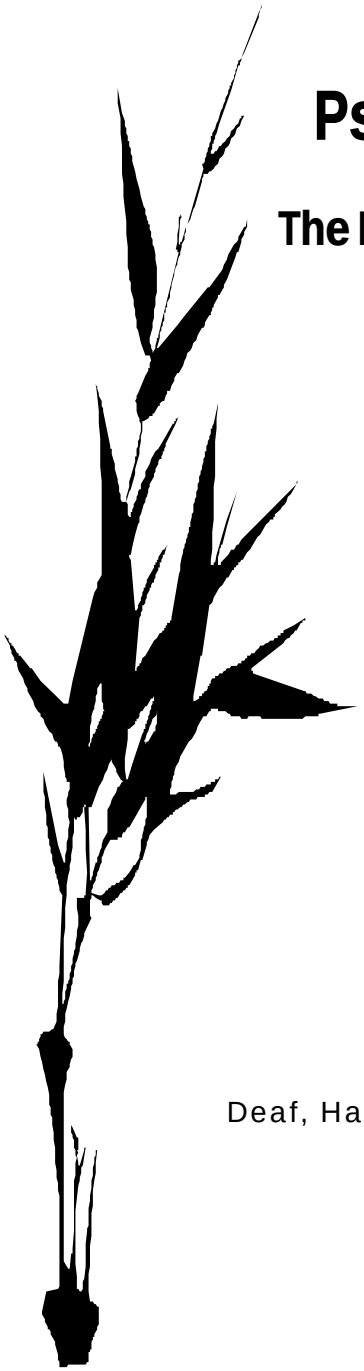

Psychotherapy with Deaf Clients:

The Evolving Process of a Therapist / Interpreter Team

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Vancouver Community Mental Health Services

May, 2001

INTRODUCTION:

The purpose of this paper is to take advantage of a unique combination of circumstances that produced an intensive and long term interaction between mental health professionals and the Deaf and Hard of Hearing communities of British Columbia. There has been much wisdom and skill accumulated over the term of this project and it would be a shame to not share the fruits of this effort with others. Perhaps other communities and helping professionals will find the learning curve more easeful with the information our experience provides.

The Well Being Program was developed to promote social, emotional, and functional health for those who are deaf, hard of hearing or deaf-blind. In particular, there has been a focus on healing from sexual abuse, and related emotional and social damage to the Deaf community as a whole. This was a pioneering concept for us – to provide ongoing psychotherapy to members of the Deaf community using for the most part hearing therapists and ASL interpreters.

There was no text book or manual on how to do this, and many difficult issues emerged along the way which had to be negotiated and worked through among the professionals involved. The evolution of the therapeutic team when working with deaf and hard of hearing clients was an intense, effortful and at times anxiety provoking experience. We are now at a point in this process where many hurdles have been overcome and confidences won as a result. There has been tremendous growth and learning for those who have continued to stay involved.

What has evolved, as therapists and interpreters have worked side by side, is a therapy that has been delivered in a more bi-cultural way which better meets the needs of the client. What has 'worked' has often been unique to the chemistry of a particular therapist, client, interpreter triad and is thus difficult to generalize. Taking this into account, we have tried to avoid being prescriptive in this document. Our goal is to describe what did take place rather than determine what 'should' take place for others. In this area of work, there is tremendous room for creativity and flexibility within the process which we wish to recognize and support.

Some of the struggles the therapeutic team went through related to theoretical or ideological issues. We have seen a movement from a focus on theory and ideology to a focus on practice and results. Over time, many disputes simply dissolved rather than being 'solved'. Those that persisted were resolved by reference to results rather than intentions. Those practices leading to positive results began to accumulate as a body of wisdom.

We hope that our experiences can provide guidance and perhaps inspiration to others involved in providing mental health support to this segment of the population which has been marginalized and sadly under-serviced in the past.

INTENT:

Our intent in creating this document is twofold: firstly, to identify the issues that have come up through working under these unique clinical circumstances as a team; secondly to describe what we learned through the process. We will also describe something of how we worked on these issues and say something about the present state of the program.

This paper might be used in the following ways:

- To be used as part of an orientation package for new therapists and interpreters for the Well Being Program.
- For use as a resource for programs elsewhere which have a similar mandate to the Well Being Program.
- For use in school programs where there is a significant deaf or hard of hearing population.
- For inclusion in the curriculum of courses related to providing services to the deaf and hard of hearing.
- To provide a foundation for workshops to be delivered by members of the Well Being Team.

BACKGROUND OF THE WELL-BEING PROGRAM

The Deaf, Hard of Hearing, Deaf-Blind Well-Being Program (WBP) is a Provincial program that provides mental health services to deaf, hard of hearing and deaf-blind individuals and their families. The Program is currently under the auspices of Vancouver/Richmond Health Board.

Mental Health Services to the above population began in 1987 following an abuse investigation into the Provincial School for the Deaf, Jericho Hill School, which included a residence for out of town students. In the years 1982, 1987 and 1992 there were separate investigations into allegations of abuse which revealed extensive sexual, physical and emotional abuse. This had a profound emotional impact on individuals, their families and the larger Deaf Community. The psychological impact will potentially impact second and third generations.

Following the final investigation the Provincial Government contracted with **Thomas R. Berger, O.C., Q.C., Special Counsel**, to review the investigations and to make recommendations around potential claims. Following is a brief quote from Mr. Berger's report:

"…These findings give credence to the view that the complaints made to the Jericho Hill Intervention Team are, by and large, true, and reflect a condition of widespread and pervasive sexual abuse of children at Jericho Hill extending over many years.

The history of Abuse in some residential schools…has revealed a pattern of sexual abuse by staff and students; in fact, in some of these institutions a culture of sexual abuse developed. This occurred at Jericho Hill.

…I make no findings here regarding individual cases. I am instead confining myself to stating my finding, applying generally to the state of affairs at Jericho Hill School, that from the 1950's, extending over about a 35 – year period, there was sexual abuse by some child care staff, sexual abuse by some older children against younger children, and that some of these younger children (once they became senior students) sexually abused new entrants."

With this in mind there could be no question that accessible mental health services for deaf, hard of hearing and deaf-blind people would be needed and must be provided.

The Mental Health Services originally set up in 1987 were mainly provided to the affected students and their families. However, following the 1992 investigation the Mental Health Services expanded to include adult survivors of sexual, physical and emotional abuse and their families.

The Well-Being Program now provides a wide variety of services to deaf, hard of hearing and deaf-blind people in the province of British Columbia. Although program planning will continue to evolve, the following services are presently provided:

- One-to-one therapy with individuals (children and adults) and/or their families. This is provided by private contracted psycho-therapists who are Registered Psychologists, Clinical Social Workers and Clinical Counselors, through the use of interpreters.
- Qualified mental health Interpreters who are used in therapeutic sessions.
- Five signing therapists.
- Support Services for clients who require assistance accessing hearing services, advocacy, supportive counseling.
- A variety of groups as needed are provided: both therapeutic and supportive, i.e. a sexual abuse group for men; a drop-in coffee group etc.
- Community education throughout the province, such as workshops.
- Professional development when funding allows.

THERAPIST AND INTERPRETER MEETINGS

Over the years the WBP has had regular meetings with the therapists and interpreters who provide the one-to-one therapy services. The intent of the meetings was originally to provide the opportunity for the therapists to learn about Deaf Culture and to provide the opportunity for interpreters to learn and understand the therapeutic process. It was considered a critical piece of professional development.

What occurred in these sessions over the years was a good deal of learning about deaf people and their various cultures. There was also learning about many therapeutic issues, for example; the complications that arose out of the third person in the room (the interpreter); or the questions about translations of meaning and intent in language use and how that gets interpreted from one language to the other. The discussions invariably left the members with much to think about as more and more questions seemed to arise. The process of discussing and learning was often exciting and seemed to keep people motivated to continue on with the meetings.

It is from those meetings that this paper came about. The 'Therapist/Interpreter' meetings occurred over approximately 7 years, in various forms. In the fall of 1999 several therapists and interpreters participated in a focus group, which was connected to the review of mental health services for the deaf, hard of hearing and deaf-blind. During that meeting, through the articulate, caring and considered responses by therapists and interpreters, it became evident that the group was transformed since our beginnings as a group years before. At that meeting a sense of having evolved to a more sophisticated level of skill and understanding became evident. Ultimately, and hopefully, this has translated into better services to the clients and their families.

This document is not intended to be a fully comprehensive account of the Well-Being Program and its services. We are not including information or comments on the excellent work done by the signing therapists, Deaf interpreters or the WBP Community Support staff. Its focus is the development of how we worked on bridging the gap between hearing therapists and deaf psychotherapy consumers.

