# Mental Health Interpreting with Language Dysfluent Deaf Clients

Charlene Crump, B.S., CI and CT,
Alabama Office of Deaf Services

Neil Glickman, Ph.D.,
Advocates Inc., Framingham, Massachusetts

## Abstract
Many deaf persons served in mental health settings show significant language dysfluency in the best language, usually ASL. Sign language dysfluency in deaf people has four major causes: neurological problems associated with the etiology of deafness, language deprivation, aphasias, and psychotic disorders. Each cause can effect language development and usage in a particular way. In this article, numerous examples of sign language dysfluency are offered along with a discussion of their implications for interpreting, especially in mental health settings. The authors draw upon the Demand-Control interpreting approach of Dean and Pollard to illustrate interpreter decision-making when faced with the challenge of dysfluent language. The advantages and disadvantages of collaboration with deaf interpreters are reviewed. Finally, suggestions for best practice in interpreting for language dysfluent deaf persons in mental health settings are reviewed.

## Mental Health Interpreting with Language Dysfluent Deaf Clients
Many deaf persons who come into mental health and rehabilitation programs have significant language problems (Glickman, 2009). Poor skills in the spoken language of the majority community are common and are a natural consequence of being unable to hear the language. However, the language problems we are referring to are evident in ASL, usually the best language of these persons. In fact, more than half of the deaf patients served on a specialty psychiatric inpatient unit for deaf people, the Deaf Unit at Westborough State Hospital in Massachusetts, were judged by the communication specialist to have severe language dysfluency in signing (Glickman, 2009). Poor language skills in deaf psychiatric inpatients have been observed in numerous other studies of this group (Altshuler, 1971; Altshuler & Rainer, 1968; Denmark, 1985, 1994; Grinker et al., 1969). Poor language skills are also the first characteristic used to describe the subgroup of deaf persons sometimes called "traditionally underserved" (Dew, 1999; Long, Long, & Ouellette, 1993).

In this article, we refer to these language problems using the term "dysfluent." By dysfluent, we mean that these persons are not skilled users of the language. Their communication in the language is unclear or, to the native's "ear," peculiar. They sound or look like persons who have not mastered the language because their language is non-grammatical, non-idiomatic, or odd. As we will see, the underlying problem may be that the person has not mastered the language, but it may also be that the person has a form of mental illness or a brain condition which effects thinking and therefore language. Mental health clinicians doing psychological evaluations will want to know if a patient uses language in a dysfluent manner, and they will try to understand the underlying reason for it. If they do not know the language of the patient and are working through interpreters, they will draw conclusions based on how the interpreters interpret the dysfluent language. If the interpreters "fix" the dysfluent language, it can impact profoundly the diagnostic conclusions that the clinicians draw (Pollard, 1998a).

The purpose of this article is to summarize what we know about dysfluency in sign language use among deaf people and discuss its implications for signed language interpreters working in mental health settings. We will begin by reviewing briefly the four main causes of signed language disorders in more depth. This is followed by a literature review and illustration of best practices for interpreters working with language dysfluent consumers in mental health settings including language samples from patients served by the Alabama Department of Mental Health. Best practices include not only familiarity with several interpreting strategies but also making decisions based on the task demands

and available resources (Karasek, 1979, Dean & Pollard, 2001, 2005). As certified deaf interpreters (CDIs) are often brought into situations when deaf consumers are very dysfluent, we also consider the risks and benefits of this practice. Finally, we conclude with a discussion of best practice for interpreter-clinician collaboration.

## Causes of Signed Language Dysfluency in Deaf People

There are some fundamental differences between interpreting for deaf people and interpreting for hearing people who use other spoken languages. A difference that concerns us here is that severe language dysfluency in hearing people, unless they have significant cognitive impairments, is relatively rare. By and large, hearing people learn their native language. If a Vietnamese person comes into a mental health clinic, the clinician can assume that the person speaks some version of Vietnamese or another local language. They may or may not be articulate. They will use a particular dialect, but they are likely to be native speakers with fluent command of some language. The same cannot be assumed when working with deaf persons. Some deaf people are fluent users of their signed language but many others are poor users of this language. In extreme cases, some deaf people are virtually alingual (Schaller, 1991). This wide range of language skill, from native users to alingual people, with all sorts of variations in-between, brings to the signed to spoken interpreting task a degree of complexity that is not found in the work of spoken language interpreters.

In the deafness educational literature, when people refer to "language problems," they are usually referring to the well-known difficulties that deaf people have acquiring spoken and written language skills. Relatively little attention has been paid to the difficulties deaf people can have developing native sign language abilities. In this article, the latter issue is our concern. The challenge for the interpreter in working with clients who are poor communicators in any language is of a different order of magnitude from interpreting for people who use different languages well. There are four key reasons why deaf people may become poor communicators in any language.

The first reason is that there may be a neurological basis for such language problems. Most of the causes of deafness in children can also cause other neurological, medical or psychological problems (Vernon & Andrews, 1990)**.** The leading causes of deafness have been prenatal rubella, meningitis, prematurity, complications of Rh factor, and genetics. Of these conditions, hereditary causes are the least likely to produce multiple disabilities although 1/3 of genetic hearing loss is associated with a trait recognizable as a syndrome (e.g., Usher Syndrome, Alport Syndrome), and these syndromes can have multiple associated disabilities. The other four leading causes of deafness can all result in developmental delays, cognitive disabilities, and learning problems affecting language. In practice it is usually difficult to separate out presumed neurological bases for language problems from the environmental causes, especially lack of exposure to ASL. However, it is reasonable to assume that when deaf persons have severe language dysfluency, there may be an underlying neurological compromise, which was then made far worse by lack of adequate sign language exposure.

