Interpreting Psychotherapy: Developing the Interpreter's Uncommon Sense

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INTERPRETING PSYCHOTHERAPY:
Developing the Interpreter’s Uncommon Sense

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Whole Interpreter Enterprises

Abstract
This article is a discussion of several under-recognized areas of unintentional influence of the sign language interpreter in mental health environments. Based on the author’s professional experience as an interpreter in private practice in the mental health field, and through her role as mentor, coach, and educator for mental health interpreters, she proposes that well-respected standard interpreting approaches may be inadequate when applied to the mental health environment. She recommends significant shifts in the practice of interpreting in mental health settings, such as increased recognition of the therapeutic alliance and the unique role the interpreter has in its development. She discusses the need for improved tolerance for ambiguity, and acceptance of non-linear thinking and therapeutic interventions. The author concludes with a discussion of the role that interpreter educators have in encouraging interpreting students toward self-awareness and psychological-mindedness.

Position Statement
Interpreters who practice in mental health settings can function as interference or an instrument of therapeutic communication. It is preferable to engage in direct therapeutic communication, within a shared and common language and culture. However, I believe that with increased knowledge, psychological-mindedness, ambiguity tolerance, and appreciation for the non-linear nature of therapeutic interventions, an interpreting professional can become an asset to therapy. There is wide acceptance in the interpreting field that before accepting assignments in mental health settings, interpreters need sufficient language proficiency and cultural awareness. I contend that an interpreter, whose language is proficient, but who lacks self-awareness and psychological maturity, is not suited to mental health environments. In order to develop professionals with these competencies, interpreter educators need to make the case for development of the self, or the person of the interpreter, alongside more the traditional topics of language, culture, and ethical decision making. For this notion to take root, it is essential that interpreter educators, who are typically generalists in nature, develop an appreciation for the unique requirements of the mental health environment.
Ethics Statement

By supporting and encouraging interpreters’ knowledge, awareness, and self-management, my work ultimately supports more meaningful access to mental healthcare for professionals and consumers who utilize the services of interpreters. I believe that during the course of our fully lived lives, most of us will have a wide-range of experiences; some memorable for their brilliance and beauty and others for the pain and hardship. If we are fortunate, the latter leave us wiser and more resilient, and more capable of rebounding from similar experiences in the future. For many of us, there will be times when self-care and support from a community of loved ones is not enough to see us through life’s complex challenges. During these significant life events and times of crisis, the mental health field can act as a safety net. At its best, a continuum of services, ranging from peer counseling and out-patient mental health therapy, to hospital-based behavioral health units is used to alleviate suffering in one form or another. Deaf and hard of hearing individuals and others who do not possess English fluency face considerable economic, socio cultural, and attitudinal barriers to this network of care. Until such time that there are sufficient numbers of providers who are proficient in the languages and familiar with the cultures of their consumers, and there is no need to access the use of a professional interpreter, it is my mission to make a positive and significant impact on the quality of interpreting in mental health settings.
Interpreting Psychotherapy: Developing Your Uncommon Sense

Scope and Dimension of the Problem

A discussion of mental health interpreting calls for broad strokes. As with the canvas of the pointillist painter, it is not until one backs up from the page that the expanse of the psychological landscape begins to emerge. To engage a subject as large as this is to risk losing all but the most enthusiastic reader in myriad details of mental health settings, providers, clients, theoretical approaches, nuances of language, and interventions. Discussions of how savvy mental health interpreters, Deaf or hearing, traverse any of these areas of mental health practice would be of great value, and also be well beyond the scope of any single chapter.

In this position paper, I intend to provide interpreter educators with information, insight and the awareness necessary for preparing students to recognize a unique set of competencies for the mental health therapy milieu. Specifically, I assert that common sense interpreting approaches and prized professional values—when applied to the mental health environment—may lead highly-skilled and well-intentioned interpreters to, at best, interfere with and, at worst, thwart elements of the therapeutic process. I also hope to provide interpreters and interpreter educators with insight into the need for encouraging the person of the interpreter toward greater self-awareness, non-linear thinking, ambiguity tolerance, and increased psychological-mindedness. Throughout, I will examine some critical but perhaps unfamiliar goals of mental health therapists.

The literature in the mental health field reveals a largely discouraging perception of the efficacy of interpreter services in mental health settings. Practitioners who recognize what may be at stake in cross-cultural therapeutic interactions are acutely aware of the impact an interpreter may have on the therapeutic process – primarily on the therapeutic relationship (RID, 2007). Hamerdinger and Karlin (2003, p.1) described monolingual clinicians using interpreters as “a necessary evil.” Critchfield (2002, p. 42) explained that the interpreter can be “both a vehicle and a filter” for therapeutic communication and others described the presence of an interpreter as offering the appearance of adequate inclusion or accommodations (Critchfield 2002; Glickman 2003). Types of interpreter errors and influence have been categorized and explored (Brunson & Lawrence, 2002; Dekker & Ginsburg, 2009; Marcos, 1979). Ironically, it appears that even highly skilled interpreters who have a well-developed ability to self-monitor and address their misinterpretations in most settings, may be less able to do so in the therapist's office. Learning to mitigate the more unconscious, unintended, and insidious interference of well-intentioned, ethical interpreters is the subject of this paper.

This discussion will highlight purposeful therapeutic communication approaches that are easily overlooked or misunderstood by interpreters along the professional continuum. Insights gained from examining the means by which mental health therapists deliberately communicate with their clients are generalizable to many other areas of interpreting practice — within the mental health field and beyond.
A few notes to the reader: this discussion presupposes that the individual in therapy is Deaf or hard of hearing and that the therapist is hearing. This choice was made based on the author’s deliberate assumption that Deaf therapists can be assumed to have greater facility with addressing their interpreting needs and assisting interpreting professionals in navigating the course of therapy communication. While this is a rich topic worthy of investigation, it is beyond the scope of this paper. In this context, then, the term “client” will be used when referring to the Deaf individual in relation to the therapist, and both the Deaf individual and the mental health professional are considered “consumers” when discussed in relation to the interpreter.

