Observation-Supervision in Mental Health Interpreter Training

Robyn K. Dean, Robert Q Pollard, Jr., and Mark Alan English
University of Rochester Medical Center

Abstract: In 2003, the University of Rochester's Deaf Wellness Center (DWC) was awarded a federal grant from the National Institute on Disability and Rehabilitation Research which, in part, was designed to examine the effectiveness of mental health interpreter training through *observation-supervision*, based on the "demand-control schema for interpreting work" (Dean & Pollard, 2001). This training/research project involves 40 certified, working interpreters, and four mental health interpreter trainers and takes place sequentially in four cities across the US. The observation-supervision training methodology proposes better outcomes in setting-specific training by allowing interpreters to observe the dynamics and nuances of work settings, without the constraining presence of deaf consumers or working interpreters, in a structured manner followed by expert interpreter supervision. This report describes the current status of the project, which has concluded two of the four training segments (in Rochester, NY, and Minneapolis).

Many of the newer philosophies in education emphasize the need for and benefits of student-centered learning, where students are responsible for, invested in, and drive the learning process. Unfortunately, for many educators who might ideologically embrace this type of learning approach, the application and the practicality of this philosophy can be challenging. Problem-based learning (PBL), which began in medical schools in the early 1960s, is a teaching

methodology which created a student-centered classroom, where medical students were no longer treated as passive vessels into which information was poured and later regurgitated, but where students were required to participate actively in their learning, most of which took place in a contextualized manner involving real patients.

PBL-style medical courses are not designed didactically, where the instructor or the textbook dictate the direction of the course or the content of the learning. Learning is instead organized around "problems" or patient cases that the medical students are assigned during their coursework. Medical students are required to investigate, diagnose, and recommend treatment options for simulated and real patient cases while the teacher elicits and monitors the teaching topics and facilitates student learning during the students' investigative process. This more accurately reflects what the practice of medicine eventually will be for these students -- patient-based learning seamlessly leading to patient-based practice.

Our new teaching approach, *observation-supervision,* borrows from PBL in that it strives to create a learning environment for interpreters which looks like situations in which interpreters actually practice. This learning technique was developed by Robyn K. Dean and Robert Pollard of the University of Rochester (UR) for their research with the University of Tennessee's (UT) Educational Interpreting Program and is a complimentary teaching methodology to their demand-control (D-C) schema for interpreting work (Dean & Pollard, in press; Dean & Pollard, 2001). The UR/UT project, "Reforming Interpreting Education: A Practice Profession Approach" (www.urmc.rochester.edu/dwc/scholarship/Education.htm) was supported by the Fund for the Improvement of Post-Secondary Education (FIPSE), a branch of the US Department of Education. (See Dean, Pollard, Davis, et al., in this volume for further information about the FIPSE project.)

Observation-supervision is a departure from the usual method employed in the training of interpreters for work in specialized settings like legal, mental health, or medical environments. Instead of taking a survey course or attending a weekend workshop/lecture on setting-specific content, observation-supervision requires interpreters to observe such specialized assignment settings when *no* deaf consumers or working interpreters are present, i.e., they shadow a

2

physician, psychologist, or other service provider and observe hearing people engaged in routine dialogues and behaviors in these settings. Learners conduct a structured analysis of observed events to gain greater insight into the challenges and "thought worlds" of professionals and consumers in these settings. Interpreter learners are guided in this task by an observation form structured in accordance with the D-C schema, where questions regarding the four categories of demands (environmental, interpersonal, paralinguistic, and intrapersonal, or EIPI) are explored. Completed observation forms then are brought to group supervision sessions, led by a teacher or mentor who is well-versed in the *teaching* application[1] of the D-C schema. The supervision leader uses the data from the observation forms to facilitate learners' setting-specific education and consideration of job challenges (demands) and how one could respond (i.e., employ "control options") in light of those demands. Controls options include knowledge acquisition, skills growth and application, and potential translation and behavioral decisions. Highly emphasized in these supervision sessions is learners' consideration of the consequences of various control options. The goal is to draw out and critique various translation and behavioral decisions that might apply to an array of hypothetical deaf consumers, in the context of the actual observed situation and the specific dialogue which took place between the hearing individuals.

