

The Psychotherapist and the Sign Language Interpreter

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Specialized psychotherapy for deaf people in the Dutch and Western European mental health systems is still a rather young specialism. A key policy principle in Dutch mental health care for the deaf is that they should receive treatment in the language most accessible to them, which is usually Dutch Sign Language (Nederlandse Gebarentaal or NGT). Although psychotherapists for the deaf are trained to use sign language, situations will always arise in which a sign language interpreter is needed. Most psychotherapists have the opinion that working with a sign language interpreter in therapy sessions can be a valuable alternative option but also see it as a second-best solution because of its impact on the therapeutic process. This paper describes our years of collaboration as a therapist and a sign language interpreter. If this collaboration is optimal, it can generate a certain “therapeutic power” in the therapy sessions. Achieving this depends largely on the interplay between the therapist and the interpreter, which in our case is the result of literature research and our experiences during the last 17 years. We analyze this special collaborative relationship, which has several dimensions and recurrent themes like, the role conception of the interpreter, situational interpreting, organizing the interpretation setting, or managing therapeutic phenomena during therapy sessions.

Specialized psychotherapy for deaf people is still a rather young specialism in the Dutch and Western European mental health systems. In the Netherlands, such care is provided by five outpatient teams in five regions, supplemented by four inpatient clinics whose

specific areas of focus are based on age and symptomatology.

A key policy principle in Dutch mental health care for the deaf is that they should receive treatment in the language most accessible to them. Usually, this is the Dutch Sign Language (Nederlandse Gebarentaal or NGT; de Bruin, 1997), as most deaf people have a poor mastery of spoken and written Dutch. Yet, situations will always arise in which a mental health professional is unable to communicate well enough with a client, thus necessitating the use of a sign language interpreter. Some psychotherapists may not yet be fluent in sign language; a client may be using an unfamiliar sign language variant, or the hearing professional may lack some subtle knowledge of sign language that is essential for refining the diagnosis. Some situations even require a relay interpreter, who can adapt standard sign language to a level compatible with that of the deaf client and vice versa. A relay interpreter is always deaf. Hence, when a relay interpreter is used, there will be two interpreters—an NGT interpreter who translates spoken language into NGT, and a relay interpreter who adjusts the NGT to the client’s language level.

Most psychotherapists feel that working with a sign language interpreter in therapy sessions can be a valuable alternative option. Yet, many unfortunately still see it as a second-best solution because of its impact on the therapeutic process. They report a sense of losing direct contact with the client, as well as interference from unwanted “interpretations” inserted

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by interpreters and a fear of undesirable therapeutic phenomena, like coalitions or transference feelings involving the interpreter (Mahler & Waters, 1984; Bot, 1998).

Although these are certainly pertinent arguments, they could also lead us to overvalue “direct personal contact” with clients and to undervalue the use of interpreters in therapy sessions. Working intensively with interpreters is actually a highly feasible prospect. In fact, when a therapist and an interpreter work together optimally, it can generate a certain therapeutic power in the therapy sessions. Achieving this depends largely on the interplay between the therapist and the interpreter.

This article analyzes this special collaborative relationship, which has several dimensions and recurrent themes. We illustrate these with case examples. For all clarity, we note that the situations described here mainly involve collaboration between hearing therapists and sign language interpreters. Although we believe that many of the considerations we highlight would apply equally to collaboration between deaf therapists and sign language interpreters, the latter contacts also involve certain specific differences that lie outside the scope of this article and which we will not address here.

Sign Language Interpreters at PsyDoN

Because the groundwork for this collaborative model was developed at our organization, PsyDoN, we begin by briefly describing the context in which interpreters and psychotherapists work together there. PsyDoN is an agency for psychological and psychiatric care to deaf and partially hearing people in the Dutch provinces of North Holland and Flevoland. It is a division of Mentrum, an Amsterdam institute for mental health care. All PsyDoN staff, including deaf employees and sign language interpreters, are given dedicated training from higher professional school teachers in Dutch Sign Language (NGT) with a focus on mental health care provision and its specific jargon.

