al., 2005; Chatzidamianos et al., 2019).

The practice of mental health interpreting has been changing in the era of increasing video remote interpreting (VRI). VRI has sometimes been looked upon with disfavour by members of the Deaf community. However, the COVID-19 crisis has forced many to reassess their opposition. A more nuanced view is emerging (NAD, 2020). VRI brings with it another set of challenges, including consistency of interpreters, vetting of interpreters, use of interpreters who may not be familiar with local dialect, and how the team can effectively pre- and post-conference. The topic deserves consideration but is outside of the scope of this chapter.

Conclusions and future directions

While training interpreters for mental health as a speciality is gaining ground, training monolingual clinicians to work with interpreters is an area that has not received as much attention. Systemic training within clinical programmes is recommended to educate clinicians on how to work with interpreters and consumers with whom the clinician does not share a language or culture (Boness, 2016).

Because information is filtered through an interpreter, it will influence and change the dynamics (Critchfield, 2002). Neil Glickman (2003) calls the belief that interpreters are sufficient the 'illusion of inclusion' (p. 55). Consumers who are deaf who have experienced significant language deprivation, communication isolation, or experience significant language dysfluency, bring with them a variety of challenges related to language acquisition and use and complicated therapeutic needs. Related fund of information challenges may also cause missteps in treatment when the clinician assumes the deaf consumers have a shared and common knowledge.

Visionaries, such as Gerber (1980), have argued for this for nearly a half-century. 'It would be ideal if more mental health clinicians learned about deafness and developed sign language skills' (p. 724). This is supported by studies that show that individuals

who are deaf prefer a clinician who can sign and understand Deaf culture (O'Hearn & Pollard, 2008; Cabral et al., 2013; Costa et al., 2014; Feldman & Gum, 2007; Sheppard & Badger, 2010).

Glickman et al. (2020) state that language fluency is a necessary but insufficient requirement for working with individuals who are deaf. Sign-fluent clinicians must also be thoroughly trained in the areas mentioned previously in this article, such as language deprivation and its sequela, how the aetiology of deafness can impact neurolinguistic processing, and how mental disorders may distort language use. Until training programmes can develop a greater clinical workforce in this field, using an interpreter appears to be the only option for most consumers who are deaf in need of services.

Like Gerber, Stansfield (1981) argued that interpreters need to be part of the treatment team to be effective and that to enhance this effectiveness they need to meet with the clinicians before and after each session. Possible collaborative models in the literature include Chovaz (2013) who proposed using intersectionality as a way to frame the interaction between clinicians and interpreters, and Costa (2017) who proposed a triangular model for collaborative practice. These and other models should be explored for potential application to future training and research.

Many interpreters enter mental health work with inadequate training (Dean et al., 2004). Such training and certification need to be more widely available (Tribe & Lane, 2009). Currently, there are limited opportunities for effective and comprehensive training. Increasing student exposure to mental health work as a speciality is also needed in interpreter programmes.

The challenges of effective clinician–interpreter work in mental health settings involving consumers who are deaf are daunting. However, strides have been made within the last two decades in identifying issues, developing approaches, designing training, educating consumers, and implementing standards. This work is far from complete and it is hoped that this chapter will stimulate further discussion and research.

Questions for consideration

1. How can the number of sign-fluent clinicians, especially those who are themselves deaf, be increased?
2. How can regulatory bodies and interpreter organisations raise standards by which interpreters who work in deaf mental health care are measured?
3. How can the challenges of language dysfluency, regardless of its origin, be more broadly promoted among hearing providers of mental health services?
4. What avenues exist for cross-training providers and interpreters so that they may more effectively work together?
5. How can we promote research into how to utilise deaf interpreters in mental health settings?

Further reading

Crump, C. J., & Hamerdinger, S. H. (2017). Understanding etiology of hearing loss as a contributor to language dysfluency and its impact on assessment and treatment of people who are deaf in mental health settings. *Community Mental Health Journal, 53*(8), 922–8.
This article explores neurolinguistic implications of various causes of deafness that have an impact on language acquisition and use.

Dean, R. K., & Pollard, R. Q. (2018). Promoting the use of normative ethics in the practice profession of community interpreting. In L. Roberson & S. Shaw (Eds.). *Signed language interpreting in the 21st century: Foundations and practice* (pp. 37–64). Gallaudet University Press.
This article proposes a different framework for decision-making for interpreters, which is based on a teleological approach as opposed to the traditional deontological approach taught by interpreter preparation programmes.

Glickman, N., Crump, C., & Hamerdinger, S. (2020). Language deprivation is a game changer for the clinical specialty of Deaf mental health. *JADARA, 54*(1), Article 4.
This article provides an in-depth discussion on how language deprivation impacts treatment and programme design.

Glickman, N. S., & Hall, W. C. (Eds.). (2018). *Language deprivation and deaf mental health.* Routledge.
This book provides an in-depth discussion of language deprivation and deaf mental health care. The chapter by Williams and Crump provides a model communication assessment to help the clinicians and interpreters understand the consumers' language abilities.

Related topics

Language Deprivation Syndrome, impact of aetiology on language development, interpreter training in mental health, training hearing clinicians on Deaf mental health care, clinician and interpreter collaboration.

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