Hearts, Minds, Hands: A Dream Team for Mental Health

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INTERPRETING IN a mental health setting with hearing staff members and deaf clientele, the ethical situations fly fast and furious, providing the interpreter with a wealth of war stories with which to regale neophyte students of this dynamic profession. Much has been written to improve the many and varied mental health services being extended to deaf populations. The most commonly described dyads are that of hearing therapist and deaf patient. However, consider the case of a deaf psychologist treating hearing clients. In this instance, the interpreter becomes the liaison between the deaf professional and the hearing patient.

When an interpreter not only works primarily with one deaf professional among hearing staff members but also serves as a de facto member of the treatment team, ethics are challenged differently, unexpectedly, and often. The interpreter and the psychologist must function as a team, and the role of the interpreter will vary from more prosaic assignments. With the tables turned, the deaf professional must find ways to capitalize on the interpreting service so he or she can fully address the needs of his or her hearing clients and function smoothly among his or her hearing colleagues. Clearly, a commitment to teamwork and collegiality is fundamental to ensure a sense of professional satisfaction for both the psychologist and the interpreter.

THE TREATMENT TEAM

This case involves a deaf clinical psychology doctoral intern, Julianne Gold Brunson, providing services to a department of psychiatry within a major university medical center. Her primary duties included interviewing patients, providing individual and group therapy, and participating in staff meetings. The patients were in emotional and mental distress, possibly creating obstacles to their ability to work with a deaf individual, their understanding of the role and function of an interpreter, and perhaps even the purpose of the psychologist’s very presence in their immediate environment. Gold Brunson’s interpreter was Judy Molner, a nationally certified interpreter with twenty years of interpreting experience in a variety of settings. Interviews with these two professionals were conducted by means of e-mail. The therapist and interpreter answered questions posed to them individually and then responded to each other’s comments in a dialogue about their work.
together. This chapter is a compilation of their recollections, comments, and analyses with additional framing commentary.

**Finding the Right Interpreter**

Deaf professionals who rely on interpreters to represent them to any hearing individual or audience must make an impressive leap of faith. A high percentage of their working day is spent interacting with people who do not use their primary language. Only one person is entrusted to transmit information and stay as unobtrusively in the background as possible. Wadensjo (1998) asserts that although the indirect relationship between parties using interpreting services is positively affected, their direct relationship can be altered by this third person in the environment. Therefore, finding the right professional match of psychologist and interpreter is critical.

In cities functioning with a dearth of interpreters, a deaf psychologist may have no choice as to whom he or she acquires as an interpreter. Fortunately, in this case, the team’s city is rich in skilled interpreter resources. There is a pool of extremely talented interpreters who frequently work in mental health settings for this particular teaching hospital as well as for clinics and agencies that serve the local deaf population.

Gold Brunson, as an intern engaged in her coursework for the hospital, consequently had access to the services they provide. Molner was assigned to work on a regular basis with other staff interpreters, filling in outside of the primary interpreter’s scheduled hours. Occasionally there would be community interpreters on the roster, all of them having extensive experience working in the mental health setting. This sort of assignment differs dramatically from the more prosaic community or college settings. Molner had worked with two other psychology interns over the past few years and was thus cognizant of what the environment and this specific sort of interpreting entailed.

Even more of a factor in this professional team’s success was their finessing of the interpersonal dynamics inherent to working with mentally ill individuals in an inpatient setting. Because the interpreter and the therapist were both female, Gold Brunson believed that the deaf psychiatrist–hearing interpreter unit was one of solid female energy. She believes that a same-sex duo was helpful because the patients would hear a female voice for a female psychologist whereas a male voice would have created a different dynamic during therapy in terms of patient rapport.

**Interpreter Preparation**

It is helpful for interpreters to have even some modicum of information as preparation before any assignment. When a patient is deaf, name signs or fingerspelled words specific to his or her case can cause disfluency in voicing production, which may in turn slow the dialogue and draw unnecessary attention to the interpreting process. With Gold Brunson and Molner, information was not provided for considerations of voicing accuracy but, rather, for the interpreter to catch nuances of
vocal expression and convey subtleties indispensable to the psychologist’s perception of the patient. Gold Brunson explains:

I often shared in advance any relevant background history (e.g., names, places, situations, diagnostic issues) and how that information might affect communication with the interpreter to help her with comprehension and fluency during therapy sessions. The more interpreters understand, the more they can focus on communication and in-session dynamics. Assurance of confidentiality forms the bedrock of trust for individuals in therapy. The therapist and interpreter are part of a pact of respect for the patient’s privacy. Information sharing is permissible only to achieve communication clarity or to warn those present in the immediate environment of imminent danger.

