Interpreting in mental health settings: Issues and concerns
McCay Vernon; Katrina Miller
American Annals of the Deaf; Dec 2001; 146, 5; Research Library
pg. 429

INTERPRETING IN MENTAL HEALTH SETTINGS: ISSUES AND CONCERNS

Sign language interpreters in mental health settings face extreme linguistic and cultural difficulties in interpreting basic, everyday language used in these settings. This is particularly true when deaf clients have limited English proficiency, which often requires interpreters to use expansion techniques in order to render messages successfully . To examine how diagnostics may be affected by interpretation, Brauer (1993), Montoya et al. (2001), and Steinberg, Lipton, Eckhardt, Goldstein, and Sullivan (1998) translated two widely used psychological screening instruments into American Sign Language (ASL). The Minnesota Multiphasic Personality Inventory (MMPI) and the Diagnostic Interview Schedule-IV (DIS-IV) were selected for translation, and data from the three studies are presented and discussed. Their implications in terms of the expectations and stresses placed on interpreters are described within a framework of demand and control theory. Finally, sections of the Code of Ethics of the Registry of Interpreters for the Deaf (RID) are examined relative to both the issue of confidentiality and what the interpreter's contribution should be in mental health settings.

MCCAY VERNON AND KATRINA MILLER

Vernon is chairperson of the Advisory Council for the National Deaf Academy, Mount Dora, FL. Miller is an assistant research professor at the Rehabilitation Research & Training Center for Persons Who Are Deaf or Hard of Hearing, University of Arkansas at Little Rock.

Interpreters play a critical role in the provision of mental health services to the deaf (Reisman, Scanlon, & Kemp, 1977; Vetri, 1993; Williams, 1993). Interpreters are essential because few mental health professionals such as psychologists, psychiatrists, and social workers are able to sign (Pollard, 1998).

Not only are interpreters vital professionals in the mental health field, but the task they face is far more difficult than most people realize, including mental health professionals and their patients.

Interpreting between English and American Sign Language (ASL) presents specific linguistic difficulties for interpreters (Brauer, 1993; Gerber, 1977; Montoya et al., 2001; Steinberg, Lipton, Eckhardt, Goldstein, & Sullivan, 1998). ASL is rooted in Deaf culture, that is, the life experiences of deaf people (Dean & Pollard, 2001). Even though some concepts are more easily and more vividly expressed in ASL than in English, deaf people historically have been largely excluded from psychiatry and psychology as well as other professional fields such as law and medicine. Thus, the terminologies of these fields have not yet evolved in ASL (Dean & Pollard, 2001). Hence, there are often no concise signs for the words used in psychology or psychiatry. For example, the term *self-esteem* cannot be used with undereducated deaf individuals unless the meaning of the term is first explained in depth. Interpreters refer to this technique as "expansion." It requires both extra time and an interpreter who is knowledgeable about mental health. In addition, the English syntax is frequently different from ASL in ways that make interpreting extremely difficult.

While few interpreters would doubt the

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

truth of what has thus far been presented, recent research not only documents the problem but also describes its magnitude (Montoya et al., 2001; Steinberg et al., 1998). First, consider the work of Montoya et al. (2001) on the Diagnostic Interview Schedule–IV (DIS-IV). This is a standardized mental health questionnaire used to identify different kinds of mental illness. It is similar to the Minnesota Multiphasic Personality Inventory (MMPI), with which most people in the mental health field are familiar. It asks a series of questions about a person's everyday life, such as "Do you feel on edge?" "Have you more than once hit your wife?" "Do you hear voices?" "Do you have the feeling that people are talking about you?" and "Have you ever crossed the street to avoid meeting someone?" When translating these questions into ASL, it is impossible to retain the English form. This is generally true for other foreign-language translations as well. For example, take the terms *Chevy Nova* or *Coca-Cola*. General Motors, the manufacturer of Chevrolet automobiles, was unsuccessful in marketing the Nova in Latin America because, in Spanish, *no va* means "it won't go." In Japan, Coca-Cola had to retranslate its product name into "happiness in the mouth" because *Coca-Cola* translates into a nonsensical phrase in the Japanese language. A similar problem exists with English-to-ASL translations.

