

Impact of Sign Language Interpreter and Therapist Moods on Deaf Recipient Mood

Julianne Gold Brunson and P. Scott Lawrence
University of North Carolina at Greensboro

This study questions how the mood and affective reactions of the interpreter and the therapist affect the therapeutic process. Professional sign language interpreters are trained to be impartial conduits who neither add nor subtract from the primary dyadic relationship. This study revealed that despondent interpreter mood caused significant negative mood changes in the deaf participant even when the therapist mood was neutral/cheerful. Practicing psychologists need to consider the susceptibility of deaf clients to the nonverbal mood presentation of sign language interpreters and its implications on the therapeutic alliance.

Can sign language interpreters facilitate communication between a deaf client and a nonsigner therapist without adding or subtracting to the primary dyadic relationship? Does the mood presented by the interpreter matter? Can nonverbal physical and visual cues seen from the interpreter have a greater impact on the deaf listener than similar cues seen from the nonsigner therapist? These questions lie at the heart of the present study, which examined how the mood and affective reactions of the signing interpreter, as well as those of the therapist, might affect the therapeutic process involving nonspeaking deaf clients.

Relatively few therapists possess adequate knowledge of the nature and culture of deafness or fluency in manual communication modalities (i.e., American Sign Language [ASL]) to effectively communicate with deaf clients (Farrugia, 1989; Gerber, 1983; Sachs, Robinson, & Sussman, 1978; Tucker, 1981). Hence, sign language interpreters play a significant and critical role in facilitating psychological assessment and treatment with deaf clients (Harvey, 1982; Maher & Waters, 1984). However, research on the benefits of using sign language interpreters to facilitate communication and therapeutic alliance between hearing therapists and deaf clients has been focused at the technical or procedural level (Farrugia, 1989; Happ & Altmaier, 1982). No known empirical examination has looked at the impact of interpreter involvement beyond the issue of facilitating the dialogue between the therapist and the deaf client.

Professional interpreters are conceptualized and trained to perform as “impartial” conduits—that is, they should neither add nor

subtract from the primary dyadic relationship (Harvey, 1982). In essence, the interpreter strives to act as a “blank slate” through which little or no personal information about the interpreter is communicated. Despite this conceptualization, a triadic effect (e.g., therapist–interpreter–deaf recipient) cannot be avoided in therapeutic settings (Harvey, 1982). Regardless of the interpreter’s attempts to be a pure translator of spoken words into signs (and vice versa), he or she may be unintentionally influenced by the nonverbal behavior of the therapist and deaf recipient (including their moods). As a result, the interpreter’s subsequent interpretation process can be affected. In turn, by inferring what the interpreter thinks or feels, both the recipient and therapist may be unintentionally influenced cognitively, affectively, and/or behaviorally by the nonverbal behavior of the interpreter (including the interpreter’s moods). For example, an interpreter may be perceived as exhausted affectively and behaviorally (e.g., he or she signs less enthusiastically). Meanwhile, a deaf recipient may perceive the interpreter’s affect as being rejecting (“the interpreter doesn’t like me”), which impacts the recipient affectively (feels depressed) and behaviorally (discloses less information). The recipient’s behavior, in turn, increases the therapist’s tension.

The question of whether mood can have an impact on relationships has been discussed in numerous studies, although most of the research has been conducted with hearing individuals only. Entire models have been developed by theorists to describe the relationship between mood and interpersonal events (Beckham & Leber, 1995). The Coyne model (1976b) describes the impact of depressed mood on the social environment. In essence, depressed people engage others in a way that elicits critical and rejecting responses in others. This can lead to a “downward depressive spiral” in which depressive symptoms or behaviors are increased and maintained. In addition, individuals who are not depressed tend to minimize future interactions with depressed individuals (Coyne, 1976a). A number of studies have confirmed these interactional effects, which can be observed in as quickly as 3 min (Beckham & Leber, 1995; Coyne, 1976a).

The relatively constant eye contact maintained between an interpreter and a deaf recipient suggests that deaf recipients are exposed to more nonverbal cues from the interpreter than from the therapist/speaker. However, whether interpreters can inadvertently

JULIANNE GOLD BRUNSON received her MA in 2001 from the University of North Carolina at Greensboro, where she is currently completing her doctorate in clinical psychology. Her professional interests include psychotherapy approaches with deaf and hearing-impaired individuals.

P. SCOTT LAWRENCE received his PhD from Arizona State University in 1969. He is an associate professor of psychology at the University of North Carolina at Greensboro. His professional interests include behavior analytic approaches to psychotherapies.