An interpreter who has received no background information before providing service during an assignment such as a therapy session is operating at a serious disadvantage. Gold Brunson had to negotiate the extremely thin line between sharing information relevant to the interpreting process and inappropriately disclosing information. Violating the sensitive and sacrosanct contract between psychologist and patient would cause irreparable damage to the trust imperative for therapeutic success. Gold Brunson was aware of what her interpreter needed to function effectively, but never provided information at the expense of her patients’ rights to privacy.

**Setting Up the Room**

Therapy sessions were held in either a large or a small community room, depending on which was available at the time. For individual appointments, Gold Brunson would sit across the table from her patient. Molner would sit behind and slightly to one side of the patient, out of peripheral vision range. This positioning maximized the eye contact between the psychologist and the patient because the interpreter was visible over the patient’s shoulder. Gold Brunson could then shift her eye gaze unobtrusively between the interpreter and the patient.

Inpatient group sessions were held in the large community rooms with participants and psychologist all sitting around a large table. At first, interpreters would be seated at the table and distributed throughout the group for outpatient groups, but Gold Brunson noted that the inpatient participants were more easily distracted by the interpreters working among them. She thought it best in these situations to move the interpreters to the outside of the physical boundary of the group to further establish their presence as separate from the therapeutic interaction and thus reduce the temptation for patients to engage the interpreters in the conversation. The interpreter would stand behind the seated participants and stay in one place, indicating the speaker by pointing, fingerspelling the name, or using a name sign. If a patient was mumbling or speaking very softly the interpreter would subtly “float” closer to him or her to capture the communication. If patients interrupted each other or spoke at the same time, Molner and her team interpreter would each
represent one of the speakers, and the psychologist would use this opportunity to reinforce the communication rule of taking turns.

Staff meetings were also held in larger community rooms, with the interpreters standing behind the hearing members in the identical configuration as for the inpatient group sessions. Meetings between Gold Brunson and her supervisors were conducted in their respective offices, with the interpreter positioned behind and to the side of the supervisor in a similar placement as for individual therapy sessions.

**Language Considerations**

Hearing therapists treating deaf patients must consider numerous communication and language variables (Cohen 2004). Before treating a deaf patient, it is helpful to be aware of onset and diagnosis of deafness, age of exposure to signed or spoken language, educational paradigm during the individual’s school years, and parental willingness and ability to communicate with the child during formative years. This list is by no means exhaustive because one can safely say that every deaf person in America has a different childhood experience depending on the constellation of abovementioned variables. Most sign language interpreting requires great range and spontaneous flexibility on the part of the interpreter to match the language needs and preferences for an ever-changing array of deaf individuals. In this hospital setting, the patients were hearing; therefore, the interpreter in this particular environment faced unusual communication and language challenges, requiring her to possess the linguistic flexibility to represent speech anomalies or disfluencies accurately to the psychologist. Molner recalls:

Ms. Gold Brunson uses her own voice, so that took a lot of the pressure off the interpreting task. She also really needed to know the exact words her clients and colleagues were using so she could respond in kind. Accurately providing this information was difficult at the psychiatric hospital because many of the clients either mumbled or spoke incoherently, so sometimes, it felt like I was just signing words that made no sense at all. My natural instinct is to try to make some sense of what I’m hearing, which is not the task in that hospital environment. Learning to let go of the urge to restructure in an attempt to make sense of what I was hearing was quite a challenge for me. The lack of discernable punctuation was quite an experience.