Even deaf children from signing deaf parents may have compromised signed language skills. One such example of a deaf child of deaf parents, exposed to British Sign Language (BSL) from birth, with normal intelligence, was recently published (Morgan, Herman, & Woll, 2007). This child used exaggerated gestures and facial expressions to compensate for poor language competence. He used repeated pointing and exaggerated facial expressions rather than grammar. Samples of his language show repetitions of single signs with few grammatical inflections. Using norms available for British signing deaf children, he was found to be more than two years behind in language development. The researchers concluded that his example provides evidence that specific language impairment can exist in deaf signers. They hypothesize that specific language impairment would occur in deaf children with at least the same incidence rate as hearing children; that is 5-7% of the population. They could only measure this because they had a standardized instrument to use (the British Sign Language Receptive Test), norms, and a deaf child of deaf parents who had full, rich BSL exposure.

The first researchers to take sign language dysfluency seriously were Poizner, Klima, and Bellugi (1987) in their research into deaf people affected by aphasias (Klima & Bellugi, 1979; Poizner, et al.). Aphasia is an acquired language disorder, usually resulting from lesions to the language relevant areas of the brain. Aphasias can result from strokes, tumors, or closed head injuries. Aphasias in

hearing people can result in the inability to comprehend language, to form words and name objects, to repeat phases, to speak in a grammatically correct fashion, and to be unable to read or write. Aphasias may cause persons to invent words, persistently repeat phrases, substitute letters, syllables or words, and alter inflexion, stress and rhythm (prosody). Depending on the location of the lesion, aphasias can manifest in problems such as difficulty narrating a story in an organized, linear fashion, slow output of words, limited vocabulary, inability to access specific nouns, use of the wrong noun or wrong verb, use of a pronoun without an antecedent (saying "he" before establishing who "he" refers to), and inability to express the point of a story (Ash et al., 2006). The research of Poizner et al. demonstrated that deaf people who were native signers of ASL, and who experienced strokes, developed sign language aphasias that were comparable to spoken language aphasias in hearing people.

Certain mental illnesses that cause thought disorders also cause language dysfluency. Along with hallucinations and delusions, patients may show disorganized thinking, an inability to put together words, signs, and thoughts in a coherent way that makes sense. This phenomena is well known in hearing people, but it occurs in deaf people also (Pollard, 1998b). Patients may, for instance, demonstrate *loose associations* where there is only a marginal connection between one idea and the next. They may be unable to think abstractly, to see patterns or relationships, or to generalize as to what things mean. They may be unable to think in logical, cause and effect terms. They may make up new words (*neologisms*) or make connections between words based not on meaning, but on sound or on the physical properties of signs (*clanging).*

The second researcher to take sign language dysfluency in deaf persons seriously was Alice Thacker in Great Britain. Thacker (1994, 1998) studied the sign language output of deaf people diagnosed with schizophrenia. She found examples of deaf persons with schizophrenia demonstrating the same kinds of thinking problems as hearing people with schizophrenia, only manifest in sign language. In particular she found evidence of:

1.  The linking of a sign to an English word that sounds similar (Interviewer: YOU SAY WOMAN INSIDE YOU HAVE? MEAN WHICH, BODY, OR SOUL? Schizophrenic subject: SOUL (conventional sign) SOLE (pointing to bottom of foot). TWO FEET JUMP IN MY MOUTH
2.  Finger spelling backwards or moving signs backwards; placing signs in the wrong location.
3.  Connecting signs based on their properties (handshapes, location, movement) rather than on meaning.
4.  Very loose associations; going off topic and not finding one's way back ("derailment").
5.  Repeating a sign or sign phrase or theme unnecessarily.
6.  Copying the signing of the examiner ("echolalia").
7.  Errors in the syntax or grammatical order of signs.

Thacker assumed that the sign language dysfluency found in deaf persons diagnosed with schizophrenia was due to the thought disorder. She did not address the issue of deaf psychiatric patients who are language dysfluent for other reasons such as inadequate sign language exposure. That fact that most deaf children are raised without adequate exposure to the only languages which are fully accessible to them, signed languages, is the most obvious and dramatic cause of poor language development.

Trumbetta et al. also examined dysfluency related to deaf individuals with schizophrenia. The article acknowledged that communication deficits might arise from reasons other than mental illness, including language deprivation, etiological complications, and the lack of familiarity of clinicians with the deaf population (Trumbetta, et al., 2001).

The Deaf Unit at Westborough State Hospital in Massachusetts was, for 23 years, a specialty psychiatric unit for deaf persons with severe emotional and behavioral problems. Research stemming from this unit showed that the majority of deaf persons served there were not fluent users of any language (Black, 2005; Black & Glickman, 2005; Glickman, 2009). Since there is no reason to think the Westborough Deaf Unit was atypical, this is presumably the case in all specialized mental health and rehabilitation programs for deaf people. The literature on "traditionally underserved deaf" bears this out (Bowe, 2004; Dew, 1999; Mathay & LaFayette, 1990), as does most of the literature on inpatient treatment of deaf persons (Glickman, 2009).

