Challenges of mental health interpreting when working with deaf patients

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Objective: The aim of this present paper is to highlight some of the issues faced by therapists and sign language interpreters when working with deaf patients.

Conclusions: Key issues include linguistic, interpreting and role challenges, and potential threats to the therapeutic alliance. Recommendations are made in relation to preparation strategies and training for sign language interpreters and therapists.

Key words: deafness, interpreting, sign language, therapy.

As a clinical social worker who specializes in working with deaf children and adolescents, and a sign language interpreter with extensive experience in mental health settings, we have collaborated on various mental health-related projects. These include curriculum design for training interpreters and counsellors, translation of psychiatric assessment instruments from written English into Auslan, and face-to-face family therapy sessions involving deaf adolescents. Through these experiences, we have identified various issues and challenges faced by therapists and interpreters when working in therapeutic contexts with deaf children, adolescents and their family members. The aim of this present paper is to provide an overview of these issues and challenges for consideration by professionals in the mental health field. We will ‘set the scene’ by considering Australian Sign Language (Auslan) and the Deaf community, and Auslan interpreters. We will then proceed to explore issues around interpreting in the therapeutic context, particularly in relation to linguistic, interpreting and role challenges. We conclude with a series of recommendations to ensure the effective outcome of therapy with deaf people when working with interpreters and the establishment of an appropriate ‘therapeutic alliance’.

AUSLAN AND THE DEAF COMMUNITY

Signed languages are natural languages, unique to every country. Signed and spoken languages have different structures and modalities. When we refer to modality, we mean that spoken languages are linear languages (i.e. one word is produced after another), and signed languages are visual–spatial languages (i.e. use the modality of three-dimensional space, where more than one sign can be produced at the same time because of the use of two hands). Signed languages have their own complex grammatical structures, vocabulary, sociolinguistic variation and discourse rules. Australian Sign Language was indirectly recognized by the federal government in the Australian Language and Literacy Policy, and has come to be known as ‘Auslan’. The first Auslan dictionary was published in 1989, and a range of Auslan research publications have appeared since that time.

The majority of Auslan users are deaf people for whom assisted listening, lip-reading and speech is not enough. This group comprises native signers (deaf people born to deaf parents) and non-native signers
(deaf people who learn a signed language as a second language later in life). A commonly cited figure in the literature refers to 1 per 1000 of the average population being deaf sign language users (as opposed to the general hearing impaired population, who might not all use sign language). A survey by Hyde and Power found that there were almost 16,000 deaf people in Australia using sign language as their first or preferred language, and who therefore made up the Australian Deaf community.12 More recently, based on census and school enrolment figures, Johnston estimated that there are approximately 5–10,000 deaf sign language using people in Australia.13 Hearing people also use sign language: some may have deaf parents and therefore grow up as native users of a signed language. These people are often referred to as CODAs (children of deaf adults) and grow up to be bilingual.14 Other hearing people using sign language are relatives, partners, friends and work colleagues of deaf people, who inevitably learn a signed language in order to better communicate with those affected. The final group of hearing people who use sign language are those professionals working with deaf children and adults, such as interpreters.

DEAF PATIENTS AND MENTAL HEALTH PROVISION

In recent years, there has been a growing recognition of deaf individuals constituting a linguistic minority with different cultural values and beliefs.15,16 This paradigm shift has informed clinicians in relation to how therapy is framed with deaf patients.17–20 In contrast to other developed countries, in Australia there are no specialized psychiatric facilities for children, adolescents and adults who are deaf. Deaf individuals with mental health problems are a geographically widespread small community that cannot access specialized mental health workers at a local level.21 Aside from the few exceptions where hearing therapists are fluent signers, clinicians must rely on Auslan interpreters to assess and treat this population.

AUSLAN INTERPRETERS

Because deaf people cannot access spoken English, interpreters are needed to facilitate communication between deaf and hearing people in a range of settings; Auslan interpreters can be found working in educational, legal, medical, employment and conference situations, to name but a few. The professionalization of sign language interpreting has led to the establishment of sign language interpreting associations and related codes of ethics all over the world.22,23 and the development of interpreter training courses.24 Consequently, research on sign language interpreting has outlined aspects of the role and communication management of interpreters,25 linguistic errors (miscues) produced by interpreters,26 cross-cultural communication techniques of interpreters27 and a range of ethical and linguistic challenges for sign language interpreters in different settings.28 In Australia, very little research has been conducted on Auslan interpreting. Nonetheless, the few studies carried out include: an analysis of the linguistic coping strategies used by Auslan interpreters,29 a survey of occupational overuse syndrome experienced by Auslan interpreters30 and a survey of Auslan interpreting demand and supply.31