These experiences are antithetical to what interpreters are taught in interpreter training programs, to say the least. The stress incurred by interpreters during the process of unpacking a message delivered in spoken English in an attempt to find the point and then deliver it in a more American Sign Language discourse style is the stuff of legend (Sgarbossa 2005). In this situation, the interpreter experienced internal dissonance from fighting her instincts to affix meaning to what she heard. There is a counter-intuitive conundrum facing an interpreter who, quite literally, must stop making sense. A patient producing a steady stream of “word salad” creates an interesting interpreting task—that of accurately interpreting disorganized
speech and thoughts without the subjective imposition of meaning or order. Gold Brunson realized how taxing this task could be for the interpreter and tried to limit the amount of time spent under these conditions to minimize the interpreter’s exhaustion. Molner states:

When I didn’t understand patients because they were mumbling, it was hard. Depending on the person, Ms. Gold Brunson would ask them to repeat what he or she had said, or she would ask a specific question to try and foster a response with a narrower context, so it was easier to follow. She didn’t hesitate to open up the process and tell the patients that the interpreter was having a hard time understanding them. Because she needed to get what they were saying through the interpreter, it was a team effort between all of us, and we all needed to work together. That was a particularly helpful approach when she was leading groups, because then the patients didn’t feel singled out.

The therapist’s familiarity of the process of interpreting heightened her sensitivity to her interpreter and de facto communication partner. Being mindful of interpreting considerations, Gold Brunson consciously directed these exchanges while simultaneously raising awareness about the communication situation, thus smoothing the process for everyone.

Cultural Considerations

Elements of culture played an important part in the interpreted therapeutic events in which these two professionals were involved. When the bilingual-bicultural theory of interpreting introduced a new paradigm for interpreters, the traditional mechanistic model that had been the norm since the inception of the interpreting profession was replaced by tolerance for a more autonomous flexibility in the way interpreters approached their work (Alcorn and Humphrey 1996). Acknowledging that culture and language are inseparable led to the realization that the interpreting task could not remain solely in the realm of translation. The choice of signs to represent a hearing person’s spoken words, or spoken words to represent a deaf person’s signs, are predicated on the interpreter’s awareness of cultural background and context as well as on the audiences in question. The sociological construct of high context–low context cultural dynamics has a direct affect on interpreter acuity in translation (Lewis 1997). As a rule, interpreters are taught that when one arrives at an assignment, language assessment and establishing rapport must happen on the spot, usually by way of small talk. By asking the deaf person culturally appropriate questions (e.g., Where are you from? Where did you go to school? Are your parents deaf?), the interpreter can get an understanding of the patient’s signing style and possible vocabulary and contextual needs for translation purposes. However, in the case where the psychologist herself is deaf and the clients are hearing, this strategy may not be appropriate at all. Molner had to realign her approach to interpreting when working with Gold Brunson, as illustrated in this comment:
The therapist asked me to arrive early for individual appointments, and rather than stay in the waiting area where the patient might be tempted to chat with me, I went immediately to the therapy room and got into my position. This choice was a revelation for me, because in the past, when it was a deaf patient and a hearing therapist, I’d always chat with the patient in the waiting room for language assessment. I didn’t realize until Ms. Gold Brunson pointed it out to me that this practice was not necessarily conducive to fostering the patient’s relationship with the therapist in this environment. In the reversal of roles, with a deaf therapist and hearing clients, I stumbled on a truism about my previous approach to interpreting that didn’t apply to this environment. I had operated under the assumption that establishing comfortability and clear communication with the deaf person was part of my job. In this clinical setting, I was there to help foster the relationship between my hearing and deaf consumers, not either of their relationships with me.

Deaf culture in America has more in common with communal societies where group rather than individual needs are paramount. It is a minority subculture, instantly identifiable by the use of a visibly different language as well as the stigma of perceived disability. Often when deaf individuals meet for the first time, they will compare backgrounds and experiences as a bonding and establishment of common ground. Interpreters are granted entrée into this dynamic. However, were the same queries posed to hearing patients, their perceptions might be that the interpreter was being intrusive because there would be no obvious need for this information. Molner had to switch cultural hats in this setting so the sole focus of relationship building was between Gold Brunson and her clients.

