

An Inside Look: What Educational Interpreters Need to Know about Mental Health Interpreting

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Moderator: Cindy Camp, LA/TX Outreach Specialist, PEPNet-South

Co-Moderator: Jennie Bourgeois, LA/TX Outreach Specialist, PEPNet-South

>>CINDY CAMP: I'D LIKE TO WELCOME YOU. THIS IS PEPNet-SOUTH'S NINTH TELETRAINING AND IT'S TITLED: AN INSIDE LOOK AT WHAT EDUCATIONAL INTERPRETERS NEED TO KNOW ABOUT MENTAL HEALTH INTERPRETING. WE HAVE APPROXIMATELY 450 PEOPLE REGISTERED FOR TODAY'S TELETRAINING. IT'S ONE OF OUR LARGEST NUMBERS YET, AND WE'RE VERY HAPPY TO WELCOME YOU ALL. MY NAME IS CINDY CAMP, AND I SERVE THE STATES OF TEXAS AND LOUISIANA FOR PEPNet-SOUTH, ALONG WITH MY CO-MODERATOR JENNIE BOURGEOIS.

WE HAVE WITH US TODAY CHARLENE CRUMP. CHARLENE IS THE STATEWIDE MENTAL HEALTH INTERPRETER COORDINATOR FOR THE OFFICE OF DEAF SERVICES FOR ALABAMA DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION. SHE HAS A LONG AND DISTINGUISHED LIST OF CREDENTIALS WHICH I WON'T BE ABLE TO GO INTO FULLY AT THIS TIME. HOWEVER, I'D LIKE TO TELL YOU A FEW OF HER ACCOMPLISHMENTS. HER WORK IN MENTAL HEALTH INTERPRETER TRAINING HAS RECEIVED NATIONAL RECOGNITION, INCLUDED THE NATIONAL ALLIANCE OF MENTALLY ILLINOIS, NAMI AND IS INTERNATIONALLY RECOGNIZED BY THE CHARTER OF LINGUISTICS. SHE IS A CONTRIBUTOR TO THE NATIONAL REGISTER OF INTERPRETERS FOR THE DEAF, STANDARD PRACTICE PAPERS FOCUSSING ON MENTAL HEALTH INTERPRETING AND HAS SERVED ON EXPERT FOCUS GROUPS, INCLUDING WORK WITH NORTHEAST UNIVERSITY IN BOSTON, IS ESTABLISHED -- IN THE ESTABLISHMENT OF A GRADUATE LEVEL CERTIFICATE PROGRAM FOR MENTAL HEALTH INTERPRETING. ADDITIONALLY, SHE WAS THE FIRST COHORT APPOINTED TO THE ALABAMA LICENSING BOARD OF INTERPRETERS AND TRANSLITERATORS AND HAS SERVED TWO TERMS AS CHAIR. CHARLENE, WE HAVE SUCH A LARGE AND VARIED GROUP JOINING US TODAY. WHEN WE FIRST DISCUSSED HOSTING THIS TELETRAINING AS A TOPIC, I WASN'T AWARE THAT IT WAS GOING TO BE AS POPULAR AS IT IS, BUT WE HAVE MULTIPLE POST-SECONDARY, AS WELL AS K THROUGH 12 SCHOOL SYSTEMS JOINING US TO LEARN MORE ABOUT HOW THEY CAN HELP THEIR STUDENTS WHO ARE EXPERIENCING MENTAL ILLNESS. I THINK IT REALLY JUST GOES TO SHOW HOW

IMPORTANT THE TOPIC IS. SO LET'S GO AHEAD AND START OFF WITH A DEFINITION OF WHAT IS MENTAL HEALTH INTERPRETING?

>>CHARLENE CRUMP: WELL, FIRST, I JUST WANT TO SAY I'M JUST VERY GLAD THAT YOU'RE ALL HERE. IT'S REALLY EXCITING TO SEE SUCH AN INTEREST IN MENTAL HEALTH INTERPRETING AND I THINK THAT THE FOCUS HAS REALLY GROWN LATELY AND IT'S JUST REALLY NICE TO SEE NATIONALLY PEOPLE TAKING A LOT MORE INTEREST IN IT SO THANK YOU FOR BEING HERE ON THE CALL TODAY. WHAT IS MENTAL HEALTH INTERPRETING? I THINK MENTAL HEALTH INTERPRETING JUST ENCOMPASSES A LOT OF SETTINGS AND PLACES. SOMETIMES THERE'S SETTINGS AND PLACE THAT WE THINK OF READILY LIKE A MENTAL HEALTH HOSPITAL, A PSYCHIATRIC UNIT, MARRIAGE AND FAMILY COUNSELING, MAYBE, GROUP HOMES. BUT I THINK ALSO THAT PEOPLE KIND OF UNDERESTIMATE WHAT THOSE SETTINGS INCLUDE AND WHO THOSE PEOPLE ARE AT TIMES. I'VE BEEN IN MANY INSTANCES WHERE I'VE GONE TO LIKE AN EMERGENCY ROOM VISIT, A PRIMARY CARE PHYSICIAN, PROBATE COURT, SCHOOL SYSTEMS, RELIGIOUS COUNSELING, ASSESSMENTS, A LOT OF THE ASSESSMENTS ARE DONE IN SCHOOL SYSTEMS AND JUST INTERPRETING IN A LOT OF FACETS OF WHAT WE CALL GENERAL INTERPRETING, OFTEN.

>>CINDY CAMP: WELL, IF SO MANY OF THE GENERAL INTERPRETING INCLUDES A MENTAL HEALTH ASPECT, WHY WOULD IT BE IMPORTANT FOR MENTAL HEALTH INTERPRETING TO BE A SPECIALTY FIELD?

>>CHARLENE CRUMP: I THINK THERE ARE A LOT OF REASONS THAT THAT'S TRUE. PROBABLY MORE THAN ANY OTHERS, I THINK THAT MENTAL HEALTH INTERPRETING REQUIRES THE INTERPRETER TO HAVE A HEIGHTENED AWARENESS OF THE RELATIONSHIPS THAT EXIST BETWEEN THE HEARING AND DEAF CLIENTS. YOUR THERAPIST AND THE DEAF PERSON WHO'S THERE AS A CLIENT, OR, VICE VERSA, MENTAL ILLNESS HAS A TREMENDOUS IMPACT ON THE PSYCHOSOCIAL MILESTONES, THE EDUCATIONAL DEVELOPMENT, AND IT HAS A TREMENDOUS IMPACT ON LANGUAGE DEVELOPMENT AS WELL. IT IMPACTS I THINK THE QUALITY OF LIFE FOR INDIVIDUALS WHOM WE INTERPRET FOR. I THINK THAT IT INVOLVES A LOT OF VERY UNIQUE EMOTIONAL BEHAVIOR AND LANGUAGE PATTERNS THAT WE DON'T ALWAYS SEE OR THINK ABOUT. I THINK MENTAL HEALTH INTERPRETING IS SO DEPENDENT ON LANGUAGE IN WAYS THAT WE'RE NOT USED TO DEALING WITH IT. IT DOES REQUIRE THE INTERPRETER TO BE FLUENT IN BOTH THE SOURCE AND THE TARGET LANGUAGE SO THAT WE CAN RECOGNIZE THE DIFFERENCE BETWEEN WHAT IS -- WHAT WE CALL A DEVELOPMENTAL DYSFLUENCY, MEANING THAT THEY'RE LANGUAGED AND DEVELOPED APPROPRIATELY BECAUSE OF, YOU KNOW, LACK OF EXPOSURE, LACK OF EDUCATIONAL EXPOSURE, ET CETERA, VERSUS A DYSFLUENCY THAT'S PRESENT BECAUSE OF THE MENTAL ILLNESS. AND THIS FIELD UTILIZES A LOT OF INTERPRETING TECHNIQUES. WE'RE USED TO, AS INTERPRETERS, I THINK, KIND OF USING THAT FIRST PERSON SIMULTANEOUS, MEANING I HEAR IT AND I SIGN IT EITHER IMMEDIATELY OR EVEN WITH SOME LAG TIME. WE STILL CONSIDER THAT AS SIMULTANEOUS INTERPRETING, WHERE, IN MENTAL HEALTH, THE NEED TO WORK IN CONSECUTIVE, NARRATIVE AND DESCRIPTIVE

TECHNIQUES ARE MUCH HIGHER. AND I THINK THAT LIKE EDUCATIONAL INTERPRETING OR LEGAL INTERPRETING, HAS A HIGH DEGREE OF SPECIALIZED LANGUAGE AND SETTINGS, AND I THINK THAT ANOTHER THING WE HAVE TO CONSIDER IS THAT IN THE MENTAL HEALTH SETTING, INTERPRETERS OFTEN -- WELL, LET ME BACK UP. IN THE COMMUNITY OR GENERAL INTERPRETING, A LOT OF TIMES WE'RE SEEN AS THE ALLY FOR THE DEAF INDIVIDUAL. WE'RE HERE TO MAKE SURE THAT THE DEAF INDIVIDUAL GETS THAT INFORMATION AND WE DO HAVE THOSE TWO CONSUMERS. IN MENTAL HEALTH SETTINGS, MORE SO THAN ANY OTHERS, YOU REALLY HAVE TO ALLY YOURSELF WITH THE THERAPEUTIC PROCESS BECAUSE TO ALLY YOURSELF WITH THE DEAF PERSON THEMSELVES CAN BE COUNTERPRODUCTIVE TO THE THERAPY SESSION.

>>CINDY CAMP: WOW, THAT'S A LOT OF GOOD INFORMATION. YOU MENTIONED A FEW EXAMPLES ALREADY, BUT COULD YOU MAYBE GIVE US AN EXAMPLE OR A SITUATION WHERE SOMEONE WHO SAYS, OH, NO, I ONLY DO EDUCATIONAL INTERPRETING MIGHT FIND THEMSELVES IN MENTAL HEALTH SETTING, A SITUATION THAT THEY WOULDN'T NORMALLY THINK THEY WOULD DO?

>>CHARLENE CRUMP: I CAN THINK OF A LOT OF THEM, BOTH IN GENERAL INTERPRETING, AND EDUCATIONAL INTERPRETING. JUST TO START KIND OF IN THE GENERAL POPULATION, YOU KNOW, I WON'T QUITE SAY ALL OF THEM, ALTHOUGH THERE ARE TIMES IT FEELS THAT WAY, BUT I WILL SAY THAT A LOT OF THE SITUATIONS WE'RE INVOLVED IN EITHER ARE MENTAL HEALTH APPOINTMENTS OR THEY HAVE THE POTENTIAL TO BE SO. AND SOMETIMES WE GO INTO IT AS INTERPRETERS NOT EVEN KNOWING THAT THAT WAS AN ELEMENT OR A PART OF WHAT WE WERE DOING. YOU KNOW, I JUST -- TO THROW OUT A FEW EXAMPLES, I THINK IN MEDICAL SETTINGS, YOU KNOW, A PRIMARY CARE PHYSICIAN APPOINTMENT EASILY CAN BECOME A COUNSELING SESSION. I REMEMBER INTERPRETING ONE TIME FOR A LADY WHO WAS THERE DOING A PHYSICAL, AND THE DOCTOR WAS DOING ALL THE NORMAL CHECKS, YOU KNOW, CHECKING HER HEARING AND HER PULSE AND HEARTBEAT AND THEN HE KIND OF LEANS OVER TO ME AND SAYS, YOU KNOW WHAT I'M REALLY WORRIED ABOUT IS THAT SHE'S GOING TO GO HOME AND KILL HERSELF AND ALL OF A SUDDEN THE DYNAMICS OF THAT SITUATION CHANGED. MEDICATION MANAGEMENT. ABOUT -- I WOULD SAY MOST PEOPLE WHO RECEIVE MEDICATIONS THAT ARE CONSIDERED PSYCHOTROPICS RECEIVE THEM FROM THEIR PRIMARY CARE PHYSICIAN RATHER THAN FROM A PSYCHIATRIST OR A MENTAL HEALTH AGENCY. I THINK THERE WAS A STUDY ABOUT TWO YEARS AGO, TWO OR THREE YEARS AGO, THAT CAME OUT THAT SAID 70% OF THE INDIVIDUALS WHO RECEIVE PSYCHOTROPIC MEDICATIONS RECEIVE THEM FROM SOMEONE WHO IS NOT A PSYCHIATRIST. BEYOND THAT, I MEAN, JUST, AGAIN, VERY QUICKLY, YOU KNOW, YOU COULD BE IN A WORK SITE THAT BECOMES AN E.A.P., EMPLOYMENT ASSISTANCE PROGRAM REFERRAL. YOU CAN -- IN LEGAL SITUATIONS, THE LINES BETWEEN LEGAL AND MENTAL HEALTH ARE SO BLURRED THAT IT'S HARD TO TELL WHICH IS WHICH. YOU CAN BE ON A VRS CALL AND INTERPRETING FOR SOMEONE, AND IF YOU'VE EVER DONE VRS INTERPRETING, YOU KNOW THAT YOU NEVER QUITE KNOW WHAT YOU'RE GOING

TO GET. I REMEMBER A FRIEND TELLING ME ONE TIME SHE WAS INTERPRETING, AND THERE WAS A LADY WHO WAS MENTALLY ILL WHO WAS CALLING A DEAF FRIEND AND SHE WAS INSTRUCTING HIM HOW TO MAKE A HAT OUT OF ALUMINUM FOIL SO THAT THE BEAMS THAT WERE COMING IN TO HIM THAT BLOCKED HIS HEARING COULD BE REMOVED AND HE WOULD BECOME HEARING. AND THOSE KINDS OF THINGS JUST POP UP ALL THE TIME. YOU NEVER EVEN KNOW -- I MEAN, WHEN YOU'RE GOING TO A COMMUNITY EVENT TO YOUR DEAF CLUB OR A SILENT DINNER, YOU NEVER KNOW WHEN THE PEOPLE THAT ARE SITTING AROUND THAT TABLE ARE MENTAL HEALTH CLIENTS OR HAVE A MENTAL ILLNESS OF THEIR OWN AND ARE ABLE TO MAINTAIN IN THE COMMUNITY. THE EDUCATIONAL SETTING IS JUST REplete WITH SITUATIONS THAT ARE MENTAL HEALTH INTERPRETING. YOU HAVE STUDENTS WHO HAVE TRAUMA IN THEIR LIVES, SOME OF THEM MORE TRAUMATIC THAN OTHERS. I MEAN, THEY CAN HAVE A DEATH IN THEIR FAMILY OR THEY COULD HAVE JUST BROKEN UP WITH A BOYFRIEND OR GIRLFRIEND. YOU HAVE STUDENTS WHO SOMETIMES WILL DISCLOSE TO YOU AS THE INTERPRETER, ESPECIALLY DEAF STUDENTS, BUT SOMETIMES HEARING STUDENTS, SOMETHING ABOUT THEIR HOME LIFE THAT MIGHT BE LESS THAN IDEAL.