In contrast to the mainstream mental health sector, interpreters at PsyDoN have been actively engaged from the very beginning in developing mental health care for the deaf. It was clear from the start that

such therapies would always involve complex communication situations requiring the use of interpreters. Sign language interpreters thus form an essential component of our services to the deaf and partially hearing.

Since 1990, PsyDoN has worked with several steady NGT interpreters. This necessitated developing a training curriculum of our own, as the specialism of mental health sign language interpreter did not yet exist in the Netherlands (de Bruin & Brugmans, 2001). We mainly had to draw on experiences and information from abroad (Harvey, 1984; Stansfield, 1981; USCF, 1987), which we then adapted to our own practice.

We have identified several constant basic themes one should be aware of in therapist–interpreter collaboration. We shall now discuss these themes, illustrating them with examples from practice.

Theme 1: The Role Conception of the Interpreter

The bedrock issue in all collaboration between an interpreter and a therapist is how each of them conceives the role of the interpreter in mental health care. Some role conceptions have already been officially spelled out by professional trade associations in their rules of conduct, such as the Registry of Interpreters for the Deaf Code of Ethics (see, e.g., Caccamise et al., 1980; Nederlandse Beroepsvereniging Tolken Gebarentaal [NBTG], 2001). Rules of conduct are highly useful in general circumstances, and they assure the client that the sign language interpreter will act impartially. In actual mental health practice, however, such rules are not always workable or desirable—interpreters who are part of treatment teams are no longer able to observe strict impartiality and neutrality. Additional ideas about the roles that therapists and interpreters can occupy in the therapeutic “translation” process have been published in various psychotherapeutic frameworks (Harvey, 1984; Bot, 1998). In view of the fundamental nature of the therapist–interpreter collaboration, we consider it advisable for any two such professionals to discuss these role conceptions explicitly before working together. Any lack of clarity or agreement on this issue can give rise to tension and friction in their working relationship

and will ultimately be detrimental to the therapeutic process.

Karlin (2001) has elucidated five different role conceptions that emerge from the literature with respect to interpreters:

1. the interpreter as a direct line between two parties who do not understand each other's languages ("the traditional, language-focused role");
2. the interpreter as a "bilingual, bicultural mediator" who, in addition to translating the conversation, relays information back and forth about the two different cultures;
3. the interpreter as a "tool for bringing interpersonal and intercultural relationships into focus";
4. the interpreter as a "clinical collaborator" who performs fully autonomous therapeutic tasks in support of the therapist(s); and
5. the interpreter as a "paraprofessional" who has specific responsibilities to carry out during the therapy in addition to those of the therapist.

A therapist was working with an unfamiliar interpreter in a therapeutic situation, when the latter began giving the client an extensive, unsolicited explanation about the purpose of the intervention. As this was not the therapist's intention, he asked to speak to the interpreter after the session to raise this issue. But the interpreter deemed such a postsession unnecessary, saying the job had been completed as commissioned. This obviously caused great dismay to the therapist, who felt the interpreter's actions had rendered his therapeutic intervention ineffective.

This simple example illustrates how a difference in role conceptions can adversely affect a treatment intervention.

Theme 2: Situational Interpreting

Individual, relational, family, and group therapies are the major forms of treatment applied in the mental health system. Their attendant settings place different sets of demands on both the "interpreting work" and the accompanying "interpreting behavior." They may also induce different types of behavioral phenomena in clients, and these must also be reckoned with. We shall briefly examine the various features.

The Added Value of an Interpreter in Individual Therapies

One reason to engage interpreters in individual therapy situations may be to help refine the diagnosis of a client who uses a dialect, facial expressions, or non-verbal language that is not fully understood by the therapist, but which is thought to be part of the client's behavior. Using a sign language interpreter ensures that the therapist is not preoccupied by the communication and can concentrate on sharpening the diagnosis.

