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INTERPRETING FOR THE DEAF IN A PSYCHIATRIC SETTING

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Interpreting for the deaf using sign language is a relatively new field which is growing rapidly because of an increase in awareness of the needs of the deaf. Within a relatively short time large numbers of people have gained signing skills enabling them to serve as interpreters and more and more social agencies are calling on them to help them work with their deaf clients in more efficient ways. Interpreters can be found working at universities, trade schools, junior colleges, social service agencies and hospitals. Professional groups such as the Registry of Interpreters for the Deaf and local groups are setting standards for professionality for interpreters to insure that the deaf people receive the maximum degree of service. As newer programs develop, however, the standards the interpreters must follow are beginning to change with each situation and a look into the aspects of each type of program where interpreters find themselves is essential.

The purpose of this paper is to describe some of the unique aspects of working in the mental health setting. Little has been written about the interpreter in this situation; and it is no surprise since there are only 12 programs of this type in the country (as reported by St. Elizabeth's Hospital in Washington, D.C.). As increase in awareness of the great need for psychological and psychiatric services for deaf patients surfaces, the need for qualified interpreters will skyrocket. The ideal psychological program would have the clinical staff proficient enough in sign language to provide therapy without the need for interpreting support, but we must face the problem realistically. The need for psychological services is with us now and the people who are

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qualified signers to staff such programs are rare. At Resthaven Psychiatric Hospital's Mental Health Services for the Deaf in Los Angeles we have undertaken to train the psychiatrist, social worker, psychologists, and activity therapists about the aspects of deafness germane to their work, but even after two years of intensive training one can hardly be called a proficient signer, language learning capabilities of the participants aside. Possibly, greatest benefit could be achieved with deaf therapists but their numbers are small and the programs to train them are practically non-existent.

With this in mind, let us set the ideal situations aside and focus on the more immediate problems that interpreters will face when assisting the clinical staff. It is impossible in a paper of this nature to describe avenues to use which will solve the problems the interpreter will encounter but some suggestions will be made to help in this regard. Some of the problems seen in the mental health setting are:

a. Reversing skills.
b. Interpreter understanding of his ability.
c. Psychological reasons for breakdowns in communication.
d. "Extra-interview" interactions between patients and interpreters.
e. Varying sign language grammars among patients.
f. Confidentiality.

REVERSING SKILLS

It is no secret that the most difficult aspect of interpreting is the ability to reverse the deaf person, that is, to comprehend the sign language of the speaker. This problem is compounded if the patient is unfamiliar to the interpreter. I believe that it is safe to say that this is the major holdup of training the clinical staff. Although on a one-to-one basis, the staff with adequate receptive skills can hammer out short conversations with a closed set of topics. The real skill of reversing is needed in the often heated group and individual psychotherapy sessions. One of the major avenues of treatment of psychological or emotional problems is to have the patient talk about what it is that is bothering him. From his utterances, the therapist can draw out inferred or suppressed meanings and thus aid the patient to look more realistically at his situation. Obviously, the interpreter must be a highly skilled reverser as faulty interpretations can lead to prolonged therapy or no benefit at all. When the therapist receives the wrong message from an interpreter, his response may confuse the patient who may already be feeling misunderstood by his world in general.

Another problem is that of different meanings associated with the same sign. For instance compare "I felt hurt" with "I felt (physical) pain." If this is the opening remark to the therapist in the session and the discrimination between the meanings is not made the therapist could formulate false impressions about the nature of the patient's complaint.

Excellent reversing skills can only be achieved by the interpreter's diligence in continued training in his profession and much experience in various situations. The problems of misunderstanding patients can be lessened if the interpreter becomes involved in clinical discussions of the patients he serves and gains insight into their individual psychological problems and physical difficulties. A demonstration of the interpreter's skill would be his ability to recognize potentially ambiguous utterances and to bring them to the immediate attention of the therapist, letting the therapist decide which meaning is to be attached to what the patient says.

INTERPRETER UNDERSTANDING OF HIS ABILITY

Interpreters must recognize where their strengths and weaknesses are. An overzealous interpreter who is anxious to become involved in work requiring more advanced skills is apt to be a hindrance to his program. Also, when working with mentally ill persons a different kind of problem can surface. One is likely to be faced with loose association, that is, bizarre utterances which either have no connection with the topic being discussed or which do relate to the topic but not appropriately. This type of patient might also not seem to understand the interpreter. It is important that the interpreter know that he is doing an adequate job and that the mix-up is part of the patient's symptomatology and not a failure to express the therapist's words. These are often disturbing situations for the interpreter who realizes the importance of good communication skills. In-service training of the interpreters can assist them in developing more confidence in their abilities and consequently make their interactions more efficient.

PSYCHOLOGICAL REASONS FOR BREAKDOWNS IN COMMUNICATION

Often the patient will be confronted by the therapist with thoughts which he does not want to face. The patient may then demonstrate resistance to what the therapist says and this resistance may be manifested by the patient saying that he does not understand the interpreter. Often, the issue at question may not be accepted for several sessions. Interpreters should be cautioned to avoid rephrasing when the patient claims that he doesn't understand them. The therapist may have uttered the phrase in such a way as to drive home a point to evaluate the patient's degree of resistance. Should the interpreter in his zeal to be helpful alter the utterance, he could provide an avenue for the patient to avoid the issue.