We will begin our discussion at the confluence where the interpreter’s professional virtues and values and the communication needs of the mental health therapist meet. We will explore these facets of mental health interpreting:

- The most easily overlooked tool of therapy
- Values that interpreters bring to the mental health therapy setting
- What interpreters can do to improve their effectiveness
- The role of interpreter educators

At the heart of this exploration is a deep respect and affinity for Deaf and hard of hearing people, the profession and the person of the interpreter, and the profound opportunities that wait to unfold in the therapist’s office. I invite you to examine this unique setting in which the interpreter’s greatest virtues — clarity and specificity, for example — may need to be managed, reexamined, or held in check. In order to better align with the goals of mental health environments, interpreters must individually and collectively explore the convergence where technical skills—the doing of mental health interpreting—meet self-management, psychological-mindedness, presence and demeanor—the being of mental health interpreting.

A Lofty Ideal

A helpful lens to look through when examining any multifaceted topic is, “What might the process look like at its best?” and the similarly optimistic, “When it’s working, what is happening?” Such an approach allows us to explore how the current reality may be out of sync with a projected, ideal reality, and within that divide, what aspects are in the interpreter’s power to address. We begin with a lofty ideal.

In a perfect world, consider that every interpreter who accepts an assignment in a mental health setting, from the secure inpatient unit to a peer-led personal growth retreat in a local community center, has a strong foundation of interpreting experience, insight, and skill. Each interpreter appreciates and respects people and exudes a calm, open, unruffled demeanor that aligns with the process of mental health therapy.

In this perfect world, every interpreter who interprets in mental health settings has pursued a thorough education in mental health interpreting, including the unique application of mental health interpreting strategies and tools. Each interpreter recognizes and communicates meaningfully about language form as well as content, and follows up with supervision and collegial consultation. Deaf and hearing interpreters and language specialists enjoy effective and
collaborative professional relationships. Interpreters have exquisitely managed boundaries, fully-realized self-awareness, and an understanding of the continuum of mental health and mental illness. Interpreters engage in productive consultation with mental health providers. Providers welcome the opportunity to engage in a professional exchange of essential information about the other’s practice in order to work effectively in concert for the benefit of the client. Ultimately, in this most perfect world, Deaf therapists are abundant in number and available across the globe, making this discussion less necessary.

A Practical Reality

There is no doubt that it is vital for our profession to promote and educate interpreters with the standards of excellence that this lofty ideal would suggest. It is equally important to take a practical look at where we are as a field and as individuals within the field.

Every day across the globe, interpreters navigate an array of settings, topics, and consumers, and few specialize in mental health interpreting. Dean and Pollard (2004) contributed a concept to the professional discourse of the interpreter: that of the practice professional. This term encapsulates the interpreter’s management of a dynamic balance of moment-to-moment interpersonal variables along with the more technical points of practice. These dynamics are present in every setting in which the interpreter practices.

While a few interpreters have pursued thorough training in mental health interpreting, most highly-skilled interpreting professionals and interpreter educators could be described as generalists in practice. In every assignment, interpreters attempt to bridge very real divides between Deaf and hearing people in a variety of settings. They manage language continua and registers, from the often-intimate nature of video relay conversations, to board meetings, to solemn and reverent graveside services. To all but a few, mental health therapy is something that comes up on the schedule occasionally. When it does, many well-intentioned effective interpreters approach it as they do other settings. Other highly-skilled interpreters, who become sensitized to appreciate their potential impact in mental health settings but lack knowledge of how to adjust their approach, simply say, “I don’t do mental health interpreting.”

It would be outrageous to imagine an ethical interpreter getting up in the morning and dulling the tools of the mechanic for whom he or she interprets, standing in the way of a respiratory therapist, or muting the volume of a presenter’s microphone. An interpreter in a medical setting may be taken aback to find that she is standing on a patient’s oxygen cannula—but who among us would refuse to move, once it was brought to our attention? So too, the interpreter who learns of the need to make fine adjustments to his or her approach in mental health settings, may need only to step off the cannula, and not necessarily to leave the room altogether.

A Curious Paradox

Carl Rogers, considered one of the most influential psychologists in the 20th Century, once observed, “. . . the curious paradox is that when I accept myself as I am, then I change” (1961, p. 17). It would follow that if we recognize aspects of ourselves in these pages and appreciate our influence without judgment, then we might change more easily than we might
Given that we do not know what we do not know, how then can the self-identified generalist interpreter approach this work, aiming to be an instrument and not an interference in mental health settings? The first step is to develop a clearer understanding of the particularities of therapy and the therapeutic relationship. The second step involves approaching these situations with open-mindedness and noticing.

The Most Easily Overlooked Tool of Mental Health Therapy

It may be surprising to the non-therapist to learn that one of the most essential tools of the effective therapist is considered by many to be the therapist him or herself—the person of the therapist (Skovholt & Jennings, 2004). Because the field of clinical psychology has produced so many distinct methods and approaches to mental health therapy, along the way there have been many attempts to determine the most effective factors and techniques (Mozdzierz, Peluso, & Lisiecki, 2009). Researchers have found that the most successful outcomes are achieved less through a particular theory or methodology (e.g., psychodynamic or cognitive behavioral therapy), and more by the personal qualities of the therapist (Mozdzierz et al., 2009). Throughout the psychological literature, there is consensus that therapists who are adept in theory and technique, but lack the ability to personally connect with clients—to show empathy, understanding, and warmth—lack the most key factor in achieving positive therapeutic outcomes (Lambert & Barley, 2002).