INTERPRETER’S ROLE

The role of any spoken or signed language interpreter is to facilitate communication between two or more parties that do not share the same language, and to ensure that all parties have equal access to the content of interactions. Interpreters are expected to abide by a Code of Ethics, which maintains their professional behaviour through the key tenets of accuracy, confidentiality and impartiality. Over time, there has been more recognition of the holistic nature of interpreting and the interpreter’s role, which encompasses the need for interpreters to account for differences in participants, cultural backgrounds, norms of discourse and communication protocols, as well as language base. Thus, interpreting is regarded as a ‘discourse process’,32 with the interpreter present being a participant within the interaction,33 rather than a mere ‘conduit’ who channels information. Clark and Karlin have succinctly defined the specific role of mental health interpreters: The mental health interpreter will, as far as possible, accurately convey the content of messages between mental health care providers and patients, and consult with care providers on matters limited to their expertise relating to language, communication, assistive technologies and Deafness.34

INTERPRETING IN THE THERAPEUTIC CONTEXT

In the spoken language interpreting field, several studies have explored linguistic, interpreting and role challenges within medical interactions between medical specialists and patients, whereby the dynamics of the interaction are influenced by the interpreter’s presence, thus causing potential conflict between ethical codes and actual practice.35,36 These studies have highlighted the notion of an interpreter being ‘invisible’ or ‘neutral’ is not realistic and the importance of acknowledging the interpreter’s presence within medical interactions. Studies of sign language interpreters working in medical settings have identified similar issues.37,38 Bot39 and Wadensjö40 have acknowledged that the dynamics of interaction in mental health settings are already very sensitive, and can be exacerbated by the presence of an interpreter. Several papers have recognized the challenges for signed language interpreters working in mental health settings.41–43 In a previous article, we discussed the dynamics of interpreters and therapists working together and suggest that interpreters adopt an ‘interactive-therapeutic’ model of interpreting.
in order to ensure that the goals of a therapy session are preserved.44

Various mental health professionals have highlighted the prevalence of mental illness among deaf people, and cultural and ethical challenges of working with deaf adults and children, especially when the professional is hearing and does not use sign language.45–49

Here, we attempt to draw together the various issues that have been discussed in the literature, and indicate particular challenges for interpreters and professionals in the therapeutic context. Cromwell has referred to ‘therapist-centred’ or ‘interpreter-centred’ issues in this context.50 However, we would like to focus specifically on linguistic, interpreting and role challenges, and use illustrative cases from our clinical experiences.

ISSUES FOR SIGN LANGUAGE
INTERPRETERS AND THERAPISTS
WORKING WITH DEAF PATIENTS

Linguistic challenges

Because there are few deaf people working as professionals in the mental health field, an Auslan vocabulary does not exist for mental health terminology. In 1997, the British Society for Mental Health and Deafness published a mental health sign vocabulary dictionary, which was collated by a group of deaf mental health professionals.31 We have not yet reached that stage in Australia, which means that interpreters often need to explain certain concepts using more than one sign, because there is no one exact sign choice. Therefore, when a therapist carefully frames a question in a neutral manner, the impact may be lost if the interpreter explains a concept and perhaps manipulates a response. For example, if a clinician asks ‘how is your mood?’, a culturally effective interpretation in Auslan would normally be: ‘You feel how? Happy? Sad? Good? Bad? Your m-o-o-d what?’

The reader will notice immediately that the spoken and signed versions are different with the signed version containing more information. Clinicians have to be mindful of possible ambiguity in a Deaf person’s response if the interpretation is too literal (possibly leading to misunderstanding) or too leading (possible shaping the patient’s response).