Glickman (2007, 2009) presented examples of the kinds of language errors that were commonly

seen among deaf persons on the Westborough State Hospital Deaf Unit. These language errors were attributed mainly to language deprivation and not to mental illness although it is reasonable to assume that neurological problems contributed as well. These common errors were:

1. Impoverished vocabulary with many signs used incorrectly. The limited vocabulary is the most obvious form of language dysfluency seen, with some deaf patients communicating only with isolated signs or short sign phrases.

2. Inability to sequence events in time. This often includes a lack of signs and grammatical structures to indicate tense. These persons seem unable to tell any story, using a beginning, middle, and end, much less the story of their own life. They jump back and forwards in time without indicating that they are doing so. This deficiency also makes it difficult for them to see cause and effect or to use conditional phrasing (if this, then that).

3. Spatial disorganization. Inability to use the space around the signer grammatically. For instances, referents are not established and maintained in one part of the spatial field. Sign inflection involving movement through space is absent or inconsistent.

4. Syntax. The topic comment structure of much ASL is missing. Subjects are not established clearly, nor are they related appropriately to verbs and objects. Pronouns (like an index finger to establish a person) may be used without any referent. Often these patients seem to be listing nouns or sometimes verbs without establishing relationships. They make heavy use of sign repetition as a poor substitute for grammar.

5. Mixture of gesture and pantomime with sign. Because their vocabulary is so poor, these persons make frequent use of gesture and pantomime. While competent signers may do this on occasion, usually for emphasis or for creative storytelling, they have the necessary language structure if they choose to use it, while these persons have no alternative but to act things out.

The treatment challenges when working with language disordered deaf persons are so prominent that the Westborough Deaf Unit ultimately had to devise major adaptations to best practices in cognitive behavioral therapy in order to work with them (Glickman, 2009).

Just as Poizner et al. (1987), demonstrated that aphasias can exist in deaf people by studying the sign language errors of deaf persons who had experienced brain injuries, Thacker demonstrated that thought disorders could exist in deaf persons by examining the sign language errors of deaf persons with schizophrenia. To make their respective points, the researchers had to study deaf persons who had relatively good sign language skills prior to their injury or illness. Both kinds of language errors would be confounded dramatically if the samples of deaf persons included those with the far more common problem of language dysfluency due to language deprivation. With this latter group, one *cannot* say that their previously intact signing abilities suffered as a result of a new condition. Rather, their sign language skills were always impaired (i.e., they have a developmental deficit) and now they have one or more new problems (an aphasia, a severe mental illness), creating language deficit upon language deficit, and probably making it impossible to figure out any single etiology. The caseload from the deaf psychiatric unit at Westborough State Hospital showed that relatively pure examples (proficient signers who suddenly experience a dramatic loss in signing abilities) are rare. Far more common are deaf patients who, as best staff can determine, have always signed poorly, and now may *also* have a mental illness. In a mental health setting, aphasias related to strokes or other forms of traumatic brain injuries are easier to rule out because there will be other neurological evidence for such events, and there will be a story about a dramatic worsening of language skills following some event. Language deprivation, on the other hand, is widespread in the deaf clinical population (Glickman, 2009). Indeed, when faced with a patient who demonstrates a severe sign language disorder, the most likely cause will have been language deprivation, and this should be the working default hypothesis for clinicians.

## Interpreting for Deaf Persons with Language Dysfluency: Literature Review and Core Strategies

There is very little written on the subject of interpreting for deaf persons with language dysfluency. A literature review found 16 publications that mention the problem but only four provide any substantive discussion of the issue (Glickman, 2007; Karlin, 2003; Trumbetta et al., 2001; Pollard, 1998a, 1998b).

We were unable to find any research that has been conducted examining the effectiveness of varying interpreter responses to this challenge.

Karlin (2003) outlines the types of language errors made by deaf persons with schizophrenia, based on Thacker's work (1998), and discusses strategies for interpreting from ASL to English when faced with these errors. She explains that clinicians are often less interested in the specific message the patient communicates than in what the language patterns reveal about the consumers' mental world. The Registry of Interpreters for the Deaf, Inc. (2007) Standard Practice Paper, "Interpreting in Mental Health Settings," states that "The interpreter can provide information and opinion related to the communication process, but not on the therapeutic process". In other words, it is well within the interpreter's role to comment on a person's language and communication abilities, if appropriate to the context, but not to offer an opinion about what language skills and deficits mean clinically.

Pollard (1998a) has written the most extensively on the subject and examines the interpreting role with dysfluent patients as a part of a mentored curriculum for mental health interpreters, including a section on strategies for interpreting with language dysfluent consumers. Pollard's curriculum goes into some depth about the interpreting strategies recommended by RID (2007). In this article, we draw most heavily upon his work.

Pollard identifies four strategies that can be used by mental health interpreters for interpreting dysfluent communication. These include use of the first person, third person, description, and glossing. Each of these strategies can be illustrated with reference to a specific kind of language error.

**First person** is the strategy for which interpreters are most familiar. This works best when the consumer's language is reasonably clear and intact but the consumer is showing a distinct mood or varying his speed, tone, or intensity.

**Third person** is the strategy of saying "he or she is saying that…". Sometimes it is better for the interpreter to describe the language of the deaf consumer in this manner. For example, if a deaf consumer is very agitated, it could be disruptive for the interpreter to mimic the same level of agitation. This could make a difficult situation much worse. Using third person strategy, the interpreter could explain in a calm voice, rather than trying to match the intensity and specific word choices used by the consumer, that "the consumer/he is screaming that his siblings have stolen his money left to him by an uncle who passed away recently and now he has no money for food or rent."