Personal rapport between therapist and client allows for the development of trust. Rapport and trust are at the foundation of therapy. People see therapists for many reasons. One client may be coping with tragedy; another may need to work through an issue or pattern in order to shift something in their life; and a third may be managing symptoms of mental illness. Ultimately, something is not working in his or her life and needs to change (Corsini & Wedding, 2005). Depending on the therapeutic methodology of the therapist, the need for change might initiate an exploration of the unhelpful thinking that sustained the problem. It might suggest a deeper exploration of how today’s problems could have been set in motion during childhood. While the manner in which a therapist frames a client’s presenting problem will differ, change of this foundational nature happens in an atmosphere of safety and trust, or rapport.

In the video, Interpreting for Therapy, Dr. Laurie Johnson, a Deaf psychologist in Minnesota, “Rapport is essential in therapy and therapy progresses based on the quality of that rapport” (Anderson, 2006b). Mozdzierz et al. defined therapeutic rapport as “being in synch, harmony, alignment and accord with one’s client” (2009, p. 118). They described rapport as a resonance between therapist and client:

A simple “experiment” from an elementary school science class may also demonstrate what rapport is about. If a tuning fork is struck, it vibrates. If the vibrating tuning fork is then moved close to a nonvibrating fork of the same (or similar) frequency, the nonvibrating fork will begin to “resonate” with the frequency of the vibrating fork (without ever directly contacting the vibrating
fork.) In other words, the vibrations in the air are picked up by the second tuning fork, causing it to vibrate in sync. (p. 118)

This image suggests that the interpreter has a unique role in the conveyance of rapport. In the video, *Interpreting for Therapy*, (Anderson 2006b) Dr. Bart Main, a child and adolescent psychiatrist, described the challenge of conveying empathy and connection to his client with an interpreter present, “It is like trying to make love through the phone operator—it just doesn’t go.” He added, “For the interpreter to be empathically connected, both with the therapist and the client, is really, really useful”.

The challenge of building and maintaining rapport exists in every therapeutic relationship. Even when the two individuals share a language and culture, the therapist who is concerned with building rapport will be deliberately attempting to communicate such qualities as warmth, understanding, and affirmation. Deaf and hearing therapists communicate these and other qualities subtly, but just as deliberately, through eye contact, gestures, voice or sign tone, and inflection. Signs of empathy and understanding and a score of other deliberate responses are used in an attempt to assure the client that the therapist’s office is a uniquely safe place where familiar defenses might eventually be relaxed. It is necessary to develop a secure client-patient relationship of this type in order have the benefit of a working therapeutic alliance (Mozdzierz et al., 2009). This important tool of therapy is found in the quality of connection between the therapist and the client. It is essential, therefore, that interpreters be conscious of and committed to strengthening their role in supporting that relationship (Duffy & Veltri, 1997).

**Values that Interpreters Bring to the Mental Health Therapy Setting**

It is an illusion to think that simply providing an interpreter is sufficient to give meaningful access to mental healthcare (Glickman & Gulati, 2003). Roadblocks and challenges are numerous, especially when the therapist, and the system within which he or she operates, lacks awareness or familiarity with Deaf culture, language issues, and experience. In spite of the challenges, as a mental health interpreter in private practice I have been witness to extraordinary events in the therapist’s office — being present for profound healing and growth, among them. I have also been witness to scores of missed opportunities and thwarted interventions — many of them due to my own and my colleagues’ lack of awareness of the goals of providers. Over the decades, as I sought to improve my effectiveness, I found that what I wrestled most with was how my most treasured professional values and practices were at times counterproductive. The more I learned, the clearer it became that changing my approach was right, but these necessary shifts in my approach felt wrong somehow. They went against the very characteristics I valued in my work as an interpreter. The challenge became more about managing my internal stress that resulted from altering my approach. I came to realize that the work of interpreting for therapy required realignment within myself.

We will look at these valuable qualities and how they are at times misapplied in mental health environments. The professional values that are most likely to hinder the patient-therapist dynamic are common sense and linear thinking, clarity, and use of our existing schemas to assist
in the interpretive process. We will look at these qualities and how they can be misapplied within the mental health context.

**Common Sense in a Non-linear Setting**

Common sense guides our responses to the situations we encounter throughout the day. For example, if a child is crying, our response is to pick the child up and comfort him or her. If a person is crying in the therapist’s office, we expect there to be some kind of comforting comment. If a husband is belittling his wife in couples counseling, we believe that he should be confronted and told that it is wrong to belittle one’s wife. Common sense responses are often characterized as "natural" or "correct." They simply feel right to us. However, the term “common sense” is a misnomer, as it is a highly individual, subjective perception of what one assumes most people would do (Mozdzierz et al., 2009). It develops over the course of one’s life. Whether or not we practice what our common sense prescribes, it dictates to each of us how we should behave, what is respectful, practical, and polite.

The effective interpreter uses common sense to orient to novel environments. In the majority of settings, an interpreter’s common sense is an asset and should be nurtured and admired. Common sense guides our professional decisions, especially when we do not have the benefit of experience. It helps us choose the register and degree of formality we use when interpreting an intimate phone conversation between a mother and son, or a job interview for a university professor. We depend on common sense to maneuver amongst grieving family members at the bedside of a dying patient. Common sense does not take the place of experience or education, but without it, an interpreter would be less effective.