**Psychologist-Patient-Interpreter Dynamics**

The dynamics of working with a population of patients under psychological distress are understandably different from those encountered in the general population. Language is one factor, as we have just seen. Vital to the patient’s success are the actual relationships formed between the therapist, the interpreter, and the patient over the course of treatment. An individual in a psychiatric setting is already in an emotionally vulnerable position, seeking help, and usually experiencing psychic pain. The insertion of a third person into this extremely sensitive scenario can be tricky. This encounter may well be the first instance in which a patient has had any experience with a deaf individual or an interpreter; therefore, the role and function of interpreters as well as room logistics must be addressed immediately to ensure a safe and comfortable therapeutic environment. Gold Brunson states:

In reality, having an interpreter frequently creates a triadic (three-way) rather than a dyadic (two-way) relationship. Acknowledging this reality helps minimize the mystery of the interpreter while clarifying our individual roles. Because I am a deaf individual with understandable speech, my hearing patients or clients could literally go several sessions without ever
hearing the interpreter’s voice. There exists a “mystery” of the interpreter, the unseen and unheard-from listener, that may increase anxiety in the patient. Permitting a limited amount of small talk or weather talk between the interpreter and the patient before and after sessions helps to reduce patients’ fears of being negatively evaluated by interpreters, which can hinder therapeutic rapport. A lot of this friendly contact between the interpreter and the patient happens largely during the first session, where I tend to spend time discussing interpreters’ strict compliance to confidentiality and his or her code of ethics, one that is even more strict as compared with other professions because of the small-town nature of the deaf community. I explain that we aim to assign the same interpreter to this patient for all sessions. I also describe the patients’ options in the event that he or she runs into the interpreter outside of the session. I promise the patient that the interpreter will not be insulted or confused if he or she chooses to ignore the interpreter, especially if acknowledging the interpreter would alert bystanders’ curiosity as to the circumstances of this acquaintance. The interpreter will understand why it might feel comfortable and appropriate to say hello in some social contexts, but not in others.

There are no studies as to hearing client perceptions about confidentiality concerns when there is an interpreter present to facilitate communication with a deaf therapist, although research has been undertaken for the reverse situation (Cohen 2002). The “small-town” nature of the deaf community gives rise to clients’ practical worries about ethical breaches. A community interpreter working for several agencies may be privy, and therefore entrusted, with sensitive information about many deaf peoples’ lives within the scope of a limited geographical area. This new configuration of a deaf therapist treating a hearing client begs for studies to indicate whether parallel concerns are present for the hearing recipient of these services.

There are dangers to having the patients become too comfortable with the interpreter in the room, as Molner relates:

One tricky thing was that the patients were very interested in talking directly to the interpreter. Ms. Gold Brunson was excellent at dealing with that situation, partly because she wasn’t too rigid about it. Sometimes it was more appropriate to just have the interpreter answer a question that was directed at her, if the question was something simple and benign like, How are you today? I felt that the therapist utterly trusted me to make my own decisions about which questions I could answer directly and which would be better handled by her. In those instances, she would say something like, “You know, it’s nice that you’re being friendly, but the interpreter is trying to do her job, and when you talk directly to her, it makes it harder for her to do it.”

This intervention on the part of the therapist provided acknowledgment of the interpreter’s humanity while simultaneously inserting a gentle clarification of the role and function of this third party present in the room. It is vital that any pro-
fessional who uses interpreting services exhibit a clear understanding of the interpreter code of ethics as well as when and how to apply it. Gold Brunson was expert in her ability to avoid sounding as if she were admonishing, which could potentially put the patient on the defensive. Possessing the sensitivity and tact to educate in a subtle manner while guiding a patient toward self-awareness is a rare and wonderful gift.

**Interpreter Emotions**

Patients seeking mental health services are pursuing treatment in the hopes of attaining some measure of self-discovery, illumination, and healthy autonomy. The nature of this work, undertaken with an interpreter present, places this third person in an environment rich with possibility for the client, but potentially fraught with emotional danger for the interpreter. Unlike spoken language interpreters whose instruments to convey affect are limited to one, the voice, sign language interpreters literally wear the language they are conveying. The message is the medium. The interpreter’s body and face become three-dimensional handwriting for the deaf therapist to peruse for meaning, a Rorschach blot animated by hands. Emotionally laden conversations take a toll on interpreters as these expressions are embodied. According to Harvey (2003), “It is largely inevitable—a psychological reflex—to experience some degree of empathic pain” (207; see also Harvey 2001).

Sometimes topics resonate within the interpreter and must be processed after the interpreting event. For instance, while under the care of Gold Brunson, one patient in particular was experiencing many traumatic events, both physical and emotional that intersected with a painful time in Molner’s life. She recalls:

> For many reasons, this woman just tore at my heart strings regularly. I remember one session with her when the topic of one’s inevitable death was brought up. The therapist pursued it as much as possible. After we were done, she immediately asked me how I was doing. This session was before my mom’s death, and the connection was definitely on my mind. I appreciated her addressing it so directly with me.

