Therapy Using Interpreters:
Questions on the Use of Interpreters in
Therapeutic Setting for Monolingual Therapists

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1. *Can there be meaningful work in a counseling session when the client must either use a deaf interpreter or a foreign language translator?*

The answer hinges on developing a common understanding of what is meant by "meaningful work. It is our view that the answer is a qualified, "yes, but…"

Before addressing the main issue, it is important to clarify some terms. "Deaf interpreter" is misleading. There are such people as "deaf interpreters", but they are not whom we suspect the inquirer is asking about. Deaf interpreters are people who are themselves deaf and by virtue of their native fluency in American Sign Language and understanding of dysfluent language use are able to function as intermediate interpreters, relaying message between a deaf consumer with minimal or dysfluent language skills and a secondary interpreter working between English and American Sign Language. An interpreter is a person who works between the spoken (or in this case signed) forms of two languages providing communication facilitation between speakers of those languages. On the other hand, a translator is a person who works between the written forms of two languages. Thus, we can properly say that a deaf person will probably make use of a sign language interpreter, and a Hispanic person with limited English proficiency will make use of an interpreter working between Spanish and English.

The work of therapy in a counseling session using an interpreter will never be the <u>same</u> work that is done when both the therapist and the client speak the same language. The Southern District Court in Florida ruled in *Tugg v. Towey* (1994) that providing mental health services through an interpreter was not providing equal access. The court went on to order the Florida Department of Health and Rehabilitation Services to provide mental health services to the deaf using signing clinicians. While this is a wonderful goal, it will be difficult, if not impossible, to fulfill any time in the near future. There are simply not enough clinicians who are able to sign fluently to meet the demand. Clinicians using interpreters will continue to do much of the work of mental health therapy. It is then, a "necessary evil"—one that has to be addressed in a holistic manner if there is to be a reasonable expectation of successful therapeutic work.

The effectiveness of the work will depend on a number of factors. The first factor we have to consider is the qualification of the interpreter. The interpreter has to be relatively fluent in both the source and the target languages in order to be able to produce equivalent renditions. While it seems like stating the obvious, it is our experience that there is a tendency toward a synchronicity between levels of fluency. Put another way, most interpreters are more comfortable in one language than the other. Frequently we encounter situations where a person with native skills in one language but only conversational skills in the other will be pressed into service as an impromptu interpreter. This individual will have difficulty producing equivalent renditions in both languages simply because their level of fluency is significantly asynchronous.

The second factor we need to consider is the training and/or experience the interpreter has in the interpreting process. One of the common misconceptions we see is the idea that if someone "knows how to speak" a language, they will be able to interpret. This is not necessarily the case. It is one thing to mentally process how to say something in a language and say it. It is quite another thing to listen to someone say something, mentally process how to say it and preserve all the original nuance and intent and then produce the rendition–often while still interpreting the previous thought or concept. The interpreter needs to be trained to interpret in order to avoid the tendency to "filter" information. Marcos (1979) discusses a number of ways these filters can distort interpretation in clinically significant ways. He identifies three major sources of distortion: 1) deficient linguistic or interpreting skill, 2) lack of

knowledge and sophistication in mental health, and 3) interpreter attitudes toward either the client or the clinicians.

Obviously then, the interpreter has to be trained to work in the clinical setting. The Department of Justice defines a qualified interpreter as "an interpreter who is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary" (U.S. Department of Justice Civil Rights Division A.D.A. Title III Technical Assistance Manual). Department of Health and Human Services (2001, pg 72) *Culturally and Linguistically Appropriate Services* standards echo the same guidelines for interpreters working with spoken languages. By necessity, this means the interpreter has to have a basic understanding of the therapeutic process. The Missouri Department of Mental Health has developed some guidelines to help agencies understand what an interpreter needs to know to function effectively in a mental health setting. These competencies are included in Appendix A.

Having the standards is only half the equation. There must be a mechanism for training interpreters in order to give them the knowledge needed to meet the standards. A model training program is the Missouri Department of Mental Health's Mental Health Interpreter Resource Project training (Karlin and Clark, 1998). This annual 40-hour training covers all the competencies listed in the standards and provides for a mentored practicum. Successful completion of this training provides evidence of at least minimal preparedness for working in mental health settings.