The more dysfluent the deaf consumer's language becomes, the more necessary it becomes to use third person and/or to **describe** the consumer's language. Pollard recommends the descriptive strategy any time the interpreter is unsure of logic or meaning and when such a description may be clinically useful.

A neologism, a made up word, would have no generally understood translation. It can be hard for interpreters and clinicians to be confident that an unrecognized sign is a neologism, rather than a home sign, a regional variant, a gesture, ethnic variant, or even a sign from a different signed language. Additionally, ASL users can form signs in creative and unique ways while still maintaining the sign's meaning. An example of a neologism in sign language, provided by Roger Williams, Director of Deaf Services for the South Carolina Department of Mental Health, and was about a consumer who knew that aliens were coming to earth because "computer keypad signed on the nose." This is actually a very sophisticated play on a sign, which, outside of an artistic context, suggests a thought disorder, not language deprivation. Faced with an apparent neologism, interpreters probably should describe it and comment on it. "I don't recognize that sign. It appears to be something that the consumer understands, but it is similar to the sign for a 'computer keyboard used to input information,' but it is placed in an unusual space, on the nose."

In topic derailment, the person changes topics mid discourse and is unable to stay on point. This is illustrated in the following segment of an interview, audiotaped with a hearing psychiatric patient at Westborough State Hospital.

"I'm just afraid of great things happening.  I'm not afraid of little wars. I'm just afraid of the… (inaudible).  I'm afraid of big wars…and the main problem I'm having over the last days or weeks or so is who I am. They say I'm a liberal intellectual and I'm a Christian sometimes and it's always a pleasure to be with you. I'm very happy with you doctor. I appreciate all you have done to me. You'll have to excuse my nastiness. It's caused by…I was very dismayed. I prayed

for a little bit for a boy this morning from a suburban high school who was gay and who was shot to death by another student, by a straight student. Blew him away, you know?"

First person strategy can work well in the situation described above. In this example, no one would think this person was not a fluent speaker of English. People would recognize his skill in English but note that his thinking appears off in some way. This is usually the case with persons suffering from thought disorders. They do not give the appearance of not being fluent or native users of their language. Rather, they appear to be confused, have strange ideas, or be unable to stay on point. They do not usually, for instance, forget subjects, verbs or objects, or inflect verbs incorrectly. More commonly, they are just putting thoughts or ideas together oddly.

This is in striking contrast to many deaf persons who are dysfluent because of sign language deprivation. In extreme cases, their language skills can be so poor that they are incoherent or barely able to communicate an idea, even to native signers. When using first person strategy breaks down, the interpreter can incorporate **third person narrative** and **descriptive** strategies. The descriptive strategy differs in that it refers to commenting on the person's language as well as paralinguistics. When a deaf consumer's language skills are exceptionally poor, the interpreter must rely increasingly on third person, description and even on the strategy known as **glossing**.

Interpreters sometimes refer to glossing as a word for word translation of the source material. It is the process of applying a common label for the sake of convenience or expediency often disregarding grammar or sentence structure (Pantel & Lin, 2000). For example, a variety of English words (angry, enraged, livid) might all be glossed with the sign ANGRY even though the different shades of meaning are conveyed through how the sign is made. Glossing can be a technique utilized in interpreting especially when the language is very dysfluent or incoherent.

Pollard (1998a) gives the following example, which combines glossing with third person and descriptive strategy. The interpreter explains that he is attempting to provide the clinician with individual words or short clauses that as near as possible represent the language sample he is seeing. He says,

> "She is saying something about her mother and a devil and something about an argument, but she is not speaking in complete sentences and she is using past tense and present tense in a way that doesn't make sense to me."  (p. 95)

Additionally, some of the message that is being signed may be glossed as follows…

> "Mother…went (somewhere)…devil with red eyes glaring, coming…(something about) shouting and hitting…mother was girl a long time ago…the devil won't, won't (I missed some here)… you know the devil…I'm 50 years old."  (p. 95)

ASL and English have very different grammars, and literal transliteration from ASL into English, just like such transliteration from other foreign languages into English, gives the appearance of bad English. Glossing is not recommended with persons who are signing well, and must always be used carefully, with explanations, with hearing people who are unfamiliar with ASL.[1] Whenever glossing is done, it inevitably makes the deaf person appear even more language impaired. Glossing may be more acceptable with clinicians who have some familiarity with ASL and who want in certain situations to know specifically the signs that are being used, as much as possible.

Finally, one could cite one more strategy in which the interpreter provides contextual or background information to help clinicians understand a deaf person's statements. For example, if the clinician asks the consumer the question, "who is the President of the United States?" and the person responds "Bobbie Scoggins," the interpreter might add, in the third person, "he gave the name of the person who is/was the president of the National Association of the Deaf." This addition to the interpreting process provides contextual information that will help the clinician evaluate the deaf person's thinking. The clinician could probe further if he or she wishes. This strategy might also be used when an interpreter

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1 This could be explained as follows: "I will attempt to provide you with a rough equivalent of the concepts expressed as one possible interpretation. However, the English words that I am presenting are not a complete representation of the signs being conveyed, as single words do not exist in a vacuum and need the structure of the sentence for its complete meaning to be understood."

comments that a person from a signing deaf family who attended a residential school would normally sign much more proficiently that what she or he is observing at that moment.

Interpreters need to be careful to limit their comments to their areas of expertise (RID, 2007). Sometimes clinicians unfamiliar with deaf people and interpreters ask the interpreter to make clinical judgments such as "is he hallucinating?" or "why doesn't she make sense?" As someone who is not trained to make clinical assessments, an appropriate response would be to help the clinician understand the interpreter's role. The interpreter could say, "I'm not trained to make that type of determination. What I can provide you is access to the person's language and also discuss how they are using language."