Again, the patient who cannot adequately deal with the realities of the world may utter very unusual statements which have no association with the discussion at hand. The interpreter, because of the ambiguity of the language, may struggle to connect some meaning to the utterances and disguise an

important diagnostic aspect of the patient's problem. It is advised that the interpreter, if he is able to discern any meaning from the utterance which might be ambiguous, give the meaning to the therapist and then quickly add something such as "Possible ambiguity" or "Meaning may unintensional." Then let the therapist handle it from there.

IDENTIFICATION OF THE INTERPRETER AS THERAPIST

There seems to be a tendency for the patient to see the interpreter as the therapist, which is not so unusual since the patient might be perceiving the words of understanding and advice coming from the interpreter. This is complicated by some deaf patients who are resistant to associating with hearing people who do not sign. Added to this are friendly conversations between interpreters and patients during socialization periods. Thus, often the patients will come to the interpreter for advice or ask such questions as "When will I be discharged?", "Can you give me a pass for the weekend?", or "When can my mother come to visit me here?" Often the interpreter knows the answers to these questions from meetings with the clinical staff and they do not hesitate to answer the questions. This should be avoided. A clinical policy should be developed for handling these situations. It is important that the patient know where the decisions are coming from regarding his life or his stay in the program. In order to make the patient aware of his therapist's involvement with him, it is our policy to direct him to his therapist to answer all clinical questions.

The problem of identifying the interpreter as the therapist might be averted by rotating interpreters in the individual psychotherapy sessions. This can, however, lead to difficulties in developing trust in the interpreters, especially with out-patients who only come to the facility to see their therapist about their problem but who do not interact with the other patients and staff at the facility. We believe that a highly professional staff of interpreters can give the patient the feeling that he can trust them after a few sessions with various interpreters. It might be beneficial for the therapist to identify to the patient the possibility of the problem arising so that the patient can be more aware of it should it develop.

One problem which arises must be dealt with according to the interpreter's own feelings. Often, when conversing with patients over lunch or during recreational activities, the patient may reveal something about himself to the interpreter which may or may not be connected to his therapy or his problem. An example would be the patient telling the interpreter that he smokes marijuana. The interpreter must decide whether this information which was told him out of trust is an important consideration for the therapist. Such things which are mentally harmful such as LSD or other hallucinogens must be revealed to the therapist but in the case of something questionable, such as marijuana, the interpreter assumes the burden of dealing with this

information. Such controversial things have varying degrees of impact on different people and the issue should be discussed with the clinical staff to determine a policy.

VARYING SIGN LANGUAGE GRAMMARS

The case load of the mental health program may cut across a large age range of the patients. This will result in a variety of sign language grammars used by the patients. The interpreter in this setting should become proficient in all of the major sign language forms, or he should be aware of which patients he is best suited to deal with. The task of learning the various sign language grammars is not monumentally difficult as the differences are often minimal to the person with a good sign language foundation. It is important in this issue that we put aside our feelings about which sign language grammar would be the best one for the patient to know and work with him as he comes to us. It is his language and we should respect his right to use the form he is most comfortable with.

CONFIDENTIALITY

Because there are so few interpreters available who qualify for difficult assignments, those who do often work in more than one location. Some of the interpreters on our staff also work at the nearby universities and trade schools. Often, students from the universities or trade schools feel the need for psychological counseling but hesitate to continue in the program because they recognize the interpreters on the staff. The issue of confidentiality is crucial to the success of the programs in mental health, not to mention laws which would send a person to jail for failure to maintain confidentiality. Although one cannot prevent the patient from having anxiety about lack of confidentiality, a professional image set by the interpreters can lessen the patient's fears and encourage him to remain in therapy. On the other hand, indiscretion on the part of the interpreter can lead to a breakdown in rapport between the community and the program which is trying to serve that community.

CONCLUDING DISCUSSION

Interpreting in the mental health setting is very taxing to the interpreter. Unlike the classroom or court room interpreter (whose job is by no means easy) the mental health interpreter must make more decisions about his language use and his interpretation when reversing. Other types of interpreting do not for the most part have to deal with loose associations, bizarre temper tantrums, flying ashtrays thrown at the therapist sitting next to you, patients making overt sexual advances or exposing themselves. While the pace of the interpreting may be less rigorous than classroom settings, it calls for

more problem solving about ambiguities (which in the classroom is the problem of the instructor) and personal involvement with the people served. Other problems which could not be covered in this paper are the therapist's reliance on the interpreter, emotional involvement between patients and interpreters, interpreters seeing themselves as therapists, extra-interpreting duties and demands placed on interpreters and scheduling difficulties to cover a large hearing staff.

At our facility, the interpreting staff has identified a two hour time slot which they use for in-service and discussion. This time slot was chosen after monitoring the scheduling of patients and finding the least active period. During the meetings, various aspects of the patient population are discussed such as which interpreter can best work with a certain patient, who uses which sign language grammar and what are the variations to look for, what situations interpreters should not be involved in, and other related items which facilitate and expand their services.

One thing to keep in mind when entering into this very rewarding type of work is that nothing is routine and new situations are constantly arising for which there is no manual to turn to for assistance. Preparation seems to be the key to successfully adapting to this setting. At the end of this paper are some suggested readings which may be helpful to the interpreter as far as understanding the linguistic and psychological aspects of the people he deals with whether it be in mental health or in other interpreting situations. More workshops on mental health interpreting at national interpreting conventions would also be of some help.

It is the responsibility of the interpreters to constantly strive to upgrade the calibre of their services. The population we serve has long been neglected and the opportunity to change all that is here now. The interpreter is an important part of the mechanism and he should do his best to keep the avenues of change open and accessible.

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