PART ONE - A DISCUSSION OF ISSUES THAT RELATE TO THE THERAPISTS PERSPECTIVE AND THE PROCESS OF THERAPY

1. Preparing To Work With The Interpreter.

For the therapist who is preparing to work with an interpreter for the first time, it is crucial to set up a time to meet with the interpreter before the initial session with the client. The therapist needs to understand the role of the interpreter, and be clear of the protocol involved in having the interpreter present e.g. the therapist speaking directly to and maintaining eye contact with the client. There may be questions the therapist has about Deaf culture which the interpreter can answer, and the therapist may want to tell the interpreter about their particular approach to therapy and the kind of issues they will be addressing. In discussing this issue with interpreters, the feedback is that therapists have not generally spent time explaining their theoretical approach, and this would be useful. Establishing an open line of communication from the outset means that any potential problems in the future can be addressed and dealt with before they interfere with the therapy. The interpreter should be able to feel comfortable, for example, giving the therapist feedback around elements of their communication style that present technical difficulties for the interpreter, or not work well when translated into ASL.

If the therapist is going to use an approach such as EMDR, Psychodrama, Anger Release work etc. the interpreter should understand what the therapists expectations are of both the interpreter and the client. Understanding the point or desired outcome of the work helps the interpreter put things in a context. This may involve giving the interpreter a brief overview of and rationale for using the therapeutic approach in question.

The therapy process can evoke strong feelings for the client, therapist and interpreter alike. Many therapists view their own emotional reaction to the client as an integral part of the work. They refer to their own feelings during the session as an important source of information about the dynamics between themselves and the client, and what might be going on within the client. The therapist may or may not disclose what they are feeling, depending on their theoretical approach, where the client is in their therapy, and the nature of the therapeutic relationship. The interpreter, on the other hand, does not have an opportunity within the session to express or process whatever might be going on for them. In addition, their training may not have included developing awareness of the needs for emotional self care that is usually part of a therapist's training. The therapist may inquire how the interpreter may be feeling after a session, and in so doing, acknowledge and validate what the interpreter's experience is. This level of caring and involvement helps build the relationship necessary to work well as a team. The therapist can provide this acknowledgement and validation of the interpreter's feelings but should not cross the line into 'doing therapy' with the interpreter. Should really deep and distressing feelings be evoked for the interpreter, the therapist can encourage them to seek whatever additional support they need.

The interpreter may be able to give the therapist input on what is going on with the client from a Deaf culture perspective. The therapist should be aware though, that the interpreter is not there as a clinical consultant or to provide a sounding board for the therapist's issues with the client.

While arranging an interpreter for a new client the therapist should check out with the interpreter if they have had any prior contact with the client and if there is any reason it may not be appropriate for them to work with this client. The client also needs to participate in deciding who the interpreter will be.

2. Vulnerability And Trust With The Interpreter Present.

In this section, we will address the impact of the interpreter's presence in the therapy session specifically as it relates to issues of trust and safety for both therapist and client.

As a therapist, most of the work we do gets done behind closed doors in the privacy of our offices. Privacy and confidentiality are essential for the level of safety and trust most of our clients need in order to do their therapeutic work. It is rare that others get to observe what we do unless we choose to tape our work for supervision or teaching purposes. In addition, we tend to view our relationship with our clients as contributing to the healing process - a supportive, nurturing and empathic other who is consistently emotionally present to the internal process of the client. Having on observer in the room can influence the dynamics of this relationship for both the client and the therapist.

For the therapist there can be performance anxiety, particularly when unaccustomed to the presence of the interpreter. This may be experienced as an awkwardness, concern about judgements the interpreter may be making about our work, and a consequent lack of spontaneity in our responses. This can be heightened since a portion of our therapeutic repertoire is unavailable for use when working with a deaf or deaf-blind client, for example, the tone and pacing of your speech or the use of guided fantasy.

Working as a therapist frequently involves using your personal feelings and reactions to guide the direction therapy takes. How much of our own process gets shared with the client depends on our training and personal comfort level. However, whether we're expressing our reaction of shock and pain at some experience of abuse our client has had, or we're struggling with the clients resistance to move into deeper emotional states, or confronting some boundary issue, who we are as individuals shines through. Bringing ourselves into the process is important, and at the same time exposes us to scrutiny from the interpreter. There can be a tendency to stay on 'safe ground' therapeutically, doing what one 'should' do, and not necessarily what one might do more spontaneously, making the process feel mechanical.

These issues for the therapist can be dealt with by spending some time with the interpreter, debriefing feelings about the session and getting a sense of who the interpreter is as a person. It may be important to let the interpreter know what the therapeutic intent is of a particular technique or activity you as the therapist might suggest. Once there is a sense of rapport between therapist and interpreter, you can really relax and move into the experience of working as a team. If you have strong negative feelings about the interpreter, it is probably best to ask for different person who you can feel comfortable with. Just as it is important that the client feel comfortable with the interpreter, the therapist also needs to feel comfortable in order to do his/her work.

As therapists, it is important to face our own feeling of inadequacy and fears of judgement, as well as get support and reassurance from colleagues that we're doing okay. This may mean taking these issues into our own therapy or seeking out clinical supervision and additional training in order to build confidence and keep our clinical skills well honed.

For clients starting therapy, there are often lots of feelings of shame, fear, and vulnerability present because of the newness of the situation and because of the material they are there to deal with. It is hard enough to take the step to talk to someone individually about these things - having a third party there can make it even more difficult. It is impossible to say how many people avoid asking for therapy for this reason, although most of my hard of hearing clients prefer to make do without an interpreter, which suggests that it is an issue for some people. At the same time, deaf clients are usually accustomed to having an interpreter present when they are accessing services out in the community and for the most part seem to accept the presence of the interpreter quite easily. The presence of the interpreter, however, can become a bigger issue when the client needs to talk about something they have deep shame about, or when they are overwhelmed by the intensity of feelings such as grief or anger.

Since interpreters are frequently involved in other aspects of the Deaf community the client may have information about the interpreter, such as their religion or sexual orientation, that affects the information they share. On several occasions, it has been important to check out the clients projections onto the interpreter - asking the client to be explicit about what they imagine the interpreter might be thinking or reacting to what they are saying. Two examples of this are (1) a client was being vague & evasive around the question of a sexual problem he thought he had. He was glancing at the interpreter in an uncharacteristically anxious way. His concerns about the interpreters judgements had to be addressed before beginning to talk openly about a compulsive sexual habit, and needed to be addressed again at the end of the session. (2) a sexually abused client who had been dealing with guilt and shame about offending as an adolescent did not want to deal with this issue with one interpreter who he knew was religious, but would bring it up with other interpreters.

While it is appropriate to address these feelings openly, it is not appropriate to push the client to deal with the material if they continue to be uncomfortable with the interpreter. This can feel like a violation and only serves to reinforce defenses.

Sometimes clients just need a bit of space & time, sometimes they will need a different interpreter.

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3.The Therapy Triad: Are interpreters simply conduits in their role or are they more?

This is a highly complex question to answer, and as with many of the issues discussed in this paper, each therapy situation consists of a unique, highly individualized set of dynamics involving the therapist, client and interpreter. We cannot assume that the interpreter does not influence the process - the very presence of another person who is witnessing the thoughts and feelings of the client is powerful in itself, providing validation of these thoughts and feelings. In addition, the interpreter is the medium through which the message is conveyed. It is the interpreter who is conveying nurturing and supportive statements and conveying the permission to express what has been held in. Is the relationship with the interpreter or with the therapist?

The client may come into therapy having had a lot of prior contact with the interpreter in other settings. There may well be a stronger relationship with the interpreter than with the therapist at this stage and the therapist needs to put in the time and energy to develop their own relationship with the client. If there is a strong previous connection with the interpreter, there can be a tendency to attribute the message to the interpreter rather than the therapist. This can interfere with the development of the therapeutic relationship. At the same time, the client's strong positive connection with the interpreter can help facilitate trust with the therapist, particularly when the client can see that the therapist and interpreter work well together. It may be necessary to clarify the roles of therapist and interpreter in therapy with some clients. Clients at times have tried to continue their therapy discussion with the interpreter as they leave the office, or when they bump into each other socially. This is problematic in that the therapist (who is ultimately responsible for treatment) is not party to this information and the interpreter may be burdened with information they are not trained to deal with. It takes skill to sensitively establish boundaries when this occurs. The interpreter may need to establish a clear boundary right at the time the client tries to engage them on a 'therapy' subject (e.g. "I can't talk to you about this, you need to wait until your next therapy session or contact your therapist"). The issue then needs to be addressed during the session following the outside contact.

In the early stage of therapy there may be some clues that the client is more connected with the interpreter than the therapist, such as making more eye contact with the interpreter while signing than with the therapist, or directing clinical content questions to the interpreter. Over time, the relationship between the client and therapist

intensifies particularly after painful emotional material has been worked on. Just as with hearing clients, there is a clear shift in the relationship when a bond has formed - the heart of the therapeutic alliance. When I reach this stage with my deaf clients, I have been able to have productive sessions even when the interpreter has had to cancel at the last minute or has not shown up. While this is a definite second choice, using gesture, writing, and drawing can take people into the core of what's going on if the relationship is there.