CORRESPONDENCE CONCERNING THIS ARTICLE should be addressed to Julianne Gold Brunson, Psychology Clinic, University of North Carolina at Greensboro, P.O. Box 26170, Greensboro, North Carolina 27402. E-mail: jtgold@uncg.edu

influence the therapeutic alliance through their expression of non-verbal cues is not known. Thus, we examined whether the presenting mood of the interpreter can interact dynamically on the primary dyadic therapeutic relationship at the interpersonal level: Do interpreter and therapist moods influence deaf recipient mood and to what degree?

The Deaf Impressions Study

Community samples of 18 deaf adults (9 men and 9 women) were recruited from various community locales (e.g., clubs for the deaf, churches, schools) in a southeastern state. These participants were fluent in ASL, had completed at least 2 years of college, and ranged in age from 20 to 47 years (and had acquired minimal skills necessary for reading questionnaires). All participants received monetary compensation totaling \$10. The individuals were told that they were participating in a study examining the reactions of a deaf person to several sections of an ongoing initial therapy interview shown on videotape.

A 2×2 randomized block factorial design was conducted in which participants were crossed with each treatment combination: therapist mood condition (despondent vs. neutral/slightly cheerful therapist) and interpreter mood condition (despondent vs. neutral/slightly cheerful interpreter) as independent variables and questionnaire scores as dependent variables. Two different teams of licensed psychologists/health service providers by the state of North Carolina and nationally certified interpreters were videotaped: a male team (a male therapist with a male interpreter) and a female team (a female therapist with a female interpreter). To increase face validity, we videotaped each therapist and interpreter team seated alongside each other (a commonly used placement), with the interpreter sitting to the left of the therapist (from the participant's point of view). Each team spoke/interpreted a 3-min scripted passage directly into the camera while presenting one of two moods: despondent or neutral/slightly cheerful. Four scripted passages (rated neutral in message and tone) discussed how therapy benefited four different hypothetical clients regarding problem solving, assertiveness training, social skills training, and communication skills training. Both teams filmed each script in all four mood conditions (a total of 16 videotapes per script): despondent interpreter and despondent therapist, neutral/slightly cheerful interpreter and despondent therapist, neutral/slightly cheerful interpreter and neutral/slightly cheerful therapist, and despondent interpreter and neutral/slightly cheerful therapist. Participants were randomly assigned to videotapes (a total of 8 videos per participant).

Script Development

To increase face validity, we designed the four scripted passages to elaborate on the nature of therapy and what a client can expect from therapy (e.g., two from each mood condition [one from each team] from all four scripted role expectations regarding approaching sessions). Each script incorporated a case study involving one of four hypothetical situations: work (problem solving), family (assertiveness training), marriage (communication skills), and friendship (social skills training).

Prior to filming, each of the four scripted passages was rated for general neutrality of content matter and emotional tone by four

clinical psychology graduate students who were blind to the intended affective valence. During filming, the experimenter (Julianne Gold Brunson) worked with each team to prepare for their performances depicting each mood condition. Although there is much empirical data as to the specific behaviors typically seen in despondent and depressed individuals, no such parallel data have been empirically identified for despondent or depressed sign-language interpreters. As a result, we relied on open-ended discussion of anecdotal evidence related to despondent behaviors in interpreters. Hence, the following behaviors were used to portray despondency in the interpreter: slouched posture, "bored" or slack facial expression, minimal use of additional facial expression or "adjectives" (i.e., signing in a "monotone"), minimal direct eye contact, and signing at a slower rate and at a physically lower level against the body. Both the therapist and interpreter spoke and signed directly into the camera. Each portrayed interpersonal behavior and affect that were consistent with the intended mood condition. After the videotaped segments were developed, each segment was reviewed and rated by a deaf adult and a sign-language interpreter knowledgeable in ASL and its related facial expressions. The raters were blind to the intended affective valence. Each segment used in the study received reviewer means within the targeted affective range. Thus, we determined that each videotaped segment adequately presented the intended affective valence for each segment.

Procedure

At the screening, participants were informed that they were involved in a study examining the reaction of a deaf person to a typical "initial interview" with a licensed psychologist/health service provider and a nationally certified interpreter. Participants were assured of the confidentiality of their responses and informed of their rights. Each recruited participant was screened for demographic histories and administered the Beck Depression Inventory (BDI; Beck, Steer, & Garbin, 1988) to screen out participants with high scores, indicating depression. Participants were also evaluated for ASL fluency (i.e., participants watched a videotape of a deaf adult telling a story in ASL and then answered questions that tested their comprehension).

