

Mental Health TeleTraining Follow up Questions

You mentioned the workshops held in Alabama, are they open to residents in other states?

Yes, in fact we usually have a large out of state contingent. You can find information about our trainings by going to www.mh.alabama.gov/MIDS or joining the ALMHI listserv on yahoogroups.

Can interpreters share info with another interpreter about a MH assignment when they are interpreting for the same client but not in the same session?

If the two of you are the regular interpreters and you are the interpreter team for this treatment, then yes you may share information with the other interpreter as needed to assist them in providing interpreting services. This is true whether they were physically present at one event or not since they are considered part of the "team." As always, you should make sure that the information being shared is appropriate and is shared in a way that allows the information to be protected. DHHS has guidelines that state that the interpreter or interpreters may have access to information needed to interpret the session and are not required to have a HIPAA release signed from the client.

Do you think RID will ever offer a specially certificate in mental health?

I hope so. We were pleased to see the RID Standard Practice Papers updated recently. And there seems to be some interest in the area recently, as evidenced by an increase in training opportunities. However, we are currently without the Special Interest Group in Mental Health Interpreting and it would be a good first step to seeing progress in a specialty certification. Beyond that, we would need to have the motion made and brought up for a vote.

The laws are clear with mandatory reporting as it relates to a child under the age of 18. Where does an interpreter's responsibility lie when it is a post secondary student ages ranging from 18 to

Anytime a person is a danger to himself or others and you are working in an environment where you could be considered a mandatory reporter, you are obligated to report it to the authorities. I would suggest that you check your local (state) laws for more specific information on how you might be impacted in various settings.

In a mental status examination a doctor may ask a patient to explain the meaning of a parable such as: "A rolling stone gathers no moss." Because a deaf individual may have language deprivation he/she may not know the English words for the parable. However, you stated that the interpreter

shouldn't clarify too much or he/she could give away information that is being looked for by the professional. What should the interpreter do?

I would usually inform the therapist (hopefully beforehand if I know that it's going to be a mental status exam or that it might come up). If I can't or didn't talk with the therapist beforehand, then I will tell them (briefly) before I provide the interpretation that English parables are often ineffective when it involves interpreting them to another language. Sometimes the therapist will want to try anyway, if this happens, then I usually like to try the parable in its original form (English). Since any interpretation changes the question and/or gives away the answer. It may be that the deaf person had some exposure to the parable. However, once that is done and the response is inappropriate, the therapist may move on. Bob Pollard has a video on spoken language interpreters demonstrating just this question that's extremely well done. The interpreter in that situation offered a parable in their language/culture and used that in lieu of the English parable.

How do you as an interpreter sign the question from the counselor, "Do you hear voices?"

A very difficult question to answer in written form. ☺ I will often use a sign behind the right ear that looks like someone talking to them. Deaf individuals, who have experienced auditory hallucinations in the past and have the language exposure to it, will often recognize the question in that format. If this is ineffective, then I will let the therapist know that this question is a very difficult concept to ask a deaf person because of issues related to "hearing" and we may need to ask a line of questions in order to discriminate between ability to hear and experiencing auditory hallucinations, including the fact that due to fund of knowledge deficits that can exist, they may not be familiar with the concept of "hearing voices" (in an auditory hallucination sense).

Where does the role an interpreter as a bicultural mediator come into play in the role of mental health interpreting? For example if the client is giving a rambling answer.

Anytime issues come up that related to language or culture that can be misconstrued as a psycholinguistic error or bizarre behavior that is typical of language or behaviors of individuals in the deaf community, it is important that we share the information with the therapist. (So that the deaf person wouldn't be inaccurately diagnosed or improperly medicated.) However, we should be concise and accurate in our comments and be open to the possibility that it could also be a symptom of mental illness or that it could be a combination of language/culture related to deafness and a presenting symptom.

Is there any documentation that records and compares psycholinguistic errors with ASL language structure?

Yes, there have been a few limited studies.

Do You Hear Voices? Problems in Assessment of Mental Status in Deaf Persons with Severe Language Deprivation by Neil Glickman; Language-Related Symptoms in Persons with Schizophrenia and How Deaf Persons May Manifest These Symptoms by Trumbetta; and some recent studies in England by Joanna Atkinson are worth a read if you are interested in comparisons of language/culture in hearing and deaf populations.