In terms of the connection that develops with the interpreter there is a wide range of experiences, with some clients relating on an emotional level only with the therapist, and others clearly having a strong bond with the interpreter as well as with the therapist. The strongest bonds seem to form when the interpreter is consistently present from the initial session onwards. To complicate matters, I believe that any form of transference (1) that can occur with the therapist can potentially also occur with the interpreter. For example, in one situation the interpreter physically resembled a person who had sexually abused the client. The client initially accused the interpreter of being the person who raped her, however, after thinking it through realized it would not have been possible given the relative ages and time frame. The interpreter was able to continue working with this client once the feelings had been addressed. In another situation, a client was deeply attached to an interpreter who he idealized and had romantic feelings for. There was a period of mourning after this interpreter made a career change and was no longer available. It is inevitable that these kinds of attachments or projections onto the interpreter will happen. If handled in a direct and open manner they are a rich source of therapy material, opening up old feelings and unfinished business with important figures from the past. A final example - where the client engaged in 'splitting' (2). In this therapy situation the therapist experienced a client who projected all good 'ideal' attributes onto the interpreter and devalued the therapist. The therapist worked with this by attributing to himself opinions which might arouse resistance, while attributing to the interpreter opinions and suggestions which might be necessary and useful for the client's progress. For example saying "Now (client), I think that you really don't have the courage that's necessary for therapy, whereas (interpreter) on the other hand believes that you do". The interpreter and therapist were able to work with this dynamic in a co-operative way and avoid the divisiveness that can result from splitting.

(1) TRANSFERENCE – " refers to the displacement onto the therapist of feelings and thoughts originally experienced in previous relationships. In traditional analysis, the therapist is supposed to present a "blank slate" to the client so as to facilitate this transference of feelings. Once the transference is established, it can be analyzed and destructured so that the archaic feelings and beliefs no longer affect the client's present functioning. Counter-transference, in this view is the mirror image of transference; it is the thoughts and feelings of the therapist, left over from old relationships and transferred onto the client."
(Erskine, Moursund, Trautmann 2001)

(2) SPLITTING – a defensive process in which someone tends to see things in polarities – good/bad, right/wrong. It often involves holding an extreme view of self, other, or of life in general. For example, a person may either idealize or devalue others, may see themselves as omnipotent or worthless. Their feelings may alternate from one polarity to the other with little capacity to tolerate and appreciate the in between states. Experiencing things in dissociated extremes protects the person from the stress of working out a more adult, mixed view or developing an integrated understanding and experience of things as they are.
(p.p. 14 Character styles Stephen M. Johnson W. W. Norton 1994)

A strong positive connection with the interpreter can create a more familiar, relaxed emotional tone in the therapy. This may or may not be seen as desirable by the therapist, depending on their approach and personality. If the interpreter is distant, or doesn't like the client this also comes through and affects the therapy in a negative way. On one occasion, an interpreter approached me after a session to say she didn't want to continue working with the client. For various reasons the interpreter had difficulty maintaining an empathic and accepting stance with this particular client. I greatly appreciated the interpreter's honesty and integrity in being open about her feelings and a different interpreter was arranged for.

It is clear that in many therapy situations, the interpreter takes on a role and importance beyond what it is traditionally expected. As such, psychotherapy interpreting presents a whole set of new challenges for interpreters as well as presenting a whole set of unique rewards. It would be interesting to discuss this issue with Well Being Program clients who have completed therapy. Their perspectives, I'm sure, would be highly varied and provide many useful insights.

4. Communication: A question of matching the language to the intent.

In every communication there is either an implicit or explicit outcome that is desired by the speaker. Once that is identified, then a choice has to be made as to the most effective way of "languaging" that intent to produce the desired result. We assume that a *therapeutic* intent is the same as the intent to *communicate* accurately and faithfully. But this might not always be the case. A therapist may wish to evoke the information that the situation calls for from *within the client.* However, from a communication standpoint it makes little difference from where the information comes. Telling the deaf person the "answer" is just as effective as drawing it out from them with Socratic questioning...as long as the deaf person "gets it", that is all that matters. In other words, there are different assumptions structuring therapeutic exchanges than those that govern social communication. That is, the therapist's intentions are to *elicit* information whereas the interpreter's intent is to *impart* information (of course this isn't always the case) For example, the therapist might ask the client "How are you?" This is a vague ambiguous statement and intentionally so because the therapist is curious as to which level of that question the client will choose to respond. The interpreter on the other hand might want to make the communication more specific and concrete in order to give the client an easier entry point into the conversation. She might frame the "how are you?" question as "How are you feeling today; what kind of mood are you in today; are you glad/sad/mad today?" All these interpretations limit the range of possible answers that the client is likely to give and so masks the choice the client might have made if the question hadn't already narrowed the list of possible responses. Hopefully the longer we work together the more we will see the interpreters coming to understand the special languaging requirements that are operative in a therapy session.

A more critical example demonstrating the tension between the therapeutic and communication requirements follows: I might want the client to acknowledge that their best intentions aren't producing the results that they desire. They might believe that by being "buddies" with their teenage daughter then their child will "owe" them. That is, when the parent asks for compliance the teenager will agree because of all the favours they've received from the parent. Usually this belief is implicit rather then explicit. That is, the parent is not consciously aware that this belief is governing their behavior. As a therapist I want to accomplish two things with this parent. First, I want them to *become aware* of the belief that governs and structures their interactions with their teen. Secondly, I want them to evaluate the results that they are achieving. The interpreter on the other hand, from their personal knowledge of the parent, knows that the parents conceptual and languaging skills are rudimentary. From that knowledge the interpreter decides that the most effective way to communicate with this client is by telling them in simple declarative sentences. The interpreter picks up the implication in my question ("do you think your parenting style is effective?") and states to the client "Your parenting skills aren't working." Clearly this is a situation in which the apparent therapeutic and communication requirements are different. The way this "difference" was discovered was through a debriefing that took place between the therapist and interpreter immediately following the session. The interpreter was both conscious of her intervention and remembered it afterwards and thus the discrepancy came to light. One has no way of knowing how often this is not the case.

An even more fundamental difference between the therapeutic need and the interpreting need has to do with sequencing of ideas. I've been asked by a number of interpreters to begin my utterances with the main point. My sense is that they need that knowledge in order to begin to construct and elaborate the meaning in ASL. Without that central meaning to begin with, would be like attempting to build a house without the foundation; or like drawing the margins of a mandala before knowing what the central pattern was. That is the interpreter's need. The therapist, on the other hand, wishes to construct his message without "announcing" the point prematurely. My style of working often involves generating messages that have an effect similar to a haiku poem. Such a poem doesn't resolve its meaning until the last two or three words. Those words have the power to transfigure every word that preceded them - the meaning is resolved by the ending and isn't present at the beginning. The same thing happens with a joke. The beginning of a joke sets up an implicit expectation but the ending violates that expectation while still fitting with the beginning. As a therapist I know that what I am working with are the client's meanings, expectations and assumptions. If I approach those meanings from the "front door" by being explicit about my point, then the client will automatically activate their assumptions about that topic and resist any fresh slant that I may wish to open up.

For example, I was asked to work with a group of teens with regard to sexuality issues. There was considerable sexual exploration (with the parallel risk of exploitation) going on within the group. Their behavior indicated that they seemed unaware of the risks or the social consequences of their behavior. If I announced that the groups were going to be about "sexuality", the interpreter would thereby be orientated. However, the group would have begun experiencing the awkwardness that often accompanies formal talks about sexuality. Instead of dealing with sexuality, I would be dealing with their preconceptions about 'yet another adult talking to us about sex'. To avoid this, I began with the following "You know, most adults have developed amnesia for their own teenage years. We adults don't remember that the biggest decisions that we would ever face come to us while we are teens - what kind of work/career do we want? Will we find a mate? Will we find the right mate? If you don't make the right choices you end up in a job (or many jobs) that you hate; or you end up in a loveless marriage, with constant fighting and a miserable time for your children. So of course you're going to be careful what choices you'd make...and you're going to take your time. For your parents on the other hand, those choices are behind them. The decisions they make are about when to mow the lawn, wash the car, shop for a mortgage -- not nearly as big as the ones you're now making. By the way, what is the one event that could happen that could take all that decision making out of your hands?"

"An unwanted pregnancy. Means the end to your childhood. Either you lose your innocence or you lose your actual teen years as you are prematurely promoted to adulthood with the arrival of your own child"

I am attempting to come to the topic through the back door. Or I am attempting to place the topic of sexuality in a larger, more existential context. I am choosing to do so

in the elliptical way that I do because I don't wish to evoke their fixed ideas on sexuality or their resistance to kids discussing sexuality with an adult.

As a side bar, I used the word "amnesia" which the interpreter initially translated as "forgetting". Only with my repeated, emphatic usage of "amnesia" did she realize that I was conscious and intentional in my choice of words. Then she advised me what substitution she had made. We conversed and corrected her interpretation so that it was more in line with my intent (she substituted a sign that indicated "brain injured"). Again, I wanted a word that evoked the kids curiosity not a word that they could pass over lightly and dismissively. I wanted a word that might also explain to them why their parents couldn't understand what seemed so obvious to the teen - that they were making life choices and were frightened by awesome responsibility that such choices entail.