Assuming the interpreter is qualified to work in the clinical setting, the next factor to consider is the qualification of the therapist in working with an interpreter. As mentioned before, the process is very different when working through a third person than working one-on-one with the client. The differences mean that the therapist has to know and appreciate what is happening in the counseling session and be willing to make adjustments for those differences. Harvey (1982, 1989) has written extensively on making use of sign language interpreters in therapy sessions, and he explains some basic alterations that have to be made in approaches in order for interpreters to work. These same alterations are needed when working with people with limited English proficiency. In addition to the language issues, the therapist must be aware of, and make allowances for, culturally embedded information. Such information is not readily discernible through interpretation and requires a sophisticated level of cultural awareness. An important publication for understanding some of this is Glickman and Harvey's (1996) *Culturally Affirmative Psychotherapy with Deaf Persons.*

Frequently, however, therapists are simply not conscious of the fact that using an interpreter alters the nature of the relationship. There is no longer a dyad. There is a third person in the room, bringing his or her own psychological baggage into the session—baggage that may reveal itself in subtle nuances during interpretation. When the skilled clinician is teamed with a highly qualified interpreter, both professionals will be constantly monitoring each other for such shading and skewing of the message. The difficultly lies when the therapist is not experienced in using interpreters and is not aware of the effects of the interpreter on the therapeutic relationship. Considerations of alliances become critical. Is the client allied with the therapist or the interpreter? More importantly, is the interpreter allied with the therapist or the client? Do both the client and the therapist trust the interpreter and the interpretation? Being unprepared to deal with these dynamics will make the work less effective.

On the other hand, in many cases interpreters allow for opportunities for transference and countertransference that do not exist in dyads. In this respect, in the hands of a skilled therapist using a highly qualified interpreter, good work can be done—work that is not possible using any other approach. Further, the presence of an interpreter, especially when the clinician is skilled in using language facilitation, makes the difference more figural (Harvey, 1989). Issues and problems caused by the failure to have effective communication can be dealt with up front. Finally, it is a powerful and unspoken acknowledgment of acceptance, especially when the interpreter is viewed as a conduit between the therapist and the client. "The interpreter is here for us," instead of "You use an interpreter."

2. *Is a counselor's (psychiatrist's, psychologist's, counselor's, therapist's, etc.) ability to assess a client's sincerity, truthfulness and attitudes as expressed by the client's use of facial expressions, tone of voice,*

> *body language, choice of words and phrasing, repetition of word and phrasing, sarcasm and/or humor changed by the use of an interpreter or translator?*

The clinician's ability to assess sincerity, truthfulness, and attitudes are affected by the use of an interpreter, but in our view, not to the same extent as unfamiliarity with cultural norms do. The degree of impact caused by the interpreter hinges on the competence of the interpreter and the working relationship between the clinician and the interpreter. This was addressed in question 1.

On the other hand, if the clinician is not familiar with the culture of the client, expressions, mannerisms, and behaviors, all can be misinterpreted. Cultures typically are not monolithic. Ware and Kleinman (1992) state that, "across class, caste, gender, age, religious and political lines cross-cultural conflicts may be more deeply rooted, for such difference embody not just different opinions or beliefs, but different ways of every day living and different systems of meaning." Thus within every cultural group there are different strata, different values, and different communication styles that may be influenced by socio-economic issues, age, gender or religion. These differences all impact communication style. Most notably they have impact on such subtle things as word choices and conceptual construct. They also impact how the client presents to the therapist. Some people may engage the therapist with eye contact, while others will avoid that because their station in life is lower than the clinician. Whether a person sits open or closed, near or far, whether one appears casual or anxious may all be part of perceived class differences, which are culture-bound. Non-verbal communication markers are often culturally embedded as well. Effective therapy relies on thorough understanding of these cultural differences. To quote Ridley, et. al (1994),

> *"Effective counseling is equivalent to assisting individuals in achieving therapeutic goals, (b) effecting counseling depending on understanding clients as individuals, and (c) that individuals are products of the cultures that shape them, therefore to assist individuals clients in achieving therapeutic goals, counselors need to tune into clients individual experience as cultural beings."*

Viewing deaf and other limited English proficient people within the context of their culture is at least as important as assuring linguistic access. For example, many deaf people appear very animated and very expressive compared with hearing people. They use facial expressions, body movements and other non-verbal markers to convey a great deal of linguistic information. The clinician who is not aware what is "normal" when communicating with a deaf person runs a significant risk of either over- or under-diagnosing. For example, "flat affect" means something very different among people who are primarily users of ASL. On the other hand, a clinician with an expectation that all deaf people are fluent signers will be nonplussed when confronted with a late-deafened person who cannot sign. Ignoring these factors will likely result in non-therapeutic outcomes. We can justly ask, "How can the therapist perceive what is abnormal until the normal is fully grasped?" (Ibid.)