A deaf woman aged 40 from a former Warsaw Pact country, holding asylum-seeker status, was referred to us by a mainstream mental health agency. She was described as having sleep disturbances and being difficult to reach. Because each country has its own unique sign language, we decided to engage an interpreter, who was proficient in international sign language, right from the first interview. During that interview, we indeed found that the woman had a poor knowledge of Dutch Sign Language but was fluent in the sign language of her former home country and that she also understood international sign language. The interpreter's presence enabled the therapist to concentrate fully on the content of the woman's story—what she had to say, how she expressed it, and what symptoms she was bringing to the therapy. This made it easier for the therapist to establish the diagnosis of posttraumatic stress disorder.

Relationship Therapies Using an Interpreter

For a hearing therapist, conducting relationship sessions with two deaf partners can be a strenuous and awkward undertaking. In addition to the relationship problems, which have relational and content aspects, the therapist also has to deal with the subtleties in sign language use common to the two partners, with the cultural differences between hearing and deaf people and sometimes even with language differences between the two members of the couple. Besides putting the therapist's language skills and flexibility to the test, this also complicates the treatment. An interpreter can be

a valuable asset here by contributing sensitivity to key aspects of complex situations like these. This can result, for example, in necessary adaptations to the language level in the therapy and in verbal clarifications of facial expressions and nonverbal sign language elements.

A deaf woman presented with her deaf partner as a consequence of relationship and childrearing problems. Differences of opinion promptly arose between the couple, which were not understood by the therapist. Every time the therapist thought the problems between the couple had been fully mapped out, new discussions flared up again which threatened to escalate. In a postsession review with the interpreter, it emerged that the interpreter had noticed a difference in language knowledge, proficiency, and skills between the two partners. The therapist suspected this might be the source of the quarrelling and decided with the interpreter to adapt the level of language; they agreed on signals the interpreter could give if the therapist's language level started becoming too abstract. After that, the therapy sessions proceeded much more smoothly, and the relational and childrearing problems could be addressed relatively easily. Needless to say, the observed difference in language level was also discussed with the clients and made into a focus of the treatment.

Working With an Interpreter in Systemic Therapies

For both hearing and deaf therapists, conducting family sessions for mixed hearing-deaf families presents another set of problems that can complicate the therapy situation. Organizational issues may arise, such as the nature of the interpreting work—into sign language only or also into spoken language by a sign-to-voice interpreter. Another issue involves the actual positioning of the interpreter amidst the family; this is especially pertinent in therapies conducted by both a hearing and a deaf therapist. If the interpreter chooses a seat that is most convenient to the deaf people attending the sessions, the deaf therapist may end up sitting among the deaf family members—a rather undesirable seating arrangement. A further problem is that hearing family members sometimes oppose the

use of a sign language interpreter in family sessions, and this can impede the progress of the therapy (Harvey, 1989). A dual complication may arise if an additional language interpreter is needed alongside the sign language interpreter, as when part of the family is not fluent in Dutch, as might occur, for example, in families of mixed Arabic- and Dutch-speaking origin.

The therapist and the interpreter will also need to coordinate their working methods if the therapist decides to apply particular visual or physical techniques to induce a process of change in a family, for instance, by having family members to change seats during a session. The interpreter will likewise have to adjust to the altered communication situation and will sometimes have to unobtrusively go sit or stand somewhere else.

Ms B., a deaf woman, presented to us with severe depressive symptoms. Her feelings of gloom and emptiness kept her in bed for large parts of the day. The rest of her family consisted of her severely hearing-impaired husband and three hearing children aged 14, 11, and 8. The oldest was a girl, and the two others were boys. The youngest had learning difficulties and needed sustained attention. The therapist quickly suspected that the woman's individual problems were closely connected to a range of family problems. He decided to initiate family sessions. During these sessions, it became clear that the daughter had taken on the role of an auxiliary parent. She ran a large part of family life. Both parents allowed this to persist because of the father's demanding job and the mother's depression. In a first step towards addressing this unhealthy situation, the therapist asked each family member to take up a position in the therapy room that they felt corresponded to reality. This left the daughter sitting in the middle of the family. As the lines of communication had now been suddenly redrawn, the interpreter was forced to find a new place to sit or stand.