In many ways, the mental health therapy setting would seem to call for common sense as well. The “conversations” we interpret in mental health settings resemble ordinary conversations, albeit surrounding highly individual and sometimes unusual circumstances. Unlike other specialty areas, such as legal and medical interpreting where interpreters encounter specialized nomenclature and processes (e.g., medical diagnoses, legalese), therapeutic conversations can appear simplistic. Many of us understand the content of these conversations based on our understanding of human nature, emotions, and our prior experience of how supportive conversations proceed. These conversations often move down recognizable avenues of human relationships, daily lives, and emotions. Whether in a psychotherapist’s office, group therapy, or in an occupational therapy group on a locked behavioral-health unit, people who are clients in mental health settings discuss events in their lives and the impact of these events on the way they think, feel, and behave. Therapists respond with nods and utterances of comprehension and what looks to the non-therapist like the giving of advice—all of which can feed the illusion that this is a casual, normal conversation. On the surface, it would appear to require no more than standard interpreting strategies.

Common sense thinking flavors our judgment of how to best respond to people who are in emotional or psychological pain. It helps us know how to relate to victimizers and abusers, and how to respond when accused or blamed for something we did not do. Ironically, in mental health environments it is not only the sometimes unusual thinking of the client that challenges
our common sense—we come to expect that; rather, it may be the approaches of the mental health therapist that can leave us feeling perplexed and confused.

Common sense proceeds from an efficient and linear thought process (Mozdzierz et al., 2009). We perceive a situation and expect a common sense response to it. As novice therapists begin working with clients, they are challenged to move beyond common sense interventions, where there is a straight line between clients’ presenting problems and the solutions to them. They learn to recognize that people are more complex than that. The presenting concern that brought an individual into therapy may be viewed by an experienced therapist as the catalyst for an exploration of larger patterns of behavior, habitual thinking, and deeper issues. Understanding their clients’ problems may require therapists to follow along the circuitous, nonlinear, sometimes impractical, or bizarre routes that created them – and possibly the systems that sustained them. In supervision novice therapists are encouraged to look deeper in order to begin the task of learning to think like seasoned therapists.

When interpreters use common sense as a mental backdrop in order to understand therapy communication, many otherwise highly-ethical, nonjudgmental interpreters end up feeling perplexed. This can contribute to a sense of discomfort or dissonance with how things are proceeding. Many interpreters respond to these feelings of discomfort by pushing them down, trying to ignore them, and above all seeking to stay neutral and objective. Keeping such feelings out of our interpretation is an essential goal, and yet, may not prevent the interpreter from taking a critical stance, or a position in his or her mind about the client’s situation and the therapist's responses to it. When the interpreter silently questions the course of therapy, subtle emotional overtones may be disruptive to the therapeutic relationship. Interpreters have reported having such thoughts as:

- “Why isn’t the therapist answering the question the client just brought up?”
- “Why doesn’t the therapist ask more about this man’s childhood?”
- “The client is sweet and funny. Why isn’t this therapist laughing at her humor?”
- “Why is the therapist just sitting there and not saying anything? Obviously the client feels uncomfortable. The therapist doesn’t understand Deaf culture.”
- “Huh. Obviously, this person is upset. The therapist is not validating the pain and oppression this person is going through. This therapist isn’t very empathic.”
- “When is this therapist going to confront this man about the abusive way he’s talking to his wife? This therapist is chauvinistic!”
- “The client is obviously confused and disoriented. It would help if the psychiatrist would look up from his notebook and just tell her that I am NOT a spy with the CIA. And, also, I’m NOT the interpreter on the TV and I DIDN’T put anything in her brain!”

Each of these internal responses has the ability to add emotional nuances to the interaction that were unintended by the therapist. Each response has the potential to subtly degrade the quality of trust and rapport between therapist and client.

Take a deeper look at the third example: “The client is sweet and funny. Why isn’t this therapist laughing at her humor?”
Maria is the ongoing interpreter for a weekly psychotherapy session. She reports that the client is particularly witty. On several occasions, she and the therapist “cracked up” at the client’s humor. It even seemed to Maria that those moments of loss of control made a noticeable difference in the quality of the rapport and trust between the three of them. On one recent occasion, the client made a funny comment and Maria started to smile and laugh. Being sensitive to the affect of the therapist, Maria noticed that this time he did not laugh or smile. When she recognized that he was going a different direction, she abruptly stopped smiling and tried to match his affect. For a moment, Maria felt awkward, slightly puzzled and felt a subtle undercurrent of embarrassment. In a brief post-session conversation, the therapist explained that he will at times make a quick internal decision not to laugh at a client’s humor: “This may be because I want to draw a client’s attention to their unconscious tendency to use humor to avoid a painful emotion.”

Maria’s very normal and automatic common sense response, (e.g., smiling and enjoying a person’s humor) was not an egregious error. It had the effect, however, of blunting the therapist’s intervention.

Because most interpreters and interpreter educators are generalists by training, they are often unaware of the un-common, multi-layered, nonlinear processes contained within therapeutic communication. As interpreters we do not need to become experts in the process of therapy; however, it is essential that we learn to manage our discomfort with the sometimes confusing, ambiguous-looking approaches used by therapists.

In order to maintain alignment with the emotional tone and content being set by the therapist, interpreters need to find an internal sense of calm (Pollard, 1998). It can be useful for interpreters simply to expect that skillful therapists will not always approach clients’ concerns in predictable, common sense ways. They are likely weighing the appropriateness, degree, and timing of their interventions. This knowledge and the practice of engaging in productive post-session consultations can help the interpreter let go of expectations and stay oriented and calm in settings that are anything but common (Pollard, 1997).

**Balancing Clarity and Ambiguity**

Among the compliments an interpreter receives, “Interpreter, you are clear,” may be among the most welcome. Few moments may be as professionally satisfying to experienced interpreters as when a complex message carried across the gulf of language and culture lands with a nod of comprehension from the person for whom it was intended. Novice interpreters quickly learn to scan the faces of consumers for signs of recognition and comprehension of the message they are interpreting—and more precisely, how their interpretation of it is working. Our consumers’ nods of comprehension, on-target responses, and maintained concentration are clues that combine to suggest that we are likely interpreting successfully and clearly. At times we become concerned and feel the stirrings of anxiety at painful-looking half-smiles, and nods of comprehension that appear disingenuous. We become sensitized to these and other cues to help
us judge when and how to alter our approach in order to better serve our consumers, both Deaf and hearing.