Gold Brunson was vigilantly aware of these wearing episodes when they occurred and tried to be mindful of the potential for vicarious suffering that can occur whenever an interpreter lives through another person’s emotions and experiences. She emphasizes the importance of taking the time to debrief after an especially tough session to help interpreters transition through the emotions and, hopefully, avoid burnout.

Interestingly, these same embodied emotions that can leave interpreters depleted may sometimes, in and of themselves, prove to be another visual tool resulting in therapeutic benefit for the patients. Gold Brunson described how, previously, she had run an outpatient therapy group for hearing women with fibromyalgia. The interpreter sat opposite her in the same circle. The interpreter was very skilled and emotionally available in that she did not hesitate to facially express the underlying
emotions she heard. Many weeks later, several members expressed how much they valued the interpreter as a member of the group and appreciated being able to see the interpreter as she signed and expressed their own words to Gold Brunson. They stated that seeing their emotions mirrored back to them in this way was extremely validating.

These hearing patients did not experience the signing in their environment as communication to them but about them and, ultimately, in their estimation, for them. In most group mental health settings with deaf participants, the interpreter is sitting next to the hearing facilitator, facing toward the group so the moderator can communicate with the deaf clients. Because of these more common logistics, the interpreter could be perceived, either overtly or subconsciously, as a unified front with the hearing leader. In the situation described in this chapter, the interpreter was placed amid the group, and the hearing group members experienced the interpreter as a visual manifestation of their feelings. This manifestation provided the deaf therapist with a pictorial representation of vocal inflections that, in the absence of the interpreter’s signed rendition, might not have been discerned from faces and body language alone.

**Patient and Interpreter Transference Issues**

The term *transference* denotes a situation whereby an individual undergoing therapeutic treatment ascribes either physical or emotional characteristics of someone in their past to the clinician or anyone else in the treatment environment. Connor (2005) claims that transference “creates an ‘emotional time warp’ that transfers your emotional past and your psychological needs into the present.” However, transference is not limited solely to the person in treatment. Anyone is vulnerable to the mind’s need to take past memories and paint a new canvas with something old and familiar to solve internal riddles or to feel safe and comfortable. Gold Brunson and Molner share a story about this dynamic and how the situation was used to achieve positive results. One client transferred onto the interpreter her memories of someone she once knew. *Countertransference* occurs when the recipient of the patient’s projections experiences a reciprocity of these feelings. In one case, Molner was mutually affected. She recalls:

There was one patient who was particularly emotionally challenging for me. She kept talking about how I strongly resembled a girl she had known during her childhood in Brooklyn. She reminded me of some of my relatives on my dad’s side. So we had this mutual cultural recognition and some kind of connection with each other. Several incidents occurred while she was in the hospital that made it obvious she was not always receiving proper physical care. My mother was becoming more ill at that time and had stayed in a hospital and then a rehabilitation facility. She was not having a positive experience herself, resulting in my experiencing some pretty heavy transference issues about the problems of how older women are treated in institutional settings. I did not let this personal internal noise affect my
work in the setting: however, the patient became a bit fixated on me. Ms. Gold Brunson was quite good at using this fixation to get her talking about her childhood experiences and her old neighborhood.

The seating arrangement, as described earlier, was instrumental in minimizing these sorts of interactions. Gold Brunson would direct the interpreter to sit behind the patient and slightly to the side, undetectable to peripheral vision. This position fostered the relationship directly between Gold Brunson and her patient, decreasing the possibility that the patient would be distracted by the interpreter.