Unencumbered by the constraining influences of a *specific* deaf consumer and the pull to observe a working interpreter's sign choices, observation-supervision expands upon traditional methods of interpreter training and reinforces the D-C schema's emphasis on consumers' thought worlds and EIPI factors in interpreting work. Observation-supervision allows broader consideration of varied types of deaf consumers who *might be* in the given interpreting situation (as hypothesized by the supervision leader). It also fosters advanced learning about the observed situation's normal social and dialogic realities prior to the supervision leader superimposing aspects of ASL translation and Deaf culture onto this foundation knowledge.

Outcomes of Observation-Supervision: In the FIPSE project, observation-supervision was first piloted in medical and educational environments with interpreting students, not working

---

[1] We have learned that familiarity with the D-C schema does not necessarily equate to competence in teaching the schema to others or employing it in supervision. Our research findings indicate that mastery of the schema's concepts and vocabulary must precede the acquisition and practice of specific D-C schema teaching methods, such as picture analysis and observation-supervision. Attempting to teach with the schema prior to achieving such mastery has resulted in poorer student learning outcomes in our ongoing studies.

interpreters. The UR/UT project collaborators have documented the benefits of this type of training for interpreting students (Dean, Davis et al, 2003; IAE, 2003). Most noteworthy were the benefits students gained through their interactions with professionals (medical staff and educators) and their clientele (patients and students). Students not only observed a wide variety of direct interactions between professionals and clients, they also were privy to behind-the-scenes observations and discussions with professionals that provided unique insights into the goals of the environment, the goals of specific interactions and communications with specific types of clients, and professional and client "thought worlds." Interpersonal skills are an important aspect of the work of interpreters. The twenty-five hours of observations that were required in both the educational and medical observation-supervision courses in this UR/UT project allowed students to develop, practice, and hone these skills. Especially in the often-sensitive nature of doctor-patient appointments, students were challenged in the complex skill of balancing compassion with professionalism.

Unlike most interpreter training methodologies, observation-supervision provided students with far greater insights into the "other side of the story" -- the hearing professional's "thought world" and communication needs and goals than traditional classroom or even practicum training leads to. It often is the case in interpreter training that due attention is given to the unique linguistic and sociocultural aspects of deafness but, too often, the ways in which hearing people function within their professional or personal realms is insufficiently explored and understood, despite their equal importance given that they, too, are consumers of interpreter services and, moreover, typically "steer" the interactions with deaf consumers. Especially in the medical observation-supervision course, the medical staff would share information about the patient with the student, an overview of the patient's disease and treatment needs, the specific purpose of the appointment, and even the personal opinions of the staff. Students learned that clinicians must develop personal and professional insights and boundaries that allow them to balance the feelings they acknowledge having about patients (e.g., like, dislike, empathy, frustration) with their professional responsibilities. We believe that interpreting, like medicine or law enforcement, is a practice profession involving a similar need to acknowledge the personal-professional balance and develop insightful judgment skills that take personal feelings into account, not deny them or view them as inappropriate or unethical.

When students were not observing direct actions between professionals with their clientele, they were observing professionals interacting with one another. For example, in the medical settings, students were able to follow physicians into their offices or conference rooms where they dialogued with one another about patient cases. Students were privy to rather complex decisions that practice professionals must make. Similarly, during supervision sessions, the students were able to discuss with each other and the supervision leader how the behavior and translation decisions of the interpreting profession also involve complex factors where benefits and drawbacks are weighed rather than stark, black-and-white views of interpreting decisions. Students noted that they felt more "on par" with the practice professionals they observed.

It also was reported by the UT students that the professionals they observed were curious about this approach to training. Students had the opportunity to articulate the philosophy of observation-supervision and also why certain types of information would be helpful to them in their future interpreting work. Invariably, the professionals involved in the project reported that they learned a great deal from the interpreter-observers and that they gained a much better understanding and appreciation for the work that interpreters do.

The experiences of the working interpreters in the NIDRR mental health training project have been similar to these experiences reported by the students in the FIPSE project. But, as detailed below, the participants in the NIDRR project reported other unique learning benefits as well.