THEY MAY BE HAVING ABUSE ISSUES AT HOME, SEXUAL ABUSE, PHYSICAL ABUSE. I HAD A DEAF STUDENT ONE TIME WHO CAME UP TO ME IN THE MIDDLE OF CLASS AND JUST ALL OF A SUDDEN BLURTED OUT THAT HER PARENTS HAD SOLD HER FOR SEX TO THIS MALE FRIEND OF THEIRS IN EXCHANGE FOR DRUGS. SOMETIMES YOU HAVE YOUNG GIRLS WHO FIND OUT THAT -- WHO JUST FOUND OUT THAT THEY'RE PREGNANT, YOU HAVE ISSUES WITH BULLYING, YOU KNOW, SUICIDAL ISSUES, ADHD, CHILDREN WHO HAVE SED, SEVERE EMOTIONAL DISTURBANCES. YOU HAVE CHILDREN WHO HAVE FAMILY MEMBERS WHO HAVE MENTAL ILLNESS. AND PUBERTY AND YOUNG ADULTHOOD SEEMS TO BE JUST A PRIME TIME FOR A LOT OF THOSE MENTAL ILLNESSES TO PRESENT THEMSELVES. AND I THINK THAT OF COURSE IT ISN'T AN EXHAUSTIVE LISTING, BUT IT'S A LOT, AND FOR YOU GUYS WHO ARE EDUCATIONAL INTERPRETERS, SOMETIMES I KNOW YOU FEEL LIKE I DID IT FOR SEVERAL YEARS AND I LOVED IT AND I KNOW THAT THERE WERE DAYS IT FELT LIKE ALL OF THOSE HAPPENED IN ONE DAY.

>>CINDY CAMP: WELL, YOU'VE KIND OF ANSWERED OUR NEXT QUESTIONS. IT'S OBVIOUS THAT IT IS IMPORTANT TO THE EDUCATIONAL INTERPRETER, AND FROM THE NUMBER OF SCHOOL SYSTEMS WHO HAVE ASKED THEIR INTERPRETERS TO ATTEND THIS TRAINING, I CAN SEE THAT IT'S A GROWING PROBLEM. WHEN WE'RE TALKING ABOUT SOME OF THE ISSUES LIKE SCHOOL SHOOTINGS AND SCHOOLS ARE BECOMING MORE CONCERNED WITH THE ISSUE OF BULLYING AND MAKING SURE THAT STUDENTS DON'T GO OFF THE DEEP END, SO TO SPEAK. SO I THINK IT IS A VERY IMPORTANT TOPIC. WE'LL MOVE ON. WELL, AND YOU'VE KIND OF ANSWERED THIS ONE AS WELL, BUT --

>>CHARLENE CRUMP: I'M SORRY. I GOT AHEAD OF YOU.

>>CINDY CAMP: NO. THAT'S GREAT. THAT WILL LEAVE US PLENTY OF TIME FOR AUDIENCE QUESTIONS. BUT YOU SAY IT'S IMPORTANT FOR ALL INTERPRETERS TO BE AWARE OF SOME OF THE MENTAL HEALTH ISSUES BECAUSE THEY NEVER KNOW WHEN THEY'RE GOING TO ENCOUNTER A SITUATION. SO AT WHAT AGE DOES MENTAL ILLNESS USUALLY OCCUR?

>>CHARLENE CRUMP: MENTAL ILLNESS CAN REALLY OCCUR AT ANY AGE, BASICALLY. I MEAN, WHAT WE'RE GOING TO TALK ABOUT TODAY, AND I GUESS I SHOULD JUST PUT A DISCLAIMER OUT THERE. IT'S GENERAL INFORMATION, AND YOU'RE LOOKING AT GENERAL POPULATIONS. THERE CAN ALWAYS BE EXCEPTIONS TO ANY OF THE DATA OR INFORMATION THAT I PROVIDED YOU, BUT WE DO KNOW FROM RECENT MEDICAID STUDIES THAT THERE'S AN INCREASE IN CHILD AND ADOLESCENTS BEING PRESCRIBED ANTIPSYCHOTICS. WE KNOW THAT TIME FOR PUBERTY AND YOUNG ADULTHOOD, SO HIGH SCHOOL AND COLLEGE, SEEMS TO BE A PRIME TIME FOR MENTAL ILLNESS TO PRESENT ITSELF AND OFTEN IT PRESENTS ITSELF IN THE SCHOOL SYSTEM BECAUSE THOSE ARE THE PEOPLE WHO SEE THEM FOR SUCH A LONG PERIOD OF TIME. AND -- ON A DAILY BASIS. THE TERM THAT YOU HEAR A LOT OF TIMES IN THE SCHOOL SYSTEM IS SED, SERIOUS EMOTIONAL DISTURBANCE, AND IT USUALLY REFERS TO CHILDREN WHO ARE UNDER THE AGE OF 18, AND THEY HAVE A DIAGNOSABLE MENTAL HEALTH PROBLEM THAT -- IT DISRUPTS THEIR ABILITY TO FUNCTION, WHETHER, YOU KNOW, SOCIALLY WITH THEIR FRIENDS OR IN SCHOOL, ACADEMICALLY AND EMOTIONALLY, AND IT DOESN'T REALLY REFER TO A PARTICULAR DIAGNOSIS, BUT IT'S JUST A LEGAL TERM THAT GETS USED IN THE SCHOOL AND IT TRIGGERS THEM TO PROVIDE MANDATED SERVICES FOR THE CHILD. ONCE -- SOMETIMES THE CHILD OR A STUDENT IS GIVEN A DIAGNOSTIC LABEL OF HAVING A PARTICULAR MENTAL ILLNESS. THE INTERESTING THING ABOUT IT IS -- OR I THINK THAT IT'S INTERESTING -- IS THAT SOMETIMES A DIAGNOSTIC LABEL WILL BE GIVEN TO A CHILD, AND THEN ONCE THEY BECOME 18, THEY ALL OF A SUDDEN HAVE A DIFFERENT MENTAL ILLNESS, AND IT'S JUST BECAUSE THE WAY THAT THE DSM-IV, THE BIBLE OF CLINICAL DIAGNOSES SEPARATES A LOT OF THE DISEASES IS THAT SOMETIMES A CHILD, OR SOMEONE UNDER THE AGE OF 18, CANNOT HAVE A PARTICULAR MENTAL ILLNESS. AND SO, YOU KNOW, AND SOMETIMES IF YOU HAVE ANOTHER MENTAL ILLNESS AND YOU'RE OVER THE AGE OF 18, THEN YOU HAVE THIS ONE. SO THERE ARE JUST DIFFERENT TERMS THAT GET USED WITH CHILDREN AND ADULTS. AND I CAN SIGN THAT MUCH BETTER THAN I CAN SAY THAT. THEY DO PRESENT THEMSELVES AT DIFFERENT AGES. JUST TO GIVE YOU SOME REALLY QUICK EXAMPLES OF SOME THAT WE'VE SEEN. SCHIZOPHRENIA, FOR EXAMPLE, A LOT OF TIMES YOU HEAR THAT THAT HITS KIND OF IN THE TEENAGE YEARS, AND THAT IS TRUE. FOR MALES, USUALLY IT HITS SOMEWHERE BETWEEN 16 UP TO MAYBE 25, 20 TO 25. FOR FEMALES, IT'S A LITTLE BIT DIFFERENT. A LOT OF TIMES YOU SEE THE AGE OF ONSET BE 20 TO 30, ALTHOUGH THERE HAVE BEEN CASES REPORTED IN CHILDREN AS YOUNG AS FIVE OR SIX YEARS OLD. THE PEOPLE WHO HAVE ANXIETY DISORDER USUALLY REPORT THEIR FIRST EPISODE BY ABOUT THE AGE OF 21. OCD, THAT ACTUALLY MUST OCCUR DURING THE CHILDHOOD OR ADOLESCENCE IN ORDER FOR SOMEONE TO BE DIAGNOSED WITH HAVING OCD. USUALLY THE MEDIAN AGE

FOR THAT IS ABOUT 19. SEPARATION ANXIETY IS ANOTHER ONE OF THOSE THAT HAS TO OCCUR BEFORE THE AGE OF 18. AND, YOU KNOW, THEY CONTINUE THAT DIAGNOSIS AS AN ADULT. THERE ARE CONDUCT DISORDER, YOU MAY HEAR OPPOSITIONAL DEFIANT DISORDER. YOU'LL SEE THOSE IN CHILDREN AND ADOLESCENTS. HOWEVER, THAT'S ONE OF THOSE I WAS EXPLAINING THAT IF YOU'RE OVER THE AGE OF 18 IT'S CALLED SOMETHING ELSE. IF YOU'RE OVER THE AGE OF 18 IT WOULD BE THE ANTI-SOCIAL PERSONALITY DISORDER. SO ANY OF THE PERSONALITY DISORDERS THAT PEOPLE HAVE AS ADULTS HAVE TO BE TRACED BACK TO CHILDHOOD OR EARLY ADOLESCENCE, SO YOU SEE, AND THOSE ARE JUST A SMALL SAMPLING BECAUSE THERE ARE OBVIOUSLY A LOT OF MENTAL ILLNESSES OUT THERE.

>>CINDY CAMP: THANK YOU. WHAT'S THE RATE OF MENTAL ILLNESS IN THE GENERAL POPULATION?

>>CHARLENE CRUMP: GENERALLY YOU HEAR ABOUT ONE IN FIVE ADULTS WILL HAVE A DIAGNOSABLE MENTAL DISORDER THAT WILL INTERFERE WITH THEIR LIFE. AND WHAT I THOUGHT WAS REALLY INTERESTING, WHEN I STARTED KIND OF WORKING IN THE FIELD, WAS THAT MENTAL DISORDERS ARE THE LEADING CAUSE OF DISABILITY FOR PEOPLE -- FOR ADULTS, USUALLY LIKE 15 TO 45, 45.

>>CINDY CAMP: SO HOW DOES THAT COMPARE WITH THE DEAF POPULATION? ARE THEIR RATES OF MENTAL ILLNESS MORE OR LESS?

>>CHARLENE CRUMP: IT DEPENDS ON THE CATEGORY. MENTAL ILLNESSES ARE TYPICALLY YOU LOOK AT FIVE DIFFERENT AXIS. BASICALLY THEY'RE BIOLOGICAL. THERE'S A BIOLOGICAL COMPONENT TO IT. AXIS II TENDS TO BE LIKE A DISORDER THAT'S IMPACTED BY ENVIRONMENT. IN THE AXIS I CATEGORY, WE FIND THAT DEAF INDIVIDUALS HAVE EXACTLY THE SAME RATE OF BIOLOGICAL MENTAL ILLNESS. THAT INCLUDES THINGS LIKE SCHIZOPHRENIA, BIPOLAR, DEPRESSION, MANIA. HOWEVER, IN AXIS II AND REMEMBER THAT I SAID THAT THAT RELATES TO KIND OF ENVIRONMENT, WE SEE THAT DEAF INDIVIDUALS TYPICALLY HAVE A HIGHER RATE OF MENTAL ILLNESS THAN THEIR HEARING PEERS. AND THE REASON TO THAT, OR, YOU KNOW, SUSCEPTIBILITY TO STRESSORS, TO SOMETIMES MALADAPTIVE ENVIRONMENTS WHERE THEY DON'T HAVE GOOD COMMUNICATION AT HOME WITH THEIR PARENTS, THEY DON'T LEARN GOOD SOCIAL SKILLS, AND WE FIND THOSE NUMBERS ARE MUCH HIGHER. I THINK THE STUDIES HAVE SAID SOMEWHERE BETWEEN, LIKE, 43 TO 50% OF DEAF CHILDREN WILL HAVE AN EMOTIONAL OR BEHAVIORAL DISORDER. WE DO KNOW THAT IT'S ABOUT THREE TIMES HIGHER IN DEAF CHILDREN.

>>CINDY CAMP: VERY INTERESTING. SO ARE THERE ANY OTHER FACTORS THAT WE SHOULD CONSIDER THAT MIGHT INCREASE MENTAL ILLNESS IN THE DEAF POPULATION?

>>CHARLENE CRUMP: WELL, AGAIN, IN THAT AXIS II CATEGORY, THE SOCIAL FACTORS ARE REALLY IMPORTANT TO AN INDIVIDUAL'S PSYCHOLOGICAL WELL

BEING. THERE ARE VARIOUS STUDIES THAT ARE OUT THERE. WE KNOW, FOR EXAMPLE, WITHIN THE DEAF POPULATION THERE ARE HIGHER RATES OF DEPRESSION THAT ARE ASSOCIATED, INTERESTINGLY ENOUGH, WITH EITHER A FEELING OF NEGLECT FROM THE MOTHER OR OVERPROTECTIVENESS FROM THEIR PARENTS. WE KNOW THAT THE MORE DIFFICULTY A CHILD HAS WITH COMMUNICATION, THEY'LL HAVE LOWER SELF-ESTEEM, AND POOR ACCEPTANCE OF THEIR HEARING LOSS LEADS TO MORE SELF-ESTEEM ISSUES AND DEPRESSION, AND INADEQUATE DEVELOPMENT OF LANGUAGE, SOCIAL SKILLS. WE ALSO KNOW ALL OF THOSE CONTRIBUTE TO THE AXIS II CATEGORIES. AND WE ALSO KNOW THAT DEAF CHILDREN HAVE HIGHER RATES OF NEGLECT AND PHYSICAL AND SEXUAL ABUSE. AND ACTUALLY, OF THOSE, THE HIGHEST RATE OF MALTREATMENT IS NEGLECT FROM PARENTS, AND ALL OF THOSE WILL INCREASE THE POTENTIAL FOR A DEAF INDIVIDUAL TO HAVE A DIAGNOSABLE MENTAL ILLNESS IN THE AXIS II CATEGORY.

>>CINDY CAMP: WOW. HOW DOES THE ETIOLOGIES OF DEAFNESS IMPACT THE PSYCHOSOCIAL AND EDUCATIONAL DEVELOPMENT OF THE INDIVIDUAL?