Interpreting in Group Therapy

In addition to the processes of "ordinary" group dynamics, group therapy with deaf clients produces specific new elements that operate directly or indirectly as

long as the group exists. Many such groups include clients who already know each other fairly well from the Deaf community. Some people have been to school together for shorter or longer periods or were even in the same class. This will always be a reality, since people in the deaf minority are basically just stuck with one another. It implies that therapists will always, often in an indirect manner, be confronted by unknown histories shared by clients, some of which are not always pleasant.

Ensuring a sense of safety in the group is therefore essential, and it is highly contingent on the interplay between the interpreter and the therapists—which can also serve as an example to the group members. Over time we have learned to create safety by taking certain measures before and during the therapy. We invite two clients to each introductory interview so they can get acquainted with the therapists and the steady interpreter. The latter can also take this opportunity to agree with clients on the desired interpreting method. This is necessary because of the wide differences in language and skills that can be expected between the group members.

In the first group session, we focus in considerable detail on how members should deal with confidential information they learn about their fellow group members during the sessions. We also discuss the roles and status of the therapists and the interpreter. To make all members feel obliged to respect the privacy of the other members, we have each of them to sign a secrecy agreement during the first session. They, the interpreter and the therapists, thereby pledge before all members of the group not to repeat anything about other group members to anyone outside the therapy.

During the sessions, the sense of safety within the group can be further enhanced if the interpreter exhibits “unambiguous group behavior.” Ways of underlining the interpreter’s role include the following.

- The therapists make it clear from the start that they, and not the interpreter, are in charge of conducting the session.
- During the group conversation, the interpreter clearly indicates which person has the floor; a sign-to-voice interpreter, for example, would state the person’s name and point to them.

- The interpreter makes sure to look at every group member separately while interpreting; otherwise, some members may feel less engaged and not take active part in the conversation.

- The interpreter stays alert to which people are wanting to say something.

Holding Meetings in a Mixed Hearing–Deaf Mental Health Team

The skills an interpreter needs during policy-oriented or client-oriented meetings are different from the situations described above. Different types of meetings also differ. Case consultations, for example, demand more knowledge of abstract mental health jargon and the associated signs and gestures. In policy meetings, the pace of discussion will be somewhat faster.

Sometimes the interpreter’s opinion may be needed. If so, it is important to avoid confusion arising from the dual role the interpreter thereby assumes—first expressing his or her own opinion, then translating it for the deaf participants. Engaging a second interpreter who can take over the interpreting work at that point is one way to ensure that everyone is clear about whose words are being translated. This has the added advantage of enabling the interpreters to alternate during meetings, giving each other a needed rest without slowing down the meeting.

Theme 3: Organizing the Interpretation Setting

This basic theme encompasses all the structural prerequisites that indirectly but effectively ensure the smooth working of the clients’ therapy sessions. A key point to remember is to clearly and visibly show how the clients’ privacy is being protected and what safeguards exist in legislation or in the professional codes of conduct of therapists and interpreters (Caccamise et al., 1980; NBTG, 2001). Deaf people can be highly sensitive about this issue, and many are well aware of how people can become victims of gossip within the deaf community. If interpreters and therapists discuss the confidentiality and privacy standards with their clients before the therapy begins, that will strengthen the clients’ trust, and the sessions will proceed more smoothly.

Ensuring Pre- and Postsession Reviews By the Therapist and the Sign Language Interpreter

In our search for viable collaborative models that do justice to the professionalism and equitable status of the therapist and the interpreter, we soon arrived at a working model like the one set out by Stansfield (1981). One of its vital components is the practice of pre- and postsession reviews by the therapist and the interpreter. The purpose of the pre-session is to review together the anticipated therapy situation and to gauge the various communication aspects involved. Issues to discuss include the choice of language modality, the clients' expected language level, the objective of the coming session, the therapist's intended intervention, and the ways the two professionals can communicate about these issues during the session.

The purpose of the postsession is to give the therapist and interpreter the opportunity to round off the session both technically and emotionally. Issues may arise here such as the quality of the interpreting work, the cooperation, the clients' communicative and other behavior, and distinctive oral components of sign language used by the clients. Beyond the informative nature of the postsession for the two professionals, an important added benefit to the continued collaboration is that they become increasingly familiar with each other's working methods, thus enhancing their mutual trust and helping them work better in tandem.