NIDRR Interpreting Project Beginnings: Observation-supervision as a teaching methodology was a natural extension of the occupational paradigm shift regarding the nature of interpreting work that Dean and Pollard envisioned with their D-C schema. They view interpreters as practice-professionals -- more akin to doctors, teachers, and police officers, for whom work dynamics and environments are constantly shifting and involve considerable human and momentary situational judgments -- as opposed to technical professionals like architects or engineers for whom knowledge and skill acquisition is emphasized in training more so than nuanced human interaction and rapid situational judgment (Dean & Pollard, in press). If the work that interpreters do is more like that of a practice professional than a "technician of translation,"

then interpreters should be educated in ways that are similar to how other practice professionals are trained. Further, their own daily practice and ethical judgments also should mirror the process employed by practice professionals. The D-C schema and observation-supervision as a specific learning methodology, both reflect this practice-profession view of interpreting work.

After observation-supervision showed promising results with UT's interpreting students, the question of its potential effectiveness with working interpreters was posed. A research project was designed to answer this question, specifically focused on the utility of observation-supervision to enhance interpreting practice in mental health settings. In 2003, the project was funded by NIDRR as a part of the DWC's larger NIDRR grant project, "Toward Equity: Innovative, Collaborative Research on Interpreter Training, DBT, and Psychological Testing" (www.urmc.rochester.edu/dwc/scholarship/Equity.htm).

The NIDRR interpreter training project examines the effectiveness of observation-supervision as a training technique for working interpreters who accept assignments in mental health settings. Many interpreters receive no training to help them work effectively in mental health settings, especially since on-the-job learning is so common in the interpreting field (Dean & Pollard, in press). When interpreters are able to avail themselves of specialized training for working in mental health settings, such training opportunities typically involve lectures or workshops focused on content information regarding mental illnesses, diagnosis, and treatment. While such content information is important, the most challenging and important aspects of mental health work stem from the relationships between professionals and consumers. These relationships are directly manifested in complex communication styles and objectives which invariably fall squarely on the interpreter's shoulders to understand and manage successfully. In no other field of medicine is communication so important as in mental health, for mental health diagnosis *and* treatment are nearly completely dependent on communication, unlike other medical specialties. Experienced mental health interpreting trainers emphasize the need for interpreters to work in close partnership with clinicians. We believe that observation-supervision is an excellent method for fostering both contextualized content learning and clinician partnering skills and judgment in the mental health practice arena.

NIDRR Interpreting Project Specifics: Four cities, Rochester (NY), Minneapolis, New York City (NYC), and San Francisco and four mental health interpreter trainers, Robyn K. Dean, Mark Alan English, Jody Gill, and Dan Veltri (respectively, by city) are collaborating on this project. Each site is training approximately ten interpreters and gathering data on the training's effectiveness. At the time of the 2004 CIT convention, two sites (Rochester and Minneapolis) have completed their training. The remainder of this manuscript will discuss essential elements of the research design and the preliminary findings at the project's midpoint.

Before the first (Rochester) training session began, the remote site supervisors (English, Gill, and Veltri), the project director (Dean), and the principal investigator (Pollard) convened in August of 2003 for three days of training and planning regarding the project. The remote site supervisors already were familiar with the D-C schema as a theoretical construct. During the August meeting, the site supervisors learned how to employ the D-C schema in the teaching of specialty topic content and fostering judgment skills through the dialogic work analysis process that the schema involves (see Dean, Pollard, Davis, et al., this volume). The goal of this meeting was not to create a rigid curriculum to be used at all four sites, although important mental health topic areas to be covered over the course of each sites' training were agreed upon. Instead, since each supervisor already had expertise in mental health interpreting, the goal of this initial meeting was to become familiar with how to impart their mental health interpreting knowledge and expertise through the PBL-style mechanism of observation-supervision (and the D-C schema). It was the philosophy of the UR researchers that maximal trainee benefit would result from modification of traditional teaching styles (i.e., employing a PBL approach rather than a didactic approach), not standardization of the training sites' mental health interpreting content. There are other opportunities within the interpreting field to access content-focused curricular materials. The observation-supervision approach was to be radically different than didactic, content-driven learning and was to make maximal use of the teacher's inherent expertise within the context of actual, recent student observations and their resulting learning needs/desires. In short, process was to drive content, not the other way around.