>>CHARLENE CRUMP: THAT'S A GREAT ONE. I THINK GALLAUDET DID A STUDY THAT SAID ABOUT 40% OF DEAF AND HARD OF HEARING STUDENTS HAD CO-OCCURRING CONDITIONS, AND THAT AFFECTS THEIR EDUCATIONAL PROGRESS. DEAF CHILDREN WHO ARE BORN TO HEARING PARENTS ARE MORE OFTEN DEAF BECAUSE OF TRAUMATIC CAUSES OF DEAFNESS RATHER THAN ONE THAT'S JUST HEREDITARY, AND SOME OF THESE CAUSES ACTUALLY HAVE MENTAL, BEHAVIORAL AND EMOTIONAL DISABILITIES THAT ARE ATTACHED TO THEM. AND I THINK I INCLUDED SOME OF THESE IN YOUR HANDOUTS, AND I HAVE SOME MORE INFORMATION WHICH YOU'RE WELCOME TO CONTACT ME, I'M MORE THAN WILLING TO SHARE. RUBELLA, WE ALL KNOW AND WE'VE HEARD FOR YEARS ABOUT THE RUBELLA BULGE, THE PEOPLE WHO WERE BORN IN THE '60s AND BECAME DEAF BECAUSE OF RUBELLA, THEY ALSO FOUND THAT RUBELLA HAD A DEGENERATIVE NEUROLOGICAL IMPACT, MEANING THAT AS THEY -- THEY GET OLDER, THEY START TO PRESENT SYMPTOMS. THERE ARE ALSO SOME PHYSICAL SYMPTOMS WHICH GO WITH IT. THEY CAN HAVE HEART ISSUES, KIDNEYS, THYROID ISSUES, BUT THEY FOUND OTHER ISSUES RELATED TO MENTAL HEALTH LIKE IMPULSIVITY, DECISION MAKING, DD. THEY HAVE ABNORMAL LANGUAGE AND BEHAVIORAL PATTERNS, MORE APT TO BE HYPERACTIVE. THEY SOMETIMES CAN BE VERY RIGID. THEY HAVE LEARNING DISABILITIES, AND THEY ALSO MORE LIKELY TO HAVE PROBLEMS WITH VISION IMPAIRMENT. I BRIEFLY MENTIONED LANGUAGE, AND I'VE WORKED WITH SEVERAL INDIVIDUALS. IT'S REALLY INTERESTING IF YOU HAVE THE OPPORTUNITY TO WORK WITH SOMEONE WHO ARE RUBELLA, AND YOU GET TO WORK WITH THEM ON A DAILY BASIS TO KIND OF SEE THEIR LANGUAGE HABITS, BUT SEVERAL OF THEM THAT I'VE WORKED WITH, ABOUT THE BEST WAY YOU CAN DESCRIBE IT IS YOU'RE LISTENING TO A RECORD AND THEN ALL OF A SUDDEN THE RECORD JUMPS AND IT GOES ON TO ANOTHER SECTION OF THE RECORD. SO IT'S LIKE THEY'RE SIGNING, AND IT'S PERFECTLY UNDERSTANDABLE, AND THEN THEY'RE STILL SIGNING, BUT YOU HAVE NO IDEA WHAT THEY'RE SAYING, AND THEN ALL OF A SUDDEN IT'S JUST CLEAR AS A BELL AGAIN. AND IT JUST MAKES THESE

LANGUAGE JUMPS. NOW, DIFFERENT PEOPLE WILL EXHIBIT LANGUAGE PATTERNS IN DIFFERENT WAYS, AND I THINK THIS IS REALLY IMPORTANT FOR EDUCATIONAL INTERPRETERS AND INTERPRETERS IN GENERAL TO KNOW BECAUSE SOMETIMES WE THINK THAT IT'S JUST BECAUSE WE'RE NOT UNDERSTANDING RATHER THAN THERE'S SOMETHING UNUSUAL GOING ON WITH THEIR LANGUAGE.

SOME OF THE OTHERS, MENINGITIS, THERE'S -- THERE'S A HIGH INCIDENCE OF PHYSICAL AND COGNITIVE DISABILITIES THAT GO ALONG WITH MENINGITIS. DD, MR, LD, APHASIA AND BEHAVIORAL AND EMOTIONAL PROBLEMS. THE CMV, DON'T KNOW IF YOU'VE EVER HEARD OF THAT BEFORE, BUT IT ACTUALLY IS NOW THE LEADING CAUSE OF DEAFNESS, AND A LOT OF KIDS WHO ARE IN YOUR SCHOOL SYSTEMS NOW ARE DEAF BECAUSE OF CMV, IT'S CYTOMEGALOVIRUS INFECTION, AND THERE ARE A LOT OF CONDITIONS THAT HAPPEN BECAUSE OF CMV. A LOT OF THEM GO UNNOTICED UNTIL THEY HIT SCHOOL AGE. IT IMPACTS THEM IN A VARIETY OF WAYS, AND SIGNIFICANT IMPACT, COGNITIVELY, DEVELOPMENTALLY, EVEN PSYCHOMOTOR DIFFICULTIES. OTHER THINGS, LIKE RH FACTOR COMPLICATIONS IN YOUR BLOOD. IF SOMEONE BECAME DEAF BECAUSE OF THAT, THEIR -- THEY CAN HAVE CP, APHASIA, DD, MR. PEOPLE WHO BECAME DEAF BECAUSE OF SYPHILIS CAN HAVE INTELLECTUAL DELAY, VISUAL DISABILITIES, AND MENIERE'S DISEASE. WE KNOW A LOT OF DEAF INDIVIDUALS HAVE SOME TYPE OF MENIERE'S DISEASE, AND WE FIND THAT RELATED TO MENTAL HEALTH, THESE INDIVIDUALS HAVE A HIGHER RATE OF SUICIDE COMPARED TO THE GENERAL POPULATION, AND THERE ARE A LOT OF OTHER REASONS THAT PEOPLE BECOME DEAF, AND IT'S VERY IMPORTANT TO UNDERSTAND THAT DEAFNESS IN ITSELF DOESN'T CAUSE SOMEONE TO BE MENTALLY ILL OR HAVE A, YOU KNOW, COGNITIVE IMPAIRMENT, BUT SOME OF THE CONDITIONS THAT CAUSE DEAFNESS DO HAVE IMPACT ON THEIR BEHAVIORAL AND EMOTIONAL ABILITIES.

>>CINDY CAMP: THAT'S REALLY GOOD INFORMATION, ESPECIALLY WHEN YOU'RE TALKING ABOUT EDUCATIONAL INTERPRETERS WHO MAY BE THE ONLY ONES WHO RECOGNIZE THAT SOME OF THESE CONDITIONS ARE OCCURRING. THEY OBVIOUSLY AREN'T GOING TO HAVE THE BACKGROUND TO DIAGNOSE IT, BUT THEY COULD BE A VERY IMPORTANT PART IN GETTING HELP FOR THE CHILD.

>>CHARLENE CRUMP: THAT'S RIGHT. AND THEY'RE OFTEN THE ONES WHO DO NOTICE IT BECAUSE THEY SEE THEM ON A DAY TO DAY BASIS AND THEY CAN START TO PICK UP PATTERNS OF THINGS THAT ARE GOING ON AND REPORT THOSE TO INDIVIDUALS WHO WOULD MAKE THE DIAGNOSIS.

>>CINDY CAMP: THAT'S WONDERFUL INFORMATION. IT'S TIME FOR OUR FIRST QUESTION FROM THE AUDIENCE. SO I'M GOING TO TURN IT OVER TO JENNIE, MY CO-MODERATOR, AND HAVE WE GOTTEN SOME QUESTIONS THAT HAVE COME IN?

>>JENNIE BOURGEOIS: OH, YES, WE HAVE SOME QUESTIONS. THEY'RE FLOODING IN. ONE OF THE QUESTIONS THAT'S COME IN IS CONCERNING THE

USE OF CDI'S, CERTIFIED DEAF INTERPRETERS. HOW OFTEN DO YOU FIND OR WHAT IS THE TREND NATIONALLY IN THE USE OF CDI'S WITHIN THE MENTAL HEALTH SETTING?

>>CHARLENE CRUMP: TALKING ABOUT THE PROGRAMS THAT I'M FAMILIAR WITH, I WOULD SAY THAT MOST OF -- MOST ALL OF US USE A CDI OR A VISUAL GESTURAL SPECIALIST OF SOME SORT. WE HAVE ONE ON STAFF WHO WORKS AND DOES CONSULTATIONS WITH US IN THE COMMUNITY AND THROUGHOUT THE STATE WHEN WE WORK WITH INDIVIDUALS BECAUSE OBVIOUSLY IT'S A TREMENDOUS IMPACT ON LANGUAGE, YOU KNOW, DEVELOPMENTALLY AND WITH THE MENTAL ILLNESS ITSELF. I DON'T KNOW THAT THERE ARE ANY STUDIES OUT THERE THAT TALK ABOUT HOW MANY CDI'S ARE USED IN MENTAL HEALTH SETTINGS, BUT IT'S -- YOU KNOW, IT'S DEFINITELY A WONDERFUL TOOL THAT WE -- THAT WE UTILIZE, AND, YOU KNOW, PROMOTE WITHIN OUR OWN PROGRAM. AND LIKE EVERYTHING ELSE, IT'S ONE OF THE CONTROL OPTIONS THAT WE HAVE.

>>JENNIE BOURGEOIS: THANK YOU. AND WE'LL HAVE TIME FOR SOME MORE QUESTIONS A LITTLE LATER ON. ARE THERE SITUATIONS WHERE A QUALIFIED INTERPRETER, WHO IS NOT TRAINED IN MENTAL HEALTH INTERPRETING MIGHT CAUSE HARM IN A MENTAL HEALTH SETTING?

>>CHARLENE CRUMP: WELL, I THINK THERE'S A DISTINCTION BETWEEN CERTIFIED AND QUALIFIED. AND, YOU KNOW, QUALIFIED IS DEFINED BY ADA AS BEING, YOU KNOW, SOMEONE WHO'S ABLE TO -- LET'S SEE IF I CAN REMEMBER IT EXACTLY -- ABLE TO INTERPRET EFFECTIVELY, ACCURATELY AND IMPARTIALLY, I THINK, AND THAT INCLUDES RECEPTIVELY AND EXPRESSIVELY, AND USING ANY NECESSARY SPECIALIZED VOCABULARY. I'M NOT SURE IF THAT'S AN EXACT QUOTE, BUT IT'S SOMETHING AROUND THAT. AND SO AN INTERPRETER WHO WORKS IN A MENTAL HEALTH SETTING SHOULD BE QUALIFIED. THEY SHOULD BE ABLE TO WORK IN THAT ENVIRONMENT. AND NOT EVERYONE WHO'S CERTIFIED IS QUALIFIED TO WORK IN A MENTAL HEALTH SETTING, JUST LIKE NOT EVERYONE WHO'S CERTIFIED IS QUALIFIED TO WORK IN AN EDUCATIONAL SETTING OR A LEGAL SETTING. SO I DEFINITELY THINK THAT THERE'S A DISTINCTION BETWEEN THOSE TWO. I THINK THAT THERE ARE TIMES WHEN THEY MIGHT CAUSE HARM. ANY INTERPRETER CAN CAUSE HARM, AND IT'S IMPORTANT TO KNOW THAT WHENEVER YOU'RE AN INTERPRETER IN THAT SITUATION, IT ISN'T THE SAME AS TWO INDIVIDUALS HAVING DIRECT COMMUNICATION IN THAT IT'S ALWAYS A LESSER STEP TO HAVE AN INTERPRETER, AND I KNOW THAT SOMETIMES IT'S HARD TO HEAR -- YOU KNOW, TO HEAR THAT, BUT IT'S NEVER THE SAME AS BEING ABLE TO COMMUNICATE WITH SOMEONE DIRECTLY. SO HOW THAT CREATES ISSUES -- I MEAN, THERE'S -- I COULD DO A WHOLE EIGHT-HOUR TRAINING ON THAT, BUT YOU REALLY HAVE TO LOOK MOST IMPORTANTLY, I THINK, AT BOUNDARIES, AND BEING AWARE OF THE THERAPEUTIC INTERVENTION. THOSE ARE VERY IMPORTANT, AND JUST KIND OF HAVING AN AWARENESS OF WHAT THE SPECIFIC DIAGNOSIS IS AND WHAT THAT CAN MEAN TO YOUR ROLE. I THINK WE'RE GOING TO GET INTO SOME OF THOSE LATER SO I DON'T WANT TO JUMP AHEAD OF CINDY AGAIN.

>>CINDY CAMP: NO PROBLEM. SO IF AN EDUCATIONAL INTERPRETER FINDS THEMSELVES IN A SETTING THAT SUDDENLY TURNS MORE MENTAL HEALTH, WHAT SHOULD THEY DO? HOW CAN THEY HANDLE THAT?

>>CHARLENE CRUMP: I THINK IT'S ONE OF THOSE IT DEPENDS RESPONSES. IT'S GOING TO BE DIFFERENT FOR EVERY SITUATION, FOR EVERY INTERPRETER, FOR EVERY DEAF PERSON THAT WE'RE WORKING WITH, BUT I THINK I JUST KIND OF THOUGHT OF THE LITTLE STORY AS A LITTLE KID WHO PUTS HIS FINGER IN THE DIKE. IF YOU'RE THE PERSON WITH THE FINGER IN YOUR DIKE, YOU CAN'T JUST PULL IT OUT, SOMETIMES -- YOU KNOW, AND PRETEND THAT THE DAM IS ABOUT TO BUST OR THERE ISN'T WATER, YOU KNOW, COMING OUT. SOMETIMES YOU JUST HAVE TO BE THERE AND HOLD ON UNTIL YOU CAN GET HELP. YOU SHOULD PROBABLY EXPECT TO GET WET. BUT I DEFINITELY THINK THAT, YOU KNOW, EDUCATIONAL INTERPRETERS -- AND AGAIN, I THINK WE HAVE SOME QUESTIONS THAT COME UP RELATED TO THIS, BUT YOU DO SERVE A WONDERFUL BENEFIT, EVEN IF YOU HAVEN'T HAD MENTAL HEALTH INTERPRETER TRAINING. THAT'S IMPORTANT TO THE TEAM, AND IS IMPORTANT TO THAT MOMENT OF CRISIS.

>>CINDY CAMP: GREAT. WELL, ARE THERE SITUATIONS WHERE IT MIGHT BE BETTER TO HAVE NO INTERPRETER?

>>CHARLENE CRUMP: I CAN THINK OF A FEW. INTERPRETERS, TYPICALLY WE HAVE KIND OF A PROPENSITY FOR CLEANING LANGUAGE UP. I THINK THAT'S PART OF OUR TRAINING. WHEN WE START CLEANING UP PSYCHOTIC LANGUAGE OR DYSFLUENT LANGUAGE OR KIND OF MASKING OVER WHAT WOULD BE CONSIDERED INAPPROPRIATE OR UNUSUAL BEHAVIORS, THIS CAN COVER UP A PATHOLOGY OR AN EMERGING PATHOLOGY. NEIL GLICKMAN TALKS ABOUT INTERPRETERS BEING THE ILLUSION OF INCLUSION AND SOMETIMES WHAT WE DO IS WE'RE THERE TO SERVE A COMFORT TO PEOPLE. AND WHAT'S REALLY EASY TO HAPPEN, ESPECIALLY IN CRISIS, IS THAT PEOPLE BELIEVE THAT EVERYTHING IS FINE, AND IT ISN'T SOMETIMES. AND WE'RE THE ONLY ONES WHO WALK AWAY REALIZING THAT SOMETHING WASN'T QUITE RIGHT WITH EITHER THE COMMUNICATION OR THE SITUATION. AND THIRDLY, I THINK INTERPRETERS WHO THEMSELVES ARE EITHER DEALING WITH MENTAL HEALTH ISSUES CURRENTLY OR IN THE PAST, AND NOW THEY'RE INVOLVED IN A VERY HIGHLY-CHARGED SETTING, CAN COMPROMISE THE SITUATION. I MEAN, WE CAN THINK ABOUT AN INTERPRETER WHO HAS MENTAL ILLNESS IN THEIR FAMILY OR WHO THEMSELVES WAS SEXUALLY OR PHYSICALLY ABUSED AND NOW FINDING THEMSELVES IN A VERY TRAUMATIC EVENT, AND SOMETIMES THIS CAN HAVE DIRE CONSEQUENCES.

