"Umm, the Interpreter Didn't Understand": Interpreting for Individuals with Thought Disorders

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"Do you enjoy reading?"
You interpret the question and look dumbfounded as your deaf client responds "BOOK, [STACK OF 3] OPEN-BOOK CUT(around) PAINT DELICIOUS." Did I miss something? You're processing hard; the client repeats "UNDERSTAND? BOOK [STACK OF 3] OPEN-BOOK, CUT(around) PAINT, G-L-U-E DELICIOUS!"

Welcome to the world of thought disorders! This article will outline several types of communication errors associated with thought disorders identified in deaf people with schizophrenia. It will also provide ideas for how to work effectively when facing this challenge.

In a study investigating the differences in communication of healthy deaf people and deaf individuals with schizophrenia, both sets shared 29 kinds of errors in signed expressions (Thacker, 1998). Of these, six were found at significantly higher rates in the group with schizophrenia. These are: clang, illogicality, sign perseveration, stereotypy, topic derailment, and topic perseveration. Three other kinds of errors – incoherence, paraphasia, and visuo-spatial anomalies – appeared only in the expressions of those with schizophrenia. What do these errors look like?

Types of Errors

Clang: A string of signs incorrectly produced with one handshape. The sentence MY CHILD WONDERFUL GOOD is signed using only the open B handshape. But sign this sentence using only the open B handshape: THAT CAR PARKED CRAZY STRONG GREEN. The first sentence makes sense using just one handshape, however the meaning of the second one, if the same handshape is used for each sign, is unrecognizable. The latter is an example of clang.

Illogicality: Conclusions do not connect in a logical manner to previous statements, for instance, "I have a cold because my brother went to work." While both parts of the statement may be true, neither is dependant on the other.

Sign Perseveration: A sign or series of signs is repeated more than three times for no apparent reason. Typically, signers repeat words or phrases for emphasis or clarification. In sign perseveration there is no evident reason for the repetition.

Stereotypy: The frequent production of a specific sign or gesture in inappropriate contexts not for communication purposes, but for self-stimulation. Some examples are pointless hand movements, pacing, rocking, repetitive blinking, and vocalizations. These differ from the other language errors, such as sign perseveration, because they are caused by different parts of the brain.

Topic Derailment: Changing topics in mid-discourse. To illustrate: MY GRANDMOTHER VERY SICK, I HOPE SHE BETTER SOON. I GO THAT BIG STORE BUY SHOES. The two sentences are on completely different topics, there is no clear connection between them.

Topic Perseveration: Inappropriate insertion of signs related to a theme rather than to the context. For example, a person would insert words into a dialogue related to animals, food, or any such theme. Thacker gives this example: MYSELF CLEVER MOUTH CLEVER SPEAK SIGN SPEAK MOUTH <u>TEA FOOD</u> S-A-R-A-H. SOME NURSE <u>FOOD</u> THERE BAD <u>EAT</u> HERE SAW <u>C-H-E-S-T-N-U-T</u>. NO DIFFERENT ME SAY NO BAD BOY SAY DIFFERENT <u>W-A-L-N-U-T</u>. The underlined words belong to the same topic but do not fit the rest of the statement.

Incoherence: A series of unrelated signs or individual gestures that can't be identified as signs. Grammar and syntax are deficient.

Paraphasia: Gestures are produced but are not signs, though the target sign may be discernible. For hearing people, this can include mispronouncing or adding syllables in words, (i.e. telenephone instead of telephone) or using the wrong word ("picture" rather than "telephone"). In sign language, aspects of the sign are missing or incorrect; handshape, movement, or location will be wrong. Grammar and syntax are intact although the overall message is incomprehensible.

Visuo-Spatial Anomalies: A misuse of signing space (signs are produced on one side of the body, and do not cross the midline; in the air instead of touching the body; or other misuses,) or using a non-linguistic element in place of a sign. Thacker gives the example of a subject grabbing her own hair to signify "thatched roofs" in her neighborhood.

These errors, depending on type and frequency, indicate types of thought disorders. ASL poets strive to create verses using the same handshape. An individual with schizophrenia might effortlessly produce such a string of words, however it will not make sense and they typically cannot reproduce it.