Training Program Design: Both the Rochester and Minneapolis sites successfully recruited 11 interpreters, all of whom were certified by the RID and/or NAD. They represented a broad range of general work experience, experience in mental health settings, and other employment

characteristics. The interpreter participants were initially trained in the concepts of the demand-control schema for interpreting work. Subsequently, they each observed approximately 15 hours of mental health service provision situations (between hearing clinicians and hearing patients), across a variety of settings. One or two observation hours were required in settings such as acute care, outpatient group therapy, family therapy, child therapy, partial hospitalization, chemical dependency treatment, psychopharmacology, and psychological evaluations. Guided by a detailed mental health observation form, the interpreters documented and analyzed the EIPI elements of these observations. The observation forms were submitted to the site supervisor prior to supervision sessions. After 8 to 10 observation hours were completed, the supervision sessions began. Further observation hours and supervision sessions overlapped for the remainder of the teaching period.

Data Collection: A variety of outcome data are being collected. Participants are asked to complete a demographic questionnaire where they list their certifications, information about their interpreter preparation program (if any), how long they have been interpreting, and their primary work setting. Next, they are asked to provide information about how much mental health interpreting work they have done in the last six months, in which specific mental health settings, and to rate their confidence in their work performance within these settings. Participants are asked to complete this demographic and confidence rating scale every six months until the end of the project (2008) to see if this training is associated with an increase in mental health interpreting hours and/or confidence.

Participants also complete a test of mental health content knowledge before and after the training. These pre-test/post-test results are providing the researchers with information about learning and retention of mental health content knowledge via observation-supervision. The Rochester and Minneapolis pre- and post test results are discussed below. These results (and those from NYC and San Francisco) will be compared with a group of sign language interpreters who engaged in mental health training for the same number of hours (approximately 40) but using a didactic format. (These comparison group results are not available at the time this is being written but they will be discussed during the 2004 CIT presentation.) Following completion of their training, participants are asked to complete a comprehensive evaluation of

their learning experience. This evaluation is helping the researchers understand the advantages and disadvantages of this training methodology and which elements might be improved upon as the project evolves.

Finally, the project participants are asked to take a practical exam (these have not yet been graded), designed specifically for this study but with similarities to other practical exams designed by the UR researchers to document the effectiveness of D-C schema training. Such practical exams are modeled after the judgment-focused exams being employed by other practice professions. The exam developed for the NIDRR project is interview-based and allows the examiner and examinee to dialogue about mental health interpreting situations and demonstrate both content knowledge and judgment skills. While demonstration of the participant's content knowledge is an aspect of this exam, its broader purpose is to determine how well the participant understands and employs the D-C schema for interpreting work as a theoretical construct and as a tool for analyzing their work and decision-making in mental health settings. This type of practical exam is unique in the interpreting profession. While content knowledge is often tested vis-à-vis written exams and interpreting/transliterating skills are often tested vis-à-vis performance exams, the ability of an interpreter to recognize the demands and controls of a specific assignment and to demonstrate their ability to think through their decision-making in an analytical and critical manner previously have not been a prominent focus of interpreter assessment. Each of the four project sites will serve as a pilot for the administration and grading of this practical exam. The results and feedback from each site will be used to make improvements in the practical exam before it is administered at the next subsequent site. At the end of the project, a final version of this mental health practical exam will be completed and made available for dissemination.

We are also intending to obtain data from deaf and hearing consumers who work with interpreters who have been through our observation-supervision training. These data collection efforts will take place later in the study period.

Securing Mental Health Observation Sites: Since the UR researchers work for a large Department of Psychiatry, it was not difficult to secure over twenty observation sites, including

chemical dependency, inpatient units, the psychiatric emergency room, group therapy, family therapy, psychopharmacology, and outpatient day treatment. The populations observed in these settings ranged from low-functioning (psychiatrically and/or cognitively) to high-functioning. We were required to submit a variety of documents and follow other procedures to comply with medical center policy for observers. Mark Alan English, site supervisor for Minneapolis, works as a freelance mental health interpreter. His relationships with numerous mental health providers allowed for easy access to a variety of observation settings. There were seven different sites with over 90 programs around the Minneapolis area available for participants to observe, including outpatient day treatment, court commitment hearings, domestic abuse programs, group homes and Dialectical Behavior Therapy groups. English was required to submit clinical observer data sheets for the Hennepin County Medical Center site. All participants signed health and confidentiality statements that were on file and made available to all sites.