>>CINDY CAMP: I THINK THAT'S A VERY LIBERATING MESSAGE FOR INTERPRETERS TO HEAR, THAT THEY DON'T HAVE TO BE ALL THINGS TO ALL PEOPLE, AND SOMETIMES IT IS BETTER TO SAY, I'M NOT THE RIGHT PERSON AT THIS TIME. THANK YOU FOR THAT. HOW DO YOU WORK IN SITUATIONS WHERE

A FAMILY MEMBER PERHAPS HAS BEEN ACTING AS THE INTERPRETER IN PAST COUNSELING SESSIONS, OR WITH A DOCTOR?

>>CHARLENE CRUMP: WELL, THAT NEVER HAPPENS. I WORKED ONE TIME IN A SITUATION. IT WAS AN EMPLOYMENT SITUATION. EAP RELATED. AND WORKED WITH A CLIENT AND FOUND OUT THAT THEIR BROTHER HAD BEEN COMING WITH THEM SERVING IN THE INTERPRETER ROLE, AND MET THE BROTHER, AND I SAID, WELL, YOU KNOW, DO YOU SIGN AND HE'S LIKE, NO, BUT I JUST KNOW WHAT HE'S THINKING. AND I THINK BOUNDARIES ARE REALLY AN ISSUE IN THIS CASE. YOU KNOW, FAMILY MEMBERS CAN SOMETIMES GLOSS OVER THE DIRTY LAUNDRY. THEY CAN MAKE THINGS SEEM BETTER OR WORSE THAN THEY REALLY ARE. AND THEY DON'T OFTEN INVOLVE THE STUDENT OR PATIENT OR CLIENT IN THE DECISION MAKING PROCESS. THEY JUST MAKE THE DECISIONS, YOU KNOW, I KNOW WHAT THEY'RE THINKING, I KNOW WHAT THEY MEAN. AND, YOU KNOW, THIS IS INDICATIONS, ESPECIALLY DEPENDING ON THE AGE OF THE STUDENT. BUT, YOU KNOW, EVEN ADULTS, YOU KNOW, THE PARENTS OR FAMILY MEMBERS WILL COME IN AND MAKE DECISIONS FOR THEM AND MAYBE THEY'LL EXPLAIN TO THEM AFTER THE SESSION. THE END RESULT IS THAT I THINK THE FAMILY MEMBERS ARE UNABLE TO BE IMPARTIAL, AND I'M PROBABLY PREACHING TO THE CHOIR. I'M SURE YOU GUYS ARE VERY FAMILIAR WITH THAT. BUT, YOU KNOW, IN ALABAMA, WE REALLY PRESCRIBE -- WE PRESCRIBE TO PRACTICE, WE DO NOT ALLOW FAMILY MEMBERS TO INTERPRET UNLESS THE CLIENT SIGNS A WAIVER STATING THAT THEY KNOW THAT FREE AND AVAILABLE INTERPRETING SERVICES ARE AVAILABLE, AND THAT THE PERSON WHO'S PROVIDING THE INTERPRETING IN THEIR FAMILY HAS TO BE OVER THE AGE OF 18. AND I THINK IT'S REALLY IMPORTANT TO REMEMBER THAT THE INTERPRETER ISN'T JUST THERE FOR THE DEAF CLIENT WHO MIGHT BE THERE TO RECEIVE THERAPY, BUT THEY'RE ALSO THERE FOR THAT, SAY, HEARING CLINICIAN, AND WE HAVE TO MAKE SURE THAT THE COMMUNICATION IS EFFECTIVE, AND SOMETIMES ANOTHER THING WE HAVE TO REMEMBER IS THAT THERE WILL BE FAMILY MEMBERS WHO ARE IN THERAPY WHO MAY HAVE SERVED IN THAT INTERPRETER ROLE IN THE PAST, AND THEY'VE CONTINUED IN THIS, LIKE, MARRIAGE OR FAMILY GROUP SESSION, AND THEY MAY RESENT YOU AS AN INTRUSION, AND THAT'S SOMETHING THAT YOU NEED TO BE AWARE OF AND MAINTAIN OPEN DIALOGUE WITH A THERAPIST, AND SOMETIMES UTILIZE THOSE PRE AND POST SESSIONS TO WORK THROUGH SOME OF THOSE ISSUES.

>>CINDY CAMP: WELL, YOU KIND OF TOUCHED ON THIS ALREADY, BUT WHAT ARE SOME OF THE RISKS INHERENT IN THE MENTAL HEALTH SETTING FOR THE INTERPRETERS?

>>CHARLENE CRUMP: USUALLY WHAT I HEAR FIRST FROM INTERPRETERS FROM THEIR PERSPECTIVE OF MENTAL HEALTH INTERPRETING IS I THINK THE VIOLENT BEHAVIOR, THE PHYSICAL AGGRESSION THAT WE HEAR A LOT OF TIMES ON THE NEWS OR WE SEE IN TELEVISION AS BEING THE NUMBER ONE DANGER FOR INTERPRETERS. AND YES, IT IS A CONSIDERATION. I MEAN, THERE IS -- YOU HAVE TO BE MINDFUL OF YOUR PHYSICAL SAFETY WHEN YOU'RE, YOU KNOW, IN THE PRESENCE OF INDIVIDUALS, ESPECIALLY IF THEY'RE NOT STABLE, OR IF

THEY'RE DEMONSTRATING SOME INSTABILITY IN MOOD OR INVOLVED IN EMOTIONALLY CHARGED SETTING. BUT WE ALSO KNOW THAT STUDIES FROM NAMI SAY THAT PEOPLE WHO ARE MENTALLY ILL ARE NO MORE LIKELY TO BE VIOLENT THAN AN INDIVIDUAL WHO IS MEDICALLY COMPROMISED. AND I DON'T EVEN THINK THAT IT'S THE GREATEST DANGER THAT INTERPRETERS FACE. SOME OF THE OTHER THINGS THAT WE LOOK AT, YOU KNOW, THE SPREAD OF CONTAGIONS. LIKE ANY MEDICAL ENCOUNTER, YOU HAVE TO BE EDUCATED IN UNIVERSAL PRECAUTIONS. BUT I THINK THE MOST OVERLOOKED -- AND PROBABLY NOT EVEN THE MOST OVERLOOKED, BUT PROBABLY THE MOST DISCOUNTED DANGER IS THE ONE OF SECONDARY TRAUMA OR VICARIOUS TRAUMA, AND I THINK THAT'S MORE OF A SIGNIFICANT DANGER TO INTERPRETERS BECAUSE THEY'RE PUTTING THEMSELVES IN A VULNERABLE POSITION, AND BECAUSE OF THE EMPATHY THAT WE TEND TO HAVE WITH DEAF INDIVIDUALS, WE TEND TO CONNECT WITH THEM, AND WE SEE THE HURT, WE SEE THE THINGS THAT HAVE HAPPENED IN THEIR LIFE AND THAT STARTS TO HAVE AN IMPACT ON OURS, AND THAT LEADS NOT ONLY TO OUR INTERPRETING DECISIONS. IT CHANGES HOW WE INTERACT WITH THOSE SETTINGS. I SEE INTERPRETERS WHO BURN OUT MORE EASILY, AND THEY -- THEY TAKE THAT LOSS OF BOUNDARIES, AND A LOT OF TIMES THEY TAKE THEM INTO THEIR HOME ENVIRONMENT. AND ONE OF THE MOST IMPORTANT THINGS THAT I SEE IN MENTAL HEALTH INTERPRETING IS JUST AN AWARENESS OF HOW THIS SECONDARY TRAUMA AND THE EMOTIONAL TRAUMA AND HOW IT CAN HAVE AN IMPACT ON YOU AS AN INDIVIDUAL. AND YOU HAVE TO MAINTAIN JUST A HEALTHY MEASURE OF SELF CARE.

>>CINDY CAMP: THAT'S VERY IMPORTANT TO REMEMBER. SHOULD THE STUDENT'S REGULAR EDUCATIONAL INTERPRETER BE THE SAME INTERPRETER INVOLVED WITH THEM IN MENTAL HEALTH SETTINGS IF THERE IS A CHOICE?

>>CHARLENE CRUMP: AGAIN, GOING BACK TO THAT EMERGENCY CRISIS SETTING, YOU KNOW, SOMETIMES YOU ARE GOING TO BE THERE IN AN INTERIM CAPACITY. AS FAR AS BEING THE LONG-TERM INTERPRETER, AGAIN, YOU KNOW, IT DEPENDS, BUT I GENERALLY LEAN TOWARDS NO, ALTHOUGH I THINK THERE MAY BE SPECIFIC SITUATIONS WHERE IT WOULD MAKE SENSE TO DO SO. YOU DEFINITELY ARE MOST FAMILIAR WITH THE CHILD'S LANGUAGE, ESPECIALLY IF THE CHILD HAS SOME IDIOSYNCRATIC LANGUAGE OR HABITS. I THINK THAT YOU'RE ALSO THERE -- YOU'RE PROBABLY VERY COMFORTING FOR THE STUDENT, YOU KNOW, TO HAVE SOMEONE THERE THAT THEY KNOW AND TRUST. AND THERE ARE OTHER THINGS LIKE IF THE MENTAL HEALTH INTERVENTION ITSELF, IT MAY NOT BE A CRISIS SITUATION, BUT IT STILL MAY HAVE A MENTAL HEALTH COMPONENT TO IT, WHERE YOU'RE WORKING ON A GOAL OF JUST IMPROVING THEIR CLASSROOM PERFORMANCE OR BEHAVIOR AND UTILIZING THAT REGULAR EDUCATIONAL INTERPRETER WOULD MAKE SENSE TO INCORPORATE ALL OF THE REGULAR PLAYERS. WITH THAT SAID, I THINK DUE JUST TO THE UNIQUENESS OF MENTAL HEALTH, IT CREATES SO MANY CHALLENGES FOR THE EDUCATIONAL INTERPRETER AND THE -- OR THE DAILY INTERPRETER WHO'S THERE WITH THEM, ESPECIALLY IN REGARDS TO BOUNDARIES. YOU KNOW, YOU'RE THE PERSON THAT I SEE IN SCHOOL, AND

NOW I'M SEEING YOU AT MY WORST, AND HOW DOES THAT FEEL WHEN I COME BACK INTO THE EDUCATIONAL ENVIRONMENT? AND I THINK THAT IF YOU AREN'T TRAINED IN THIS FIELD, YOU SHOULD, YOU KNOW, AT LEAST -- AND THIS IS MY OPINION, YOU KNOW, ASK FOR SOME ASSISTANCE, SOMEONE THERE, EVEN IF YOU STAYED IN THE SETTING IN, SAY, A CRISIS SITUATION, SOMEONE WHO COULD BE THERE WITH YOU WHO HAS SOME TRAINING IN MENTAL HEALTH.

>>CINDY CAMP: GREAT. IF I WERE INTERPRETING FOR A STUDENT WHO BECOMES PSYCHOTIC, WHAT SITUATIONS AM I LIKELY TO ENCOUNTER?

>>CHARLENE CRUMP: I WANT TO SAY FIRST, USUALLY A PERSON -- USUALLY -- DOESN'T JUST BECOME PSYCHOTIC. THERE ARE GOING TO BE PRE CURSORS TO AN EMERGING ISSUE, AND I THINK AS EDUCATIONAL INTERPRETERS, YOU'RE THE ONES THAT ARE IN THERE FOR THE FRONT-ROW SEAT LITERALLY. YOU'RE GOING TO BE THE ONES THAT SEE THE CHANGES IN BEHAVIORS, THE INTEREST, MOOD, HYGIENE. AND YOU'RE GOING TO HAVE THAT INFORMATION. SO IT ISN'T USUALLY SOMETHING THAT JUST HAPPENS IN THE IMMEDIACY. YOU'RE GOING TO SEE SOME GRADUAL CHANGES OVER TIME, BUT IF THE STUDENT ISN'T IN CRISIS AND THEY'RE ACTING ERRATICALLY YOU MAY NEED TO CONSIDER THAT YOU MIGHT FIND YOURSELF WORKING WITH THE SCHOOL CRISIS TEAM, EMERGENCY RESPONDERS, PEOPLE IN AN AMBULANCE OR AN EMT, HOSPITAL, AN EMERGENCY ROOM, YOU'RE PROBABLY GOING TO BE WORKING WITH FAMILY MEMBERS, MAYBE WITH OTHER STUDENTS IN THE CLASSROOM, AND YOU MAY FIND YOURSELF WORKING IN PROBATE COURT OR COURT SETTINGS.

>>CINDY CAMP: OKAY. HOW DOES MENTAL ILLNESS IMPACT LANGUAGE AND LANGUAGE ACQUISITION?

>>CHARLENE CRUMP: TREMENDOUSLY. MENTAL HEALTH PROFESSIONALS -- KEEP IN MIND THAT MENTAL HEALTH PROFESSIONALS OFTEN CONSIDER LANGUAGE TO BE KIND OF THE WINDOW TO THE MIND, AND COMMUNICATION CAN BE IMPACTED OR HAMPERED BY A LOT OF PSYCHOSOCIAL FACTORS, YOU KNOW, COGNITIVELY, EMOTIONALLY, BEHAVIORALLY, SOCIALLY. AND SOMEONE WHO'S DEAF OFTEN ISN'T BORN INTO A FAMILY WHERE LANGUAGE IS READILY AVAILABLE, AND ARE ONLY -- THEY'RE OFTEN SIGNIFICANTLY EXPOSED TO LANGUAGE WHEN THEY ENTER THE SCHOOL SYSTEM. WHEN YOU TAKE THIS DELAY AND YOU COMPLICATE IT BY AN INABILITY TO PROCESS LANGUAGE, WHICH MENTAL ILLNESS CAN HAVE, OR -- OR AN INABILITY TO MAKE CONNECTIONS BETWEEN WORDS AND MEANINGS THAT EXIST, THE PROBLEMS ARE JUST MULTIPLIED. A LOT OF INDIVIDUALS WHO SEEK TREATMENT IN MENTAL HEALTH ARE DYSFLUENT, MEANING THAT THERE'S BEEN SOME INTERRUPTION IN THEIR LANGUAGE DEVELOPMENT, OR THEY'RE ALINGUAL, WHICH BASICALLY MEANS THAT THEY DON'T HAVE A LANGUAGE AT ALL, ENGLISH OR ASL OR ANY TYPE OF SIGN SYSTEM. A RECENT STUDY THAT WAS DONE OF AN INPATIENT HOSPITAL, I THINK NEIL GLICKMAN AND PATRICIA BLACK ABOUT A YEAR-AND-A-HALF AGO SAID ABOUT 75% OF PATIENTS IN THEIR UNIT WERE EXTREMELY DYSFLUENT.