In the examples above, it is inevitably the interpreter that is aware of the difference between my languaging and hers. She is the one who "catches" it and brings it to my attention.

So what can the therapist do to improve the match between his or her intent and the languaging that the interpreter imparts to it? It seems to me that there are at least two answers to this question. The first answer is that it is essential that the therapist "own" his or her communication. What do I mean by this? I mean that the therapist ***commits*** himself or her self to their utterances; that they fully ***engage*** in the communication process. In my own case I find that the more I give myself over to the reality that is being discussed the more I trust that the interpreter's signing is faithful to that same reality. When I take this leap of faith, I frequently notice that both the interpreter and the client are also more willing to engage. We each bring ourselves to the process in ways that are distinctive to our disparate roles. When this occurs I don't feel like that interpreter is a mere conduit or mimic but rather someone who comes alive to the spirit of the message. This same phenomena occurs with hearing clients. Both the therapist and client can be going through the motions and misunderstandings abound - some that are caught and many more that are not. *When there is no intent to really communicate all the training and education in the world will not make up for it. I suspect that at times when my interpreter is frustrated by my client not using fully formed signs or signs not crisply produced, it really is an indication that the client has no authentic intent to communicate. This is therapeutic data and shouldn't be masked by the interpreter working overtime to compensate by "cleaning up" the message.*

The second method for aligning therapist's and interpreter's languaging of the same message is through the debriefing process that occurs afterwards. It is here where those odd moments of disjunction can be identified and teased apart to reveal the therapist's intent and the interpreting necessities.

5. Consistency Of Interpreters.

Ideally, the same interpreter would be available throughout the course of therapy for each client. In reality, this is rarely the case and clients have to deal with a new interpreter when their regular interpreter is unavailable. Some clients do choose to cancel their therapy session when their usual interpreter is ill or away because they don't want to deal with having somebody new in the therapy session. Other clients are willing to make the adjustment in order to maintain the continuity of therapy. When clients are willing to work with a substitute interpreter, there are several things the therapist can do to make this easier on the client.

- Have a backup interpreter the client knows, and use this person consistently when the regular interpreter is unavailable. Make this arrangement explicit to the client so they know what to expect.

- Inform the client ahead of time that the regular interpreter is away so they have some time to mentally prepare themselves for a substitute being there.

- If the substitute interpreter is not someone the client has worked with in a therapy setting before, let the client know the interpreter's name. The community is small and the client may not be comfortable with that interpreter for various reasons.

- At the beginning of the session, acknowledge the change in interpreters and invite the client to express any thoughts or feelings he/she might have about this.

If the client is at a particularly vulnerable point in their therapy, the therapist may have to make a judgement call whether it is better to cancel the session if the regular interpreter cannot be there, or whether it is more important to meet anyway with a substitute.

Client reactions to having a different interpreter are varied. Some people don't seem to be affected at all and don't miss a beat. Other clients have reported that it feels like they have a different therapist when there's a different interpreter. The corollary of this is also true - for the therapist in some situations, having a different interpreter with a client can feel like having a different client.

6.Managing Couples And Families.

Family and couples work always presents a challenge to therapists because you're no longer just hearing about family dynamics second hand, you are right in the middle of them. There are often pent up feelings of anger, frustration and pain that can be highly volatile when family members come together to share openly. Running family and couples sessions means creating that delicate balance of safety and permission that allows feelings to be expressed, but protects clients from being scapegoated, labeled or otherwise re-traumatized. Almost every therapist has had the uncomfortable experience of feeling like they 'lost control' of a family session. Setting clear expectations and limits at the beginning of sessions can help prevent this, as well as preparing clients in advance.

For the Well Being Program clients I have seen, there has been a universal experience of serious communication problems within the family. Even more so than with 'hearing' families, there is often a backlog of unanswered questions, old resentments and hurts, and feelings of being left out. This may relate to the fact that the parents and siblings didn't learn ASL, or that the individual spent much of their childhood time attending residential school away from the family. The family may have had other difficulties to deal with such as alcoholism, separations etc. and the special communications needs of a deaf or hard of hearing child not attended to.

There are a number of approaches to working with the families of my Well Being Program clients that I feel have been helpful in making the experiences positive for those involved.

- **Keep it small**. The more people there are in the room, the more complicated the communication becomes - this factor becomes amplified when there is a mix of deaf/hearing people and interpreter(s) involved. I believe that effective family work can be done working with dyads - that change in one part of the system helps bring about change in the system as a whole. Building some sense of relationship with a family member and working through some unfinished business on a one to one basis can be less threatening than facing the whole family and can make it easier to be vulnerable and open. Also the impact of chaotic or avoidant communication styles can be minimized. Working with different dyads within the family can be highly productive over time, however, there will still be times when it is necessary to involve more family members in the meeting.

- **Establish expectations and limits.** Much of the success of a family session depends on the preparation the client has gone through in anticipation of the session. Being really clear about the purpose of the meeting is important as well as establishing what the client hopes will be gained by meeting. The more explicit this can be the better, and on a number of occasions I have drafted a letter with the client to family members outlining the purpose and intent of the meeting. This way, there are fewer surprises and people have a chance to think about the issues before getting together. Adequate preparation involves helping the client be realistic about what they can expect from a family meeting, and also involves assessing the intensity of feelings of rage, guilt, grief and so on the client may have in relation to their family. Validation

and release of these feelings prior to meeting with family members helps create a less volatile situation. The therapist needs to set clear limits around things such as more than one person at a time saying something, people interrupting, or making attacking or abusive statements. If you are using any particular technique, discuss this with the interpreter beforehand to make sure they understand the point of what you will be doing.

- **Be conscious of the interpreter**. Having an interpreter who knows the client and has some idea of the dynamics at work is essential in doing family work. This is definitely not the time to bring in a substitute interpreter since both the therapist and the client need to have an established working relationship with the interpreter. The therapist needs to be aware of anxieties the interpreter might have in doing family work and discuss these feelings before the meeting. The intense emotions that often come up in family meetings can be upsetting in themselves or may trigger feelings for the interpreter about ruptures that might have occurred in their own family. Having an opportunity to debrief with the therapist after the session can be a really important opportunity for the interpreter to acknowledge what's going on, unload, and get support if necessary. The therapist needs to be conscious of the distinction between providing collegial support and being therapist to the interpreter.

7. Missed Appointments.

One issue that has been a perpetual thorn in the side is that of missed appointments. This relates to those appointment times which have been scheduled where the client either fails to show up, or cancels with short notice. The understanding has been that interpreters require 48 hours notice of cancellation, therapists 24 hours notice. In the early years of the Well Being Program, both therapists and interpreters could bill for missed appointments. Clients were allowed up to three missed appointments a year, after which they needed to deal with the Well Being Program administration in order to re-commit and continue with treatment. When money became tighter, a reckoning was done as to the cost of these missed appointments, which was a significant amount. Changes in policy followed which resulted in therapists no longer being able to bill for missed appointments.

Therapists in Private Practice are accustomed to billing for missed appointments or late cancellations - this is usually an explicit agreement with the client established at the beginning of therapy. It relates to responsibility, accountability, respecting the therapist's time etc. The dynamics of this issue change when the therapy is being paid for by a third party and in my experience clients and therapists tend to be more casual around attendance when the cancellation fee doesn't have to come out of the client's own pocket. Therapists had to come up with another way to deal with missed appointments. Since many of the Well Being Program clients are unemployed or underemployed, charging clients becomes a moral dilemma. There has been no official policy made on this and each therapist has their own way of dealing with it. My practice has been to have Well

Being Program clients sign a letter at the beginning of therapy outlining my expectations around cancellations, which includes a late cancellation/no show fee. This amounts to 50% of my hourly fee for those clients who are working, and a negotiated fee for those on limited income. This may end up being only $5.00, which doesn't compensate me for the client I might have booked into that time, but does convey the expectation of accountability.

PART TWO - A DISCUSSION OF ISSUES THAT RELATE TO INTERPRETERS AND THEIR PRACTICE

1. An Introduction To Mental Health Interpreting.

Sign language interpreters serve to overcome communication barriers between deaf people who use sign language and hearing people who do not. Interpreters are fluent in two languages, English and American Sign Language (ASL). Interpreters constantly seek to understand the meaning of what is said or signed, and to convey that meaning in the other language in a way that has the same effect on the receiver as if he or she understood the language of the original speaker. Interpreting does not involve a sign-for-word match. The whole message, including tone of voice, affect, implicit and explicit meaning, needs to be understood and conveyed. This process includes an interpreter's knowledge of the different cultures involved. A simple example of cultural differences is how hearing people often use a person's name during conversation to establish a bond, while deaf people maintain eye contact and point to the person. If the interpreter signed the deaf person's name because the hearing person had said it, the deaf person may think that the hearing person is angry with them or is just somehow acting strange. The interpreter would have conveyed the form of the message, but not its intent.