Observation Dynamics: At the UR Medical Center, many psychiatry programs are outfitted with one-way mirrors, allowing observers to see (and hear) the clinician-consumer interactions in an adjacent room. Other observations occurred with the interpreter in the same room as the clinician and patient(s). In all cases, patient permission (verbal, not written) was required before the observation began. Sometimes, the interpreter was asked to introduce her/himself to the patient and explain briefly the purpose of the observation. We encouraged the interpreters simply to refer to themselves as "a trainee learning how to work effectively in mental health services settings" or, if they were asked to explain further, to discuss their professional background as briefly as possible. This was done to curtail lengthy conversations about sign language, deaf people, etc., which would interfere with the goal and time allotted for the patient's appointment. Observers from other professions are introduced to patients in a similar "matter of fact" way. This gives the patient the sense that student observers are normal occurrence in a teaching hospital and conveys that there is little to be concerned about. Very few observers in the project were turned away by patients.

Interpreter observers were discouraged from filling out their observation forms during the appointment. It was suggested that if it was appropriate or inconspicuous enough, then taking brief notes would be fine. Interpreter observers were strongly encouraged to complete as much of

the observation form as they could immediately following the observation to foster clearer and more comprehensive recall. Observation forms were shared with the clinicians ahead of time so that they were aware of the kind of information being recorded. All clinicians and patients were assured that names and other identifying information were never recorded.

Almost always, clinicians took time before the appointment to brief the interpreter about the patient case, the status of treatment, and the plan and goals for the upcoming meeting. Following the appointment, if there was time, interpreter observers were given the opportunity to debrief with the clinician and ask questions. There were a few occasions during evaluation appointments when the clinician turned to the interpreter observer and asked if he/she would like to ask any questions of the patient. Being treated as a colleague in this way by the clinician was a rare and powerful experience for the participants in this project.

Many observations also allowed interpreters to interact with clinicians and observe clinical staff interacting with one another, both formally and informally. For example, in the psychiatric emergency room, psychiatrists, psychiatric nurses, social workers, and other student learners convened in a conference room when they were not interviewing patients. The interpreter observers listened to how these mental health professionals talked about patients and how they made ethical and practical decisions about patient care. On a few occasions, interpreter observers were allowed to attend supervision sessions where clinicians and their students discussed the diagnosis or treatment plan for a complicated case. Again, these experiences were highly valued by the participants.

Supervision Sessions: In the mental health profession, the term *supervision* refers not to "oversight by one's boss" or other such punitive concepts, but to discussions between practicing professionals (whether or not they are peers in terms of work experience or where they fit on the employment hierarchy), aimed at furthering the effectiveness of one of the professional's work. Supervision of this sort is a regular aspect of mental health professionals' training and their ongoing professional development. "Seeking supervision" on complex cases, ethical issues, etc., is a fundamental and common practice that all mental health professionals engage in. In fact, ethical standards in the mental health professions mandate that such supervision be obtained

whenever needed. Failure to do so is considered an ethical breach. Patient confidentiality is understood as applying to supervision, not in the sense that patient specifics cannot be discussed -- they often must be -- but in the sense that the confidentiality commitment the clinician makes to the patient is "extended" to include the individual providing supervision. This perspective on the mandatory nature of peer supervision and the presumption that such confidential supervision is an extension of provider-consumer confidentiality is one that many interpreters find unusual, even uncomfortable, even though it is the norm among practice professionals.

In our project, supervision is the time where the learners' unanswered questions and unprocessed experiences drive the group discussion. It is when learners thoroughly explore the "So what?" of the events they observed, i.e., "While these observations were interesting, how is this information helpful to me directly as an interpreter?" Supervision is the time when the supervisor facilitates learners making connections between what they saw, heard, and felt during the observations and how this information will help them increase their competency as mental health interpreters. In keeping with the language of the D-C schema, if observations are about identifying the demands of various mental health encounters, supervision is the time to explore, evaluate, and increase controls.[2]

It also is true that just from the experience of being present in observations, the participants were gaining controls. They were gaining new knowledge about psychiatric disorders, mental health professionals, and various treatment approaches. Many participants also acknowledged new controls like respect, appreciation, even a new attitude about patients, clinicians, and mental illness itself. Through their frequent interaction and dialogues with clinicians and patients, participants had opportunities to hone their interpersonal skills. Further, interpreter participants were gaining a level of familiarity and comfort with psychiatric patients, staff, and environments.