How can we find a list of psychotic language dysfluency and examples?

Depending on the level of information that you would like. There are several examples on the internet that you can find by googling “psychotic language” or “psycholinguistic errors”. We offer this training as a part of our Mental Health Interpreter Training (MHIT) Institute and there are some research articles related to deafness on this topic (see question above).

If you are working with a student that you suspect is heading toward a psychotic state, by observing the warning signs that you spoke of. At which point is it NOT crossing the line to report this to perhaps a school counselor, or crisis team?

If you are noticing that a student is exhibiting signs that are of concern, especially psychotic symptomology, then it is your responsibility to bring this to the attention of the appropriate reporting authority. This really becomes a health and safety issue and would take precedence over your normal role. In your educational system, this may be a teacher of the deaf/hard of hearing, the principal, the school counselor, etc. (Your chain of command, in other words). As an educational interpreter, you are in a unique position to notice symptoms that others may not be aware are occurring. Once the student becomes a danger to himself or others, you are obliged to make sure that it is reported to the appropriate persons. You will want to check your local (state) laws and be aware of your school’s policies.

Would it be better for an interpreter to gloss what is being signed and to let the doctor decide or decipher the information?

Unfortunately glossing is not a representation of ASL. Glossing can be misconstrued as “word salad” or incoherence that can have clinical implications. Hearing therapists often can’t separate glossing from incoherence, since they have no frame of reference for the interpreting process. (For example, if someone signs SODA, how would you decide to gloss it SODA vs. COKE vs. SODA POP vs. POP vs. DRINK). Also, glossing can denote that grammatical structure is missing, when it may or may not be. Often what is more helpful is to state that what you are seeing isn’t making sense to you, and offer an explanation of what you are seeing.....that they are producing the words

correctly, but putting them together in a way that isn't what would normally be expected, missing time indicators, verbs are being signed, but there are no nouns, or there are transition words/concepts that are missing, or many of the signs are following linguistic rules of ASL, but are not words (signs) that you are familiar with, it's being signed too quickly, etc. This is much more productive use of your time and information that the therapist would not have without your feedback. This information can be very helpful in making a clinical decision. At this point, you might choose to incorporate some of the vocabulary that you are seeing and glossing or "just say what they are signing" can become an option. Often I will do so in third person, for example: "He keeps mentioning food items....CORN.....NUTS.....SQUASH.....APPLE.... but it isn't making sense because....." But using gloss exclusively doesn't give the therapist information that they need and can lead to misunderstandings.

Are there any regulations requiring specific training or certification for interpreters in the mental health setting?

There are federal regulations, ADA for example, that state that a qualified interpreter must be able to interpret expressively and receptively using any technical vocabulary necessary. RID Code of Professional Conduct states that "Interpreters possess the professional skills and knowledge required for the specific interpreting situation" and the RID SPPs assist interpreters in defining qualifications in mental health interpreting. Alabama has a state certification that is a part of the Alabama State Code (law) defining a qualified mental health interpreter. I'm not aware of other states that have similar requirements.

How would you handle a situation where you are voicing for a client who's signing is clear, then unclear, then clear again? What tool do you use to let the therapist know it is not the interpreter who is being ineffective but is a mental health issue for the deaf person. This seems to be a sticky situation.

It depends on the situation and the goal of the environment. For example if the person's language is exhibiting the factors that you mentioned above, it could be a natural consequence of maternal rubella and isn't indicative of their mental status or ensuing psychosis. Are they presenting at the local university on "Working with Deaf Children"? If this were true, I might use extended time lag, so that I could use the previous information to "cover" (for lack of a better word) during the portions where it doesn't make sense and then pick up again when the language is back on track. If I'm in a clinical setting and interpreting for them as a client with a hearing therapist, I would simply add (in third person) "I'm not sure what they are saying at this point (explain WHY it isn't understandable - if at all possible)" then I would pick up again when it starts making sense.

Is there research pointing to differences in rates of mental illness

between deaf students in primarily deaf post-secondary environments and deaf students in primarily hearing post-secondary environments? Deaf children of deaf parents v. deaf children of hearing parents?

