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The Use of Interpreters with Deaf Clients in Therapy

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THE USE OF INTERPRETERS WITH DEAF CLIENTS IN THERAPY

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It is generally recognized that clinicians often are extremely handicapped in communicating with their deaf clients. One possible solution to this problem is the use of interpreters to facilitate communication between the individual providing clinical support services and the client. The feasibility of this solution to the communication problem largely depends on the attitudes of the parties involved.

The purpose of the present study was to obtain information reflecting the position of interpreters as well as clinicians regarding the use of interpreters in psychotherapeutic situations with deaf clients. Although this issue has been given some attention by researchers who were focusing on other topics (Levine, 1977; Stewart, 1971; Straub, 1976; Vernon, 1965), a search of the literature revealed no research attempts reflecting professional opinion which was supported by an investigation.

In order to obtain the opinions of interpreters as well as professional therapists, two nation-wide surveys were conducted. One questionnaire (Survey I) was sent to therapists who have worked with deaf clients while a second questionnaire (Survey II) was sent to interpreters who have interpreted therapy sessions. It may be noted that Dirst and Caccamise (1980) point out that an interpreter "may be defined as a person who facilitates the conveying of messages from one person to another." Specifically, they note that

> the term 'interpreting' is used to refer to the act a person performs when conveying one person's message to another . . . This 'act' may involve: (a) a change in the mode of communication used by the sender: (b) a change in the language used by the sender; or (c) a change in both the mode of communication and language (p.1)

Participants

Random selection of participants was found to be impossible since no complete national, state, or organizational listing of professionals offering clinical services or interpreters who have worked with deaf people could be obtained. The investigators found it necessary to request names and addresses of potential participants from various contact persons and from other participants in the study.

Sample size was based on several factors. For Survey I, 140 questionnaires were mailed with 90 copies being completed and returned. This resulted in a response rate of 64%. Of the 90 completed copies which were returned, 15 had to be excluded because of omissions, ambiguous responses, or an expressed lack of experience in working with deaf clients. The final 75 participants included 6 clinical psychologists, 42 counselors, 11 psychiatrists, 9 social psychiatric workers, 3 school psychologists, and 4 other individuals who reported that, professionally, they would be classified in two or more of the above categories. It might be noted that 54% (75) of all Survey I copies mailed were finally used in collecting data. A return rate of 55% occurred with Survey II with 65 copies mailed and 36 returned. Since two surveys contained ambiguous responses, 34 questionnaires (52%) were actually included in the study. It might be noted that return rates of 64% and 55% are considered to be very good (Babbie, 1973).

In Survey I, the majority of participants were from California, the District of Columbia, Florida, Minnesota, South Carolina, Tennessee, and Virginia. In Survey II, states represented by at least two participants were the District of Columbia, Kentucky, Minnesota, New York, South Carolina, Tennessee, Texas, and Virginia. States represented by one Survey II respondent each were California, Colorado, Florida, Georgia, Indiana, Louisiana, Michigan, and Pennsylvania.

More specific background information about the participants was gathered from the questionnaires. In regard to the sample of professionals offering clinical services, it was noted that 59% had attained master's degrees and 28% more had obtained doctorates. The remaining 13% of the participants reported a

college degree and all but three of these individuals had at least one additional year of graduate work. All of these respondents listed their profession as being in the field of mental health services with 56% indicating their profession as counseling. In addition, 87% of the Survey I participants reported that they were skilled in manual communication (signing and fingerspelling) while 13% indicated that they were not skilled. Twenty-three of these professionals were hearing impaired with 18 classifying themselves as deaf and five reporting that they were hard of hearing. All hearing impaired clinicians used manual communication.

In regard to Survey II, all except one of the 34 interpreters noted that they were certified by an organization. Fifty percent of the interpreters sampled indicated that they possessed the Comprehensive Skills Certificate which is a level of certification from the Registry of Interpreters for the Deaf. In a selfevaluation of their interpreting skills, 69% reported "excellent" in expressive transliterating (sic); 61% reported "excellent" in sign to voice transliterating (sic); 59% reported "excellent" and 41% reported "good" in expressive interpreting; 38% reported "excellent" and 53% reported "good" in sign to voice interpreting; and 68% reported "excellent" in fingerspelling. None of the respondents evaluated themselves as poor in any of the skills and all but one, who was an interpreter-counselor, indicated that they have interpreted in therapeutic situations.

RESULTS

Survey I

Forty-five percent of the Survey I participants indicated that they now use or have in the past used interpreters with deaf clients. A higher percentage (56%) responded that they would be willing to use interpreters. Forty percent reported that they would not be willing to use interpreters and 4% gave no response. Of the participants using interpreters, 5% said they were responding to their deaf clients' wishes. The most frequently given reason (46%) for not using interpreters was that "a third party is detrimental to counseling." Thirty-six percent of the respondents indicated that interpreters were not needed. In addition, 12% gave both of the above (a third party is detrimental and interpreters are unnecessary) as reasons for not using interpreters. Only 3% of the respondents indicated that "interpreters gossip and fail to understand the importance of confidentiality."