Instead of attempting to nullify or minimize the meaning that this particular interpreter’s appearance held for the patient, the therapist invited her to explore the depths of meaning this relationship signified to her. According to Connor (2005), when issues of transference are explored properly, a therapist can gain new insights into a patient’s connections to the past. This information can be used to illuminate present predicaments the patient is experiencing. In the case of Molner and the patient who felt bonded to her, this information was mined to further enrich the therapeutic event. It is clear that Molner functioned as more than a communication conduit. Inadvertently, though not insignificantly, she served as a living prop in the patient’s emotional drama. The interpreter’s very presence elicited revealing responses from the patient, responses on which the deaf therapist was able to capitalize. The logistics of the meeting space served to physically establish the interpreter’s separation from the actual work that the therapist and patient were undertaking together by having Molner seated behind the patient. Gold Brunson clarified that this positioning does not work with all patients. Very paranoid and potentially violent patients might not feel comfortable with this arrangement. She invites patients to try different seating configurations, and she solicits their input. Although they may initially prefer the interpreter in their view, after the novelty of seeing the interpreter during the first couple of sessions, they prefer having the interpreter seated behind them.

**Relationships with Other Hearing Staff Members**

Working for any agency, whether a small clinic or a large hospital, requires interaction with colleagues in the environment. When there is only one deaf participant in these situations, hearing discourse style is the norm, and the appropriate concomitant accommodations may or may not be made, according to the sensitivity and the institution’s commitment to complying with the Americans with Disabilities Act (U.S. Department of Justice 2006). The presence of interpreters on the premises does not, unfortunately, guarantee full and unfettered access. The work situation described in this chapter occurred in 2005. Conditions encountered by both of the professionals in this case have not improved since the 1997 article, “Accommodations in the Workplace for People Who Are Hard of Hearing: Perceptions of Employees” (Scherich and Mawry 1997). An example of daily frustrations for the interpreter and the therapist were the staff meetings, which caused the greatest headaches, as Molner describes:
The most difficult part of the assignment was the morning report during the second half of Ms. Gold Brunson’s stay at the hospital. It was a group of women who all talked over each other, and it didn’t seem like we could have any effect.

Gold Brunson sympathizes by adding:

Many interpreting difficulties can’t be solved, and this reality can be hard to accept. For example, if there is a long-standing group such as an inpatient staff meeting whose members constantly interrupt and overlap with one another, then that is the reality, their group dynamic. The interpreter can sign to me whatever they are attending to just as if he or she were sitting there as a noninterpreter member of the group. However, at some point, I try to explain to the group that their dynamic makes it difficult for the interpreters and that there is a good chance I may be missing out on critical information. Often, others also don’t like missing out. They take pity on the interpreters and grab the opportunity to take advantage of the interpreter’s presence. Sometimes the fact of an interpreter being in the room provides a more legitimate reason to enforce turn-taking (“Hey, let’s talk one at a time so the interpreters can follow!”). Nonetheless, the dynamic might continue, to the interpreter’s frustration. I try to make it clear to the interpreter that I understand the difficulties he or she is encountering and encourage the interpreter to relax and just to go with the flow of this situation as best as he or she can. It’s no one’s fault, and relaxing is the only way to go.

How ironic that in a work situation where both the deaf and the hearing professionals are working primarily with a population in the throes of various emotional difficulties, the most frequent communication obstacle was with ostensibly sane and coherent hearing professionals! Dean and Pollard’s Demand-Control Theory (2001) outlines the schema interpreters can use to orchestrate the interpreting environment to the furthest extent possible, thus minimizing intrusions on the interpreting process, and relieving interpreters’ internal dissonance. Logistics of the interpreting setting, placement of personnel, lighting, preparation for assignments, and linguistic assessment are all tools at the interpreter’s disposal to ensure, as much as possible, that the interpreting will proceed effectively. Molner felt somewhat powerless to improve her own situation during these meetings because the method of communication was not under her control. Fortunately, Gold Brunson was familiar with the difficulties these meetings presented. Her understanding and flexibility helped lessen the stress and frustration that Molner felt while attempting to perform her job under these circumstances.

Downtime for the deaf therapist is still working time for the interpreter. With no patients present, time becomes available for staff members to interact informally, when there are typically precious few opportunities to do so. The deaf member of the team needs to be forthright with the interpreters about her needs during these social moments as Gold Brunson discovered:
When I first arrived at the hospital, the interpreters all knew each other and had worked together previously. As the only deaf intern in the pre-doctorate internship, I was anxious to connect with my fellow interns and found it difficult to join in on the social discussions. I needed the interpreters to attend to dialogue that was happening around me before meetings. I assumed the interpreters had the best of intentions and were unaware that I really wanted to participate in the everyday chatter because not every deaf person does want that interaction. I was open about this desire with my interpreters by describing the difficulties I was having in connecting with the other interns (we all shared an office and each intern had a foreign accent). The interpreters became more aware of my needs and from then on began attending to side conversations that occurred before meetings.