Interpreters follow a professional Code of Ethics, which values confidentiality, neutrality, the autonomy of consumers and professional competence. They participate in professional associations, and continue to develop further competence in their field.

What makes mental health interpreting different?

As in any setting, interpreters in mental health settings seek to understand the participants and what they mean, and to convey those meanings in a complete, accurate way. In mental health settings though the decision-making level of the interpreter is more intense. While still striving to convey meaning, the interpreter also needs to pay attention to many subtle factors which may have therapeutic significance. For example, if the deaf person's signing changes markedly every time he discusses his former teacher, it may be a significant detail to relate to the therapist. The deaf person's signing may suddenly become lethargic with incompletely produced signs. Details like these may carry therapeutic significance, and the interpreter needs to alert the therapist to these changes.

The interpreter is trained to make sense of what people are saying, and to strive to understand. Yet at times the interpreter will need to NOT make sense. If the deaf person is fragmented in their language or delusional, this needs to be interpreted so that the therapist or clinician understands what is happening with the deaf person. Interpreters are so accustomed to making sense, that it feels wrong to be saying words that seem nonsensical. That is why the interpreter must be very experienced, so that s/he can recognize what are individual variations of use of the language versus what are

disordered uses of language. It's important for the interpreter to know that sometimes, it is best for the therapist to strive to make sense of what the deaf person is saying.

The partnership between therapist and interpreter is vital to the success of the therapy. It is another point where mental health settings differ from others, because in most settings, the interpreter does not generally discuss the actual interpreting with the hearing person. In those settings, the interpreter seeks to be as unobtrusive as possible, and tries to maintain the illusion that the deaf and hearing person are communicating directly.

In mental health settings, however, the interpreter and therapist work as a team. The therapist shares his/her goals prior to the session, and therapist and interpreter debrief after the session. The interpreter is not 'invisible', and may even be the object of transference from the deaf person. The interpreter still conveys the meaning of both people as clearly and completely as possible, but much more discussion takes place regarding how well this is working than in other settings.

Another way in which mental health interpreting differs from other settings is the time commitment. In many community settings, the interpreter will work with a deaf person once, or a few times over the period of several months, and then not see that person again for many months. Interpreters in post-secondary settings may see the same deaf student several times a week for the course of a semester. But mental health settings usually involve weekly contact, and may continue for a year, or even longer. In other community settings, the interpreter can arrange for a qualified substitute if s/he is unavailable. In mental health, substitutes require a great deal of planning and negotiating with the deaf person, and may even be impossible. The deaf person may choose to cancel the appointment or re-schedule it to a time when the interpreter can attend.

Settings where mental health interpreters work.

Mental health interpreting takes place in a broad range of settings. Therapy sessions may include individual, couple, family and group counselling. Interpreters are called to psychiatric wards and outpatient clinics. Alcohol and drug counselling, as well as self help groups such as Alcoholics Anonymous or Narcotics Anonymous use the services of interpreters. Mental health interpreters also interpret for psychological and psychiatric assessments.

What are the qualities of a good mental health interpreter?

Mental health interpreters should have superior interpreting abilities and a strong sense of appropriate boundaries. Interpreters need to have some familiarity with the field, such as different therapeutic approaches and the philosophies behind them. It is important that the interpreter is clear on his or her own limits, and what issues he or she may be unable to interpret for. For example, an interpreter who experienced sexual abuse as a child may be triggered by a deaf person working on similar issues, to the point where s/he is unable to continue providing services. It is helpful if the interpreter has

gone through his or her own therapeutic process, both for familiarity with the process in general, and for identifying and resolving personal issues.

Mental health interpreters need to be open-minded and non-judgmental. It is important that they maintain confidentiality and are also perceived by the deaf client as doing so. Finally, good interpersonal skills and communication skills, and the ability to work as a team with the therapist, are necessary.

2. Interpreters As Advocates

While interpreters are seen as members of the Deaf community, they are not core members. Even though interpreters understand the norms and values of the culture, they do not live the experience of being deaf every day, and consequently do not have a first hand experience of being deaf. Because of this, deaf people prefer that deaf people are the ones who represent their community, and that they advocate for the community's needs and aspirations. Interpreters strive to support this empowerment in a number of ways.

Interpreters will generally decline to speak in public about Deaf community needs, and will instead direct the request to a Deaf community representative. They may offer to interpret for the setting, but they want to support deaf people in advocating on their own behalf. Interpreters do not teach sign language, since the culture and language belong to the Deaf community. Instead, interpreters refer these requests to qualified Deaf instructors, although they may explain to the hearing person who is making the request how deaf people communicate via TTYs, and how to access the relay service to call a deaf person.

There ARE times, however, where interpreters do function in an advocacy role. These are times when there is an immediate need for information, and where it would be problematic or burdensome to arrange for a deaf person to provide the advocacy. If a deaf person is arrested, for example, and the police officer is prepared to handcuff them, the interpreter may step in to explain that handcuffing would cease all communication for the deaf person, and may escalate the level of anger. A psychiatrist conducting a mental status review of a deaf patient may think the fact that the deaf person can't recall the spelling of their friend's last name is symptomatic of disordered thinking. The interpreter may explain the role that name signs play in the community, and how this is a common way to refer to friends. It more likely would be a sign of disordered thinking if the deaf person could not remember their friend's name sign, than not know how to spell a last name.

Deaf people vary in their degree of experience interacting in the hearing world, and their understanding of what things are puzzling to hearing people which seem matter of fact to a deaf person. Interpreters develop a sense of who has this experience, and in

mental health settings where the deaf person has this ability, the interpreter lets him or her deal with questions about the Deaf experience, and simply interprets what is being signed. When the deaf person is unfamiliar with explaining their experience to the hearing world, or is so distraught that s/he is unable to do so at the time, the interpreter will assume more of an advocate role and share some information with the hearing person in order for communication to occur. For example, if the deaf person is planning around how he will handle an upcoming stressful family gathering, and is feeling very upset about it, the therapist may suggest calling a friend for support while he is there. It may be appropriate for the interpreter to comment that there would likely not be a TTY at the family home, and therefore there is no possibility of making a call. The interpreter may decide to share this information in the post-session rather than during the session. There are times where the interpreter may judge it necessary to share some of this information during the session itself. If the person is suicidal, and the therapist is asking her to make a commitment to call 911 if she is thinking of hurting herself, it may be important to comment that sometimes 911 calls made by TTY are not answered. This will help the therapist to strategize other ways of staying safe for the person.

All of these examples require the good judgment of the interpreter. In two very similar situations, the interpreter may choose to act differently. Some of the factors that the interpreter will weigh in making a decision are:

- The deaf person's experience in navigating the hearing world
- How distraught the deaf person is at the moment
- The hearing therapist's familiarity with the Deaf community
- The Deaf community's desire to advocate on its own behalf

The pre- and post-sessions are an important time for the interpreter and therapist to confer on some of these issues, and to ensure that communication is taking place. As the therapist and interpreter develop a team relationship, along with knowing the deaf client better, it becomes easier to make the decisions of who will clarify miscommunications that occur due to differences in culture and experience.

3.Boundaries and Mental Health Interpreting

For effective therapy, it is very important that interpreters have a clear sense of boundaries. Boundaries are the limits of personal interaction and self-disclosure that we set at different points with different people. Some of the boundaries needed for the interpreter and the deaf person in therapy may seem to be common-sense. Obviously, the interpreter will not engage in a sexual relationship with the deaf person, or their family and friends, or develop a close friendship. The interpreter will not arrange to meet the deaf person outside of the therapeutic sessions.

Interpreters, however, face boundary challenges due to the close-knit nature of the Deaf community. Interpreters learn ASL through interacting in the community. Many hearing people are drawn to the language and culture, and become allied to the community and its goals. Interpreters develop their language skills through the generosity of deaf people, and they show gratitude for this gift by participating in the community and supporting its goals.

This interaction poses a dilemma for the mental health interpreter. What happens when the interpreter sees a deaf person at a community event, outside of the therapeutic setting? Some deaf people will not acknowledge that they know the interpreter, and the interpreter is accustomed to taking their cue from the deaf person's actions. Still, the interpreter must exercise caution in attending events because for some deaf people simply seeing the interpreter will create anxiety or discomfort. The deaf person may be working on relationship issues with an abusive spouse, and feel very uncomfortable if the interpreter sees them with the spouse at a social event. Someone with an alcohol problem may be drinking at a party, and fear that the interpreter is checking up on them.

On the other hand, there may be some deaf people who welcome the chance to talk with the interpreter outside the therapy session, and this too may be problematic. They may ask questions about the therapist, and what the interpreter's opinion is. They may have decided that the interpreter, who signs so well and always seems to listen to what they have to say, would be a great person to date.

Generally, interpreters choose to only attend parties with a small group of known friends, who they do not provide mental health interpreting for, or they attend large Deaf community events. The topic of how the deaf person and interpreter will relate if they see each other outside of therapy can be discussed during the therapy session.