Yes, there are several research articles that address these issues from a variety of topics . You can find many of them by going to The APA PsychInfo database: <http://psycinfo.apa.org/> or The PUBmed literature database: <http://www.pubmedcentral.nih.gov/> and typing in keywords related to your areas of interest (mental illness, deaf, students, etc.).

How can educational interpreters help the D/hh students gain better social skills?

Your school structure and the student's IEP will probably help shape the role of the educational interpreter. In some settings, the interpreter models appropriate (hearing culture) social skills or the interpreter may remind the student of expected social norms or educate them on why hearing students are reacting to them in certain ways. While in other settings, the interpreter may actually provide tutoring time during the student's study hall. Sometimes, the interpreter may provide this information to their supervisor or bring issues up during an IEP or staff meeting. Since expectations vary depending on your system, it might be best to consult with your supervisor and team to decide the best approach to your concerns.

I have a psychology background and have found that often interpreting pure ASL can be misconstrued as schizophrenia if the interpreter is not familiar with it - does the speaker agree with this statement?

Yes. Interpreters must be very careful to convey the message (voice) in English rather than ASL structure when the deaf client's language is normal ASL usage. Otherwise research has shown that ASL/deafness are often analogous with language and behavior patterns exhibited by individuals who are schizophrenic. However, interpreters must also be careful not to "fix" language that is not "normal" ASL so that true psycholinguistic behaviors never rise to the attention of the therapist. Because mental health settings are so heavily dependent on language, it requires the interpreter to be fluent in both the target and source language and to be able to recognize the difference between developmental and psychological dysfluencies.

Are different labels used for the same diagnosis depending on the age of the person? For example in a legal settings different terms are used for juveniles as opposed to adults. Is the same true in mental health?

Yes, there are different labels for childhood disorders and disorders associated with adults. The term "serious emotional disturbance" SED is used in reference to children under the age of 18 with a diagnosable mental health problem that

severely disrupts their ability to function socially, academically, and emotionally. The term does not signify any particular diagnosis; rather, it is a legal term that triggers a host of mandated services to meet the needs of these children. Adults are often referred to as “mentally ill.”

Conduct Disorder or Oppositional Defiant Disorder can occur in children or adolescents, however, if they are 18 or older it’s antisocial personality disorder.

In a postsecondary setting a student who is attending counseling will often have a different interpreter for each session. How would an interpreter contact the counseling office to set up a meeting with the therapist prior to the session?

The easiest point of contact is the time when you are making/accepting the assignment. If you have a lead interpreter or an interpreter coordinator who makes the assignment, you may want to direct the request to them or let them know that you would like to contact the therapist directly to discuss the assignment. If this is something you do on a regular basis, you and the other interpreters/interpreter coordinator may want to consider setting up a systemic way of sharing appropriate information. If I do contact the therapist directly, then I often ask for some time to consult with them regarding the upcoming appointment. Remember that their time is often very limited and you may only get a short phone call or 15 minutes in person to discuss the assignment, so you want to make the most of it and get the most critical information – diagnosis, recent breakthroughs or issues that may be addressed in the appointment, goal of the appointment, etc.

How often is a CDI (certified deaf interpreter) used in the mental health situations? Where are the most recurring uses of the CDI in this field?

CDI usage depends largely on CDI availability and funding sources. If these are removed from the current discussion, then CDI usage that should be considered include working with clients who are dysfluent, alingual, have highly contextualized language, dialectical differences, fund of knowledge deficits, etc. Sometimes CDI’s can be used in situations related to perception of power/dominance. For example, upon intake, the psychiatrist (almost always hearing, non-signing) and the nurses (also, almost always hearing non-signing) are involved, even in units where other staff are deaf or sign fluent. This sets up a situation where the first exposure to the facility can be a very “hearing” perception, so bringing in a CDI to work with the hearing interpreter can help offset power differentials, and build trust in the program. We have also used CDIs with a deaf therapist who has a variety of language levels to work with in group therapy. The deaf therapist would use ASL and the CDI would break it down into visual pictures for those deaf who were not fluent in ASL.