Also, keep in mind that a high percentage of healthy deaf people have numerous communication errors. Only incoherence, paraphasia, and visuo-spatial anomalies were

found exclusively in the BSL users with schizophrenia in Thacker's study. Illogicality, for example, a primary symptom of schizophrenia in hearing people, was found to be a fairly common error for healthy deaf people in the study (57%).

"What do I do?"

When encountering a situation similar to the one at the outset of this article your natural reaction might be "What was that?!" What do you do?

Instead of screwing up your face and feeling stupid, trust your own skills. Mental health assignments require an interpreter who excels expressively and receptively, of course, but also one with experience in differentiating between language and nonsense. This is not your run-of-the-mill job. In a survey in Belgium, Timmermans (1989), found the average length of stay for a hearing person admitted into a psychiatric facility is 148 days. On the other hand, average length of stay for a deaf patient is 19.5 years! While inexperienced interpreters are not the only cause of lengthier stays, they are a factor. If you're in this setting you should have the skills. If you don't have confidence in yourself and experience in this specialized field, don't accept the assignment.

When facing schizophrenic sign, the message is not often as important as the cognitive process it reveals. That means your voicing "I am Jesus Christ, and I am very smart and can fly" might not be as useful to a clinician as you saying "He appears to be talking to someone invisible to us. He is telling them 'I am Jesus Christ. I am very smart and can fly.'" While the message provides some insight into the patient's thinking, you can bet it's not the first time the clinician has heard it, and it's probably not the last. He isn't worried primarily about the words, but needs information about how the statement was made. This allows a better understanding of the person's thought processes. But, is it your right to form and voice an opinion of the person's language use and emotional affect?

The RID Standard Practice Paper, "Interpreting in Mental Health Settings", states: "The interpreter can provide information and opinions related to the communication process, but not on the therapeutic process." In harmony with this statement, our Code of Ethics says, "Interpreters/transliterators shall not counsel, advise or interject personal opinions." Those two principles provide guidance as to how to handle ourselves. We are to provide information and even professional opinions on language and its unusual use between cultures. (Remember, there's a difference between a personal opinion and a professional opinion shaped by training, education and experience.) To the clinician all sign language looks equally odd. We are responsible to note if it is unusual and in what way. But the meaningfulness of that language as a diagnostic tool, that remains the province of the clinician.

What are the differences between opinions on the communication process and the therapeutic process? When developing your opinion ask yourself some questions. Is what I'm going to say related to the person's language? What was odd or incorrect about their language use? Do I have specific examples of their odd or incorrect use to justify my opinion or is it just my impression? These are questions that can help you read the dysfluencies in their language, and assess for errors.

Here's what NOT to do. Do not provide your diagnosis of the client. For example, don't say "He's hallucinating; he's signing to someone who isn't there," or "She is very incoherent. She's decompensated since the last time I worked with her." These are therapeutic opinions. We may we think they are statements of obvious facts but they actually are assumptions. You could say "He is signing to someone who isn't there" or "Her signing is less coherent than when I was here last Monday. The signs are not as well formed and her grammar is poor," and leave it at that. It's not our place to provide an explanation of WHY they are expressing themselves in a particular way, it is up to the clinician's discretion to make notes or explore further. Ensuring you don't step out of your role takes practice. Be sure that your opinions deal exclusively with language use, not about the consumer's state of mind, feelings, or thinking process.

Who is the "clinician"? That depends on the location of your assignment. In an inpatient setting you would want to talk with whoever is responsible for the person's treatment. Perhaps you note something during group therapy. The first person you'd want to talk with is the group leader after the session. In some cases there is a designated contact person on the treatment team, often a social worker. In other cases a psychologist may be a patient's individual therapist. You'd want to talk to them as well. You can offer to make notes of your observations for inclusion in the patient's chart. If you're substituting for a regular staff interpreter you'd want to leave a note for them about what you observed and what course of action you took. They're more familiar with the language of the client and have a better rapport with those responsible for treatment. In outpatient therapy, simply tell the therapist in your post-conference.

Conclusion

Thought disorders are manifest through numerous kinds of communication errors. There is very little research on thought disorders and deafness which makes it difficult to prepare for every type of error. Familiarizing yourself with the types of communication errors identified and having strategies ready to deal with them will help you face them.

References

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