## Interpreter decision-making: using the Demand-Control approach to select interpreting strategies

Interpreter methods will vary, depending not only on the cause of the dysfluency, but the setting, goal of the environment, and many other factors. The demand-control schema provides a tool for analyzing the demands of any given interpreting situation and considering the appropriate interpreting choices, or controls (Dean & Pollard, 2001, 2005). Language dysfluent deaf consumers present especially difficult demands for interpreters. These demands are compounded when the clinician knows nothing about deaf people and when both parties hold unrealistic expectations for what interpreters can accomplish. The demand-control schema gives interpreters a way of discussing these challenges and will be drawn upon here in relation to interpreting for language dysfluent deaf persons.

The strategies discussed in the literature review focus primarily on dysfluent language that can occur as a result of mental illness. As noted above, there are other possible causes of language dysfluency in deaf people. The far more common cause is sign language deprivation, and the kinds of language errors that such language deprived persons show are typically different than persons with intact language who develop mental illnesses.

Interpreting choices can include timing. Consecutive interpreting can be useful to the interpreter in mental health settings when working with dysfluent consumers since it allows for a fuller, more accurate understanding of the source language message to be understood before interpreting it into the target language (Russell, 2002). Consecutive interpreting also allows the interpreter time to assess if the language produced is typical or to identify what patterns of language dysfluency are exhibited. It provides the interpreter with the time needed to provide at least some third-person description or narrative of dysfluent language if the interpreter so chooses.

While there are many reasons why an interpreter would choose consecutive interpreting, there are times within mental health interpreting when an interpreter might choose to utilize simultaneous interpreting. For example, when a client's signing is "pressured" (that is, rapid, virtually non-stop, emphatic, seemingly driven, and difficult to interrupt), the interpreter may be unable to mentally hold on to the message, and consecutive interpreting may not be possible. The interpreter might explain that the message is being signed rapidly and does not contain natural pauses that would allow her to work consecutively and to retain the content of the message. Then the interpreter may choose to work simultaneously, at least as much as is possible. There also may be times when the consumer is an above average speech reader and is hyper vigilant about the interpreter's word choices. In this case, delaying the interpretation or providing commentary on the language might hinder the therapeutic process.

An example of a language sample from a person with sign language deprivation is provided from the Alabama Department of Mental Health. There was no stimulus question and no background to the context provided prior to the person beginning the narrative. Using first person, the interpreted message would sound something like this:

"'P' a person named 'P' you know 'P'? Her Dorm. She's in trouble. I'm mad, I'm mad. Trouble mad. All. Every. No problem. I, umm, umm, zip my lips, umm, me. I calmed down. I enter hear carry out the trash all day. Fine with me. Can hear people talking, yes, yes. Can hear? Yes. Can hear? I talk a lot, hear, talk a lot. WISNERS(?), the interpreter explains to me all day. I know that they really didn't serve. I work, I'm working. The teacher writes a lot on paper

and I write to…..I, table, I will explain about the chairs all over the place. I talk and chat to deaf, hard of hearing and deaf people.  Deaf people can't hear. I can't hear people at all."

Utilizing third person narrative and descriptive techniques consecutively, the interpreter could offer the following interpretation.

"The consumer, Billy, is discussing a female whose name begins with a 'P.' (the name was spelled out, but was unclear) this individual appears to have some association with the dorm. He is stating that the female may be in trouble or has caused some trouble and that he is upset about it. There is some information that I am not understanding. He seems to be telling himself to calm down and to keep quiet about the situation (to zip his lips). He has now switched topics and appears to be talking about carrying out the trash. It is something that he has been involved in all day. He is talking about hearing and repeating the sign for 'hear' several times and stating that he can hear or that someone else can hear. Billy is fingerspelling something, which is not clear, that appears to be a person's name, 'WISNERS.' WISNER seems to be a person in the role of an interpreter who has worked with Billy. He is again talking about work and assuring that he does indeed work.  The topic now centers on a school setting including a teacher and writing and placement of chairs. He is discussing talking and mentions deaf, hard of hearing and hearing people (possibly communicating with people of varying hearing loss?) and the fact that deaf people cannot hear."

Clearly, this second interpretation provides a much clearer presentation of the message of the deaf patient. Providing additional descriptive information for the clinician on the way the message is conveyed may be even more helpful.

"The consumer is signing as if the story is urgent.  The story frequently jumps from the present to the recent past to his childhood without any indication of shifts in time or topic.  Individual names are not spelled out completely.  Many concepts and words are poorly or incompletely formed and could be representative of a number of meanings. For example, I'm not sure if he means hearing people or that he can hear and the meaning is not clear from the context. Also, I'm not sure if it is an interpreter present or that someone is explaining information to him because the sign is produced almost as a combination of the two signs, explain and interpret. There are several times when signs are repeated, and seem to indicate emphasis or clarification. There appears to be an element of disbelief, and possibly frustration, throughout most of the message. There are some signs that I am not familiar with and could possibly be a gesture used with his family or variant of the word."

The third person descriptive and consecutive technique can be less distressing for interpreters because it allows them to process the content of the message more fully and in a more accurate and coherent manner and to reveal the form of the dysfluency which they observe.