---

[2] "As adapted from Karasek, controls are skills, characteristics, abilities, decisions, or other resources that an interpreter may bring to bear in response to the demands presented by a given work assignment. Controls for interpreters may include education, experience, preparation for the assignment, behavioral actions or interventions, particular translation decisions, (e.g., specific word or sign choices or explanatory comments to consumers), encouraging "self-talk," or the simple yet powerful act of consciously acknowledging the presence and significance of a given demand and the impact it is having on an interpreting assignment. In the D-C schema, the term *control* is a noun, not a verb, and is preferably stated as *control options*. We define three temporal opportunities where control options may be employed: pre-assignment controls (e.g., education, language fluency, and assignment preparation), assignment controls (i.e., behavioral and translation decisions made during the assignment itself), and post-assignment controls (e.g., follow-up behaviors and continuing education)" (Dean & Pollard, in press).

This is in keeping with the broad definition of controls and participants noted its impact on their confidence in working in mental health settings.

Of course, the main opportunity for participants to gain controls was during supervision sessions. In Rochester, supervision sessions occurred five times over nine weeks. In Minneapolis, they occurred five times over four months. (These differences in supervision frequency had different benefits and drawbacks from the viewpoint of the two site trainers). The Rochester participants were divided into two groups due to scheduling needs, requiring two, parallel supervision tracks. Otherwise, at both sites, the nature of supervision meetings was similar. Participants gathered around a conference table for three and half hours to report on their observations (guided by their completed forms). The facilitators used a white board to document the demands of a given observation for all to see and discuss. Balancing the learning interests and opportunities presented by the group with the need to (eventually) cover the desired mental health content information was the job of the facilitators, who steered the supervision session dialogue as they saw fit in relation to these goals, but always in a manner consistent with the D-C schema.

As the group described and discussed their observations, the facilitators helped them hypothesize, "If this were an interpreting job, how would I handle (this or that element)?" During these discussions, demands were identified and controls were brainstormed. On many occasions, just the ability to name the demand and its source was highly valued by the participants. Many interpreters realized how often demands came from the intrapersonal category (stemming from something relevant only to the interpreter herself) and how often intrapersonal demands are misattributed to demand categories that pertain to the consumers. Correctly differentiating what or is or is not an intrapersonal demand became a powerful control for many.

Sometimes, the acquisition of content information during observations or supervision was a sufficient control for meeting a demand that was being discussed. The most difficult challenges (demands) were ones that pertained to ethical decisions. In these supervision sessions (as in most D-C schema dialogues), a wide array of control options first were brainstormed, focusing on all the controls that might be possible, not which were better or worse. Subsequently, the group analyzed these control options for their positive and negative consequences. It was routinely

noted that all control options potentially have some negative consequence but that did not necessarily mean it was a poor choice and should be abandoned. Sometimes, it meant that augmenting the control option slightly or employing it and then responding to the resulting consequence (demand) with a new control was most desirable. At other times, the group would determine that the negative consequences (resulting demands) were undesirable, ineffective, or ethically questionable, <u>especially in light of the goal of the environment or the goal of the mental health professional</u>.

For example, in some therapeutic situations, expressing empathy for a patient is beneficial whereas in other situations expressing empathy can exacerbate the problem. Consider a patient who is addicted to drugs or alcohol and is being evaluated for admission to a treatment program. The patient is presenting as agitated, upset, and "in crisis." Some patients like this try to pull the clinician into their "crisis" (and minimize their addiction) by attempting to elicit an empathetic or shock response from the clinician. Instead, clinicians respond to such patients in a "matter of fact" way. The goal of this non-emotive approach is to diffuse the patient's agitated mood and convey that the patient's information is not shocking in light of the nature of addiction itself.

An interpreter who is not familiar with this therapeutic approach might be confused or put off by the therapist's seemingly cold reaction and attempt to counterbalance it by using facial cues, body language, or even specific translation choices that communicate empathy. Sometimes this is an unconscious reaction of the interpreter. Sometimes it is purposeful, when the interpreter assumes the clinician is unfamiliar with deaf people and not aware that deaf patients may need a more demonstrative expression of emotion, etc. In supervision sessions, the importance of understanding and working in concert with the goal of the environment and the goal of the clinician was repeatedly stressed. One group concluded that if an interpreter felt she could not work in support of the treatment goal, then the optimal, ethical decision was to tell the clinician this and possibly withdraw from the assignment.