Ideally, interpreters in mental health settings refrain from interpreting for the deaf person in other settings. This is unique to mental health because often the same interpreter may interpret for a deaf person who is taking a course, applying for a job, or attending the parent-teacher interview at their child's school. There is a small pool of interpreters and deaf people are accustomed to seeing the same interpreters in multiple settings. Given the unique nature of the relationship between the deaf person and the interpreter in mental health settings, it is important to avoid the potential confusion of

dual relationships, and therefore the boundaries need to be clearly established that the interpreter will not provide services in other settings.

One exception to this is the situation of a small community. In some communities, there may only be one interpreter. Every creative possibility for finding a different interpreter should be explored, but if all else fails, and the interpreter needs to provide service in a different setting, the issue should be discussed during a therapy session.

As a final note, the interpreter and therapist also need to keep their boundaries clearly established. The post-session discussion should stay focused on issues pertaining to the interpretation, or any issues that arose as a result of working with an interpreter. The therapist and interpreter need to ensure that their conversations do not shift into a discussion about the deaf person's life or issues.

4.Working With A Theoretically Diverse Group Of Therapists.

In order to successfully interpret in any setting, an interpreter must understand the speaker's intent in order to convey it. In the mental health setting, this understanding includes some comprehension of the therapist's theoretical frame, in order to make sense of the message and decide on an interpretation that conveys it.

Personal styles as well as theoretical approaches differ, and interpreters need to adjust to these differences. I remember the jarring reaction I had to working with a new therapist who saw every interaction as part of the therapeutic process, and thus did not want me to chat even briefly with the deaf person in the waiting room. Coming from work with a therapist who seemed quite comfortable with those kinds of interactions, my first response was defensive. I wondered if the therapist did not trust me to establish appropriate boundaries. However, as we spoke more about her reasons for this, I understood her theoretical frame more clearly and realized that there was nothing personally directed at me.

Interpreters need some background in therapeutic approaches, and also need an open dialogue with the therapist in order to comprehend the intent of the therapist's words and actions. An interpreter who has worked primarily with a therapist using a cognitive behavioral approach may be thrown by a Gestalt approach, for example, or stymied by the use of EMDR. The interpreter will never have the same level of knowledge as the therapist has, but with a general foundation in various theoretical approaches, s/he can more accurately interpret for a variety of therapists. Open dialogue with the therapist regarding therapeutic goals will help the interpreter successfully convey the intent.

There may be some approaches that the interpreter feels more attuned to than others. It may be that the interpreter decides to decline working within a particular theoretical framework. As the interpreter experiences a range of approaches, s/he will begin to recognize the ones that s/he feels most in tune with. Generally, interpreters are accustomed to conveying messages from a diverse group of speakers, reflecting a wide range of opinions, values and beliefs. In the mental health setting, this experience holds true, so that interpreters, with preparation and consultation, are able to move comfortably between a range of theoretical approaches. Still, the interpreter may realize that they feel uncomfortable with an approach such as art or dance therapy, or unsure about the efficacy of using Jungian archetypes. If this happens, the interpreter learns to decline work where these approaches will be used.

5.Providing Service to Both Therapist And Client.

It is usually evident to people that an interpreter provides service to a deaf person. The deaf person doesn't hear what is spoken, and signs what s/he wants to express. In mental health settings, the interpreter listens carefully to what the therapist says, and strives to find a way to convey the same meanings in ASL, which will have the same impact on the deaf person that the therapist intended.

However, it is sometimes not as evident that the interpreter provides service to the therapist as well. The therapist does not understand the deaf person's language, so the interpreter interprets the message into English, again with the goal of accurately conveying the message. Along with the content (the facts, or the meat of the comment), the interpreter also works to convey the emotion that is present. Once again, the interpreter's goal is to produce a similar effect on the therapist as would result if the therapist understood the message directly in ASL.

At times there are comments made that assume a common frame of reference that does not exist. For example, if the deaf person signed that their living room light flashed so they went to the door, a hearing therapist unfamiliar with the technical devices that deaf people use may be puzzled. The interpreter might say something like "the light I have hooked up to my doorbell flashed, so I knew someone was at the door." Similarly, a therapist may reference a line from a popular song or movie, such as "Heigh ho, heigh ho, it's off to work I go". The interpreter may either reference that it's a saying, or may decide to convey the meaning without expressing the exact words.

As the therapist and interpreter work together on a regular basis, they will reach an understanding of how much of the cultural information needs to be added or deleted. At times the therapeutic goals may be better served by the mediation being omitted, so that the resultant confusion becomes grist for the therapeutic mill.

6. Vicarious Trauma* And The Importance Of Emotional Support

While working in mental health settings, interpreters will sometimes be exposed to traumatic material that may evoke emotional reactions in them. deaf people may be revealing horrible experiences of sexual and physical abuse. They may recount childhood incidents or being neglected and marginalized in their families because no other family member signed. They may talk about acts of violence and sexual assault that they have committed. Some deaf people who came to Canada as refuges may have experienced war and violence in their home countries.

Sometimes the content may not seem horrendous in and of itself, but the cumulative effects will wear on the interpreter. As the weeks go by, an interpreter may have worked with one person who is dealing with issues of feeling abandoned in the family because of being deaf, another who is struggling with convincing an employer that he can handle more challenging work, and yet another who feels angry at the inadequate education she received because teachers assumed a deaf student couldn't really learn very much.

In order to successfully interpret a person's meaning, interpreters need to experience it through their imaginations in order to really understand what the person has gone through. The interpreter thus experiences some of the trauma. This experience of vicarious trauma is intensified by the way interpreters work: we speak and sign as if we ourselves were the speaker. Rather than say, "she says that her life feels meaningless and empty, and she just wants to end it all", the interpreter says, "My life feels meaningless and empty, and I just want to end it all." The interpreter hears his or her own voice, expressing what the deaf person has just signed; the interpreter sees and feels his/her own body conveying the message into ASL. Interpreters do receive training in masking personal reactions, but it is important for the interpreter to recognize that successfully masking does not mean that s/he has not been affected.

When interpreting is going well, the interpreter's own sense of self becomes background. I often have an image that my own self has shrunk to a miniature version, to allow other people's selves to take up the space, so they can more clearly speak through me. Sometimes when I get really engaged in the interpreting, I lose all awareness of a headache I have, or a backache, only to have the awareness of it come crashing back to me when the interpreting is done. At times I have felt almost disoriented after intensely concentrating on interpreting, as if I need some time to get re-acquainted with myself.

* VICARIOUS TRAUMA – the cumulative impact of clients' traumatic stories on the helping professionals involved. Vicarious trauma results from having an empathic connection with others who have had horrific experiences in their lives. For the helper, there can be changes to worldview, somatization, intrusive imagery and strain in relationships with clients and colleagues. Other symptoms such as cynicism, despair and depression can also develop.

Interpreters need to pay attention to these feelings and reactions. Some warning signals of vicarious trauma may be: consistently having a headache after a session, feeling sleepy regularly in the session even though they have had enough sleep, bouts of crying for no apparent reason, feelings of dread prior to the session. Interpreters need a safe place to work through the vicarious trauma they may experience. While the therapist with whom they are working may be able to offer an empathetic response during debriefing, s/he is not the appropriate person to work on this issue with. The interpreter/therapist relationship would become muddied, and the therapist could end up feeling a responsibility to look after the interpreter that detracts from the therapeutic relationship with the client.

Interpreters may work with a different therapist to address the issues that are raised for them. Alternatively, they may find that having a trusted support person gives them a place to deal with the emotional aftermath of the interpretation. Interpreters are concerned about maintaining the confidentiality of the client. It is important that the support person understands this need and is able to maintain confidentiality. At times, the interpreter may not need to reveal details of what triggered their reaction, but simply needs emotional support. However, there are times that details of the session may need to be discussed to make sense of the interpreter's reactions. It is vital that the support person or therapist recognizes the need to maintain confidentiality, so that the client is protected and the interpreter feels free to express what s/he needs to, in order to move through their feelings and get the needed support.

Finally, the interpreter may reach a point of being unable or unwilling to continue interpreting in this setting. In that case, the interpreter should discuss the need to withdraw with the therapist, and together the two can strategize the process for finding a replacement, and minimizing the disruption of a switch in interpreters as much as possible.

PART THREE - A DISCUSSION OF ISSUES THAT RELATE TO THERAPIST AND INTERPRETER WORKING TOGETHER AS A TEAM

This section will attempt to sketch out some of the issues and challenges that occur when two different professional groups are required to serve the same client population (a psychotherapist and interpreter with a deaf or hard of hearing client). Initially I will focus on pragmatic issues that are challenging but nevertheless lend themselves to concrete solutions. An example would be the issue of co-ordinating three different people's schedules in order to make appointments for therapy sessions. Secondly, and more importantly from my point of view, I will look at the psychological and communication dynamics that are raised when conflict or misunderstandings occur between two professionals and there is no clear hierarchy of authority with which to resolve the dispute. For example, a psychotherapist can not say to the interpreter "I'm the boss and we're going to do it this way". Likewise an interpreter can't pull rank in order to resolve conflict.