There are multiple demands upon the interpreter in this type of situation. Interpreters are likely to consider their control choices, resulting demands and consequences of those decisions. Some of the demands that an interpreter might consider are:

- Interpreters often do not feel comfortable voicing incomplete and incoherent sentences.
- Interpreters may be unsure whether the dysfluency is a fact or whether the problem lies with their own inabilities.
- Interpreters may be concerned about the opinion of the clinician or consumer who may think that the problem lies in the interpreter's lack of sufficient skills.
- Interpreters may be concerned that the clinician may draw inappropriate conclusions about the deaf person's intelligence or over generalize to draw wrong conclusions about limited language and cognitive abilities of deaf people.
- Interpreters often fear that when the deaf person is not presented in the best possible light or the outcome is an undesirable one, that they will be blamed by the deaf person and, by word of mouth, the Deaf community, for their perceived lack of skills or inappropriate attitude.

- Interpreters are taught that it is important to match the register of consumers so that intelligent deaf people sound equally intelligent in translation. But what about the deaf person who is not clear or coherent or intelligent? Interpreters may be uncomfortable matching the register when it reveals the deaf consumer in a less flattering light.

Clearly, it takes a great deal of skill and confidence for an interpreter to know whether the problem lies with their interpretation, the consumers or, for that matter, with incoherent, unskilled, or insensitive clinicians. This is one reason why mental health interpreting requires advanced skills.

One of the most important controls is a pre-assignment understanding of the goal and resources of the clinical environment. What is the clinician's goal for the session? Is the clinician primarily concerned with communicating, as in a counseling session, or is the clinician doing a mental status exam where understanding how the consumer uses language is crucial? How experienced is the clinician in working with deaf people and collaborating with interpreters? Can the interpreter obtain a pre-session with the clinician during which time these issues can be explored? These demands shape the interpreters decision making.

Interpreters assessing demands and employing controls continuously analyze and, when necessary, change their interpreting strategy. The interpreter adjusts strategy based on the assessment of the clinicians' prior experience with deaf people and approach to this particular task. The interpreter may also consider other concurrent demands (Dean & Pollard, 2011) such as how much time is available. If little time is available, the interpreter may stick to first person and add brief comments like "this part is unclear" or "I'm unsure what he meant here." When more time is available, especially if there is the possibility of a post-session, the interpreter can obviously offer much more detailed information.

Another pre-assignment control that the interpreter can bring is the knowledge base about language dysfluency. Interpreters may want to seek out training, therefore, on the most common types of language problems, the most common reasons they occur, the assessment of language disorders and the best strategies for interpreting them. While interpreters would want to avoid overly liberal decisions such as stating, "the consumer is psychotic" or "the consumer just produced a neologism," realizing that such phenomena exist is likely to be very helpful. Gaining this knowledge can assist interpreters when they realize that sometimes the consumer really isn't clear. This facilitates an effective dialogue with clinicians.

Once the actual interpreting has begun, controls include those presented earlier in this discussion. They may also include making adjustments to interpretation such as signing slower, using less movement, voicing in a way that does not exacerbate an emotionally charged setting, utilizing listing techniques, gesture, pictures, or manipulatives such as toy figures and other visual tools, etc. The controls listed here and presented throughout the article are not exhaustive. Ideally, the clinician will be involved in helping the interpreter make these decisions because then they are working effectively as a team. Both should understand that it falls to the clinician to determine what these language problems mean. Some examples of this decision making process, with the interpreter using different controls, follow:

The setting is the intake assessment and the clinician asks the consumer, "Do you know what day it is today?" The interpreter chooses to sign TODAY WHAT? This interpretation is actually not as clear as the English question. The clinician may be asking the day of the week, but the consumer may think the question pertains to the weather. The consumer may, therefore, not respond in the way the clinician expects. Maybe the consumer is psychotic or perhaps he has language or cognitive problems or maybe the question as signed is too vague, as in this example. The interpreter might therefore interpret the question like this: TODAY MONDAY TUESDAY WEDNESDAY WHAT? This is probably more directive and specific than the clinician wanted. The interpreter could also say to the clinician, "I have asked him your question. However, it is very common when using ASL to offer suggestions or further guidance on the type of answer you want, like an example. Would you like me to do so?"

The same question might be asked as part of the morning community meeting. In this case, the group leader is less interested in an assessment of mental status and more interested in orienting patients about the world around them. Knowing this, the interpreter may be more willing to sign TODAY MONDAY TUESDAY WEDNESDAY WHAT? without consulting with the group leader. The

environmental situation (i.e., the purpose of this meeting) leads to the interpreter making a different interpreting choice (i.e., using a different control.)

Post assignment controls include the ability to have a post-session conference with the clinician to discuss the communication and interpreting dynamics that occurred. Interpreters also gain more controls as they learn more about language dysfluency and obtain supervision from experienced mental health interpreters and clinicians.

Another example of dysfluent language follows, this time of a language sample from an interview with a deaf individual who grew up with deaf siblings and attended a state residential school. He suffered a traumatic brain injury from a car accident in his mid twenties, and his language skills declined significantly after that accident.