In an effort to bring a sense of lucidity to a message, interpreters sometimes attempt to identify, underscore, and disambiguate a speaker’s point. We add specificity — often placing less emphasis on the message form than its content. We recognize the occasional need to manage the process, to interrupt and ask for a person to speak up, or wait while we expand on a concept. These and other strategies are part of a successful interpreter’s toolkit in most situations. And each can get in the way in mental health interpreting (Dean & Pollard, 2006).

Making the point. Imagine interpreting for a hearing presenter whose style is unclear, meandering, monotone, awkward, and whose point seems to be missing. The highly skilled interpreter may find it challenging to align with and represent the speaker’s lifeless cadence, social awkwardness, and apparent pointlessness. Most will focus on listening even more intently and depend on well-honed listening expertise to unearth the speaker’s point and then convey it to the Deaf consumers in the audience. It requires a great deal of confidence and savvy to leave a seemingly vague message vague—and trust one’s audience will attribute the lack of clarity to the speaker and not to the interpreter. It may feel much easier and more valuable to consumers to just clean it up.

Adding specificity. Experienced interpreters utilize strategies such as expansion, prediction, and clarification to add dimension and clarity to the messages they interpret. While we attempt to maintain a speaker’s affect, at times we find ourselves bolstering soggy, vague-sounding spoken commentary with crisp, three-dimensional structure and specificity unique to American Sign Language. We weigh the seemingly competing values of maintaining the spirit of the speaker, with our consumer’s need to benefit from our expert ability to predict and close or otherwise “read between the lines.” These examples are generalizations of decisions made using a more linear thought process: when consumers look confused, the interpreter takes the initiative to clarify; when a hearing interpreter cannot hear, he or she asks the soft-spoken individual to speak up, or moves closer; when an interpreter does not comprehend a speaker, he or she asks for repetition, when possible; and if something is vague, but still understandable to the interpreter, he or she adds structure, possibly incorporating crisp signing, use of space, indexing, and enumeration to make the point.

Managing the process. In many settings, interpreters may rightly feel a sense of ownership of or pride in these elements of the interpreting process. The interpreter is often the one person who recognizes the back-and-forth flow of communication. Managing not the content, but the complex decisions involved in the interpreting process, the interpreter decides when and if to interrupt for clarification, re-interpret using another approach, or expand on a concept.

Learning to Tolerate Ambiguity

In most settings, techniques aimed at prioritizing accuracy of message content, such as asking for clarification, expansion, prediction, closure, or repetition, are appreciated and effective. In mental health settings, however, competing priorities exist. Clarity as we have come
to know it may not always be at the top of the therapist’s list. The three examples that follow highlight how differently therapeutic communication may be viewed by interpreters and therapists.

Example 1. Tell Me More

Comments such as, “Tell me more” and “Hmm-mm. What’s that about?” are sometimes experienced as “vague” and “confusing” to the interpreter. To the therapist, their utterances may be intentionally “open-ended,” “exploratory,” or “non-directive.” The following is an example of a certified interpreter adding specificity which, unbeknownst to the therapist, narrows the possible responses from a client:

Therapist: “Uh-huh. Oh, my goodness. Yes, I see! It sounds like you have some choices. Talk to me about that.”
Interpreter: “It seems you have three choices. Which one do you prefer? Which one is best?”
Client: (points) “This one is best.”

Here, the therapist was interested in communicating a sense of empathy (“Uh-huh. Oh, my goodness. Yes, I see.”) and understanding (“It sounds like you have some choices.”) and in knowing what is in the mind and heart of the client—from the wide expanse of possibilities (“Talk to me about that.”) In this case, the therapist may also have been more interested in encouraging the client to think differently. The type of thinking that is set in motion as the client scans his mind searching for an answer to an open-ended question, as uncomfortable as it may appear, could matter to the therapist far more than any concrete answer he would have produced. In an effort to be clear and specific (a respectable value) the interpreter led the client down a more narrow line of thinking than was intended. This shift in language form had the effect of giving the therapist a linear response to a non-linear question. No one in the room recognized the shift—not even the interpreter. No one was hurt, but the intervention was blunted and a therapeutic opportunity was missed.

Example 2. Awkward Silences

Sometimes the conversation between therapist and client appears to stall and the room goes quiet for an extended time. An interpreter might experience this silence as “awkward” and may be tempted to take on a sense of responsibility for it and decide to reinterpret the last point, or try to be clearer in one way or another. He or she might smile and shrug, or maintain eye contact with the client (who might also be feeling awkward and looking to the interpreter for clarification).

In this instance, the therapist may have chosen to “use the silence,” as he or she may have seen therapeutic value in it (Hill et al., 2003). Dan Veltri maintained that strategies used by mental health interpreters (i.e., sitting quietly, breaking eye contact, looking toward the floor, and leaving open the opportunity for the therapist and client to make eye contact) can feel oddly inappropriate to the interpreter (Anderson, 2006a). However, for the client to have access to the intended impact of silence, the interpreter needs to weigh his or her options and then manage whatever discomfort he or she might feel.
Example 3. Seeking Clarity

Occasionally, an interpreter may feel the need to manage the process by interrupting either the therapist or the client to ask for repetition or clarification. The information missed could require asking the client for a simple re-spelling of the name of the city, or clarification of the timeframe. In most other settings this decision to interrupt is at the sole discretion of the interpreter.