Following the screening, participants were instructed to view eight videotapes (two from each mood condition [one from each team]), one at a time (TV volume muted), and to complete the following questionnaires after each viewing (to control for practice effects, alternate forms of each measure were given): the Depression Adjective Checklist (DACL; Lubin, 1981), the Profile of Mood States—Short Form (POMS-SF; Curran, Andrykowski, & Studts, 1995), and the Coyne's Willingness to Interact in the Future Questionnaire (Coyne, 1976a). Furthermore, on the basis of feedback received from a preliminary experimental run with a 31-year-old deaf female participant who was fluent in ASL and had an MS degree in deaf education, a brief vocabulary list was composed, because many of the adjective terms used in the DACL and POMS-SF were fairly antiquated and not commonly used in everyday language (e.g., *gay*, *forlorn*, *glum*). Participants were encouraged to review the vocabulary list just prior to the onset of the experiment and to refer to the list as needed while completing the questionnaires.

To reduce carryover effects, we asked participants to complete a number of word puzzles (e.g., mazes, “find-a-word,” crossword puzzles) for 5 min following the completion of questionnaires and before viewing the next videotape. After viewing all eight assigned videotapes and completing the questionnaires, participants were debriefed. Finally, to ensure that participants were unharmed by the experimental conditions, we again had participants complete the BDI, followed by an “elation-inducing” task in which they viewed a videotape of several deaf adults telling humorous “real-life” stories.

Results

A 2 (communicator: therapist and interpreter) × 2 (mood condition: despondent and neutral/slightly cheerful) randomized block factorial design was conducted with therapist mood state (despondent vs. neutral/slightly cheerful) and interpreter mood state (despondent vs. neutral/slightly cheerful) as independent variables and questionnaire scores as dependent variables. Participants’ questionnaire scores for each of the eight assigned videos (two from each mood condition combination) were reduced to four (i.e., scores from each pair of videotaped segments depicting the same mood condition were averaged). Factorial analyses of variance statistically examined mood states and communicator as independent variables and averaged score totals as dependent variables for each of the instruments: DACL, POMS–SF, and Coyne’s Willingness to Interact in the Future Questionnaire (see Figure 1). Results showed significant main effects of mood states across all dependent variables, with interpreter mood contributing greater additive weight than therapist mood. In summary, all three measures (DACL, POMS–SF, Coyne’s Willingness to Interact in the Future Questionnaire) revealed significant main effects for therapist mood, with *F*s(1, 51) ranging from 21.89 to 5.22 (*p*s < .01). No interaction effects were found. Significant main effects for interpreter mood were also found, with *F*s(1, 51) ranging from 28.77 to 9.65 (*p*s < .01). Furthermore, no gender effects were found.

The DACL and POMS–SF (total mood disturbance/all six subscales) scores revealed that despondent therapist mood and despondent interpreter mood elicited greater increases in the dysphoric mood of the deaf recipient than other mood conditions (means ranged from 59.55 [*SD* = 3.5] to 7.33 [*SD* = 0.88]). In contrast, neutral/slightly cheerful interpreter and neutral/slightly cheerful therapist elicited the least dysphoric increases in the deaf recipient (means ranged from 0 [*SD* = 0.88] to 36.61 [*SD* = 3.5]). Furthermore, as predicted, these main effects were additive, with the interpreter mood condition contributing greater weight than the therapist mood condition: Interpreter despondent mood (combined with neutral/slightly cheerful therapist mood) elicited greater changes in deaf recipient mood ratings (means ranged from 45.55 [*SD* = 3.5] to 4.16 [*SD* = 0.88]), compared with therapist despondent mood combined with neutral/slightly cheerful interpreter mood (means ranged from 42.66 [*SD* = 3.5] to 2.08 [*SD* = 0.88]).