Interviewer: YOUR NAME WHAT?[2]
Consumer: J-A-M-E-S-J-O-N-E-S me (names changed for confidentiality)
Interviewer: LIVE WHERE?
Consumer: live where? T-Y-L-E-R (city changed for confidentiality)
Interviewer: OLD HOW-MUCH YOU?
Consumer: 17-19-35
Interviewer: SCHOOL WHERE?
Consumer: S-C-O-O-L
Interviewer: WHERE?
Consumer: M-O-N-O-T-Y
Interviewer: NAME MOTHER WHAT?
Consumer: MOTHER  J-A-N-E-T N-J-S (name changed for confidentiality)
Interviewer: FATHER NAME WHAT?
Consumer: FATHER  M-C-H-E-L O-J-S (name changed for confidentiality)
Interviewer: BROTHER SISTER HAVE?
Consumer: BROTHER/SISTER S-E-V-E (taps on forehead)
Interviewer: BROTHER HAVE?
Consumer: HAVE J-O (pause) S-H-A-N-O-N-J-O-S (name changed for confidentiality) ME, GIRL, (taps on forehead)
Interviewer: YOU ENJOY FUN WHAT?
Consumer: H-I-I-J-U-Y (nods head)

A discussion of some demands and controls in the assignment are listed below.

### Demands

- The consumer may not understand the interpreter. If that is true, how much should the interpreter alter her language to fit the consumer within a particular setting?
- The consumer is signing unusually slowly. Should the interpreter also slow down to an unnaturally slow speed?
- The consumer has fingerspelled incorrectly. The interpreter knows that it is common for deaf people to misspell English words and names, but this information could be clinically significant. Should the interpreter repeat the names in the target language with the same misspelling or present the names as if they were correctly spelled?
- The consumer's signing is not reflective of what one would expect from a deaf person who has deaf siblings and attended a state residential school. The clinician would probably not know this, as their view of deafness might not lead them to understand the ready access and exposure to language that the consumer would most likely have had.  But, it could be diagnostically significant information. Should the interpreter offer these observations?
- The interpreter has no prior knowledge of the consumer's language skills before the session begins. Should the interpreter arrange for a pre-view meeting?

### Pre-assignment Controls

- The interpreter can ask to review the consumer's chart, including psycho-social background, medical history, diagnosis, and current level of stability.

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2  The interviewer's ASL is glossed here to illustrate that the interviewer is not language dysfluent in English. The glossing just makes it appear so.

- The interpreter can inquire about the language ability of the consumer, if known.
- The interpreter can ask the clinician if there is anything significant the interpreter should know based on their previous experience.
- The interpreter can go into the therapist's office and explain to the therapist that she will be introducing herself to the consumer and briefly assessing language needs.
- The interpreter can discuss with the prior interpreter or an interpreter who has worked with this consumer before how they perceive the language needs of the consumer.

### *During Assignment Controls*
- The interpreter could use first person simultaneous method of voicing with the inclusion of some descriptive comments.
- The interpreter could utilize first person simultaneous method and spell the names back as they appear.
- The interpreter could voice the fingerspelled names as intended and then meet with the therapist after the session to provide additional information on what was seen during therapy.
- The interpreter could use third person consecutive/narrative and state that, "The consumer is responding to the questions normally by copying the last word that you voiced and then appears to be processing the information and providing a response in a slow and awkward manner. Many of the names are not spelled correctly. Most of the responses are on the level of one word to short phrases."

### *Post-Assignment Controls*
- The interpreter can meet with the clinician to explain that the language is not typical for someone with his educational experience and language exposure.
- The interpreter, depending on the goal of the environment and whether his or her assignment will continue beyond this session, could consider use of a certified deaf interpreter, gestures, pictures, manipulatives, etc., for future appointments.
- The interpreter could continue expanding their own fund of knowledge base in working with consumers who are dysfluent by reading articles, taking trainings, etc.

Thus, the interpreter has many options and goes through a complicated decision making process.

## Using a Certified Deaf Interpreter or Communication Specialist

When most hearing interpreters are asked how they work with extremely dysfluent consumers, their response is often, "call in a certified deaf interpreter (CDI)." The use of such a communication specialist, typically a deaf individual who has exceptional communication abilities, including in visual gestural communication, is one solution to communicating with deaf people with severe language dysfluency. The Deaf Unit at Westborough State Hospital in Massachusetts and the Bailey Deaf Unit at Greil Hospital in Alabama have relied heavily upon a staff communication specialist whose many roles include that of intermediary interpreter between staff who do not sign expertly and language dysfluent deaf patients. There are now programs to train and certify deaf relay interpreters and the role of CDI is becoming increasingly recognized (Bienvenu & Colonomos, 1992; Boudreault, 2005; Forestal, 2005).

However, in the spirit of demand-control schema, with every new control, such as the addition of a CDI, there are resulting demands. There may be few individuals qualified to work as a deaf interpreter or communication specialist, especially outside large populations of the Deaf community or in rural areas. When the same hearing interpreters are questioned about how frequently they actually work with a CDI, the answer is "not often," even in assignments with language dysfluent consumers. There are even fewer CDIs who are trained to work in mental health settings. An example of a CDI, working with a hearing interpreter, follows:

A forensic psychologist was interviewing a deaf consumer to determine his competency to stand trial. The hearing forensic psychologist asked, "Do you know who the judge is and what their role is?" The hearing interpreter signed this for the deaf interpreter, who in turn proceeded with various

interpretation attempts. The hearing interpreter provided a narrative interpretation of what was going on for the forensic psychologist explaining that,

> "The interpreter has used signs that are generally accepted in the Deaf community to ask your question and the consumer was not responsive and looked somewhat confused or unsure. The interpreter then used an expansive technique where he describes the 'man up front with the black robe and a gavel' and the consumer still did not respond in a way that indicated he understood the question. The interpreter is now using a gestural system of describing a television set as a box that you watch and change channels, to which the consumer responded by nodding affirmatively. The interpreter is describing through gesture an old black and white television show, such as Perry Mason, where the judge wore a black robe and had a white wig. The consumer nodded affirmatively that he had recognized what the interpreter was explaining. The interpreter then asked using a combination of basic signs and gestures 'Who is he?' 'What does he do? What is his job?' and the consumer shrugged that he did not know."