>>CINDY CAMP: COULD YOU GIVE US SOME EXAMPLES OF PSYCHOTIC LANGUAGE, DYSFLUENCY, OR SOCIO -- I CAN'T TALK -- SOCIOLINGUISTIC ERRORS?

>>CHARLENE CRUMP: SURE. AGAIN, THIS IS ONE OF THOSE THINGS THAT WILL BE A LOT EASIER TO SHOW YOU. BUT I WILL TRY MY BEST. IT'S KIND OF LIKE DESCRIBING A SIGN OVER THE PHONE, BUT WE'LL TRY TO DO WHAT WE CAN. WE DO KNOW THAT STUDIES IN THE PAST HAVE SHOWN THAT ASL USERS EXHIBIT LANGUAGE PATTERNS THAT HAVE VERY SIMILAR TO SOME OF THE PSYCHOLINGUISTICS ERRORS, THOSE THAT ARE RELATED TO MENTAL ILLNESS WITHIN THE HEARING SCHIZOPHRENIC POPULATION. THEY'RE VERY SIMILAR. I'M NOT SAYING THAT ASL USERS HAVE SCHIZOPHRENIA, BUT THE LANGUAGE PATTERNS ARE VERY SIMILAR, AND THIS HAS LED HISTORICALLY TO DEAF INDIVIDUALS HAVING A HIGHER DIAGNOSIS AND LONGER STAYS IN HOSPITALS BECAUSE OF SCHIZOPHRENIC DIAGNOSIS. IN REGARDS TO PSYCHOLINGUISTIC ERRORS, THERE ARE OVER 20, AND SOME EXAMPLES, JUST A FEW OF THEM, ONE OF THEM IS CALLED CLANGING, IT'S C-L-A-N-G-I-N-G. AND WHAT THAT MEANS IS IN HEARING PEOPLE USING ENGLISH, FOR EXAMPLE, IT'S A REPEATING PATTERN OR A NEED TO ASSOCIATE SOMETHING, A PARTICULAR SOUND THAT'S REPEATED OVER AND OVER AGAIN, OR, YOU KNOW, A WORD MAY -- ALL THE WORDS MAY BEGIN WITH THE SAME SOUND, FOR EXAMPLE, IN A SENTENCE, OR THEY MAY DO A LOT OF PUNNING WITH DEAF INDIVIDUALS. IT'S THE SAME THING AS FAR AS REPEATING A PATTERN, HAVING A NEED TO ASSOCIATE. BUT SOMETIMES YOU MAY SEE IT DISPLAYED A LITTLE BIT DIFFERENTLY. THEY MAY, FOR EXAMPLE, TALK TO YOU USING THE SAME HANDSHAKE. SO IF THEY HAD THOSE -- THE ONE HANDSHAKE, THE WHOLE SENTENCE OR DIALOGUE THAT THEY'RE HAVING WITH YOU MAINTAINS THAT ONE HANDSHAKE AS FAR AS, YOU KNOW, LIKE THE NUMBER ONE. WE KNOW THAT DEAF INDIVIDUALS DO THAT, YOU KNOW, ABC STORIES, YOU KNOW, JUST ONE HAND SHAPE. I THINK IT WAS PATRICK GRAYBILL, MEET THE FRIENDS ON THE STREET WHO SEE EACH OTHER AND HE DOES THIS WONDERFUL RENDITION OF THE PEOPLE SEEING EACH OTHER, BEING MAD AT EACH OTHER AND HUGGING AND MAKING UP AT THE END AND IT'S ALL DONE WITH THE NUMBER ONE HANDSHAKE. HOWEVER, IF A DEAF PERSON IS DOING THAT, AND THERE'S NO RHYME OR REASON TO IT, THEY'RE NOT DOING IT ON PURPOSE, FOR LACK OF A BETTER WORD, THAT COULD BE AN INDICATOR OF CLANGING. IT'S -- IT'S SOMETHING THAT YOU'RE GOING TO SEE REPEATED AND IT ISN'T GOING TO BE AN EXCLUSIVE SYMPTOM. IT MEANS YOU'RE ALSO GOING TO SEE THOSE HYGIENE ISSUES, YOU'RE GOING TO SEE CHANGES IN BEHAVIOR AND EMOTIONS AND ALL OF THOSE THINGS THAT GO WITH IT, BUT THE INTERPRETER IS PROBABLY GOING TO BE THE ONLY ONE THAT PICKS UP ON THE LANGUAGE PATTERNS. SO THAT'S WHY I THINK IT'S IMPORTANT FOR US TO KNOW SOME OF THE OTHER THINGS THAT ARE GOING ON.

ANOTHER ONE IS CIRCUMSTANTIALITY. IT'S USUALLY DEFINED AS UNNECESSARY, TEDIOUS AND INCONSEQUENTIAL DETAIL, RAMBLING DESCRIPTIONS OR RESPONSES TO QUESTIONS. AND WE DON'T KNOW ANYONE WHO DOES THAT.

(LAUGHTER)

DEAF PEOPLE ARE OFTEN VIEWED. I MEAN, YOU KNOW, IT'S A WAY OF STORY TELLING OR A WAY OF DIALOGUING. IN THAT, YOU KNOW, YOU TELL THE ENTIRE STORY FROM THE BEGINNING. YOU START YESTERDAY IF YOU WANT TO KNOW WHY SOMEBODY WAS LATE TO WORK, OR MAYBE LAST WEEK. THIS CAN BE SEEN, AGAIN, CIRCUMSTANTIALITY COULD BE SEEN IF SOMEONE WASN'T FAMILIAR WITH ASL USERS AS A PSYCHOLINGUISTIC ERROR. BUT THAT'S NOT TO SAY THAT DEAF INDIVIDUALS ALSO DON'T EXHIBIT CIRCUMSTANTIALITY. AND WHEN THEY DO IT, WHAT'S CONSIDERED THAT NORMAL LONG STORY WOULD BE EXTENDED. IT WOULD BE, YOU KNOW, MULTIPLIED. THIRD ONE, I ONLY -- I ONLY PICKED FOUR, BUT A THIRD ONE IS ILL LOGICALITY. ONE THAT I REMEMBER HEARING WAS A LADY WHO HAD SAID IF YOU -- IF YOU WEAR NEW CLOTHES, YOU'LL DIE.

>>CINDY CAMP: OKAY.

>>CHARLENE CRUMP: SO THERE'S NO LOGICAL CONNECTION BETWEEN ONE PART OF THE STATEMENT AND THE LAST PART OF THE STATEMENT. THE FOURTH EXAMPLE IS NEOLOGISM, AND THAT MEANS AN INVENTION OF A NEW WORD. AND THIS IS -- OFTEN WE KNOW -- IT'S HARDER TO NOT DIAGNOSE, BUT HARDER TO FIND IN THE DEAF POPULATION, THOSE WHO ARE ASL USERS BECAUSE THEY HAVE VERY CREATIVE USE OF LANGUAGE, AND THERE'S ALSO -- THERE'S REGIONAL AND ETHNIC DIALECTS THAT OCCUR, SO YOU CAN SEE SIGNS THAT YOU'RE VERY UNFAMILIAR WITH, MAY NEVER HAVE SEEN BEFORE, OR YOU'RE NOT EXPOSED TO ON A REGULAR BASIS. BUT A NEOLOGISM IS A WORD THAT ISN'T A WORD RELATED TO ANY OF THOSE REASONS. IT ISN'T CULTURAL OR ETHNIC OR, YOU KNOW, REGIONAL FOR THAT MATTER. IT'S SOMETHING THAT THEY INVENT, THAT HAS A MEANING ONLY TO THEM. I LOVE LAW AND ORDER SVU, AND THEY HAD A REALLY GREAT EXAMPLE ON THERE ONE TIME OF A GUY WHO WAS KIND OF RUNNING AROUND YELLING THAT THE LOGISTICS WERE AFTER THEM, AND IT JUST ISN'T A WORD THAT EXISTS, BUT IN HIS MIND THAT WORD HAD MEANING. SO HAVE I CONFUSED YOU ENOUGH YET?

>>CINDY CAMP: NO. IT JUST REALLY GOES TO SHOW THAT YOU HAVE TO KNOW A LOT ABOUT ENGLISH AND ASL TO REALLY DO A GOOD JOB IN MENTAL HEALTH INTERPRETING. KIND OF SCARY.

>>CHARLENE CRUMP: IT IS. AND I THINK AS INTERPRETERS, THE ONE THING I WOULD CAUTION IS WE'RE NOT THERE TO DIAGNOSE THAT SOMETHING IS A PSYCHOLINGUISTIC ERROR, BUT WE ARE THERE TO KIND OF PICK UP ON THOSE PATTERNS. AND AGAIN, IT'S GOING TO BE A PATTERN, YOU'RE GOING TO SEE IT REPEATED. BUT YOU ALSO, AS AN INTERPRETER, WANT TO BE CAREFUL NOT TO KIND OF OVERCOMPENSATE, MEANING THAT -- ALL DEAF PEOPLE MAKE UP WORDS, ALL DEAF PEOPLE, YOU KNOW, TAKE A LONG TIME TO GET TO THE POINT, ALL, YOU KNOW, DEAF PEOPLE MIGHT EXHIBIT ILLOGICALITY BECAUSE OF LACK OF EDUCATION OR EXPOSURE, AND WE TEND TO KIND OF MASK THOSE

SYMPTOMS WHEN WE'RE PROVIDING INTERPRETING AND WHAT WE REALLY HAVE TO LOOK FOR IS THE LARGER PICTURE.

>>CINDY CAMP: WELL IT ALSO SHOWS THAT SOMEONE WHO'S WORKING IN AN EDUCATIONAL SETTING IS GOING TO BE ABLE TO SEE THOSE CHANGES, WHICH IS THE OTHER CRUCIAL PART, THAT IT DOESN'T JUST HAPPEN OVERNIGHT.

>>CHARLENE CRUMP: EXACTLY.

>>CINDY CAMP: WELL, WITH THAT, LET'S TAKE OUR NEXT QUESTION FROM THE AUDIENCE.

>>JENNIE BOURGEOIS: OKAY. WE HAVE QUESTIONS JUST A COMING IN SO WE WILL DEFINITELY HAVE A FOLLOW-UP DOCUMENT THAT WILL HAVE SOME REALLY GOOD INFORMATION ON IT. ONE OF THE QUESTIONS THAT HAS COME IN BY SEVERAL PEOPLE IS CONCERNING VOICING AS AN INTERPRETER, AND CHARLENE, YOU WERE TALKING ABOUT INDIVIDUALS WHO MAY SIGN CLEARLY AND THEN ARE DYSFLUENT AND THEN SIGN CLEARLY AGAIN, THEY KIND OF JUMP BACK AND FORTH. WHEN SOMETHING LIKE THAT WERE TO HAPPEN, AND YOU WERE VOICING -- AN INTERPRETER WAS VOICING FOR THEM, WHAT SHOULD THEY DO? SHOULD THEY START VOICING WITH USING GLOSS, OR IS THERE ANOTHER STRATEGY THAT THEY CAN USE TO LET -- TO GET THE INFORMATION THAT THE DEAF INDIVIDUAL IS SAYING, BUT ALSO TO LET THE PROFESSIONAL KNOW AND UNDERSTAND WHAT'S GOING ON?

>>CHARLENE CRUMP: I THINK THAT BEST PRACTICE, AND INDIVIDUALS WHO HAVE WORKED IN THE FIELD FOR A LONG TIME, USUALLY ENCOURAGE THAT WHEN YOU SEE SIGNING, WHICH IS VERY CLEARLY YOU'D BE WORKING IN KIND OF THAT SIMULTANEOUS FIRST-PERSON MODALITY. WHEN THE LANGUAGE SUDDENLY BECOMES DYSFLUENT, IT'S IMPORTANT TO LET THE CLINICIAN KNOW, ONE BECAUSE THEY'RE NOT GOING TO REALIZE THAT SOMETHING HAS CHANGED, EVEN IF YOU'RE SEEING THEM ALL OF A SUDDEN DO REALLY ODD THINGS THAT YOU THINK THE CLINICIAN WOULD PICK UP ON, THE CLINICIAN SEES ALL MOVEMENT AS SIGNING, AND IT'S ALL THE SAME, WHETHER IT'S FASTER OR SLOWER, OR NOT UNDERSTANDABLE. WHAT YOU WANT TO DO AT THAT POINT IS KIND OF SHIFT GEARS AND GO INTO A THIRD PERSON, YOU KNOW, HIS SIGNING HAS CHANGED NOW, AND ALL OF A SUDDEN HE'S SIGNING MUCH MORE RAPIDLY THAN HE HAS BEEN, AND I'M ALSO NOTICING THAT THERE'S KIND OF A TWITCH WITH HIS RIGHT HAND, AND THE NOUNS ARE MISSING OR WHATEVER YOU SEE THAT'S GOING ON. YOU WANT TO MAKE SURE THAT YOU DESCRIBE THE SPECIFICS OF WHAT'S GOING ON, NOT JUST I CAN'T UNDERSTAND HIM, BUT I CAN'T UNDERSTAND HIM HOW. AND GIVE THEM AS MUCH AS YOU CAN.

WHAT ARE YOU SEEING OR NOT SEEING THAT MAKES THE INFORMATION DYSFLUENT AS MUCH AS YOU CAN. YOU KNOW, I THINK PSYCHIATRISTS GET A LITTLE FRUSTRATED SOMETIMES WITH INTERPRETERS WHEN WE SAY THINGS

LIKE, "I JUST DON'T UNDERSTAND." I GENERALLY CAUTION AGAINST GLOSSING. AND THE REASON FOR THAT IS THAT GLOSSING CAN SOUND LIKE WHAT WE REFER TO AS KIND OF A WORD SALAD, WHICH IS ONE OF THOSE PSYCHOLINGUISTIC ERRORS IN THAT IT JUST SOUNDS LIKE WORDS THAT ARE THROWN IN THERE WITHOUT ANY CONNECTORS, WITHOUT THE GRAM MORE, AND WHEN WE START GLOSSING, HEARING INDIVIDUALS DON'T REALLY UNDERSTAND WHAT WE'RE DOING AND WE CAN KIND OF LEAD THEM DOWN TO, YOU KNOW, MAKING AN INCORRECT ASSUMPTION ABOUT WHAT'S GOING ON WITH THE LANGUAGE. IT'S MUCH BETTER TO KIND OF BACK UP AND SAY, YOU KNOW, I'M NOT UNDERSTANDING WHAT'S SAYING, BUT HE IS TALKING ABOUT A LARGE ORANGE RECTANGULAR OBJECT THAT SEEMS TO BE GETTING CLOSER TO HIM, AND THEN AS THEY GO BACK INTO LANGUAGE THAT'S MORE UNDERSTANDABLE, THEN YOU WOULD REVERT BACK TO THAT FIRST PERSON SIMULTANEOUS MODALITY.

>>CINDY CAMP: THANK YOU, CHARLENE, THAT REALLY IS KIND OF FOREIGN FOR A LOT OF INTERPRETERS, AND SO IT MAY TAKE SOME PRACTICE GETTING USED TO DOING THAT SORT OF THING. HOW DOES THE LANGUAGE CHANGE BASED ON THE CURRENT MENTAL STATUS OF THE PATIENT? YOU TALKED ABOUT THAT A LITTLE BIT.