However, consider that the therapist might be much less concerned with the specifics of content at any particular moment and, instead, desires the client to continue experiencing an important emotional state or awareness. The therapist might prefer that the interpreter briefly mention that information was missed, in order to maintain control over the decision to interrupt or to allow the client to continue uninterrupted. The therapist may choose to come back to the missed point, or not, based on his or her therapeutic goals. This again, underlines the need for the therapist and the interpreter to engage in consultation, when necessary, about issues of language, culture and the interpreting process (RID, 2007).

The details, or content, of a message is only part of what is important in the therapist’s office. Like interpreters, highly-skilled therapists are expert listeners and attend to many levels of communication simultaneously. In addition to the content, or what a person actually says, therapists also attend to a deeper process level where nuances of tone and affect may suggest emotional ambivalence, resonance, resistance, avoidance, or congruity (Mozdzierz et al., 2009). When attending to that level, a therapist may be more concerned with the dynamic process – the process that is going on in therapy at that moment – than with the fact that the interpreter missed a fingerspelled proper name. At the process level, much is also revealed to the therapist about the therapist-client relationship (Yalom, 1989).

Effective therapist-interpreter teams negotiate throughout the communication process, including if, when, and how the interpreter interrupts the client for clarification. Interpreters and therapists may agree that the interpreter will, on occasion, make meta-comments in order to correct and refine nuanced interpretations and otherwise provide information about the interpreter process. Meta-comments of this type are remarks made in the course of interpreting which aim to refer to something that just occurred in the session, usually without directly interrupting the process (Tomkins & Lawley, n.d.). For example, instead of interrupting and asking a consumer to clarify the timeframe in which their comments occurred, the interpreter makes a brief meta-comment to the therapist, “This is the interpreter speaking. I am not clear about whether the argument actually happened yesterday or last month.” Meta-commentary allows therapists to maintain control over the pace and flow of the session and ultimately over what they perceive to be in the best interest of the client. This type of communication-choreography rarely happens spontaneously, and underlies the need for development of a consultative relationship based on trust between therapist and interpreter (de Bruin & Brugmans, 2006).

Early in their training, future therapists confront the need to increase their tolerance for uncertainty and ambiguity (Corey, 2009). Ambiguity exists when there is no one clear answer and, instead, multiple possible responses or interpretations. It is a given that there is little that is
certain, concrete, or clear-cut about the course of therapy, including whether or not therapy is actually helping the client. In all but a few therapeutic approaches, the ability to tolerate, or even honor ambiguity is regarded a necessary quality of a competent therapist (de Bruin & Brugmans, 2006).

Like therapists, interpreters vary in their ability to tolerate ambiguity. Some interpreters thrive in the wildly uncertain moment-to-moment discovery of never knowing what our consumers will say next, and others prefer more stable and predictable types of assignments. There may seem to be little interpreters can do to defend themselves from ambiguity or other sources of discomfort—except possibly attempt to avoid those settings which are most likely to provoke discomfort.

The interpreter who learns of the importance of increasing her tolerance for ambiguity (and other states, such as tension and highly-charged, unresolved emotions) may be well-served by that awareness alone. It may help normalize the experience to realize that the therapist, and to another degree, the client, are also managing ambiguity. At times, sessions will conclude with strong emotions left unresolved and questions unanswered. There is nothing concrete about the process of interpreting for a consumer whose thinking is confused, or matching the emotional state of someone who is having mixed feelings. In Love’s Executioner & Other Tales of Psychotherapy (1989, p. 193), renowned psychotherapist, author, and educator, Irvin Yalom, described one of the most ambiguous of challenges - the task of ever truly knowing the mind of another person:

First, there is the barrier between image and language. Mind thinks in images but, to communicate with another, must transform image into thought and then thought into language. That march, from image to thought to language, is treacherous. Casualties occur: the rich, fleecy texture of image, its extraordinary plasticity and flexibility, its private nostalgic emotional hues—all are lost when image is crammed into language.

Therapists and interpreters, alike, may wonder, “Am I truly understanding? Am I doing this right? Is this doing the client any good? Does the client understand? Is the client getting better or worse?” As with therapists-in-training, even highly-skilled interpreters who have lower tolerance for ambiguity may experience discomfort in mental health environments. Increased tolerance for ambiguity begins with the recognition of the value it may hold in mental health settings. When we add an intellectual appreciation for aspects of the therapeutic process that we may not understand, we may diminish the intensity of our emotional responses (Lewis et al., 2000).

When an interpreter attributes her own discomfort solely to the situation that may be activating it, she may miss the opportunity to manage the emotion or learn from it. Increasing tolerance for uncomfortable feelings is furthered by our recognition of the source of the discomfort as coming from within. This does not need to pathologize the discomfort; nor should it discount the many difficult realities that we encounter. Likely, we have all endured interpreting comments we find intolerable, such as blatant discrimination, unfairness, and untruths. Still, the feelings we experience under these situations, while valid, are our own and need to be
acknowledged, accepted and managed in order to not influence the therapeutic context (Anderson, 2006a).

Our tolerance for situations we encounter varies greatly according to our own history and constellation of life experiences. Like therapists and others who work in mental health settings, it is incumbent on interpreters to continually work toward the awareness and acceptance of their emotional reactions. Our strategies for managing discomfort and ambiguity need to be as unique as the individuals experiencing it.

Schemas and Salience

The effective interpreter learns quickly based on education and life experience. Over the course of a career, an interpreter may manage thousands of distinct topics and environments. The schemas, or frames of references, that we develop over time help us structure and simplify our thinking about complex subjects (Taylor, Peplau, & Sears, 2003). They also help us determine which of the millions of stimuli coming at us is salient in that moment. With experience, interpreters orient quickly to novel settings and unfamiliar dynamics. They learn to listen and understand quickly in order to make the challenging professional decisions required. In corporate settings, parent-teacher meetings, and political rallies, interpreters recognize and then comprehend the goals and content of the individuals present based on life experience, common sense, and education. These ingredients are a part of what makes up our professional schemas.