The clinician's perception of what is "normal" or abnormal is often shaped by factors totally subconscious to the therapist. Wright (1983, pp 32-39) explains how the *Spread Effect*, which refers to the power of a single attribute to invoke a list of characteristics, effects how therapists interact with clients from a different background. Typically, a negative attribute (in this case deafness or inability to speak English) will lead to negatively evaluating the client, where as a positive one (affluence, attractiveness, gender similarities, for example) tends to invoke a more positive view of the client. The effect is subtle, unconscious, and insidious.

Unintentional bias like this occurs anytime there is cross-cultural interaction. The literature is replete with examples of this in the limited English proficient population. A good treatment of this can be found in Kaufert (1997). Dickert (1988) did a study examining attitudes of professionals working in psychiatric settings about people who are deaf. Half of the participants were employed at specialized programs for the deaf, the other half at general programs that happened to have deaf people admitted. Not surprisingly, the staff of the specialized programs generally had a more positive attitude about deaf clients than those employed in a general program. What was surprising was that the specialized staff still thought the deaf clients were more impaired than hearing clients in the same treatment setting (See also: Freeman, 1989).

The effects of this subconscious basis are pronounced in all therapy settings and are even more critical in forensic settings. It takes training and rigorous self-monitoring to keep those biases from affecting clinical determinations. At minimum, the therapist who desires an effective working relationship with a person from another linguistic minority must devote some time to studying that minority and learning about various cultural influences that affect the relationship. In short, the therapist must understand what a psychologically healthy person from the other culture is like and to have respect for the cultural norms of the other person before their clinical judgments can be trusted.

3.   *Can the counselor counsel, make judgments and reach conclusions when a client is using an interpreter or translator with the same degree of certainty/effectiveness as when an interpreter or translator is not needed?*

As with our previous answers, it depends on a number of factors. Some factors are intrinsic; others are extrinsic to the counselor. Some intrinsic factors include the level of cultural competence, experience working with a person of the other culture, experience in working through interpreters, ability to sort out personal biases related to the other culture, and comfort with ambiguous situations. Extrinsic factors include the level of competence of the interpreter, the quality of the professional rapport between the interpreter and the clinician, and the comfort of the client with the triad.

Counselors and interpreters need to view themselves as a seamless team, together working toward a specific therapeutic goal. This means that the therapist needs to see the interpreter as a colleague rather than a machine. While, as discussed in later questions, an interpreter is not supposed to interject comments or opinions in their interpretation, this does not mean they do not have salient observations. This is particularly true with well-trained, experienced mental health interpreters. Experienced clinicians learn how to draw on those observations to supplement their own. They are able to interweave their clinical impressions with linguistic and cultural data they obtain from the interpreter. The more experience therapists have working with interpreters in general, the greater the confidence in their clinical judgment. This is further enhanced when the same client-therapist-interpreter triad is together for each session (Harvey, 1989, p 180).

Developing a strong working relationship between the clinician and the interpreter, then, can be seen as one of the pillars on which effective therapy can be built. An essential element in building this relationship is the regular use of brief meetings between the interpreter and the clinician before and after the clinical session to discuss the material. These pre- and post-conferences were discussed by Stansfield (1981) and have been elaborated upon by several other authors. The practice is now considered the norm for professional collaboration in most settings where interpreters work.

The pre-conference allows the therapist to brief the interpreter about therapeutic goals for that session and to give background information necessary to allow for accurate translation of concepts raised in therapy. A good example of why pre-conferencing is helpful can be seen in applying social learning approaches to severely mentally ill patients in an inpatient setting. Certain behaviors may be targeted for extinguishing, which would require the removal of all reinforcement for that particular behavior. If the behavior being targeted is particularly bizarre, the uninformed interpreter may wonder why it is being ignored. This can lead to unintentional undermining of the intervention.