>>CHARLENE CRUMP: I THINK THE MORE DRAMATIC THE CHANGE FROM THE PERSON'S NORMAL LANGUAGE USE BECOMES, THE MORE LIKELY THAT THERE IS A PSYCHOLOGICAL OR BIOLOGICAL CAUSE FOR IT. THE MORE PSYCHOTIC AN INDIVIDUAL IS, THE MORE LANGUAGE DISTURBANCE THAT'S TYPICALLY GOING TO BE PRESENT. HOWEVER, WHAT I THINK IS IMPORTANT FOR YOU TO REALIZE, TOO, IS THAT-AS THE INDIVIDUAL'S STATUS OR THEIR FUNCTIONING LEVEL IMPROVES, SOMETIMES THEIR REMNANTS OF THAT ABNORMAL LANGUAGE USE THAT CAN CONTINUE. FOR EXAMPLE, WE HAD A DEAF/BLIND PERSON WHO WE WORKED WITH WHO HAD PRETTY AVERAGE, YOU KNOW, ASL SKILLS WHO ALL OF A SUDDEN ONE DAY STARTED TRYING TO CUT HER THUMB OFF WITH A LITTLE BUTTER KNIFE. AND, YOU KNOW, WHEN THEY FOUND HER AND SHE SAID THE REASON FOR IT WAS HER THUMB WAS GROWING EYES AND A MOUTH AND HAIR AND WAS TALKING TO HER AND SHE WANTED THE VOICES TO STOP. THAT WAS A VERY -- YOU KNOW, SO SHE WAS TRYING TO CUT OFF HER THUMB. THAT WAS A VERY ABNORMAL THING FOR HER TO DO. THIS WASN'T, YOU KNOW, THE LANGUAGE THAT SHE WAS EXHIBITING, THE CONVERSATIONS SHE WAS HAVING WITH HER THUMB, THE BEHAVIOR WAS ALL VERY DRAMATIC, AND OBVIOUSLY HAD RELATIONSHIP TO HER CURRENT MENTAL STATUS.

>>CINDY CAMP: WOW. HOW DOES MENTAL ILLNESS IMPACT THE FUND OF INFORMATION ACQUISITION FOR INDIVIDUALS WHO ARE DEAF? AND YOU MIGHT NEED TO EXPLAIN ALSO A LITTLE BIT ABOUT WHAT FUND OF INFORMATION MEANS.

>>CHARLENE CRUMP: SURE. JUST VERY SIMPLISTICALLY, FUND OF INFORMATION -- AND I'M PROBABLY WAY OVERGENERALIZING, BUT IT'S JUST YOUR KNOWLEDGE OF THINGS. THINGS THAT YOU KNOW ABOUT THE WORLD,

ABOUT HOW THINGS CONNECT AND WHO INDIVIDUALS ARE, WHO'S THE PRESIDENT OF THE UNITED STATES, THINGS THAT THE AVERAGE PERSON USUALLY WOULD BE EXPECTED TO KNOW. THAT'S YOUR FUND, YOUR LITTLE TOOL BOX OF INFORMATION.

AS WE'VE DISCUSSED ALREADY, I THINK MENTAL ILLNESS IMPACTS LANGUAGE AND LANGUAGE ACQUISITION. IT RESULTS IN A TREMENDOUS IMPACT ON THE INDIVIDUAL'S KNOWLEDGE BASE, BECAUSE IF YOU HAVE DISRUPTIONS IN LANGUAGE, EITHER BECAUSE OF LACK OF EXPOSURE OR BECAUSE OF THE MENTAL ILLNESS, IT IMPACTS HOW MUCH EDUCATION THAT YOU CAN BE EXPOSED TO, HOW MUCH OF IT YOU CAN ABSORB, PROCESS, AND RETAIN. AND STUDENTS WHO HAVE SED OR MI ARE MORE LIKELY TO FIND THEMSELVES IN SITUATIONS WHERE THEY MAY BE IN SECLUDED ROOMS, ON DISCIPLINARY STATUS, THEY MAY BE OUT SICK, OR, YOU KNOW, IN THE HOSPITAL, OR HAVE OTHER ISSUES THAT REMOVE THEM FROM AN EDUCATIONAL ENVIRONMENT, SO IT LIMITS HOW MUCH EDUCATION THEY'RE EXPOSED TO. AGAIN, THEY MAY BE UNABLE TO JUST PROCESS THE INFORMATION, EVEN WHEN THEY ARE IN THE CLASSROOM THAT'S PRESENTED TO THEM IN THE SAME WAY THAT YOU WOULD EXPECT SOMEONE TO BE ABLE TO ABSORB THE INFORMATION AND RETAIN IT. WHAT WE FIND ARE THAT INDIVIDUALS WHO HAVE DYSFLUENCY IN THEIR LANGUAGE, THEY'RE MORE LIKELY TO HAVE HIGHER RATES OF AGGRESSION, AND IT'S PROBABLY KIND OF A CHICKEN IN THE EGG ANALOGY, YOU KNOW, THE LANGUAGE DYSFLUENCY MAKES THEM A RISK FACTOR FOR EMOTIONAL AND BEHAVIORAL PROBLEMS. BUT I THINK MOST IMPORTANTLY, YOU KNOW, AS WE'VE ALREADY DISCUSSED IS THAT BECAUSE THEY'RE HAVING THAT LANGUAGE DYSFLUENCY, BECAUSE THEY'RE HAVING LACK OF OPPORTUNITIES TO PARTICIPATE AS THEY NORMALLY WOULD IN THE EDUCATIONAL ENVIRONMENT, IT JUST REALLY IMPACTS HOW MUCH THEY KNOW ABOUT THE WORLD IN GENERAL.

>>CINDY CAMP: THAT BROUGHT TO MIND A QUESTION. I DON'T KNOW THAT WE COVER IT LATER ON, BUT THAT CAN BE A STICKY ISSUE. IF YOU WERE TO FIND YOURSELF IN A HOSPITAL OR A DOCTOR'S OFFICE SITUATION AND INTERPRETING FOR A BASIC MENTAL STATUS EXAM, THERE CAN BE SOME INTERESTING ISSUES THAT WOULD COME UP BASED ON THE FUND OF INFORMATION THAT A DEAF INDIVIDUAL WOULD HAVE AS OPPOSED TO THEIR HEARING COUNTERPARTS. COULD YOU ADDRESS THAT?

>>CHARLENE CRUMP: SURE. AND AGAIN, IT'S A VERY LONG TRAINING TO GO THROUGH THAT, AND I -- ONE OF MY COLLEAGUES, BRIAN MCKINNEY, WHO DOES AN EIGHT-HOUR TRAINING ON THAT AND I KNOW THERE ARE OTHER INDIVIDUALS WHO DO TRAINING AND HAVE WRITTEN SOME ARTICLES ON THAT, BUT JUST TO GIVE YOU SOME EXAMPLES. A REALLY COMMON QUESTION THAT YOU MAY HEAR BECAUSE THEY'RE LOOKING AT A PERSON'S ORIENTATION TO TIME AND TO THE ENVIRONMENT, IS TO SEE, YOU KNOW, ARE YOU HERE WITH US? DO YOU KIND OF KNOW WHAT'S GOING ON. THEY'LL ASK THEM QUESTIONS LIKE, YOU KNOW, WHO'S THE PRESIDENT OF THE UNITED STATES OR, YOU KNOW, WHO'S THE PRESIDENT.

AND THE DEAF INDIVIDUAL MAY ANSWER WHO THE SUPERINTENDENT OF THE DEAF SCHOOL IS, OR THEY MAY ANSWER NIXON, BECAUSE THAT'S WHO WAS PRESIDENT WHEN THEY WERE IN HIGH SCHOOL AND THAT WAS THE ANSWER TO THE QUESTION.

AND IF THEY HAVE EXTREME LANGUAGE DYSFLUENCY, THEY'RE NOT ABLE TO REALLY BE EXPOSED TO INFORMATION OUT THERE IN THE REAL WORLD LIKE TV AND NEWSPAPERS, YOU KNOW, THAT KNOWLEDGE BASE IS LIMITED, AND THEY MAY NOT KNOW THAT THERE HAVE BEEN DIFFERENT PEOPLE WHO HAVE COME IN TO BE PRESIDENT SINCE THAT TIME.

THEY MAY ASK THEM TO DO THINGS LIKE COUNT BACKWARDS BY 7. IF YOU'VE NOT REALLY HAD GOOD EXPOSURE TO MATH SKILLS YOU MAY NOT -- THE QUESTION MAY BE DIFFICULT TO ASK. SO, YOU KNOW, HOW YOU WORD THAT IS IMPORTANT. BUT THEN THEIR ABILITY TO CALCULATE BACKWARDS CAN BE IMPORTANT.

ALSO, PARABLES. THEY'LL ASK THEM THINGS LIKE WHAT DOES IT MEAN TO SAY, "THE ROLLING STONE GATHERS NO MOSS? " IF YOU'RE A DEAF INDIVIDUAL, ESPECIALLY ONE WHO HAS DYSFLUENCY AND LACK OF EDUCATION BECAUSE OF ALL OF THESE MITIGATING FACTORS AND YOU ASK THEM THIS TYPE OF QUESTION, WHEN YOU'RE INTERPRETING IT YOU CAN'T, IF YOU SIGN IT, JUST KIND OF WORD FOR WORD, SO TO SPEAK, IT DOESN'T REALLY HAVE MEANING BECAUSE THAT IS A PARABLE THAT'S UNIQUE TO ENGLISH USERS. IF YOU INTERPRET IT THEN YOU COULD BE GIVING AWAY THE ANSWER. AND THEN THE FACT THAT THEY'RE UNFAMILIAR WITH IT IN GENERAL CAN HAVE IMPLICATIONS FOR THE PSYCHIATRIST OR THE TREATMENT TEAM BECAUSE THEY MAY NOT BE AWARE THAT THEY JUST HAVEN'T HAD EXPOSURE TO THAT PHRASEOLOGY IN THE PAST AND UNDERSTAND WHAT THAT MEANING IS BEHIND THE WORD OR THE PARABLE.

>>CINDY CAMP: THANK YOU. I THINK THAT INFORMATION IS HELPFUL. WHAT'S THE DIFFERENCE BETWEEN LANGUAGE DYSFLUENCY RELATED TO DEPRIVATION AND PSYCHOTIC LANGUAGE DYSFLUENCY?

>>CHARLENE CRUMP: WHEN YOU FIRST START LOOKING AT IT, IT ALL LOOKS THE SAME. AS YOU START KIND OF COMPARING BETWEEN THE TWO -- AND IF YOU EVER GET A REALLY GOOD EXAMPLE OF SOMEONE WHO'S DEMONSTRATING LANGUAGE DYSFLUENCY RELATED TO DEPRIVATION AND THEN LANGUAGE DYSFLUENCY RELATED TO PSYCHOSIS, YOU START TO REALLY BE ABLE TO PICK OUT THE DIFFERENCES. WE HAVE SOME OF THOSE VIDEOTAPED AND IT'S A WONDERFUL TRAINING TOOL FOR INTERPRETERS THAT WE WORK WITH AND UNFORTUNATELY I THINK IT'S KIND OF -- YOU KNOW, IT'S KIND OF HARD TO HAVE ACCESS TO THOSE KIND OF MATERIALS, BUT JUST IN GENERAL I'M GOING TO LIST OFF A FEW DIFFERENCES BETWEEN THE TWO, DEVELOPMENTAL DYSFLUENCY, YOU'RE GOING TO SEE FUND OF KNOWLEDGE DEFICITS. YOU'RE GOING TO SEE VERY POOR VOCABULARY. SOME OF THE SIGNED FEATURES ARE GOING TO BE FORMED INCORRECTLY. THEY'RE GOING TO BE MISSING SOME

THINGS THAT ARE USUALLY INHERENT IN THE LANGUAGE, ESPECIALLY ASL, LIKE YOUR TOPIC COMMENT, YOUR REFERENCES, TIME, GRAMMAR MAY BE MISSING.

YOU'RE GOING TO SEE REPEATED SIGNS. YOU'RE GOING TO SEE SIGNS AND PHRASES THAT ARE KIND OF USED IN ISOLATION. THEY'RE GOING TO USE THIRD PERSON REFERENCES MORE OFTEN. AND THE WAY THAT THEY USE VISUAL SPACE IS DIFFERENT. IT'S USUALLY ALTERED OR LIMITED. WITH PSYCHOTIC DYSFLUENCY, YOU'RE GOING TO SEE INAPPROPRIATE FACIAL AND/OR EMOTIONAL EXPRESSION. YOU'RE GOING TO SEE KIND OF BIZARRE LANGUAGE CONTENT. YOU'RE GOING TO SEE -- YOU MAY SEE BEHAVIORS THAT ARE SUGGESTING HALLUCINATIONS. YOU MAY SEE INDIVIDUALS WHO ARE MORE GUARDED OR VOLATILE. YOU'RE GOING TO PROBABLY SEE DETERIORATED LANGUAGE SKILLS. AND THIS IS SOMETHING I THINK THAT THE INTERPRETER, ESPECIALLY AN EDUCATIONAL INTERPRETER WHO'S WORKING WITH THE CHILD ALL THE TIME, IS GOING TO BE ABLE TO BRING TO THAT TEAM. YOU'RE ALSO GOING TO SEE CHANGES IN THEIR APPEARANCE AND BEHAVIOR, AND I THINK THE FINAL THING IS THAT THE LANGUAGE WILL IMPROVE WITH MEDICATION, WHEREAS IF IT'S A DEVELOPMENTAL DYSFLUENCY, IT'S NOT GOING TO IMPROVE JUST BECAUSE YOU GIVE THEM THE MAGIC BLUE PILL. AND I SHOULD MENTION THAT THOSE DIFFERENCES WERE DONE BY NEIL GLICKMAN IN AN ARTICLE THAT HE WROTE AND REALLY HAD SOME THINGS TO EXPOUND ON THAT INFORMATION, BUT I WANTED TO MAKE SURE TO GIVE HIM CREDIT FOR THAT.

>>CINDY CAMP: THANK YOU. SO HOW DO I INTERPRET FOR SOMEONE WITH LANGUAGE DYSFLUENCY?

>>CHARLENE CRUMP: AGAIN, I THINK THIS GOES BACK TO WHAT YOU ASKED EARLIER, BUT IT REQUIRES THE USE OF A LOT MORE INTERPRETING TECHNIQUES THAN WE'RE USUALLY TRAINED OR ACCUSTOMED TO USING. YOU KNOW, THE FIRST PERSON SIMULTANEOUS INTERPRETING CAN BE VERY INEFFECTIVE IF YOU'RE WORKING WITH SOMEONE WHO'S EXHIBITING DYSFLUENCY. AND THIS IS WHETHER IT'S DEVELOPMENTAL DYSFLUENCY OR PSYCHOTIC DYSFLUENCY, AND SOMETIMES -- AND I WOULD SAY OFTEN IN THE CLIENTS WHO COME TO OUR PSYCHIATRIC UNIT, WE SEE BOTH. AGAIN, YOU KNOW, MENTAL HEALTH IS A LOT MORE THAN JUST ONE PSYCHIATRIC HOSPITAL AND AS THEY GO OUT INTO THE COMMUNITY YOU MIGHT NOT SEE AS MUCH PSYCHOTIC DYSFLUENCY ON A REGULAR BASIS.