In a medical setting. Prior to actually interpreting in medical settings, most interpreters will have at least a rudimentary understanding of the medical environment and of what is salient to medical personnel. Based in part on personal experience, including having been a patient, interpreters may have a sense of how medical appointments typically proceed, what one discusses with whom, and how patients are typically treated. Though interpreters are not trained physicians, they may recognize what information could be most relevant or salient to a doctor. However, while an interpreter will not censor the content of a patient’s speech based on an assessment of what is relevant or salient to medical personnel, an awareness of the goals of the professionals in any given environment will heighten one’s attention to those details. When interpreting for a patient who is complaining of back pain, the interpreter is aware that the medical provider’s examination is likely an attempt to determine the source of their pain. This knowledge informs the interpreters’ decision to vocalize “That hurts!” when they see a painful grimace on the patient’s face, especially if the doctor did not see it. In addition, having been patients themselves, interpreters may recognize what the patient may be experiencing and what is important to him or her. Over time, interpreters broaden their schemas for what is “typical” and perhaps more importantly, quickly recognize and adapt to that which is “non-typical.”

In mental health therapy. In contrast, imagine an interpreter working for the first time in a mental health therapy session. On what does the generalist interpreter base his or her recognition of what is salient to the therapist? Interpreters who have had experience in therapy have schemas that may be helpful in recognizing aspects of the goals of the environment from the point of view of the client. When asked, therapists frequently mention that it is helpful when interpreters have had personally transformative experiences of one kind or another, as a result of
therapy. While it is recommended that anyone who works in the mental health field experience therapy themselves, this experience may do little to help us understand the perspective of the provider. As discussed, common sense is an inadequate lens through which to gauge the goals of the therapist. Most of us have little experience and even less knowledge from which to draw to assist us in aligning with the process of therapy.

While there are many distinct variations in approaches to individual psychotherapy, it is generally concerned with the individual and subjective experiences of clients – their moods, emotions, thinking, and behavior. Marriage and family therapies also vary, but are typically less with any one individual’s symptoms, and more with health of the family system – the nuanced patterns of attachment, allegiance, and interaction of its members (Nichols & Schwartz, 2008). The RID Standard Practice Paper on Interpreting in Mental Health Settings (2007) emphasizes that mental health professionals are concerned with nuances of language revealed through its form and structure, as well as its content. Nuanced language is, in part, the vehicle to promote change, to reveal and refine diagnoses, to connect and convey relationship-building empathy, and more.

It can be useful for interpreters to know that, apart from the content of what a client says, clients reveal a broad diagnostic picture in many aspects of their presentation. Therapists are typically concerned with the finer shades of tone meaning contained in what a person says. Their own nuances convey how they receive, understand, and feel about clients. Perceptive interpreters will look beyond simple emotional nuances (e.g., happy, sad, and mad) and recognize and incorporate subtleties of tone and quality of speech (e.g., pressured, hesitant, slow), and affect (e.g., flat, constricted, or euphoric). Attending to theses nuances of communication is core to the interpreting process. However, whether or not we notice and attend to the more subtle nuances contained within the therapist’s pleasant voice, patient pause, concerned look, tilted head, empathic exhale, will to some degree depend on how salient those nuances are to us in our own lives.

Interpreters have a lifetime of experience in relationship with others, and based on that history, place our own level of value and importance on the softer nuances of connection. Effective mental health interpreters attend to these nuances of communication which facilitate empathic connection, to the dance of knowing and being known, seeing and being seen that flows between client and therapist. It is not enough for interpreters in this setting to simply not interfere with the developing therapeutic alliance (Dekker & Ginsburg, 2009). If the interpreter is busily interpreting a client’s comments to the therapist, but ignores the attentive “uh-huh’s” and “mmm-mm’s,” of the therapist – considering it background noise – he may be blunting the most simple and possibly the most effectual tool of therapy.

**What Interpreters Can Do to Improve their Effectiveness**

It is neither necessary nor practical that every generalist interpreter mine the depths of the psychological universe in order to better support the process of mental health therapy. However, a few key insights and fine-tuning of standard interpreting approaches go far to help interpreters
maintain equilibrium, comfort, and effectiveness. When integrated into thoughtful practice, the following techniques can begin to shift the interpreter from interfering, to being an instrument of the work:

**Recognize the Relationship**

Respect that the development of the relationship between therapist and client may be of primary importance to the therapist. Support the relationship by attending to the nuances of tone, pace, posture and specific structures of language. Incorporate the therapist’s efforts to communicate empathy, develop a strong therapeutic alliance, and maintain rapport with their client.

**Work in Partnership with Therapists**

It is a professional courtesy to place a phone call to a therapist in advance of an appointment. Once initiated, the conversation about how to better align with their approach for the benefit of their client may ensue. Offer to provide resources and to help them learn what they might not know about issues of language, culture, and the interpreting process (RID, 2007). Help them learn how to communicate effectively while using an interpreter.

**Assume that There is More to the Picture**

Presume that mental health therapists have a theoretical basis for how they conduct therapy. Allow that assumption to still or quiet internal confusion or disagreement with the course of therapy. Use the rapport built in your professional partnership to check out that which concerns you.

**Build Tolerance (and Appreciation) for Ambiguity**

Recognize and manage negative reactions to patients, therapists and the therapeutic encounter. Develop strategies for returning to a calm and relaxed state in the midst of uncertainty or personal discomfort.

**Look Within**

In therapy sessions, many stories of abuse, trauma, and perpetration are told. Without self-awareness of one’s own deeply-rooted issues, values, problems, or trauma, interpreters may be unprepared for the strong emotions (e.g., anxiety, anger, and so forth) that may emerge unexpectedly. We cannot manage what we don’t know is there.