Dean and Pollard (in press) state, "Ethical decision making in the practice professions must include consideration of the impact of the professional's decisions and actions on the consumer as well as other matters such as the concordance between the professional's decisions and actions

with the principles and standards of practice in that profession. Figure 1 depicts our view of the relationship between ethics and work effectiveness in a practice profession such as interpreting. In the center of the figure, a range of ethical decisions and actions is depicted which includes those that are more liberal (i.e., active, creative, or assertive) to those that are more conservative (i.e., reserved or cautious). In this central range between the dotted lines any decision or action – from liberal to conservative – may be effective and ethical depending on the circumstances of the situation. Which decisions or actions within this range are *optimally* effective would be a matter of professional debate or perhaps interpersonal consumer or interpreter variation. Practice professionals commonly discuss liberal vs. conservative approaches to their work, be it medical care, law enforcement, financial investment or other topics. Neither end of this ethical and effective range of professional judgment and behavior is inherently better or worse, nor is the median necessarily optimal."

Figure 1. A practice-profession model of ethical decision-making
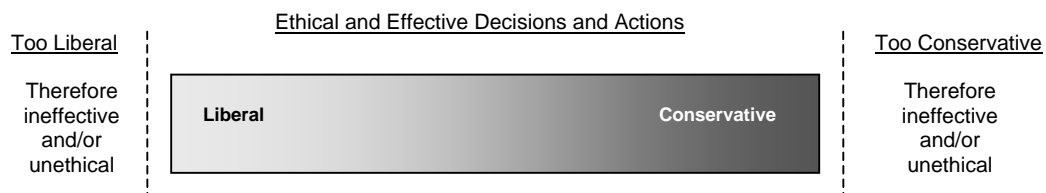
During supervision sessions, interpreter participants learned how to look at their own and others decisions (control options) in this manner. Many interpreters commented on how much they benefited from learning other's control ideas for job demands, especially when their own decisions tended to be constrained within a small area of the liberal to conservative spectrum shown in Figure 1. Many also commented on how this approach increased their professional respect for their colleagues, not only the others in the supervision sessions but colleagues outside of the project as well. This perspective on ethical and effective decision making was particularly beneficial when individuals or conversations began to bog down in "black and white," "I wouldn't do it that way" discussions of behavioral or translation decisions.

Balancing Judgment Skills and Content Knowledge: Throughout these supervision sessions, mental health content information also was taught but unlike most didactic forms of teaching, it was interspersed throughout the discussions of observations and demand-control analyses, when

such content topics arose naturally. One of the research questions we're investigating is whether imparting content information via this PBL approach is more or less effective for learning and retention than didactic teaching approaches. As noted earlier, the main similarity between the Rochester and Minneapolis trainings (and NYC and San Francisco) is not the curriculum employed nor the mental health content addressed but the process of the learning experience. While the site supervisors are monitoring supervision discussions so that they (eventually) impart the important content we agreed upon in the August, 2003, meeting, the goal of this project is not to standardize topical discussions but instead to standardize the process of the training.

Interpreter trainers who are used to didactic-style teaching may find this process-oriented teaching approach challenging at first. Yet, based on the experience of the site supervisors in this project and others who have been trained to employ PBL-style methods in the classroom, the experience is energizing. Many say this type of exploratory, contextualized, dialogic information exchange benefits both teacher and learner; learning is bi-directional in such sessions.

Preliminary Results: Unlike the students in the FIPSE project, the working interpreters in the NIDRR project were able to comment on this unique style of specialty training in direct comparison to other types of specialty training. They also were able to compare the types of dialogues about interpreting work they had with their colleagues in the project with the types of dialogues that normally occur between interpreters about the complex work of translation. In response to ten open-ended questions on the final evaluation, the following themes appeared more than five times among both the Rochester and Minneapolis Project participants.
This type of training:

- allowed me to attend to the <u>complete picture</u> of what I was observing, including my feelings and reactions to the people and the dynamics and how these were impacting me. I was not otherwise attending to my own interpreting work or the work of other interpreters
- was more effective than other types of training because seeing something first-hand is a much better learning environment than hearing about something in a classroom
- allowed me to employ what I was learning immediately within my interpreting work
- was beneficial because it allowed me to talk with my colleagues, share my experiences, and control ideas and to learn about theirs

- was beneficial because it allowed me to learn how to use the demand-control schema

- caused me to be more analytical or critically-minded about my interpreting work

- encouraged me to consider the consequences of my decisions

- helped to create a sense of objectivity when thinking about, discussing, or analyzing interpreting work

- allowed me to develop a connection and new respect for my colleagues in and out of the training

The 17 individuals who completed the training in Rochester and Minneapolis responded to the following evaluation questions, designed to elicit objective, quantifiable feedback:

A. The observation-supervision approach to interpreter training in general was _____ than other interpreter trainings/workshops that I have been involved in.