BUT YOU HAVE TO BE ABLE TO CHANGE MODALITIES AND INTERPRETING APPROACHES, DEPENDING ON WHAT YOU'RE SEEING WITH THE SEVERITY OF THE DYSFLUENCY, THAT THIRD PERSON NARRATIVE DESCRIPTIVE LANGUAGE. AND ALSO ANOTHER THING THAT YOU NEED TO CONSIDER, WE'RE SO USED TO INTERPRETING THE CONTENT OF THE MESSAGE, MEANING THE WORDS OR THE CONCEPT OF THE MESSAGE, AND IN MENTAL HEALTH INTERPRETING, THE FORM, HOW THINGS ARE SIGNED, THE WAY IT IS DELIVERED, IS OFTEN AS IMPORTANT, SOMETIMES IT'S MORE IMPORTANT THAN THE ACTUAL WORDS THEMSELVES. AND LEARNING THE DIFFERENT TECHNIQUES OF INTERPRETING, FIRST PERSON,

THIRD PERSON, SIMULTANEOUS, CONSECUTIVE, NARRATIVE, DESCRIPTIVE, ARE PARTICULARLY EFFECTIVE WAYS TO PROVIDE INFORMATION TO THE CLINICIAN THAT OTHERWISE IS PROBABLY GOING TO GO UNNOTED BY THE THERAPIST THAT'S THERE. AND, YOU KNOW, YOU HAVE TO BE ABLE TO PROVIDE THAT INFORMATION. FOR EXAMPLE, IF YOU HAD A DEAF PERSON WHO WAS SIGNING EVERYTHING ON ONE SIDE OF THEIR BODY, THINGS THAT WOULD NORMALLY CROSS THE MIDLINE, LIKE CONGRESS WOULD MAYBE HIT THE LEFT CHEST AND COME OVER TO THE RIGHT, AND THEY START SIGNING IN THE MIDDLE OF THE BODY AND COMING OVER TO THE RIGHT, AND EVERY SIGN LIKE THAT THAT SHOULD CROSS OVER ACTUALLY STAYS OVER ON ONE SIDE, THE THERAPIST IS NOT GOING TO HAVE ANY IDEA THAT THAT'S OCCURRING AND YOU'RE GOING TO BE THE ONLY ONE THAT SEES THAT INTERRUPTION OR THE DIFFERENCE IN LANGUAGE. AND I THINK THE SAME THING IS TRUE REGARDLESS OF WHAT TYPE OF DYSFLUENCY OR LANGUAGE INTERRUPTION YOU'RE SEEING. IT'S JUST BEING ABLE TO UTILIZE THE VARIOUS TECHNIQUES.

>>CINDY CAMP: OKAY. WHAT INTERPRETING CONSIDERATIONS WITH LANGUAGE AND BEHAVIOR SHOULD I CONSIDER WHEN INTERPRETING FOR SOMEONE WITH MENTAL ILLNESS?

>>CHARLENE CRUMP: INTERPRETING FOR SOMEONE IN MENTAL HEALTH SETTINGS CAN BE VERY DEPENDENT ON THE DIAGNOSIS OR THE THERAPEUTIC APPROACH THAT'S BEING USED. IT'S AN EXTENSIVE SUBJECT, AND JUST TO HIT ON A FEW OF THE THINGS THAT I THINK THE QUESTION IS ASKING, WHEN WORKING WITH SOMEONE WHO HAS -- JUST TO GIVE YOU SOME EXAMPLES. IF YOU'RE WORKING WITH SOMEONE WHO HAS BORDERLINE PERSONALITY DISORDER, USUALLY IT'S VERY IMPORTANT IN THE THERAPY THAT EVERYTHING THAT OCCURS INVOLVES VERY FAIR AND CONSISTENT AND UNDERSTOOD GROUND RULES. THE INTERPRETER HAS TO BE A PART OF THAT. AND IF, YOU KNOW, RECUSING OURSELVES AND SAYING THAT, YOU KNOW, I'M JUST HERE AS THE INTERPRETER, I'M JUST PASSING ON LANGUAGE CAN BE COUNTERPRODUCTIVE TO THE THERAPY SESSION, AND CAN ACTUALLY CAUSE THE THERAPY TO FAIL. IF THE TREATMENT -- IF THE TREATMENT TEAM, FOR EXAMPLE, IS STATED THAT FOR WHATEVER REASON THE CLIENT WASN'T TO HAVE CIGARETTES, THE INTERPRETER SHOULD NOT GO OUT AND GO BY A PACK OF CIGARETTES FOR THE DEAF PERSON BECAUSE THEY FEEL SORRY FOR THEM OR BECAUSE THEY FEEL LIKE THE HEARING PEOPLE ARE AGAINST THE DEAF PERSON. YOU KNOW, IF A INDIVIDUAL HAS AN ISSUE WITH PICA, MEANING THAT THEY WOULD EAT THINGS THAT ARE NORMALLY INDIGESTIBLE LIKE GOLD, METAL, THEY WOULD ACTUALLY SEAT THAT, IT'S CALLED PICA, P-I-C-A, YOU SHOULDN'T LOAN THEM YOUR JEWELRY BECAUSE THEY THINK IT'S PRETTY BECAUSE THIS, TOO, SHALL PASS, IF YOU DO.

INTERPRETING TECHNIQUES I THINK ARE GOING TO VARY AS WELL. VERY BRIEFLY YOU'RE GOING TO, SOMETIMES, DEPENDING ON THE SEVERITY OF THE PSYCHOSIS, OKAY, IN SOMEONE WHO'S IN ACUTE STAGE, YOU'RE GOING TO SEE WHERE YOUR SIGNING MAY NEED TO BE SLOWER, IT MAY NEED TO HAVE MORE PAUSES, YOU MAY NEED TO USE LESS FACIAL EXPRESSION, YOU MAY NEED TO

LOOK AT LESS COMPLICATED SENTENCE STRUCTURES. SOME THINGS MAY NEED TO BE MORE CONCRETE. SOMETIMES YOU MAY NEED TO USE LESS FINGER SPELLING. YOU MAY NEED TO CHANGE THE QUESTION FORMAT, LIKE A YES, NO OR A LISTING OR CHAINING, GIVING OPTIONS.

MATCHING. MOST IMPORTANTLY, I THINK, MATCHING THE BODY LANGUAGE AND THE TONE, THE LANGUAGE, DELIVERY OF THE THERAPIST RATHER THAN THE DEAF PERSON. IF YOU HAVE A DEAF PERSON WHO'S A CLIENT WHO'S EXTREMELY AGITATED AND UPSET AND THEY START SCREAMING AND YELLING AND YOU'RE TRYING TO VOICE TO MATCH THAT, THEY'RE NOT GOING TO BE IN A PLACE WHERE THEY'RE GOING TO DISTINGUISH BETWEEN THE INTERPRETER AND THE THERAPIST AND YOUR FACIAL EXPRESSIONS AND YOUR BODY LANGUAGE WHILE YOU'RE VOICING ARE GOING TO EXACERBATE THE SITUATION, AND THEY'RE GOING TO BECOME ANGRIER AND ANGRIER AND LOSING CONTROL AND WHEN THEY CLIMB OVER THE TABLE TO HIT SOMEBODY IT'S PROBABLY NOT GOING TO BE THE THERAPIST SO WHAT YOU PROBABLY HAVE TO DO IS NOTICE THAT THE THERAPIST IS MAINTAINING A VERY CALM DEMEANOR, AND, SO, ARE YOU UPSET.

BUT YOU WANT TO BE CAREFUL ALSO NOT TO BE PATRONIZING. I MEAN, AS YOU SEE THAT THEIR ABILITY TO PROCESS LANGUAGE IMPROVES OR, YOU KNOW, AS YOU'RE INTERPRETING THAT THEY CAN HANDLE MORE, THEN YOU NEED TO MAKE SURE THAT YOU'RE ALLOWING THEM THE OPPORTUNITY TO PARTICIPATE IN MORE COMPLICATED SENTENCE STRUCTURE, MORE COMPLICATED IDEAS AND THAT YOU'RE NOT MAINTAINING ONLY A VERY SIMPLISTIC FORMAT.

>>CINDY CAMP: OKAY. HOW DOES CONFIDENTIALITY UNDERSTOOD WITH EDUCATIONAL AND MENTAL HEALTH SETTINGS?

>>CHARLENE CRUMP: I THINK IT'S UNDERSTOOD WITHIN THE CONTEXT OF WHERE YOU WORK AND WHAT SETTING YOU'RE IN. THE NEW CODE OF PROFESSIONAL CONDUCT STATES THAT, YOU KNOW, INTERPRETERS ADHERE TO STANDARDS OF CONFIDENTIAL COMMUNICATION, AND IT LOOKS FOR THE INTERPRETER TO ENSURE, YOU KNOW, REASONABLE USE AND DISCLOSURE OF CONSUMER INFORMATION.

DISCLOSURE OF INFORMATION CAN VARY BASED ON, YOU KNOW, SOME FEDERAL AND STATE LAWS. HIPAA REQUIRED MANDATORY REPORTING OF ABUSE OR THREATS OR SUICIDE OR RESPONDING TO SUBPOENAS. SO I THINK THAT IT'S DEFINITELY JUST UNDERSTOOD WITHIN THE CONTEXT OF WHERE YOU ARE.

>>CINDY CAMP: OKAY. GREAT. ARE INTERPRETERS CONSIDERED MANDATORY REPORTERS?

>>CHARLENE CRUMP: ANOTHER ONE OF THOSE IT DEPENDS. I THINK IF NOT LEGALLY, THEN OFTEN MORALLY AND ETHICALLY, WE ARE. STATE LAWS DO

DIFFER. AND YOU SHOULD BE AWARE OF WHAT YOUR OWN STATE LAWS ARE IN REGARDS TO MANDATORY REPORTING. YOU KNOW, A LOT OF TIMES A REALLY QUICK GOOGLE SEARCH WILL PULL THAT UP FOR YOU. I'VE INCLUDED A COPY OF ALABAMA'S MANDATORY REPORTING LAW. I THINK IT'S ON THE DOCUMENTS SECTION ON THE WEB SITE. AND LEGAL REQUIREMENT OF MANDATORY REPORTING, IT DEPENDS ALSO JUST, AGAIN, ON THE SITUATION, THE CONTEXT OF WHERE YOU WORK. YOU KNOW, ARE YOU INTERPRETING IN AN EDUCATIONAL SETTING, A MENTAL HEALTH SETTING VERSUS A TUPPERWARE PARTY.

AND IN SOME CASES, YOU KNOW, HAVING KNOWLEDGE OF ABUSE, YOU'RE STILL RESPONSIBLE FOR REPORTING THE INFORMATION, EVEN IF SOMEONE WHO'S IN A DIFFERENT POSITION, WHO YOU MIGHT THINK WOULD BE THE REPORTING PARTY, OR IN A POSITION OF AUTHORITY, WHO'S AWARE OF IT, SHOULD BE THE REPORTING PARTY, IT IS -- YOU STILL MAINTAIN THAT RESPONSIBILITY TO REPORT INFORMATION.

AND LIKE I SAID, THIS VARIES SO MUCH DEPENDING ON YOUR OWN STATE LAWS, BUT DEFINITELY ALL INTERPRETERS, NO MATTER WHAT SETTING THEY'RE IN, YOU KNOW, EDUCATIONAL, MEDICAL, COMMUNITY AND GENERAL, YOU SHOULD BE AWARE OF WHEN YOU'RE NOT REQUIRED TO BE A MANDATORY REPORTER.

>>CINDY CAMP: RIGHT. AND I THINK YOU'VE REALLY HAVE ALREADY TOUCHED ON THE FINAL QUESTION ON THIS SLIDE, THAT SOMETIMES INTERPRETERS MAY FEEL CONFLICTED BETWEEN THE REQUIREMENTS OF BEING A MANDATORY REPORTER AND FOLLOWING THE RID CODE OF PROFESSIONAL CONDUCT, BUT REALLY THE NEW CODE OF CONDUCT ADDRESSES THAT AND KIND OF PICKS OUT SOME OF THE CONFLICT THAT WE HAD PREVIOUSLY.

>>CHARLENE CRUMP: RIGHT. I AGREE. I DON'T REALLY THINK THAT THEY ARE IN CONFLICT. I THINK THAT THE NEW CPC DOES A MUCH BETTER JOB OF APPLYING CONFIDENTIALITY, PROBABLY IN THE WAY THAT MOST PROFESSIONS PRACTICE IT OR ADDRESS IT. THE OLDER CODE OF ETHICS, I THINK SOMETIMES PEOPLE UNDERSTOOD THAT TO BE THIS TOTAL NONDISCLOSURE RATHER THAN THE WAY THAT CONFIDENTIALITY IS GENERALLY UNDERSTOOD AND APPLIED.

AND THE NEW CPC ALLOWS MORE FLEXIBILITY, DEPENDING ON THE WORK SETTING. I THINK CONSIDERATIONS SHOULD, OF COURSE, BE GIVEN TO SITUATIONS WHERE, YOU KNOW, INFORMATION IS AT TIMES PRIVILEGED AS WELL, LIKE WORKING WITH LAWYERS OR MAYBE CONFSSIONALS OR WITH A THERAPIST. BUT YEAH, I THINK THAT THE NEW CPC DOES A GREAT JOB.

>>CINDY CAMP: GREAT. LET'S TAKE ANOTHER QUESTION FROM THE AUDIENCE.

>>JENNIE BOURGEOIS: OKAY. THIS IS A QUICKIE QUESTION. IF YOU'RE INTERPRETING WITH A COUNSELOR AND THE COUNSELOR ASKS THE DEAF CLIENT, DO YOU HEAR VOICES, HOW DO YOU, AS THE INTERPRETER, HANDLE THAT?