Being a de facto staff member sometimes creates dissonance in the interpreter when there does not appear to be an immediate interpreting requirement, yet another hearing staff member needs help. The Registry of Interpreters for the Deaf (RID) Code of Professional Conduct (2005) dictates only the obvious role-delineated response of an interpreter performing the function of facilitating communication, no more and no less. Interpreters are to translate from the source language to the target language, with no expectation of performing tasks unrelated to the satisfaction of the immediate communication goal. In the moment, the coast may seem clear, and one can safely assume there is no imminent danger of a dramatic, ethical breach looming on the horizon. However, as Molner relates:

I remember an awkward situation that came up during staff coffee hour. They were short staffed, so one of the other staff members asked me to help bring refreshments around to folks. I should have said no, but she was quite harried, so I agreed. I lived to regret it. Not only did I have to deal with many patients trying to engage me in conversations but also I was across the room when one of Ms. Gold Brunson’s patients was trying to talk to her. I wasn’t any help to her. It was a good learning situation for both of us. The therapist mentioned to her supervisor that it would be helpful if staff members didn’t ask the interpreters to do tasks other than interpreting, and I learned once more the importance of asserting my specific role.

Gold Brunson recalls the same event:

I remember, too, that there was a long lull where no one spoke, but everyone was busy setting up food for a party. Thus, hearing people saw an interpreter who wasn’t moving her arms and assumed she was not working. In hindsight, if I had simply engaged the interpreter in conversation, our separation may not have occurred.

An interpreter really does stand in the middle of no-man’s-land. The deaf professional-interpreter pair need not be inseparable, yet the interpreter’s primary
responsibility is to facilitate communication for the deaf professional whenever it is needed, at any given moment. However, other staff members’ perceptions of the interpreter cannot be minimized. It is important to foster a sense of collegiality and to reinforce the fact that the interpreter is a member of the service providers’ team. Gold Brunson’s proposal for a potential solution was to take preemptive action by taking Molner out of the loop of availability when volunteers are needed for noninterpreting tasks.

Rarely do interpreters possess dual degrees in sign language interpreting and mental health. The deaf clinician is dependent on the visual information that is transmitted, yet there is also another pair of eyes and an alert pair of ears in the room. The RID (2005) Code of Professional Conduct is clear in its insistence that interpreters adhere to the role of communication professional by abstaining from offering opinions or conjectures as to what transpires in a given situation: “The interpreter can provide information and opinions related to the communication process, but not on the therapeutic process. The interpreter . . . cannot provide information about the mental emotional state of the deaf person” (RID 2005). Applying this construct to the deaf professional–hearing patient scenario, Gold Brunson recalls:

We discussed clients as part of our debriefing from sessions whenever needed, and often, the interpreter provided me with critical additional information after sessions (such as a patient’s odd spacing of words while speaking, lack of vocal intonations or inflection, accents). This approach was not so much a solicitation as it was a collaboration. My interpreters were wonderful in determining the line between collaboration and usurping my role. Their feedback did not replace my own clinical judgment.

Gaps in Accommodations and Access

There is a good reason why so little has been written about deaf professionals using interpreters for communication with hearing clients in mental health settings. The pool of such individuals is small thus far, ostensibly obviating the need for such research. It is understandable, although no less frustrating, that there exists a lag in awareness and accommodations for accessibility in institutions that hire deaf individuals as staff members. There is a lack of foresight coupled with a failure to anticipate the detriments of ignoring needs to adjust and accommodate. This lack creates more work and stress for both members of the deaf and hearing professional pair. A perfect example for Gold Brunson and Molner is that of medication management educational videotapes, which were not captioned, but which Gold Brunson was required to use in conducting her groups. Consequently, Gold Brunson was forced to rely on the services of an interpreter while preparing for her groups because there was no other way for her either to determine the content of each video segment or to construct a lesson around it. Because the hospital regularly employs deaf interns, it stands to reason that these videos should be captioned. To date, no captioning has been done.