Therefore, questions on the MMPI and DIS-IV can only be interpreted "content-for-content." This means that an equivalent ASL sign for the English concept will be used, depending on the content of the passage that is being interpreted. Selection of this sign is in many cases a subjective judgment; hence, concepts will often be translated somewhat differently by each interpreter. To represent the concept of "on edge," an interpreter may use a sign or combination of signs, such as NERVOUS, SCARED, CRABBY, IRRITATED, or UPSET. Interpreters may also fingerspell English words that are difficult to translate, a process that retains the form (English) but not the content. The words produced in this way are meaningless to deaf people who are undereducated or are nonfluent in English. In most cases, the English form of the psychological term must be discarded altogether if an equivalent meaning is to be relayed to the average client using ASL.

Additional difficulties relating to questions of a psychological nature stem from how deaf people use language, or their communication style. Many deaf people provide a substantial amount of background information to each other when conversing (Mindess, 1999). The purpose of this informational exchange is to establish a common set of references. Similarly, deaf people in mental health settings will want to know the context in which a question is being asked: For instance, do they feel nervous or edgy in relation to what? Are they edgy now, or were they edgy earlier? Did a mother-in-law make them nervous, or was it traffic on the way over? Without expansion, or more specific background information, even yes-or-no questions may not be clearly understood by clients. However, in a mental health situation, providing expansions of this nature can have the undesired side effect of influencing the client's responses, particularly for those clients who have a habit of agreeing with whatever is being said, either because they do not understand the question or because they just want to get through the intake process. In the case of undereducated deaf people, one would almost need to enroll deaf mental patients in a preparatory class prior to evaluation and therapy, a process sometimes mandated for semilingual deaf defendants to prepare them linguistically for adjudicative processes such as trials, plea bargains, and contracts (Davis, 1993).

Translation of the DIS-IV

The DIS-IV is a widely used instrument that has already been translated into 25 languages. In 1978, the National Institute of Mental Health decided that it should be put into ASL so that it might be used with deaf people.

A highly sophisticated research team was put together that included, among other professional personnel, certified deaf and hearing interpreters, mental health specialists, and bilingual-bicultural researchers, all of whom knew both ASL and English (Montoya et al., 2001; Steinberg et al., 1998). What initially seemed a relatively simple task turned out to be extremely difficult. To ensure that the items were interpreted in a clear, understandable way, they were back-translated. This means that an item was first signed to a deaf individual. The deaf person then signed it to another person who was fluent in sign language and who did not know the question. If that person could then write or sign the original question accurately, that proved that the interpreting was understandable to the deaf person to whom it was originally signed.

Despite all the assembled expertise, a substantial amount of grant money, and about a half-decade to work on the project, the researchers had only limited success. Ultimately, they were able to interpret the DIS–IV adequately enough for it to be understood by a group of deaf people consisting entirely of fluent signers, and 41% of whom had had some postsecondary education. This was obviously an elite, relatively well-educated group compared to the general population of deaf people, only 9% of whom have any postsecondary education (Montoya et al., 2001).

Translation of the MMPI

A similar effort was made to interpret the MMPI into ASL. The MMPI consists

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

of 566 basic questions of the kind asked during the diagnosis of mental patients. This research on the MMPI was done by Barbara Brauer (1993), a deaf psychologist.

It takes a hearing person approximately 42 minutes to read the questions on the MMPI aloud. The ASL version developed by Brauer took about 2 hours for a deaf person to sign (Brauer, 1993). The deaf sample she used consisted of deaf professionals working at Gallaudet University (25%) and deaf Gallaudet graduate students (75%). In addition, 25% of her sample were the children of deaf parents, who generally exhibit superior language skills in both English and ASL. Getting the translation of the MMPI into a form understandable to this highly sophisticated group took Brauer and her colleagues several years.