**Maintain Calm in Chaos**

Whether due to heightened emotions, ambiguity or personal sensitivities, interpreters in mental health therapy sessions may be affected by the content. Collect strategies for returning to a calm, centered state of mind. Breathing, thinking affirming thoughts, and building our knowledge of the mental health environment are a few strategies that combine to orient the interpreter to otherwise disorienting environments.

**Cooperate with Therapists Regarding the Flow and Pace of Therapy**

This includes decisions about when to interrupt, clarify, and expand. As stated, it is rare that synchronous communication of this type occurs spontaneously between therapist and interpreter without discussion. If the practice of pre- and post sessions, or meta-commentary feels inappropriate, consider that performing arts interpreters preview a show and engage in
discussions with people involved with a production. Even the decision to not engage in mutual consultation discussions, for whatever reason, is best made deliberately and in the spirit of mutual consultation. Interpreters act in the service of their consumers when they develop professional rapport with providers.

**Tune into the Nuances and Emotional Resonance**

Focus on recognizing, reflecting, and producing nuanced affective states in your interpreting into both ASL and English. Observe and expand your awareness of your emotions — including resistance or willingness to express variations in emotional affect. Interpretation that is skillfully infused with relevant psychological and emotional nuances allows therapist and client to “see” one another more accurately and increases therapeutic options.

**Practice Self-Care**

Every mental health interpreter is at risk of developing vicarious trauma-type reactions. In mental health interpreting, self-care is not only suggested, it is essential. Strive for maintaining self-care practices that support a balanced, healthy life. Building up your reserves of well-being will help you manage difficult situations.

**Develop Somatic Awareness**

One’s body is a useful and practical self-management tool. Oftentimes emotions will manifest first in our bodies (e.g., tension in the shoulders, shallow breathing, a knot in the stomach) before we are consciously aware of the emotion. By recognizing these physical signals, we can acknowledge and address the potential difficulty before it has a chance to amplify.

**The Role of Interpreter Educators**

With experience and training, a seasoned interpreter may be able to adopt the techniques of mental health interpreters, but the *person* of the interpreter develops over time. Therefore, educators have an important role to play in expanding and defining the professional expectations of our field for our future colleagues.

Educators can decrease stigma surrounding mental health care by modeling respect for the mental health of our consumers and ourselves. It is essential that interpreters who will one day work in mental health settings (whether they intend to or not) examine their attitudes toward mental health and its treatment. Deaf individuals seeking mental health services face multiple barriers—interpreter attitudes need not be one of them. We need to “unpack” the societal and familial messages that we have accumulated throughout our lifetimes. More important than changing students’ attitudes is helping them become aware of the attitudes they have. To do so lessens the potential for the interpreter’s unexamined attitudes to contaminate the relationship between the therapist and the Deaf consumer.

Some students come to the interpreting field with a well-developed identity and examined inner life. Still others will be learning to be neutral and objective even before they know who they are and what they are setting aside. Educators can help students understand the importance of developing a non-judgmental awareness of their uniqueness and of which situations and behaviors tend to “trigger” strong responses in them. While it is the professional responsibility of
interpreters to learn to set these to the side in service of consumers, again they cannot manage what they do not know is there. Neutrality and objectivity are among our most prized values. And yet over time, as we become more adept at mentally setting ourselves to the side in order to maintain objectivity, we may become less adept at recognizing our internal landscape.

Interpreter educators have the opportunity to help students begin to develop tolerance for ambiguity. Ambiguity is what we embrace when we answer a student’s question with, “It depends.” That there is no one right answer frustrates and irritates many students who would much rather be told a definitive black-and-white answer. The vivid experience of frustration is the perfect laboratory for building reserves of tolerance for ambiguity and exploring methods for managing it. While students may not be able to mentally project themselves into a future time and place where the fine points of self-awareness and self-care will be useful, their visceral response to ambiguous situations can provide a training ground in which they may begin to value this self-awareness and to practice this self-care. Instructors can re-frame the student’s experience as “building tolerance for ambiguity” and assure them that it is a necessary step in order to be comfortable in settings that they might otherwise find disorienting.

Some of the most intimate and impactful educational experiences are those that occur in vivo. Students will experience wide-ranging emotions during their education, and, with awareness and intention, their increased emotional palette can embolden their interpreting and enrich their lives. Concurrent with the broadening of linguistic and cultural fluency that is standard in interpreter education, educators can also guide students to learn to identify and understand their own emotions, and this enriched emotional vocabulary will prove essential in mental health therapy.

If the interpreting profession is to look beyond simply mitigating the interpreter’s interference in mental health settings, we need to encourage and support development of the person of the interpreter throughout various levels of interpreter education, so that the individual is inspired to pursue meaningful self-awareness and fulfilling strategies for self-care and self-management. Regardless of a student’s intention to interpret in mental health settings, nearly every practicing interpreter will one day find him or herself interpreting in a setting where mental health takes center stage. Mental health is present in every interpreting assignment to a greater or lesser degree — and at times it is our own mental health that we are managing. Like mental health therapy itself, an exploration of mental health interpreting is a dynamic process that has the potential to promote professional growth and inspire meaningful personal discovery. Educating ourselves and our colleagues to better orient to mental health environments is challenging, important, and ripe with opportunity.

Conclusion

Finally, let us acknowledge that mental health environments are at once highly professional and profoundly personal. They contain within them the real and often troubling stuff of human lives. In those brief moments when interpreters carries content-filled messages across the gulf separating two languages and cultures, they also hold the very essence of the therapeutic
relationship. From that essence may grow true connection and nuanced human understanding – the “active ingredients” in a uniquely personal kind of healing.
References