In a therapy with Ms P., the therapist found that although she herself could use Dutch Sign Language well to communicate with her client, she had considerable difficulty in reading the client's signs and mouth patterns. After consulting the client, the therapist decided she might work better if she engaged an interpreter for this purpose. In a preliminary consultation between the interpreter and the therapist, they agreed that the therapist would sign to the client, but that the client's answer would be voice interpreted by the interpreter.

This enabled the interpreter to report in the postsession that the therapist's level of language abstraction was too high for the client and also that the client did not complete many of her signs. They agreed on how to approach this in the next

therapy session. The interpreter was to give certain signals if the therapist's language became too abstract. She was also to translate the client's words and nonverbal components more literally than before.

This made the following session rather bizarre. The client was seen to give very tangential answers and to only halfway complete her sentences. This prompted the therapist to order a psychiatric examination.

Seating Arrangement of the Sign Language Interpreter and the Therapist

Stansfield's working model also emphasizes the seating arrangement of the therapist and the interpreter. This is a key factor in demonstrating that the therapist is the person leading the therapy. Obviously, there is a very real risk that clients will address themselves more to the interpreter than to the therapist, since the former makes more direct contact with them; the interpreter may thus become a more attractive discussion partner than the therapist. The arrangement most suitable for the therapist is one in which the interpreter is seated in a not too prominent place, but where the client can take in both the interpreter and the therapist in a single view. This effect is achieved by having the interpreter sit immediately next to the therapist, but slightly to the rear, and at the same elevation or even slightly lower.

In our practice, we do not rule out any other position either. Much depends on the cooperation and trust between the therapist and the interpreter. If they work well together, their interplay will be more natural, and the client will automatically be aware of who is leading the session.

Adapting to a 'Mobile' Therapist

The ways of conducting therapy vary not only by therapeutic tradition or technique but also from person to person. There are therapeutic techniques that are oriented to

- visualizing the problems or insights, as by drawing genograms on a whiteboard;

- taking up positions in the therapy room, as in the family photo technique, whereby family members are to position other family members in the room to depict their emotional distance or proximity to one another; and

- tactile elements or various forms of play.

Some therapists like to move around the room themselves, using tactics such as walking over to a client or sitting down next to them.

The family sessions we conduct are often driven by the spontaneity of the therapy, notwithstanding the general planning in advance. For the collaboration between the therapist and the interpreter, this once again means that they need strong confidence in each other to adapt to the unexpected twists that may occur in therapy sessions. Harvey (1989) has described this as a “unique dance” between the interpreter and the therapist.

In a relationship therapy with a deaf married couple and our steady sign language interpreter, we asked the couple to take up positions in relation to one another in the therapy room according to their perceptions. Each went to stand in an opposite corner of the room. This created a situation in which the wife was likely to lose contact with the therapist if the latter walked over to the husband to discuss why he had gone to stand there. This forced the interpreter to choose a different position in the room too, in order to safeguard the communication and information flow to all parties.

Theme 4: Managing Therapeutic Phenomena

Psychotherapy is usually accompanied by a number of peripheral phenomena, which, though intrinsic to therapy, are often not directly related to the client’s presenting problem. These therapeutic phenomena, many of which involve behaviors on the part of the client, may evoke feelings of incomprehension, anger, compassion, or frustration. Psychotherapists learn to manage such phenomena during their training or in professional supervision. Interpreters working in therapy sessions automatically face these phenomena, too, but they are unable to address them because of their position in the therapy and their lack of appropriate

knowledge and skills. This difference in knowledge and skills can interfere with the cooperation between therapists and interpreters, and it therefore needs to be discussed in pre- and postsession reviews. We will now examine some common therapeutic phenomena from the interpreter’s perspective.