The Problem of Interpreting in Mental Health settings

The Montoya et al. (2001)/Steinberg et al. (1998) and Brauer (1993) studies, both done by nationally prominent scholars, vividly illustrate that interpretation of even the relatively simple psychological terminology of the MMPI and the DIS-IV for a relatively sophisticated segment of the deaf population took years to get right. Achieving the level of comprehension of the MMPI obtained by Brauer required that the test takers be deaf graduate students and deaf professional people. The average deaf person, by contrast, has a fourth- to fifth-grade education. Thirty percent of the deaf are functionally illiterate (Vernon & Andrews, 1990). Because of language deprivation, neurological disorders, or other developmental delays, an estimated 20% of the deaf population is using language and other forms of communication that are nonstandard (Miller, 2001). Ironically, it is individuals who represent these latter populations whom interpreters in mental health settings see most often. These issues illustrate how extremely difficult it is to interpret accurately the terminology involved in psychotherapy and other psychological and psychiatric discourse between mental health professionals and deaf patients. Furthermore, an interpreter is asked to do the translation simultaneously, not over a period of years, as did the scholars who interpreted the MMPI and DIS-IV.

It is beyond the scope of the present article to go into detail on the type of linguistic structures that pose specific problems, but examples include time concepts, English idioms, hearing-specific phenomena, category words, and English concepts that are especially complex.

One final point regarding the difficulty of mental health interpreting: This type of interpreting involves more than translating between two languages (Pollard, 1998). It requires forming a bridge between two cultures and usually between two very different types of individuals, that is, the mental health professional and the deaf person who is the patient.

It is important to realize that it is humanly impossible to interpret complex mental health discourse simultaneously with sufficient accuracy to meet the criteria of back-translation without a period of preparatory education with the interpreter and client. ASL is too different from English and too lacking in vocabulary and the syntactical structures of English to make such accuracy possible. This does not necessarily mean that ASL is inferior syntactically to English, just different. A skilled sign language interpreter does not use the syntactic structure of English to provide an equivalent interpretation, but the interpreter does need an advanced understanding of the field of psychology, and fluency in both the target language (ASL) and the source language (English). As we indicated earlier in the present article, ASL vocabulary is not as developed as English vocabulary in relation to technical fields such as mental health, but this is only because deaf people have not had the same exposure to mental health terminology that hearing people have had (Steinberg, 1991). Interpreters, mental health professionals, and patients need to know that what is interpreted in mental health settings is often not the exact same thing that was said. But hopefully it is at least a close approximation that conveys the basic concepts. Interpreters have sensed this all along, but perhaps not fully realized the degree to which it is true.

Most thinking on the difficulty of interpreting mental health material assumes most of the deaf clients in mental health settings are within the average range of intelligence and have an educational achievement level of fourth to fifth grade or below. For the upper 25% of deaf clients who have relatively good English and a larger vocabulary, interpreting is obviously much easier (Vernon & Andrews, 1990). But, as Montoya et al. (2001) and Brauer (1993) indicate, even under those optimal conditions, if accuracy is to be achieved, the process takes about three times as long in ASL as in English.

One way to address the problem is by using more consecutive interpreting and less simultaneous interpreting (Vernon & Miller, in press). *Consecutive interpreting* is a technique in which the interpreter does not provide the interpretation until the person's entire thought is completed, thus improving accuracy and providing for the structural differences between ASL and English. For example, negation often comes at the end of a communication in ASL, while in English it is evident at the start of communication. Generally speaking, interpreters and deaf clients prefer consecutive interpreting. However, therapists and mental health professionals often feel that they lose control of the situation or that too much time is consumed when

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

consecutive interpreting is used.

Stress and Mental Health Interpreting

The best recent work on stress in mental health interpreting has been done by Dean and Pollard (2001). These researchers took the concept of *demand and control theory* from industrial psychology and applied it to interpreting. By *demand they* mean the requirements of the job the individual has to perform and the work environment. *Control* refers to the extent to which the interpreter has the power to act upon the demands of the job by using her or his interpreting skills or by changing the environment.

For example, assume a skilled interpreter is working in a situation involving a homicide case in which a plea of insanity has been offered as a defense. The defendant in this case is an illiterate mental patient who depends on nonstandard or underdeveloped ASL to communicate. In addition, he is highly emotional. Second, the judge resents the interpreter's presence, is insistent on a fast trial, and thinks all deaf people can lipread and understand the law. In such a situation, the demands are impossibly high and the interpreter has few, if any, controls. The result is total stress and frustration.

Contrast this setting with one in which the interpreter has the same defendant, but the judge has deaf parents, realizes the case will move slowly, and is willing to make the adjustments the interpreter feels are necessary. As an added advantage, the interpreter has a qualified deaf relay interpreter or certified deaf interpreter with whom to work.