Interpreting challenges

According to the Code of Ethics,1 key tenets relate to interpreters rendering ‘accurate and faithful interpretation’ and accepting work ‘within (their) own limita-

1 The Code of Ethics for Auslan interpreters is ‘owned’ by the Australian Sign Language Interpreters’ Association. The key tenets of the Code are similar to those found in Codes of Ethics for spoken and signed language interpreters in other countries. Therefore, it can be assumed that all interpreters adhere to the same ethical principles, regardless of the languages used.

tions’. The second tenet is premised on the interpreter making a cogent choice about whether or not they are able to interpret in a particular situation, based on their experience, skills and qualifications. The situation is complicated because interpreters are only provided with sparse details relating to potential work in mental health settings in order to respect patient confidentiality; ergo interpreters are denied the opportunity to know if they are able to do the job. Mental health interpreting tends to involve highly challenging and often provocative material that will impact on the persons present. We have made a clear distinction between what we term ‘linguistically out of depth’ and ‘emotionally out of depth’.44 The former relates to skills and experience, while the latter relates to the emotional reaction interpreters may have in counselling scenarios. In Australia, ‘there is a shortage of sign language interpreters in general, and few are familiar with psychiatric terminology and phenomenology’.21 Difficulties processing the emotional impact of the therapeutic material will have clear consequences on the quality of interpretation. As Harvey states, ‘interpreters, as human beings, would be expected to perceive inaccurately and therefore interpret inaccurately content that is highly emotionally loaded for them’ (p. 307).52 Recently, when discussing an alleged rape in therapy, a sign language interpreter did not use the conventional sign for ‘rape’ and instead fingerspelled the word ‘molest’. The deaf patient did not understand the word molest and the therapeutic opportunity to explore the issue was lost at that time. These interpreter errors may occur more frequently than we know, but of course are not observed unless a clinician is fluent in the host and target languages or the interpreter indicates that there is a problem.

Role challenges

Although interpreters are expected to abide by a Code of Ethics, which governs their role as communication facilitator, our experience tells us that many interpreters ‘step outside’ of their conventional role in therapeutic contexts. This can occur for a variety of reasons, such as feeling uncomfortable with the content, commenting on a deaf patient’s linguistic capabilities, and reasons to do with the Deaf community as a linguistic and cultural minority group.

Threats to the therapeutic alliance

In treating a deaf patient, the role of the therapist may easily be confused. Common misunderstandings can centre on maintaining good eye contact (the deaf patient will be looking mostly at the interpreter). Of course, the most useful tool a hearing therapist has is audition, that is, listening skills. The process of joining the patient in therapy is thought to be the single most important predictor of the success or failure of therapy, independent of the type of therapy offered, and has been investigated extensively.53,54 Large-scale clinical trials have found that a
positive alliance is a significant predictor of a successful outcome.\textsuperscript{55,56} This centralizes the role of the therapeutic alliance (the working relationship between therapist and patient). The therapeutic alliance can be conceptualized as bonding and agreement on tasks or goals,\textsuperscript{57} or the patient regarding the therapist as helpful and feeling that therapy is a collaborative process.\textsuperscript{58} If, however, the deaf patient is focusing more of their attention on the interpreter in order to access the message, there is a danger that the patient will ally with the interpreter rather than the therapist.\textsuperscript{59}

Duffy and Veltri state that therapy using sign language interpreters can work, but only if the patient wants to change and work on issues, the therapist respects Deaf culture and sign language, and the interpreter recognizes and studies the complexity of the mental health setting.\textsuperscript{60}

**RECOMMENDATIONS**

A review of the literature indicates there are a range of issues and challenges faced by interpreters and therapists when working with deaf people. Many of these issues could be easily resolved through improved communication and training, and others will be better understood with more research. All discussions have relied on anecdotal descriptions of interpreter/therapist experiences; thus, there is a need for empirical evidence to support our understanding of the issues and challenges identified. Nevertheless, we offer the following recommendations drawn from our clinical experience.

1. Interpreters and therapists take the time to prepare for sessions, and also take the opportunity to debrief after each session, to ensure that: (i) therapeutic goals are clear; (ii) linguistic and cultural issues can be discussed; and (iii) emotional and psychological reactions can be shown and discussed.

2. The development of specific guidelines for the application of the Code of Ethics to interpreting in mental health settings, to account for the specific dynamics of interpreting in this context.

3. Specialist training for therapists, which includes knowledge about the cognitive, social, emotional and psychological development of deaf people.

4. Specialist training for interpreters, which includes counselling theories and practices, with opportunities to practice interpreting in therapeutic contexts.

5. Experienced therapists and interpreters work in collaboration with Deaf community organizations to provide information/psychoeducation workshops to members of the Deaf community, and to inform them of the role of the therapist, the purpose of, and techniques used in, therapy, and the role of interpreters and families in the therapeutic process.

6. Empirical research is undertaken, which analyses the impact of the sign language interpreter’s presence on the dynamics of therapeutic interaction, and in particular on the therapeutic alliance. Research should focus on communication and turning management, interpreter interference and interpreting strategies.

**REFERENCES**