1. A lot less effective
2. Less effective
3. At the same level of effectiveness
4. More effective
5. A lot more effective

Average answer: 4.6 out of 5.0

B. The observation-supervision approach to <u>mental health training</u> was _____ than other <u>mental health trainings/workshops</u> that I have been involved in.

1. A lot less effective
2. Less effective
3. At the same level of effectiveness
4. More effective
5. A lot more effective

Average answer: 4.6 out of 5.0

C. The observation-supervision training _____ how I approach and perform my interpreting work in a general way.

1. Has not at all impacted
2. Somewhat impacted
3. Impacted
4. Greatly impacted

Average answer: 3.5 out of 4.0

D. The observation-supervision training _____ how I approach and perform my interpreting work in mental health settings.

1. Has not at all impacted
2. Somewhat impacted
3. Impacted
4. Greatly impacted

Average answer: 3.8 out of 4.0

Demographics and Pre-test/Post-test Results: While the written evaluation comments from the Rochester and Minneapolis projects showed striking similarities, the results of the pre/post-test show a divergence between project sites. The pre-test results of mental health content knowledge were quite similar (45 % and 41%) but the post-test gains in Rochester were almost twice those of Minneapolis.

	Rochester Project	**Minneapolis Project**
Average Years of Experience	8.1 years	7.6 years
Average hours of MH work	5 hours a month	8 hours a month
Average Pre-Test Grade	45%	41%
Average Post-Test Grade	79%	59%
Number of test points gained	34 points	18 points

As shown in the table, there was not a great difference in the average years of experience between the two project cohorts. The Minneapolis cohort averaged three hours more mental health work per month than the Rochester cohort but this did not manifest in pre-test score differences. The post-test differences were marked, with the Rochester cohort scoring 20 points higher than the Minneapolis cohort. One possible reason was the differing schedule of observation and supervision sessions in Rochester and Minneapolis. The Rochester participants

experienced five supervision sessions over nine weeks. The Minneapolis participants also experienced five supervision sessions but they were spread out over six months. Another distinction between the sites was the size of the training group. As noted above, the Rochester cohort was forced to divide into two approximately equal sized groups (4 or 5 participants weekly) whereas the Minneapolis supervision sessions had eight to ten participants. The smaller group size in Rochester may have facilitated greater content learning. Finally, the Rochester sessions were led by Dean, who developed the D-C schema and observation-supervision. Her experience with these teaching methods is greater than that of the other three site supervisors. The forthcoming project data from the NYC and San Francisco training sites will shed further light on possible outcome differences.

References

Dean, R.K., Davis, J., Barnett, H. Graham, L.E., Hammond, L. Hinchey, K. (2003, January). Training medically qualified interpreters: new approaches, new applications, promising results. *VIEWS,* 20; 1, 10-12.

Dean, R. K. & Pollard, R. Q (in press). Consumers and service effectiveness in interpreting work: A practice profession perspective. In M. Marschark, R. Peterson, & E. Winston (Eds.), *Interpreting and interpreter education: Directions for research and practice*. New York: Oxford University Press.

Dean, R. K. & Pollard, R. Q (2001). Application of demand-control theory to sign language interpreting: Implications for stress and interpreter training. *Journal of Deaf Studies and Deaf Education, 6*(1), 1-14.

Institute for Assessment and Evaluation (2003). *Reforming interpreter education: A practice profession approach. University of Rochester -- University of Tennessee (FIPSE) grant project. Report #2* . Knoxville, TN: University of Tennessee.

Author Notes

Correspondence regarding this article should be addressed to Robyn Dean, URMC Deaf Wellness Center, 300 Crittenden Blvd., Rochester, NY 14642 or via e-mail to Robyn_Dean@urmc.rochester.edu.