In this latter hypothetical case, the demands remain high. A life is at stake and the case is legally and psychologically complex. However, because the interpreter is good and has the controls needed to do the job, the situation can be highly satisfying.

Thus, true job satisfaction comes both when the demands are high and the interpreter has adequate controls. A good balance between job demands and control is essential to job satisfaction.

Some common causes of interpreter job stress identified by Dean and Pollard (2001) and ourselves include:

- inadequate training for the realities of the job
- lack of professional support after graduation
- unduly high expectations of the interpreter
- involvement in emotion-laden situations
- seeing deaf people being treated unfairly but being unable to protect themselves
- interpreting for a psychologist who knows nothing about deafness but thinks he or she knows everything and is crude and insensitive to deaf people

Registry of Interpreters for the Deaf (RID) Guidelines and Ethics

Questions need to be raised about parts of the Registry of Interpreters for the Deaf (RID) Code of Ethics (1996). The guidelines state: "The interpreter's only function is to facilitate communication." In mental health and most other interpreting situations with undereducated and unassertive people, this wastes half of what an experienced interpreter has to offer. It uses the linguistic half and wastes the interpreter's insights into Deaf culture. It also takes away a potential source of great satisfaction for the interpreter.

Most of the time in a mental health setting, the interpreter is going to be working with a psychologist, psychiatrist, or social worker who does not know nearly as much about deafness, Deaf culture, and ASL as the interpreter does. Most interpreters have a wealth of information on issues of relevance to the mental health professional, such as:

- differences between ASL and English
- the need for expansion when interpreting
- the relative merits of consecutive interpreting and simultaneous interpreting
- educational levels of deaf people
- the fact that poor English skills do not necessarily mean low intelligence

This information and related data can be vital to treatment and is lost if "the interpreter's only function is to facilitate communication." A broader interpretation of what "facilitate communication" means is needed. For example, the interpreter's knowledge can and should be shared with the mental health professional with whom she or he is working. This is best done before or after treatment sessions. If this is not possible, the interpreter can at least give the psychologist or therapist some literature on deafness to read. With several journals now devoted exclusively to interpreting (such as *Views* and the Journal *of Interpreting*), and other journals in deafness now including more articles on interpreting, there is plenty of good material available.

Confidentiality

One of the more controversial issues in interpreting is confidentiality. For

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

example, suppose an interpreter is involved in a psychological evaluation of a deaf client for the purpose of vocational rehabilitation. The interpreter has worked with this client many times before and knows his work history, educational background, level of involvement in the Deaf community, hobbies, etc. All of this information is vital to a good vocational evaluation. In some cases, it may be appropriate for the interpreter to ask the client beforehand if it is all right to share this information with the psychologist, or else ask the client to share it himself. If the client agrees to let the interpreter relay the information, the interpreter can then tell the psychologist that she knows the client well and that the client has stated that the interpreter may share relevant background information with the psychologist. If the psychologist agrees, the interpreter then offers the information to the psychologist in ASL and speech in front of the client. In fact, this is already occurring with deaf clients who ask the interpreter to help explain their situation because they are tired of repeating their story to various mental health workers, or because they do not have the ability to distinguish pertinent information and present it to the examiner.

Often, undereducated clients are unaware of which items of historical information should be volunteered. If the interpreter can assist in a way that does not diminish the client's power, this input could be valuable. On the other hand, interpreters also need to realize that there are things that deaf clients may wish to withhold from their therapist, or information that they are not yet ready to reveal. Deaf clients have the right to set the pace of their therapy, or to participate less than fully in a therapeutic relationship, just as hearing clients do.

Additionally, the continued use of the same interpreter in therapy sessions is an excellent idea. The interpreter will have access to the client's therapeutic history, understand the goals of the treatment, and have a growing and intimate knowledge of the communication skills and style of the client. Advanced background knowledge of a client also provides the potential to greatly enhance the accuracy of the interpretation. The consistency provided by a regular interpreter can also eliminate wasted therapy time used to resolve communication issues, as well as reduce frustration or anger around communication issues that can otherwise impede a therapeutic relationship. In short, the interpreter can become a regular part of the treatment team rather than a distant and changing third party.