1. Scheduling Difficulties:

As mentioned above, co-ordinating schedules for three people seems to be exponentially more difficult than for two. This is especially true for the initial interview when the team is being constructed. Frequently the therapist finds a day and a time that would work for both the therapist and the client. Then the search for an interpreter begins. The client may state a preference for a particular interpreter. Phone calls to that interpreter reveal that she is not available on dates that have already been agreed upon. Calls back to the client..."Would another interpreter be acceptable; would other dates be acceptable". The client might make a counter offer...and so on.

Once the team has been formed this anxiety provoking and time consuming exercise is greatly reduced. However, the same concerns can be re-ignited when the interpreter goes on holidays, attends a conference, changes careers, etc. Thus the process of therapy and the function it serves in providing a safe place for the client to explore their issues is vulnerable to potentially twice as many disruptions or breakage's. Little has been done on a group basis to explore these issues and their impact on the therapeutic process. Some individual therapists appear to be keenly aware of how to work with these issues, making the disruptions grist for the therapeutic mill, while other therapists seem to treat them as obstacles to be overcome for the "real work" to begin.

2.Differences In The Assumptive Worlds:

When I think back over many discussions that I've participated in, both with individual interpreters and between groups of therapists and interpreters, it would seem that many of the misunderstandings and even disagreements are generated from differing world views between the two groups. For example as a therapis, I begin with the notion

that personal growth in the client is optimized when the therapist is "optimally frustrating". That is, the therapist doesn't give the client what they wish...rather the therapist should fall short *a bit.* In order to close that gap the client *mobilizes their own resources.* In so doing the client grows a self. Much of the way I understand interpreters behavior is based on an assumption of advocacy. The emphasis is placed more on "doing for" the client in order to compensate for the systemic discrimination of the dominant culture. In other words, the therapist frustrates, while the interpreter compensates for the client. Of course this is a simplification. Both therapists and interpreters do a combination or ratio of these two relational stances. The ratio is unique to each individual. However, as a generalization I would say that therapists tend to give more weight to optimal frustration while interpreters give more weight to supplementing and complementing the client's resources.

3. "Personality" and "Chemistry":

When we use these terms we're attempting to identify what impact personality has on the therapeutic process. That is, over and above the professional skills that therapists and interpreters bring to their task, their personalities will also have an impact on the therapeutic process. These issues were touched on but not explored in any depth in our committee's discussions and deliberations. However, it is clear to a psychotherapist that the primary tool that they use is the self. That is, the therapists are at least theoretically aware that their personality is going to have a marked influence on the therapeutic process. As part of a therapist's training they are asked to consider this influence at all times. Of course this is a difficult and challenging process. However, one becomes more accustomed to it over the years. It is quite another matter to explicitly examine the influence of the interpreter's personality on the therapeutic process. This would be much more fraught with anxiety and so it remains largely unexplored territory. The interpreter's influence is revealed implicitly when a substitute interpreter enters the triad. Several people reported that the emotional tone is markedly different when this occurs. Others have said that it's like having a different client when a "strange" interpreter substitutes. Why hasn't this influence been discussed explicitly? I believe it is because we lack the form to do so. By "form" I mean an explicit agreement or contract that makes this a legitimate topic of conversation. For example, it is an accepted part of my contract with a hearing client that I can talk about their private behavior, thoughts, and feelings but the reciprocal can't be assumed. There is no such agreement that I can initiate discussions with the client about the impact of the interpreter's personality on the therapeutic endeavor. Likewise it seems to me that the interpreter's personality is "out of bounds" for post session discussions. There may be exceptions to this that I am not aware of...and if that is the case we might all learn from the example that they could provide.

Likewise the "chemistry" between the therapist and interpreter will also have an influence. If, for example, the two exclude each other by relating only to the client while maintaining rigid professional boundaries between themselves than the therapeutic

atmosphere will be less than optimal. It is my opinion that the personal reality of the situation is being denied in favor of an exclusively professional definition. I think that the client would sense and be disturbed by the deletion of the personal dimension.

4. Conflict Resolution and Team Building:

One could say that each therapy session represents an opportunity and necessity for the interpreter and the therapist to act as a team. This would be the implicit means by which we hope to accomplish our main task: providing good therapy for our clients. I suspect that most if not all of our attention was directed to the primary task: providing good therapy and good interpretation. For me the prospect of working with deaf clients was already a formidable challenge - one that demanded all my attention. That left little attention for the implicit task of learning how to work with another professional as a partner. What we don't notice has the potential to sabotage us. Of course there were many misunderstandings and possibly some disagreements as we discovered that the "other" in this triangle was not what we assumed her or him to be.

I've worked with other agencies where we had a developed ritual or process for working out differences. A process which both disputants agreed produced worthwhile results would answer questions like:

1. How can I tell her/him that I have a different opinion on this manner without offending her/him?

2. What types of issues can this process handle? Can we speak of competitiveness or must we restrict our talk to code of ethics debates?

Similar approaches that have been used in other contexts entail conflict resolution skills. For example, assertiveness and active listening. An assertive statement would take the form of, "When you do _____, then I feel _____ I would prefer it if you did _____" Active listening involves reflecting back the other person's statement, so they can be sure that you understand their position, before you reply with your own response. As one interpreter pointed out the occupational demand on interpreters is that they void or bracket themselves in a professional context. In a sense this occupational demand is the opposite of assertiveness. So interpreters would have little experience in asserting themselves. Furthermore, most non-mental health work involves "one-shot" sessions and they will never see that particular professional again. Mental health interpreting of course is the opposite with frequent contact over an extended period of time. In the latter context there is an opportunity to *develop* a better working relationship. In summary, mental health interpreting provides the opportunity and the requirement to develop better working relationships. That is a process that takes time and is facilitated with skills like assertiveness training and reflective listening. Of course relationships aren't only working ones... good friends have developed their own unique forms or methods for resolving conflict...with the friendship deepening with each successful encounter. Every

one of us can draw on these experiences for the knowledge, skills, and attitudes that would be helpful in our working relationships.

Because the interpreters and therapists didn't anticipate the need for such skills we initially bumped into each other. Or should I say that our assumptive worlds bumped into each other. And those collisions began a process whereby each group became aware of assumptions that they held about the other. That is, as we encountered the reality of the other (as opposed to our expectations) our assumptions about each other began to fall away...to be replaced by seeing and listening. Blame of course is always an alternative to exploration and we took that route too. Blame is often what we do when we discover a gap between our assumptions and reality. We blame the other for not being what we expected them to be. As if we could "shame" the other into conforming to our assumptions. One of the initial ways we would try to defend against this blame, either anticipated or actual, was to refer to our professional ideology. The it-says-here -so-I-must-be-right way of not settling disputes.

I think that what allowed us to pull past that particular obstacle was the client. The undeniable presence of that third party with all their complexities needs and challenges. I think that we returned our attention to the client only this time with fewer assumptions about the "other" in the room with us. We began to learn about each other while we learned about the client. This type of event led to personal and individual knowledge. That is, each specific team of therapist and interpreter fumbled and groped their way towards a good working relationship. For example, "Sally" and I learned how to collaborate with each other in order to form an effective team. However, as a *group* of therapists and interpreters, I don't think that we've yet reached a point where we can make generalizations about how we can best work together as opposed to the concrete particulars of Larry working with Sally. I think that those generalizations are just beginning to be articulated in the bimonthly discussions that take place between the two groups. As we do work these out, one option that needs to be available is the right to say "no". If for some reason the "chemistry" just doesn't work, then in some instances it is preferable to break up the team rather than always toughing it out. At the other end of the continuum one must be aware of the situation where the therapist and interpreter enjoy each other so much that too much of the engagement is between these two parties rather than between the therapist/interpreter and client.

A third trust building factor that came to light as a result of these discussions was the issue of the therapist protecting the interpreters boundaries. For example, the therapist should intervene if the client begins to direct personal questions towards the interpreter. If the interpreter needs to make a scheduling change and advises the therapist of this matter then the therapist has the onus to bring this forward in the session. Finally, if there are any safety issues such as the client making covert or overt threats to the interpreter, the therapist should make it clear that such behavior will not be tolerated. These are really issues that need to be addressed rather than prescriptions for the one correct way of handling them.

Finally, we have a workshop in mind that could accelerate the learning process between and within these two groups. The mode of learning would emphasize role play,

video and discussion. A therapy session would be enacted. When it was replayed, a section would be selected for analysis. It would be viewed then followed by a therapist discussion about the issues, strategies and implementations (how the therapist "languaged" his or her intervention). Interpreter's would observe this exchange and at the end would have the opportunity to ask questions. Then the interpreters would have a discussion group about the way the message was interpreted; alternate choices that might have worked and the interpreting process itself (i.e. the mental processing the interpreter engages in during the task). Therapist would observe that discussion and at the end ask questions. This would facilitate a deepening understanding and appreciation of each of our roles and functions.