>>CHARLENE CRUMP: ALL RIGHT. LET ME BACK UP FIRST AND JUST SAY THAT, YES, DEAF INDIVIDUALS CAN EXPERIENCE AUDITORY HALLUCINATIONS. I'VE BEEN IN SITUATIONS WHERE, YOU KNOW, I'VE EITHER HEARD OF OR SEEN INTERPRETERS WHO WOULD TURN TO THE THERAPIST AND SAY, YOU KNOW, THEY'RE DEAF, THEY CAN'T HEAR VOICES, AND THEY CAN. REMEMBERING THAT HEARING VOICES REALLY IS A COGNITIVE ISSUE, IT'S A MENTAL ISSUE, RATHER THAN AN AUDITORY ONE, AND IF YOU'RE HEARING VOICES, EVEN FOR A HEARING PERSON, YOU'RE NOT REALLY HEARING SOMETHING. YOUR MIND IS TELLING YOU THAT SOMETHING IS OCCURRING THAT REALLY ISN'T. THERE ARE VARIOUS INTERPRETATIONS. I'VE SEEN, FOR LACK OF A BETTER WORD, YOU KNOW, WHEN YOU USE YOUR HAND AND YOU DO KIND OF THE TALK TALK, LIKE A GESTURE LIKE SOMEBODY'S RUNNING THEIR MOUTH, AND THEY'LL PUT IT BEHIND THE HEAD, AND I'VE HEARD PROFESSIONALS IN THE FIELD, NATIONAL EXPERTS, SAY THAT A LOT OF TIMES DEAF INDIVIDUALS WHO HAVE HAD EXPERIENCES WITH AUDITORY HALLUCINATIONS WILL IMMEDIATELY KIND OF KNOW WHAT YOU'RE TALKING ABOUT BECAUSE THEY'VE HAD THAT EXPERIENCE. FOR SOMEONE WHO COMES IN, THIS IS A FIRST-TIME INCIDENT, OR INDIVIDUALS WHO DO NOT HEAR AUDITORY VOICES, A LOT OF TIMES YOU'RE GOING TO HAVE TO DO SOME, YOU KNOW, EXPANSION ON THAT AND ASK A LOT OF OTHER QUESTIONS. BUT I WOULD CAUTION YOU THAT THIS IS REALLY SOMETHING YOU NEED TO GIVE BACK TO THE THERAPIST IN SAYING THAT THAT QUESTION IS VERY DIFFICULT TO ASK, AND, YOU KNOW, I THINK WE NEED TO BREAK IT DOWN TO SOME MORE SPECIFIC QUESTIONS BECAUSE YOU'RE PROBABLY GOING TO HAVE TO GET INTO WHETHER OR NOT THEY HAVE, YOU KNOW, AN AUDIOLOGICAL, DO THEY HAVE AN ABILITY TO HEAR VOICES WITH OR WITHOUT A HEARING AID, DO THEY HAVE A COCHLEAR IMPLANT, CAN THEY READ LIPS, DO THEY UNDERSTAND WHAT IT MEANS THAT SOMEONE ISN'T PRESENT AND MIGHT BE TALKING TO THEM, AND ALL OF -- ALL OF -- THERE'S SOME WONDERFUL RESEARCH STUDIES THAT HAVE BEEN DONE VERY RECENTLY, SOME IN ENGLAND, AND WOULD DEFINITELY -- I CAN MAKE SOME ARTICLE RECOMMENDATIONS IF YOU'RE INTERESTED. BUT, YOU KNOW, IT DEPENDS ON THE PERSON AND THE LEVEL, BUT IT'S A VERY COMPLICATED QUESTION TO ASK FOR JUST FOUR LITTLE WORDS.

>>CINDY CAMP: WE'VE GOT ABOUT EIGHT, NINE MINUTES LEFT BEFORE WE NEED TO MAKE CLOSING REMARKS, AND WE HAVE GOT ONE SLIDE LEFT. SO WHAT STANDARDS ARE THERE THAT GUIDE INTERPRETERS WORKING IN THE MENTAL HEALTH SETTINGS?

>>CHARLENE CRUMP: I DON'T THINK THERE ARE ENOUGH. I DO THINK THAT THE ALREADY STANDARD PRACTICE PAPERS ARE NEW. IF YOU HAVEN'T HAD A CHANCE TO LOOK OVER THEM, I WOULD JUST STRONGLY RECOMMEND THAT YOU DO. I THINK THEY DO A REALLY NICE JOB OF KIND OF EXPLAINING WHAT

MENTAL HEALTH INTERPRETING IS AND WHAT IT INVOLVES, AND SOME OF THE THINGS THAT YOU NEED TO LOOK TO FOR TRAINING IF YOU'RE INTERESTED. THERE IS IN ENGLAND, THEY DEVELOPED A CODE OF PRACTICE FOR SIGN LANGUAGE INTERPRETERS WORKING IN MENTAL HEALTH, AND ALSO -- AND YOU CAN DOWNLOAD THAT FROM THE INTERNET. JUST DO A QUICK GOOGLE SEARCH, AND IT'S AN EXCELLENT GUIDELINE. THERE ARE SOME FEDERAL AND STATE RULES. THERE'S DHS -- DHHS, DEPARTMENT OF HEALTH AND HUMAN SERVICES THAT OFFERS SOME PRIVACY RULES AND GUIDELINES RELATED TO HIPAA. I THINK IT'S IMPORTANT FOR INTERPRETERS TO KNOW BECAUSE IT KIND OF ASKS THE QUESTION ABOUT WHETHER OR NOT A HEALTHCARE PROVIDER HAS TO OBTAIN AN INDIVIDUAL CLIENT'S AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION TO AN INTERPRETER, AND NO, THEY DON'T. SO YOU DO NOT HAVE TO HAVE A SIGNED HIPAA FORM IN ORDER TO BE ABLE TO INTERPRET FOR AN INDIVIDUAL OR FOR THAT DOCTOR OR THERAPIST TO PROVIDE INFORMATION TO YOU ABOUT THEIR CONDITION OR SITUATION.

LASTLY, STANDARDS THAT I'M AWARE OF, ALABAMA DOES HAVE STANDARDS ON DEFINING WHAT A QUALIFIED MENTAL HEALTH INTERPRETER IS, AND THESE ARE WRITTEN INTO OUR STATE LAW, AND I THINK THEY'RE THE ONLY ONES THAT I'M AWARE OF. AND I THINK THOSE ARE SOME OF THE MAIN STANDARDS THAT ARE OUT THERE GUIDING INTERPRETERS WORKING IN MENTAL HEALTH.

>>CINDY CAMP: FOR ONCE, ALABAMA'S NOT LAST IN LINE.

>>CHARLENE CRUMP: THAT'S RIGHT.

>>CINDY CAMP: AND NO, IT WASN'T ALL VOLUNTARY. AS WITH EVERYTHING ELSE, IT WAS BASED ON A LAWSUIT, BUT ACTUALLY SOME VERY GOOD OUTCOMES. SO WHERE CAN INTERPRETERS GO TO OBTAIN ADDITIONAL TRAINING IN MENTAL HEALTH INTERPRETING?

>>CHARLENE CRUMP: THERE AREN'T, UNFORTUNATELY, AT THIS TIME A LOT OF ESTABLISHED ONGOING TRAININGS FOR INTERPRETERS IN MENTAL HEALTH. I'M GOING TO TAKE JUST A MOMENT AND BRAG, BUT I WON'T SPEND TOO MUCH TIME ON IT. WE DO IN ALABAMA, WE RUN AN ANNUAL 40-HOUR TRAINING ON MENTAL HEALTH INTERPRETING AND WE BRING IN NATIONAL EXPERTS. WE ARE FUNDED BY THE STATE AND IT'S ONE OF THOSE MANDATORY REQUIREMENTS AS PART OF THE SETTLEMENT, THE LAWSUIT THAT ALABAMA WAS INVOLVED IN. AND SO THEY PAY FOR MOST OF THE COST OF THE TRAINING.

IN CONJUNCTION WITH THAT, AND FOR THE CERTIFICATION THAT THE STATE OFFERS, THEY ALSO HOST A SUPERVISED PRACTICUM THAT'S AN ADDITIONAL 40 HOURS, AND THEN INTERPRETERS HAVE TO TAKE A COMPREHENSIVE WRITTEN EXAMINATION BEFORE THEY CAN OBTAIN THEIR CERTIFICATION AS A QUALIFIED MENTAL HEALTH INTERPRETER. IN ADDITION TO THAT, WE HOLD SOME REGULARLY-SCHEDULED MONTHLY ONGOING DISCUSSIONS THROUGH JACKSONVILLE STATE UNIVERSITY'S BLACKBOARD PROGRAM AND WE HAVE

QUARTERLY CLINICAL TRAININGS. USUALLY THEY'RE GEARED TOWARDS CLINICIANS WORKING IN DEAFNESS, BUT WE ALSO ENCOURAGE THE INTERPRETERS TO GO BECAUSE THE MORE THEY KNOW, THE BETTER THEY'RE ABLE TO INTERPRET EFFECTIVELY. AND WE HAVE ACTUALLY 1 ONE OF THOSE COMING UP MARCH 7TH ON UTILIZING THERAPY FOR DEAF CONSUMERS. BEYOND ALABAMA, BOB POLLARD AND ROBIN DEAN, THEY DO VARIOUS WORKSHOPS THROUGHOUT THE COUNTRY AND THEY DEVELOPED A MENTORED MENTAL HEALTH INTERPRETING CURRICULUM. THERE'S A CONFERENCE CALLED BREAKOUT, WHICH SPECIFICALLY ADDRESSES MENTAL HEALTH AND DEAFNESS. NORTHEAST UNIVERSITY IS DOING A CURRENT STUDY RIGHT NOW. THEY'RE KIND OF IN THE STATE -- STAGE WHERE THEY'RE GATHERING INFORMATION ON THE VIABILITY OF ESTABLISHING THE MASTERS LEVEL MENTAL HEALTH INTERPRETING CERTIFICATE SIMILAR TO WHAT YOU'VE PROBABLY SEEN BEFORE, THE MENTORING PROGRAMS, THE LEGAL CERTIFICATE, AND WE'RE CROSSING OUR FINGERS THAT THAT GOES REALLY WELL, AND THAT THEY DETERMINE THAT THEY HAVE VIABILITY FOR THE PROGRAM. I THINK BEYOND THAT, THERE'S A SMATTERING OF KIND OF AD HOC INTERPRETING, DEAF TRAININGS THAT OCCUR JUST IN ALL OVER, DIFFERENT STATES, AT DIFFERENT LEVELS AND DIFFERENT LEVELS OF QUALITY THAT ARE OUT THERE. SOME OF THEM ARE EXCELLENT AND SOME OF THEM ARE PRETTY BASIC AND IT JUST DEPENDS ON WHAT YOU NEED AND WHAT YOU HAVE ACCESS TO.

>>CINDY CAMP: OKAY. WHERE CAN PARTICIPANTS GO TO FIND OUT MORE INFORMATION?

>>CHARLENE CRUMP: I HAVE -- I HAVE SOME URL'S WHICH I'LL BE HAPPY TO SEND TO JENNIE AND CINDY AND THEY CAN POST THEM IF THEY'D LIKE, BUT I THINK OUR OFFICE OF DEAF SERVICES WITH THE ALABAMA DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION, THE DEAF WELLNESS CENTER AT THE UNIVERSITY OF ROCHESTER, THAT'S WHERE BOB POLLARD AND ROBIN DEAN WORK, THE STANDARD PRACTICE PAPERS, YOU CAN GET THOSE ON LINE. MINNESOTA CHEMICAL DEPENDENCY PROGRAM FOR DEAF AND HARD OF HEARING INDIVIDUALS. THERE'S THE ATA PSYCHE INFO DATABASE. A LOT OF GOOD INFORMATION THERE IF YOU'RE WANTING TO STUDY A PARTICULAR TOPIC OR IF YOU HAVE A QUESTION. PUBMED LITERATURE DATABASES, VERY SIMILAR IN USE. GALLAUDET ALSO HAS A MENTAL HEALTH RESOURCE DIRECTORY, SO YOU CAN LOOK IN YOUR LOCAL STATES AND COMMUNITIES TO COME SEE WHAT'S AVAILABLE THERE. AND OF COURSE NEITHER THIS QUESTION NOR THE LAST ONE ARE AN EXHAUSTIVE LISTING, JUST KIND OF SOME OF THE ONES THAT I'M AWARE OF AND WANTED TO HIGHLIGHT.

>>CINDY CAMP: GREAT. I THINK WE MAY HAVE TIME FOR ONE MORE QUESTION FROM THE AUDIENCE BEFORE WE CLOSE DOWN.

>>JENNIE BOURGEOIS: OKAY. ONE OF THE QUESTIONS THAT I HAD COME IN IS AGAIN ABOUT CONFIDENTIALITY, AND IF THERE IS A TEAM OF INTERPRETERS WHO MAY BE WORKING IN A MENTAL HEALTH SETTING AND, SAY, YOU KNOW, ON ONE DAY, SUZIE GOES, AND THEN ON THE NEXT DAY JANE GOES AND THEY

ALTERNATE, OR WHATEVER, IS IT APPROPRIATE FOR THE TWO OF THEM TO TALK AND DISCUSS WHAT'S GOING ON SO THE OTHER PERSON IS IN THE LOOP BEFORE GOING IN THERE, OR IS THAT A BREACH OF CONFIDENTIALITY?

>>CHARLENE CRUMP: I THINK IT'S DEFINITELY APPROPRIATE. I THINK YOU WOULD BE PROVIDING A DISSERVICE TO THE CLIENTS, THE HEARING AND THE DEAF CLIENTS, FOR BOTH OF YOU NOT TO BE AS PREPARED AND PREPPED AS YOU COULD BE. WE'VE ALWAYS ENCOURAGED AS MUCH AS POSSIBLE TO HAVE CONSISTENT USE OF AN INTERPRETER OR TEAM OF INTERPRETERS, AND, YOU KNOW, PART OF BEING ON THAT TEAM IS SHARING INFORMATION. AGAIN, YOU KNOW, CONFIDENTIALITY IS NOT A TOTAL NONDISCLOSURE OF INFORMATION. I WASN'T THERE, AND I DIDN'T SEE ANYTHING, BUT IT'S RATHER THAT YOU HOLD THAT INFORMATION IN TRUST, AND THAT YOU'RE NOT GOING TO BE PROVIDING INFORMATION TO PEOPLE WHO SHOULDN'T HAVE ACCESS TO THAT INFORMATION. THE PERSON WHO'S PART OF YOUR TEAM -- AND THAT'S VERY SIMILAR TO WORKING IN AN IEP OR A TREATMENT TEAM OR, YOU KNOW, A LEGAL -- IN A LEGAL SETTING WITH A LEGAL TEAM, ALL OF THOSE PEOPLE WHO ARE ON THAT TEAM USUALLY SHARE INFORMATION, AND INFORMATION THAT, YOU KNOW, WE SOMETIMES CONSIDER CONFIDENTIAL INFORMATION BECAUSE THEY'RE SHARED IN AN APPROPRIATE WAY AND IN AN APPROPRIATE SETTING FOR THE REASON TO BENEFIT THE CLIENT AND THE TREATMENT THAT THEY'RE RECEIVING.

AND AGAIN, YOU KNOW, IF THEY WERE HAVING SIGNIFICANTLY IMPACTING INFORMATION THAT WAS ALL OF A SUDDEN COMING TO THE SURFACE IN THE LAST SESSION, AND YOU'RE GOING INTO IT AS JANE BEING THE NEW INTERPRETER, AND YOU'RE NOT AWARE THAT THERE WAS SOME TYPE OF BREAK THROUGH IN THE LAST SESSION, OR THERE'S BEEN A CHANGE IN THEIR BEHAVIOR, OR THAT THIS ISN'T NORMALLY THE WAY THAT THEY SIGN, THEN YOU'RE PROVIDING A DISCONTINUITY.