In situations such as a psychological evaluation for vocational rehabilitation or an intake interview at a mental health facility, the purpose is diagnosis. In most instances, good psychological diagnosis is 85% case history and 15% psychometrics. Often in these situations the psychologist will never see the client again, will be given little or no case history data, and will have only an hour or so to complete the evaluation. In a mere 5 or 10 minutes, the interpreter can provide information of tremendous value to both the client and the psychologist. Such information can have a profound impact on the deaf client's future.

Another issue involving confidentiality has to do with conferring with professional colleagues about a case. When visiting a doctor for a physical examination or about an emotional problem, most patients see no problem with the doctor going to a colleague or supervisor to discuss the case and obtain help. RID's rather rigid rules on confidentiality preclude such consultation, however (Dean & Pollard, 2001). This limits interpreters' opportunities for growth because mental health professionals can learn a lot from interpreters. Conferring with colleagues and supervisors regarding cases can benefit both the client and the interpreter.

Because the Deaf community is so small, confidentiality is a huge issue. Therefore, cases should be discussed with professional colleagues only with very specific permission from the client or under circumstances in which the client's anonymity can be assured.

Interpreters have information about Deaf culture and specific deaf individuals that can be of critical value to the client or patient. In addition, sharing such information can bring much greater job satisfaction to the interpreter and facilitate the work of the mental health professional. Dean and Pollard (2001) discuss this issue in some depth. The key issue is that the interpreter's skills and the information the interpreter possesses should not be wasted, but be put to use for the good of all parties involved in mental health settings.

References

Brauer, B. (1993). Adequacy of a translation of the MMPI into American Sign Language for use with deaf individuals: Linguistic equivalency issues. *Rehabilitation Psychology, 38*(4), 247-260.

Davis, L. (1993). Prisoners of silence. *Nation, 257*, 354.

Dean, R. K., & Pollard, R. Q. Jr. (2001). Application of demand-control theory to sign language interpreting: Implications for stress and interpreter training. *Journal of Deaf Studies and Deaf Education, 6*(1), 1-14.

Gerber, B. M. (1977). Interpreter effects with deaf patients. *American Journal of Psychiatry, 130*(7), 990.

Miller, K. R. (2001). *Forensic issues of deaf offenders*. Unpublished doctoral dissertation, Lamar University, Beaumont, TX.

Mindess, A. (1999). *Reading between the signs*. Yarmouth, ME: Intercultural Press.

Montoya, L. A., Eguatovitch, R., Eckhart, E., Goldstein, M., Goldstein, R. H., & Steinberg, A. G. (2001). *Translation challenges and strategies: ASL translation of a computer-based psychiatric diagnostic interview*. Unpublished manuscript.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Pollard, R. Q. (1998). *Mental health interpreting: A mentored curriculum.* Rochester, NY: University of Rochester School of Medicine.

Registry of Interpreters for the Deaf. (1996). *Code of ethics. Silver* Spring, MD: Author.

Reisman, G., Scanlon, J., & Kemp, K. (1977). Medical interpreting for hearing-impaired patients. *Journal of the American Medical Association, 237*(22), 2397-2398.

Steinberg, A. (1991). Issues in providing mental health services to hearing-impaired persons. *Hospital and Community Psychiatry, 142,* 380-389.

Steinberg, A. G., Lipton, D. S., Eckhardt, E. A., Goldstein, M.,& Sullivan, V. J. (1998). The diagnostic interview schedule for deaf patients on interactive video: A preliminary investigation. *American Journal of Psychiatry, 155*(11),1603-1604.

Vernon, M. (1996). Deaf people and the criminal justice system. *A Deaf American Monograph, 46,* 149-153.

Vernon, M., & Andrews, J. F. (1990). *The psychology of deafness: Understanding deaf and hard of hearing people.* White Plains, NY: Longman.

Vernon, M., & Miller, K. (2001). Linguistic incompetence to stand trial: A unique condition in some deaf defendants. *Journal of Interpreting, 11*(1), 99-120.

Vetri, D. (1993). What makes the mental health setting different? Transference! *Views, 10*(5), 1, 7-8.

Williams, R. (1993). What is mental health interpreting? *Views, 10*(5), 1-2.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.