Some of the participants in Survey I noted that they would use interpreters, but insisted on restrictions. For example, the counselor or therapist must train the interpreter in regard to vital considerations, such as confidentiality and terminology (29%), and the interpreter must be RID certified (8%). Both restrictions were indicated by 19% of the respondents. In response to the question, "If you would not use interpreters in counseling under any circumstances, how would you communicate with deaf clients?", 47% of the respondents indicated that they would employ the deaf clients' preferred methods of communication, whether these were oral or manual. An additional 3% of the respondents indicated that participants would communicate with the help of another counselor or therapist who could sign. Both of these choices were indicated by 3% of the respondents. There was no response to this question from 48% of the participants.

In Survey I the participants were asked, using an open-ended question, to give the advantages of using interpreters with deaf clients in counseling or psychotherapy. Most frequently, the participants (76%) noted that an interpreter provides fast, accurate communication which can make clinical services available which otherwise would not be possible. Another advantage listed (8% of the respondents) was that interpreters with special skills can make communication and counseling services possible for foreign or minimal language skilled deaf clients with special communication needs. Table 1 shows these and other advantages which were less frequently expressed by the participants.

Also, the participants were asked to indicate the disadvantages of using interpreters in therapeutic situations. The disadvantage expressed most often was the possibility of some type of negative third-party influence (63%). Included in this concern were the following: (1) loss of meaning as a result of the interpreting process, 19%; (2) loss of eye contact, 4%; (3) disruption of emotional expression between client and counselor, 7%; and (4) the client

becoming uncomfortable in the presence of a third party, 15%. Another set of disadvantages were problems with interpreter ethics, gossip, and confidentiality. These disadvantages were indicated in 32% of the responses.

TABLE 1
Advantages In Using Interpreters In Therapeutic Situations As Indicated by Survey I Participants

Advantages Of Using Interpreters	Percent
Provides fast, effective communication which can make counseling services available which otherwise would not be possible	76
May provide special communication skills necessary for foreign or minimal language skilled deaf clients	8
Only better than nothing; last resort	5
Gives client idea that counselor is interested and sincere in desire to help	4
Helps in family meetings when family cannot sign or read sign (with either deaf or hearing counselor)	4
Interpreter may be especially understanding and sympathetic to the client's problem	3
May help inexperienced therapist understand the culture and nuances of deaf people	3
Helps in group counseling	1
No advantages or no response	15

Note 1. N = 75

Note 2. Since participants could indicate more than one advantage percentages do not total to 100%.

The only other disadvantages recognized by at least 10% of the participants consisted of problems with the interpreter's role (21%) which might involve the interpreter assuming the role of therapist, the client placing the interpreter in the role of therapist, or the therapist placing the interpreter in the role of therapist. Twenty percent of the participants indicated no disadvantages or provided no response.

Survey II

In response to the question, "Do you think interpreters should be used in counseling or psychotherapy?", 76% of the interpreters responded "Yes, but with restrictions", and 24% responded with an unqualified "Yes"; therefore, all of the interpreters felt that interpreters should be used in psychotherapy and counseling. Those eight (24%) interpreters responding with an unqualified "Yes" checked both of the following multiple-choices: "because deaf people are entitled to the right of the best possible means of communication which many interpreters can help provide"; and "because most counselors and psychotherapists lack training in manual communication".

Participants who responded that interpretors should be used, but qualified that use, indicated the following restrictions: (1) only RID certified interpreters be used, 70%; (2) interpreters maintain strict confidentiality, 68%; (3) the interpreter must be oriented to the specific counseling situation, 50%; (4) only an interpreter who is also a licensed counselor or psychotherapist be used, 6%; and (5) the interpreter should be specially certified by RID to interpret in psychotherapeutic situations, 35%.

In Survey II as in Survey I the interpreters were asked to note advantages (See Table 2) and disadvantages of using interpreters in therapeutic situations. Similarly to the participants in Survey I, 91% of the interpreters indicated that the major advantage is that the interpreter provides a means of communication which makes clinical services available to deaf people when the therapist is not fluent in manual communication. Another advantage expressed (24% of the interpreters) was that a qualified interpreter may provide the clinician with insight into deafness, such as nuances of language or of gesture. In addition, 21% of the interpreters pointed out that complete communication is possible with an interpreter. Other advantages expressed by interpreters include: (1) provides safeguards against misunderstanding of communication, 9%; (2) helps the deaf client feel at ease, 9% (3) may allow deaf client to "open up" because he/she knows and trusts the interpreter, 6%; (4) allows the deaf clinician to communicate with hearing professionals or with the families of clients, 6%; and (5) may facilitate group counseling, 3%.