The Coyne’s Willingness to Interact in the Future Questionnaire also followed this same trend. (The higher the questionnaire score, the more willingly the participant expressed interest in interacting in the future with the team as portrayed.) As predicted, when both the therapist and the interpreter portrayed despondency, participants reported being less willing to interact with the team again in

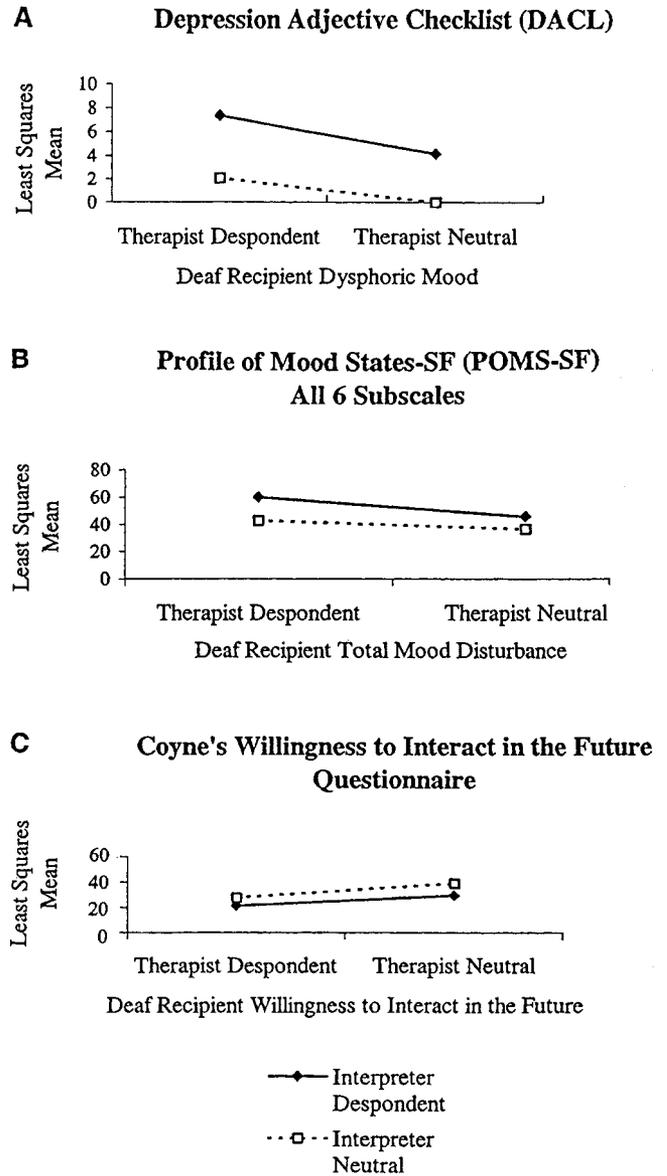


Figure 1. The impact of interpreter and therapist moods on (A) deaf recipient dysphoric mood, (B) deaf recipient total mood disturbance, and (C) deaf recipient willingness to interact in the future.

the future (*M* = 20.97, *SD* = 2.11), compared with when both the therapist and the interpreter were affectively neutral/slightly cheerful (*M* = 38.97, *SD* = 2.11). Again, the effects were additive, with a despondent interpreter (paired with a neutral/slightly cheerful therapist) having greater impact on the deaf recipient’s willingness to interact in the future (*M* = 29.42, *SD* = 2.11), compared with a despondent therapist paired with a neutral/slightly cheerful interpreter (*M* = 27.64, *SD* = 2.11).

Implications

The results of this study revealed clear support for the hypothesis that therapist and interpreter behavior characteristic of despon-

dent mood will elicit negative mood and rejection from the deaf recipient. Furthermore, evidence strongly suggests that interpreters, rather than having no impact on the dyadic therapeutic alliance, may have greater influence on the alliance than has previously been believed. This finding is noteworthy for several reasons. First, this present study indicates that Coyne's model regarding the impact of depressed mood on nondepressed individuals is applicable to the unique facilitating role of the sign-language interpreter. This indicates that deaf recipients who are not depressed are also likely to experience mood changes produced by the interaction with depressed individuals, as demonstrated in numerous studies examining Coyne's model with hearing individuals. Second, in addition to the intended content matter and emotional message being interpreted or transmitted through a sign-language interpreter from the therapist, the deaf recipient perceives extraneous nonverbal behavioral stimuli from *both* the therapist and the interpreter. However, because of the consistent eye contact that must be maintained between a deaf recipient and a sign-language interpreter, an additive effect of mood state from both the therapist and the interpreter occurred, with interpreter mood having a greater impact. As a result, a "filtering" effect was seen: A neutral/slightly cheerful interpreter appeared to act as a "buffer" against the nonverbal source of stimuli presented by a despondent therapist. Likewise, a despondent interpreter induced significant negative mood changes in the deaf recipient despite the presentation of neutral/slightly cheerful stimuli or behavioral cues from the therapist.