Transference and Countertransference

A common and widely discussed phenomenon in therapy sessions is feelings of transference and countertransference (Freud, 1936/1994), which can develop in both clients and therapists during the course of the therapy. Transference phenomena may manifest themselves in a variety of ways; they may consist of resistance, acting out, or sexually charged behavior. In cases where the therapist succeeds in dealing adequately with transference, the interpreter may be a prime target for it. The neutral position of interpreters puts them right in the middle of the emotional exchanges between a therapist and a client. This makes them an unintended part of the described mechanisms, which may also be further fuelled by emotions experienced by the interpreter during a therapy session (Dematteo, Veltri, and Lee, 1986). The interpreter risks becoming emotionally overstrained, with potential adverse effects on the therapy. Issues of transference and countertransference therefore merit attention in pre- and postsession reviews, work planning meetings, and professional supervision sessions undergone by the therapist and the interpreter together.

Coalitions and Alliances

Another therapeutic phenomenon, mainly in individual therapies, may occur when the therapist, interpreter, or client gets the feeling that the other two have formed an alliance against her or him. In the most extreme form, situations are known in which sign-to-voice interpreters have translated answers differently than the client gave them to ensure the client’s eligibility for benefit. High-risk situations for the forming of alliances are present when

- an interpreter is engaged who is unfamiliar with interpreting in mental health care, but who already

knows the client from other interpreting situations (Bot, 1998);

- interpreters unconsciously subdue or intensify nonverbal elements they use in interpreting, for example, when they reinforce a client's behavior through subtle eye contact, thereby potentially weakening a therapeutic intervention made by the therapist;

- an interpreter and a client have met each other previously outside the therapy, for instance, in the waiting room, or the therapist exits the therapy room to consult with someone outside, leaving the interpreter behind with the client; and

- a therapist experiences needing to work with an interpreter as a personal failure; unconscious behavior on the part of the therapist can then help induce coalition formation between the interpreter and the client (Baxter & Cheng, 1996).

Learned Helplessness

Not uncommonly, deaf people have been viewed as disabled in their childhood families and, consequently, as helpless people in serious need of assistance (Harvey, 1984). The message is that others can solve their problems much better than they themselves can. This "learned helplessness" can be so deeply ingrained that our deaf clients seem incapable of carrying out even the simplest assignments at some points in the therapy. Both clients and family members can impress this "helplessness" on the therapist in very persuasive ways. This phenomenon can be a pitfall for interpreters, too, who may inadvertently translate a client's statements to make them sound more intense than the client actually means them. By approaching this strategically, however, the therapist can actually utilize the interpreter to reverse the family members' perceptions.

Hank, a prelingually deaf man with maladaptive behavior, was a cause of despair and great concern to all those around him. He still resided with his single mother, and he frequented the local deaf club, where he was prone to get plastered. Hank was what one calls a "mean drunk". He would become course and quarrelsome towards his mother and had already thrown a good deal of

the household furnishings out the window. Hank and his mother were referred to us by the crisis services. To create a broader forum in view of the apparent severity of the problems, we invited Hank, his mother, and his three brothers (who no longer lived at home) to discuss how serious the situation was. Our interpreter was present too—much to the mother's displeasure. She felt no interpreter was necessary, because Hank could actually lip-read quite well and because he also needed to do his best. We insisted on the interpreter because we wanted to handle these contacts as carefully as possible. The mother gave up her opposition to the interpreter, and when Hank, via the interpreter, began to show a completely different side of himself, the mother became convinced that the interpreter was essential. It became clear during the conversation that Hank was actually not pathetic or helpless at all but was a disagreeable, stubborn man who did exactly as he pleased. He was also fully capable of expressing what he wanted and did not want. This gave a new turn to the conversation. It now became feasible, even in the eyes of the family, to make entirely different demands on Hank. As expected, Hank was not very happy about this.

Conclusion

The basic themes discussed here have been generated in our long years of collaboration. We have had to seek solutions to problems we ran up against in our therapeutic practice but did not encounter in the literature. We have grown into our current model quite naturally as a result of our mutual respect and our desire to listen attentively to each other's contributions.