Also, interpreters were asked to indicate the disadvantages of using interpreters in counseling or psychotherapy. The most frequently expressed disadvantage (59%) was the difficulty of functioning solely as an interpreter; that is,

avoiding personal involvement by remaining impartial, neutral, and objective in attitude. Also, as in the first survey, the Survey II participants (41%) indicated the problems which they believed were imposed by the presence of a third party. Closely related to this problem was Survey II participants' concern (27%) that, with an interpreter present, clients might not fully disclose information. Another disadvantage, which was expressed by 29% of the participants, was that an unqualified interpreter may hinder communication or may mislead the clinician because of communication errors or loss of nuances and feelings. About one-third of the interpreters (29%) indicated that direct communication between the clinician and deaf client is preferred over the use of interpreters. Twenty-one percent of the interpreters noted that the therapist or the client may view the role of the interpreter as that of a therapist. Other disadvantages listed by Survey II participants received less than 10% of the responses.

TABLE 2
Advantages Of Using Interpreters In Therapeutic Situations As Indicated by Survey II Participants

Advantages Of Using Interpreters	Percent
Provides means of communication which can make counseling services available	91
Qualified interpreter provides therapist with insight into deafness	24
Provides complete communication	21
Provides safeguards against misunderstanding of communication	9
Helps deaf client feel at ease	9
Deaf client may "open up" because he knows and trusts the interpreter	6
Allows deaf clinician to communicate with hearing professionals or with families of clients	6
Facilitates group counseling	3

Note 1. N = 34

In further analyzing the results, three chi-square (X^2) values were calculated between various groupings of participants. A comparison between the choices of deaf and hearing professionals on the issue of the usage of interpreters in therapeutic situations showed a significantly high frequency of deaf clinicians rejecting the use of interpreters with X^2 (1, N = 68) = 9.04, $p < .01$. Also, a comparison of the positions of those offering clinical services and interpreters showed a significantly more favorable attitude in regard to the use of interpreters by interpreters with X^2 (1, N = 107) p .001. A third comparison of clinicians who use manual communication and those who do not showed no association (X^2 = 2.30, df = 1, N = 73, $p > .05$) with willingness to use interpreters.

Discussion

Deaf people may find it difficult to participate in clinical support services requiring verbal interaction with professionals. One solution to the communication problem is the use of interpreters. However, clinicians indicated some reluctance to add a third party to the therapeutic situation. Over one-half (55%) of these professionals had not used an interpreter and 40% of them said that they would not be willing to use interpreters. Since many clinicians (47%) indicated a preference for a direct, one-to-one relationship with a deaf client in that client's mode of communication, it seems that for almost one-half of the clinicians the use of an interpreter would be a second choice. On the positive side, it can be seen that 45% of these professionals had used interpreters and 56% of them noted that they would use interpreters if this became necessary for clear communication. Apparently they recognized that interpreters are needed in therapeutic situations and this need will continue in the future, but the general impression is that the majority of the sampled professionals offering clinical services would prefer to decrease the frequency of using interpreters and increase the frequency of professionals who can sign fluently.

Interpreters favored the use of interpreters in therapeutic situations. Specifically, 76% favored restricted use, while 24% reported that they favored use of interpreters and noted no restrictions. Although the interpreters favored the use of interpreters, the opposing attitude

of the majority of clinicians is likely to be more influential in practice since they control the therapeutic process. One might argue that the mode of communication should be decided by the deaf client, but the therapist could contend that the client may not be in a position to make this judgment since emotional disturbance may interfere with ability to make decisions. Vernon (1965) notes that the final, most likely solution is to train deaf counselors for deaf people. In the present study, a significant difference was found between the frequency of deaf and of hearing clinicians' opinions in regard to the use of interpreters. In contrast to hearing clinicians, deaf clinicians in this sample tended to reject the use of interpreters and if the question had been addressed, perhaps the deaf clinicians would have agreed with Vernon's proposal of training deaf counselors for deaf people.

Apparently, differences in opinions of professionals regarding the use of interpreters in therapeutic situations is not strictly related to their ability to communicate manually. Clinicians who used manual communication accepted the use of interpreters as readily as those who had no manual skills.

In agreement with previous viewpoints (Straub, 1976; Vernon, 1965), the majority of both groups of participants in the present study emphasized that interpreters are necessary for adequate provision of mental health services to deaf people at present. However, the general impression reflected was that the interpreter is a vital but "temporary" bridge over the communication barrier. Emphasis was placed on the need for more professionals offering clinical services who are competent in manual communication.

The tremendous need for extensive research in this area is obvious. At this time we know very little about the actual effects of using interpreters in therapeutic situations. What are the variables which determine the facilitative effects of using an interpreter or would contraindicate the presence of an interpreter in therapy? Until more is known regarding how interpreters actually change the therapeutic environment, decisions regarding their use can only be made on the basis of highly subjective opinion.

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