Concluding Remarks

Reflections On The Evolution Of The Well-Being Program's Therapeutic Teams:

An Interpreter's Perspective

The formation of the Well-Being Program brought together a diverse group of interpreters. Some of us had many years of experience in mental health settings, while others were very new to the process. Some of us had talked together about mental health interpreting and some of the challenges we encountered, but none of us had experienced holding those conversations with a group of therapists on a regular basis.

We approached the experience with trepidation. In our work in community settings, we often have very little interaction with the hearing people for whom we interpret, whereas we see deaf people regularly. Interpreters are drawn to the field out of a fascination for the language and the community of users, and we recognize the struggles that deaf people face as a minority in the larger hearing world. Our work has also made us witnesses many times to the lack of understanding that exists, and the paternalism or disregard with which deaf people are often treated. This creates a sense of alliance to the Deaf community, and suspicion of the hearing world with whom deaf people interact.

The initial meetings between therapists and interpreters then, were cause for concern. Would this be yet another group of hearing people who did not understand the Deaf experience? Would we be asked about the deaf person's experience or actions, rather than the hearing person asking the deaf person directly? Many of the interpreters feared that hearing therapists would not be able to effectively provide therapy for deaf people because of their lack of knowledge of deaf people's language and culture.

Those initial meetings were also scary because of revealing my practice to other interpreters. Interpreters commonly work alone. There is no one else in the room who can evaluate the interpretation. Of course, the deaf person can say if the ASL made sense and the hearing person can say the same for the spoken English, but no one else can say whether what was conveyed was what the other person meant.

So, speaking about what interpreting I did to my colleagues in sessions, was a risk. I wondered if I would be judged, or would find out I was doing it 'wrong'. However, the actual experience was liberating and energizing. I discovered that some of the things I found hard to handle were also hard for other interpreters. For example, I learned that other interpreters also felt concerned about the deaf person’s perception of the debriefing that takes place between the interpreter and therapist after the session. We were able to talk together as interpreters about what needed to be said to the deaf person to allay any misgiving they might have. But most importantly, interpreters began to form alliances with the therapists, so that we truly felt we were working as a team, rather than as two individuals in the same room, with unstated and sometimes contradictory goals.

Some of the dilemmas I faced were ones that only the therapist could help me resolve and they were ones that were part of the therapeutic process. For example, a client who was working with personal boundary issues began to ask me personal questions when I would bump into him outside of therapy sessions. I brought the issue back to the therapist, who was able to address it during the session. The issue was resolved leaving me feeling safe and able to continue in the interpreter role.

Even times when I felt sleepy or confused could be discussed with the therapist, and I learned that it was not necessarily my personal weakness, but could well be a significant part of the therapeutic process. I began to understand what the therapist was doing, and was able to use my experience within the Deaf community to work jointly with the therapist to find effective strategies that benefited the deaf person.

The regular meetings between therapists and interpreters continue to be valuable. It seems like just when I think the issues have all been addressed, something new gets raised that challenges my thinking, and consequently my practice. The respect, collegiality, and learning atmosphere that exists continues to both stimulate and support me as an interpreter, and to strengthen the work we, interpreters and therapists, do together with deaf people.

A Therapist's Perspective.

One consequence of the sexual abuse at Jericho Hill School for the Deaf, was the emergence of a body of expertise and wisdom with regard to psychotherapy for the deaf and hard of hearing client populations. Gradually, through trial and error, we became more proficient. We were "doing it" without necessarily knowing how we were doing it...it was implicit knowledge. In order to make this emergent wisdom explicit; we began to converse about the process of conducting therapy with this client population. We formed a committee consisting of two therapists and two interpreters. Our mission was to articulate and document this accumulating knowledge. Through our discussions and writing we began to become more aware of the unique aspects of this work. With this shift to the reflective level, the rate of learning began to accelerate. The curiosity that initially propelled our committee began to spread beyond the confines of our immediate group to the therapist/interpreter meetings which began to hum with excitement of intellectual stimulation. .

But I'm getting ahead of myself. Let us go back to the beginning. I'd like to look at the process we went through and any steps that were taken that perhaps amplified the process of us ***becoming aware*** of the unique challenges, skills strategies, and knowledge necessary to increase our effectiveness with this client population.

I will be speaking from a therapist's point of view. Almost immediately after joining the Well Being Program, we began to experience a gradual modification of the hard won assumptions, skills, and knowledge that we had earned through schooling and

previous experience within the hearing community. This modification was required in order to engage with the unique *lifeworld* of the Deaf. Effective therapy without this kind of engagement would either be useless or, even worse, might replicate the damage already experienced.

In the beginning, as they say, it was thought that a workshop should be organized in which the therapists' would be introduced to and educated about the deaf world. Re-orientation. We needed to shift our frame of reference...or at least become aware of it. That was the conscious intention. However, as with most human interactions the results often exceed the intentions. As one of the therapists attending these initial workshops, I found that there was an emotional component that accompanied and ran under the more cognitive learning that was taking place. I received the unpleasant news that for many of our potential clients I was viewed as being part of an oppressive majority. A majority, who carelessly, perhaps without intention or awareness, overlooked, ignored and invalidated the deaf reality. As one of those therapists in attendance I was discomforted by being treated as a category rather than as an individual. That is, I was being treated as a "hearing person" not as myself. I found it difficult to take individual responsibility for a collective failure that is, I resented starting with a handicap of guilt and blame. *But isn't this precisely what is offensive about racism, sexism, etc. the individual feels that their uniqueness will not be perceived or recognized. That the identity* ***assigned*** *to them will be a collective and not individual one and thus they will be robbed of their personhood. Furthermore the identity being assigned is one of less worth than that of the mainstream. And isn't this what our deaf clients were telling us..."allow us to be persons and not just a category."*

Also, at the time, it was shocking to move from being viewed as the "rescuer" to that of the "persecutor"...from a positive social identity to a negative one. Looking back I've come to understand what had occurred but these later understandings were initially obscured by my emotional reaction. Interpreters, on the other hand were "in on the secret". That is, they appeared to be more knowledgeable about the Deaf community and more accepted by them. Perhaps they were further along in the process than were the therapists. By that I mean that they may have gone through a similar initial phase where they were viewed with some skepticism if not suspicion initially but that did not appear to be the case now.

As a result of this meeting and several others that occurred in that same time frame the two professional groups, therapists and interpreters, always seemed on the verge of falling into an opposition or adversarial relationship. The therapists felt often that their territory was being contested...that interpreters appeared to think that they knew best what worked for deaf clients. The therapists, on the other hand, were already feeling a strange and unaccustomed dependency on another person to convey our thoughts. Now, it began to appear that even our thoughts or assumptions were "wrong", misinformed, etc.

Fast forward to now. There is no longer an adversarial relationship or if there is, it is merely vestigial. This was revealed most clearly when an interministerial committee

met with therapists and interpreters to ascertain the appropriateness of the Well Being Program's delivery of mental health services to the deaf. In that meeting one was very pressed to distinguish, on a content basis alone, which contributions came from therapists and which, from interpreters. Perhaps a more refined way of putting it was that each group had a contribution to make. And each contribution had a place in terms of a larger picture. The pieces didn't contradict but rather supported and complemented and even overlapped. It seemed that we now had a common vision and objective...and we respected the contribution that each person had to make.

So how did we get here? What helped us along the way? The primary method was a built in structure that encouraged reflection and self-awareness. We had monthly meetings of therapists initially; then we'd meet every other month with interpreters. We had a very supportive administration team. They weren't conflict phobic and continued to provide venues where the two groups could come together to express and appreciate differences and commonalties. I remember taking a family therapy course where I learned that a dysfunctional family viewed any differences of opinion as a signal for all out war...whereas a healthy family responded to signs of difference with curiosity...a desire to know more. I would say that the meetings that we've had over the past year have been marked increasingly by the active play of curiosity.

Furthermore, I think that the current project to examine the evolution of the Well Being Therapy program is amplifying this reflective curiosity. We are opening issues up rather than closing them down. These recent conversations have revealed the enormous complexity involved in the interpreter's task - to move quickly and efficiently between two different cultures, languages, lifeworlds is daunting to say the least.

In conclusion, there were three main factors contributing to our mixed group becoming self-aware. First, our regular inter and intra professional meetings which gave us a forum within which to process our experience. Second, the work itself kept calling us away from the temptation to fall into ideological or professional debate. Faced with the immediacy of our client's distress we rapidly learned ways of augmenting each other's effectiveness in order to help our clients. Third, the threat of funding loss followed by a review process staffed by government appointees demonstrated the solidarity that existed between the two professional groups. Formerly we had focussed on our differences at the cost of recognizing our commonalties. Finally, this review project which has been six months in duration has prompted a reflective turn in all who've been touched by it. As a result meetings are characterized by open ended questions and deepening understandings regarding the unique challenges we face in working together.