If the hearing interpreter had chosen to simply wait until the deaf interpreter had completed the interpretation and voiced "no," the psychologist would have no understanding of the language skills of the consumer, which is directly relevant to the issue of competence (Solow, 1988; Vernon & Miller, 2001, 2005; Vernon & Raifman, 1997). Most clinicians would want this level of detail about the consumer's language skills and the interpreting process in order to draw appropriate conclusions regarding issues like mental status and competency.

When two interpreters work in tandem, while striving for collaboration, they may struggle over varying opinions regarding the communication process. For example, a hearing psychologist was interviewing a deaf consumer with the aid of a hearing interpreter and a communication specialist/ CDI. A question was passed from the psychologist to the interpreter to the CDI, and when the deaf consumer began to respond, the interpreter began to voice the response. However, at that moment, the communication specialist stopped the interpreter and told her, "I will tell you what to voice when I'm done." The relay interpreter then tells the hearing interpreter to voice a response that the hearing interpreter believes is much clearer than the consumer actually was presenting. The hearing interpreter acquiesced. When asked later why she acquiesced to the CDI, the interpreter responded, "Because he (the communication specialist) was deaf."

The dilemma inherent in this situation is that the hearing interpreter and the CDI have information about the language level and processing ability of the consumer that the clinician needs, but is unaware of. This disconnect can impact not only the understanding that the clinician has regarding the mental status of the consumer, but also the clinician and consumer's ability to develop a therapeutic relationship.

While the use of a CDI or communication specialist is highly valued for their language competency, there are important factors to consider in mental health settings. In the same way that naive clinicians imagine that the provision of an interpreter fixes all the communication problems, the provision of a deaf interpreter can allow the hearing interpreter to believe that now "all is good." In reality, language interpretation remains a highly complex process, even when the client is a fluent language user. The interpreter or interpreting team is making complicated choices which can influence the assessments that clinicians make.

Little research or training has been done to address the dynamics of a deaf/hearing interpreter team in mental health settings. Because neither hearing nor deaf interpreters have training in analyzing demands that may occur within this partnership, the controls may not always be appropriate for mental health settings. They may not realize that clinicians are not just interested in communicating. They are interested in understanding how the consumer thinks. An interpreting process that "cleans up" dysfluent language can lead a clinician doing a psychological assessment to draw wrong conclusions. The risk for this is heightened when CDIs are brought in for work with very dysfluent consumers.

Despite the potential challenges that may arise when adding another team member to the process, there are many benefits of using a certified deaf interpreter. The deaf interpreter can help ensure a more accurate understanding of the message, provide balance to any perceived hearing versus deaf hierarchies, provide clarification to obscure or dysfluent language and allow for linguistic or

cultural collaboration to ensure that the best possible determination is made. In addition, the level of interpreting skill required to work between ASL and English and the level of skill required to interpret for very dysfluent signers are different. Sometimes the interpreting process won't be successful without the help of someone with the exceptional language and nonverbal communication skills typically possessed by a CDI.

## Conclusions Regarding Best Practices

In this article, we've been describing best practice for interpreters in mental health settings working with deaf persons with severe language dysfluency. Best practice assumes that clinicians and interpreters are both very familiar with the issue of language dysfluency in some deaf people. However, it is relatively rare for this to happen. It is far more common for one or both members of the team to be unprepared for the interpreting and clinical challenges of evaluation and treatment of deaf dysfluent signers. What, then, might be some "rules of thumb" for interpreters just becoming aware of this issue?

First, it is important to educate oneself about language dysfluency. For interpreters, this means getting specialized training in mental health interpreting and practicing the strategies for interpreting for language dysfluent consumers. The Mental Health Interpreter Training (MHIT) developed by the Alabama Office of Deaf Services provides such training. Dean and Pollard's (2001, 2005) demand-control approach is particularly helpful to guide interpreter decision- making and has been incorporated as a part of the aforementioned MHIT. It also means seeking supervision from a mentor experienced in mental health interpreting. So, it is important that the interpreter and clinician have pre- and post-sessions with each other in which the language and cultural issues can be discussed. Interpreters and clinicians need to ask each other whether they are comfortable having this discussion. Clinicians need to be aware that the expertise of interpreters usually extends to language and culture, not to psychology. They need to develop skill in asking interpreters the appropriate questions. Interpreters should recognize that they have the option of not just interpreting but also being a language and culture informant.

Third, the demand-control model provides the best framework to guide interpreters regarding their interpretation options in work with language dysfluent consumers as well as in collaborating with certified deaf interpreters. Fourth, collaboration with certified deaf interpreters may be a best practice, but both kinds of interpreters need training in mental health work. They need to understand that clinicians doing diagnostic assessments need to know about the language skills of consumers. They do not usually want the interpreting process to mask the language deficits of clients because language usage is a primary means by which clinicians make inferences about mental processes.

The key idea really is collaboration. Clinicians and interpreters are a team of professionals working together. It helps interpreters to understand the reasons for dysfluency and the clinical implications. It helps clinicians to understand the interpreting decision making process when working with dysfluent clients. Best practice must surely be a clinician-interpreter team skilled in responding to this formidable interpreting and clinical challenge.

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