Although professional interpreters appear to function successfully with impartiality and neutrality in many settings (e.g., classrooms, business meetings), the therapeutic setting appears to be unique in terms of greater emotional import. This study clearly indicates that an interpreter can influence the therapeutic process affectively and behaviorally in subtle yet important ways. However, rather than viewing the interpreter as an impartial psychological presence having no effect on the alliance, the therapist can recognize and become more cognizant of the interpreter as a dynamic member of a triadic therapeutic process (Halgin & McEntee, 1986; Hoyt, Siegelman, & Hilde, 1981).

As part of a triadic system, the therapist will need to be aware of the number of possible alignments that can occur between a deaf client, therapist, and interpreter during a session. Alignments are reflective of shared relatedness or empathic closeness (Gerber, 1983). Ideally, in the preferred alignment, all three members are joined in an empathic and therapeutic alliance, with the therapist and the client aligned as the primary unit and the interpreter as a concerned and engaged facilitator of accurate communication between the two parties. Other alignments are also possible, however: The interpreter and the client may be perceived as one alignment, with the therapist being perceived as an outsider within the triad. Likewise, the interpreter and the therapist may be perceived as one unit, with the client as the outsider. Lastly, the client and the therapist could be perceived as one unit, with the interpreter being perceived as the mediator rather than as a facilitator of communication. The phenomenon of transference and countertransference can occur within each of these alignments (Harvey, 1982; Henwood & Pope-Davis, 1994).

The therapist can increase the interpreter's ability to perform as an accurate facilitator by establishing regular pre-session preparations, debriefings, and short breaks during long sessions. During

pre-session discussions, the therapist might inform the interpreter of historical and clinical information regarding the client's presentation, personality, or pathology. Thus, by increasing the interpreter's sense of empathy and receptiveness toward the client's concerns, the therapist can enhance the transmission of the therapist's communications while reducing role confusion and the import of extraneous interpreter reactions (moods, nonverbal behavioral cues). During this time, the therapist can also gain much valuable information from the interpreter related to procedures, language, interpretation issues, cultural information, and so on. Furthermore, one-on-one pre-session meetings with the interpreter might provide the therapist with distinguishing or "base rate" information regarding the interpreter's current mood state and speech intonations (unaffected by the presence of the client) in order to assist in better determining the source of depressive or other affective cues being perceived by the therapist for diagnostic purposes. Because interpreters may lack the training and experience to quickly process emotionally charged clinical material, they may be vulnerable to vicariously experienced emotional distress or reactivation of their own past emotional distress, or they may become more quickly fatigued and generally less able to self-monitor their own affective and behavioral influences during difficult sessions. Thus, short breaks and debriefings may help the therapist monitor the therapeutic process and ameliorate any reactions that could potentially contaminate the session.

Future studies may find that the influence of nonverbal physical and affective cues from linguistic interpreters in the therapy settings may vary depending on the demands of eye contact or receptiveness on the client. Clients who speak a spoken foreign language (e.g., French or Spanish) may find that they are better able to maintain eye contact with the therapist while listening to the speaking interpreter. For deaf clients, having the interpreter and therapist seated within the client's line of vision may increase eye contact with the therapist. In contrast, clients who are both deaf and blind may receive little or no nonverbal physical and affective cues from the therapist, because they typically feel the interpreter's hands (i.e., tactile interpretation) and have no physical contact with the therapist. Therefore, they are more dependent on the interpreter for transmission of communications from the therapist. Thus, the therapist will need to be even more cognizant of any nonverbal affective and behavioral cues that might contaminate the intended message being tactically signed by the interpreter.

One easily overlooked yet substantial barrier to developing rapport or therapeutic alliance with a deaf client via an interpreter lies in the rigid adherence to the traditional 50-min session. The interpreting process simply takes longer whether signed or spoken. One recommendation is to adopt a 90-min session.

In summary, the critical role of interpreters in providing accessible mental health services for the deaf must never be underestimated, and this study does not intend to undermine their importance. Evidence suggests that interpreters, rather than being "blank slates" facilitating a dyadic relationship, have a substantial interpersonal influence. Neutral/slightly cheerful interpreters may act as a buffer against the impact of despondent therapists. However, despondent interpreters may elicit greater dysphoric mood changes in the deaf recipient. Practicing psychologists need to consider the susceptibility of deaf clients to the nonverbal mood presentation of sign-language interpreters and its implications on the therapeutic

alliance. By identifying the individual influences (such as mood states) that have an impact on the deaf recipient and the nonsigner, the significant role of the interpreter may be further enhanced.

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