This meant making strenuous demands of one another, as we were also intent on shaping our conception of sign language interpreting as a specialism in mental health care. It is a profession that puts heavy demands on the knowledge and skills of the interpreters. As well as having an excellent mastery of their own trade with all its language options and modalities, interpreters must also have a basic knowledge of subjects like psychopathology, diagnostic practice, and different types of therapies (Adams, 1989). Mental health workers are

sometimes faced with extreme situations that require good stress-management skills. They must regularly adapt from one extreme to the other—from explosive and bizarre behaviors on the part of clients to therapists' conferences rich in professional jargon (Taff-Watson, 1984). Maceachin (1982) was therefore right to observe that the profession of mental health sign language interpreter is a demanding one.

We are nevertheless convinced that psychotherapy with deaf people can be strengthened at certain points by the presence of an interpreter. A vital prerequisite for this, however, is that the interpreter and the therapist have succeeded in building a rigorous collaborative partnership based on a keen sensitivity to each other's meanings (Harvey, 1989). Only then will the argument lose its force that an interpreter's presence threatens the trust and intimacy within the therapy. Important premises are to work with a steady interpreter and to ensure that both the therapist and the interpreter hold identical conceptions about the status and role of the interpreter.

References

- Adams, J. (1989). *Interpreting in psychiatric settings*. A training course for social workers with deaf people. Department of Psychiatry for the Deaf, Whittingham Hospital, Preston, NJ.
- Baxter, H., & Cheng, L. Y. (1996). The use of interpreters in individual psychotherapy. *Australian and New Zealand Journal of Psychiatry, 30*, 153–156.
- Bot, H. (1998). Werken met tolken in psychotherapie [Working with interpreters in psychotherapy]. *Tijdschrift voor Psychotherapie, 24–25*, 311–326.
- Caccamise, F., Dirst, R., DeVries, R. D., Heil, J., Kirchner, C., Kirchner, S., et al. (1980). *Introduction to interpreting for interpreters/transliterators, hearing-impaired consumers, hearing consumers*. Silver Spring, MD: Registry of Interpreters for the Deaf.
- de Bruin, E. (1997). Netwerkhulpverlening aan dove mensen [Network mental health care for the deaf]. *Maandblad Geestelijke Volksgezondheid, 6*, 621–632.
- de Bruin, E., & Brugmans, P. (2001). When professionals meet in therapy. *Proceedings of the ESFLI Conference Raising the Profession* (pp. 24–27). Zandvoort, Netherlands: NBTG.
- Dematteo, A., Veltri, D., & Lee, S. M. (1986). The role of the sign language interpreter in psychotherapy. In M. L. McIntire (ed.), *Interpreting: The Art of cross-cultural mediation* (pp. 183–206). Silver Spring, MD: Registry of Interpreters for the Deaf.
- Freud, A. (1994). *Das Ich und die Abwehrmechanismen [The ego and the mechanisms of defence]*. Frankfurt am Main, Germany: Fischer. (Original work published 1936.)
- Harvey, M. (1984). Family therapy with deaf persons: The systemic utilization of an interpreter. *Family Process, 23*, 205–221.
- Harvey, M. (1989). *Psychotherapy with deaf and hard of hearing persons: A systemic model*. Hillsdale, NJ: Lawrence Erlbaum.
- Karlin, B. (2001). *Caught in the middle still*. Paper presented at the 5th conference of the ESMHD, Copenhagen, Denmark.
- MacEachin, A.D. (1982). Experiences of a psychiatric interpreter. *The Reflector, 3*, 17–20.
- Mahler, P., & Waters, J. E. (1984). The use of interpreters with deaf clients in therapy. *Journal of Rehabilitation of the Deaf, 17*, 11–15.
- Nederlandse Beroepsvereniging Tolken Gebarentaal. (2001). *Beroepscode Tolken Gebarentaal [Code of ethics for interpreters]*. Zandvoort, Netherlands: Author.
- Stansfield, M. (1981). Psychological issues in mental health interpreting. *RID Interpreting Journal, 1*, 18–32.
- Taff-Watson, M. (1984). *Sign language interpretation in mental health settings: Strategic perspectives*. University of Arkansas, Little Rock, AR: Internal Publication.
- USCF. (1987). *Guidelines for mental health professionals. Applications from UCCD*. University of California, San Francisco: Center of Deafness, RT-23.

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