Deaf staff members were also excluded from access to all manner of overhead speaker announcements. These ranged in importance from the very serious
“Camelots,” which indicated a patient was out of control and in need of restraint, to lower priority announcements such as changes in programming for the day, announcements of illegally parked cars being towed, and so forth. Regardless of whether or not an announcement is a crisis matter or mundane in nature, any verbal communication to the general public in this institution should have been made available in some form to deaf personnel.

Present in this workplace were not only the more predictable communications and inclusion barriers but also some surprising logistical inconveniences occurring from ignorance as to how an interpreter should be classified. There is common institutional puzzlement as to where interpreters fit in the professional hierarchy (David 2001). Confusion has persisted around the issue of access rights for the psychology intern’s interpreter. Molner describes the inconveniences:

The first month I was there, the interpreters had no office or restroom keys and no code on our ID cards to be able to swipe in and out of the units. In the hospital, everything is locked, including the bathrooms. This situation meant that any time we needed to go anywhere, the intern had to go with us. She had to leave whatever she was doing to swipe us in or out, or walk us to the bathrooms to get us in. It took an incredible amount of assertiveness from her and her interpreters, as well as advocacy on the part of a senior member of the faculty, to get us any rights at all. We finally did get keys to the office and the restrooms, but we never did get the code on our badges for swiping in and out of the units. The intern still had to walk us in or out, even when she wasn’t leaving herself, or come get us when she had arrived early to work that day. It was quite a hassle.

Gold Brunson concurs that the simple act of going to the bathroom was made unnecessarily complicated. She adds:

This institution, like many companies, had great difficulty in including or considering the interpreters. They often put up incredible roadblocks such as insisting that all interpreters complete an all-day training on HIPAA, confidentiality, fire drills, etc. This was not feasible because all of my potential interpreters were with me on the day that I completed this training. There was no time allotted for them to satisfy this requirement.

This hospital exhibited a confluence of disregard for both sets of rights, those of the deaf professional and those of the interpreter. It created more work and inconveniences for both parties and wasted energy that could have been more effectively spent on the task of preparing for rendering services to the patients in need. Clearly, there exists the need for persistent advocacy and more education of those in administrative positions to resolve these obstacles.

**Why It Works: Eyes Toward the Future**

A fitting maxim by an anonymous author says, “Teamwork cannot tolerate the inconvenience of distance.” In all of the examples Gold Brunson and Molner kindly
provide, it is obvious that among the numerous factors contributing to the success of their work, a willingness to be open and honest stands out as paramount in importance. Of the deaf therapist with whom she worked so closely, Molner says:

She is utterly clear in her needs for the interpreter. The one thing that made the interpreting experience there so positive was her directness about any issue that came up. Nothing was unspoken. She dealt with everything up front and invited her patients and her interpreter to do the same.

Gold Brunson returns the compliment:

Ms. Molner has great emotional availability and was very attuned to my needs while clearly conveying information related to group or individual dynamics. I felt great support and respect from her. Because I was an intern, this availability was very encouraging for me as I attempted new and awkward tasks.

Mutual respect and admiration created a climate conducive for both parties to learn and grow within their respective fields while satisfying the immediate task at hand—helping a troubled human being regain mental health.

The gains in psychiatric services rendered to the deaf population in America are impressive. There are articles addressing the needs of services offered to culturally deaf adults, deaf-blind individuals, chemically dependent deaf adults, deaf children and adolescents, as well as discussions of adapting various therapeutic techniques to these populations (Isenberg 1999; Wax 2001; Poor 2004; Feldman 2004; Freedman 1994; Brennan 1997; Wyatt and White 1993). This chapter has provided a window into the world of a deaf therapist and her interpreter, a duo operating with scant research to provide such validation and underpinning to their often spontaneous daily decisions.

With the proliferation of colleges and universities providing interpreting, note taking, and captioning services, there are more opportunities than ever for deaf students to set their sights on careers requiring higher degrees in fields that had heretofore been closed to them. Ten years ago, Vernon (1995) projected that the synergistic effect of the deaf power movement and the Americans with Disabilities Act could create conditions ripe for a proliferation of deaf practitioners in the fields of education and mental health. This prediction, optimistic and prophetic as it was, envisioned that these future deaf professionals would be working with deaf clientele. There are still very few deaf individuals with doctoral degrees in psychology treating hearing individuals. These pioneers are breaking new ground, learning as they go, and their interpreters are right there, learning alongside them.

References