Debriefing after a session, or post-conferencing, allows the interpreter to share information of clinical importance that could not be brought up during the session. An example of clinically relevant information that would be shared in a post-conference would be atypical language use, which, perhaps did not rise to the level of obvious dysfluency, but nonetheless was remarkable. Changes in effect, signing style and speed and size, all represent things that few clinicians without special background in deafness would notice. Similarly, changes in word choice or register could be important for the client using a spoken language other than English.

Obviously this kind of close collaboration would not go unnoticed by the non-English speaking or limited English proficient (LEP) client. Inevitably, questions of the "are you with me or against me" nature would arise. These questions are emotionally laden and have culture-bound implications. They are also clinically

rich with therapeutic potential—if the clinician is able to skillfully make use of them. Nevertheless, interpreters are generally trained to think that they are "neutral." We are beginning to understand that neutrality is a myth (A thorough treatment of this topic can be found in Metzger, 1999). In reality the interpreter is allied either with one person or another. In most community interpreting assignments, this alliance is with the non-English speaking person. Even in the medical setting, the alliance is skewed to the non-English speaking person. This skew is potentially dangerous in a mental health setting. Issues of co-dependency on the part of the interpreter, transference issues, counter transference, and borderline behavior on the part of the client, can all subtly undermine the therapy. Because the therapist and the interpreter are working together toward a specific therapeutic goal, it is critical that the alliance be between the interpreter and the clinician. The consistent use of pre- and post-conferencing helps ensure this happens, and that it is therapeutically productive.

4. *Can a client have meaningful participation in group therapy through an interpreter or translator?*

There is virtually no literature addressing the inclusion of an interpreter in groups. Our response is therefore based on our clinical experience at DMH, supplemented by anecdotal evidence gleaned from interaction with colleagues and peers in both the mental health and the interpreting arenas. Our experience suggests that this arrangement can only be considered partially successful and only under the most controlled situations. These situations include: 1) lower-level psychotherapeutic groups; 2) groups that are staff-intensive so that individual clients are given attention although present together as a group; 3) educational groups where clients work on tasks independently; 4) groups that are primarily lectures by a single speaker; and possibly, 5) groups conducted by a therapist who is consistently aware of the need to meet the cultural and therapeutic needs to the LEP client. These groups share at least one of two characteristics: clients, whether English-speaking or not, have little or no participation or the groups are, for all intents and purposes, individual therapy sessions.

These characteristics are essential because of the nature of interpreted talk (Roy, 2000, pp 68–83). It is only possible to interpret expressions that have already been completely expressed. Thus, the LEP member always lags somewhat behind the primary speaker. (We use the term "primary speaker" because, while several persons present may talk over one another, the interpreter can only convey the speech of one at any time.) The group experience for an English-speaking participant is synchronous, that is, events are experienced at the time of occurrence, and multichannel, allowing the participant to attend to several speakers at a time. For an LEP participant, the group is asynchronous, that is, events are experienced after they have occurred, and speech is compressed to a single channel.

Further compression occurs due to the ability of the interpreter to only attend to expressions in one language at a time and respond in one language at a time. It is possible for two English-speaking members to talk over one another, altering their speech to address and respond to concurrent speakers; it is impossible for this to occur in interpreted talk.

The experience of LEP group members is further influenced by the interpreter acting as a filter. (This deliberate, conscious filtering is very different from the filtering addressed in responding to question 2, which is not conscious.) Since the interpreter can convey only one thing at any give time, he/she must determine what (in his/her mind) the most important thing is and interpret that. During the course of a group discussion, the focus shifts from person to person—in an orderly manner only when the therapist is aware and keeps tight rein—or sometimes to talk or events outside of the group. Things like overhead pages, people walking by the meeting space, interruptions for messages, and even talk between participants in asides to one another all crowd for attention in the collective conscious of the group. It is the interpreter who determines where the focus of the interaction is at any given point and conveys that information to the LEP patient. Thus, the clinician is not in control of the information received by the LEP person. Indeed, often the clinician does not know what information is actually conveyed.

Despite all this, attendance at a group may have some limited benefit for the LEP client—but only in certain situations. The intentional, therapeutic goals of groups can, in our experience, be realized only if there are individual sessions that brief or debrief the client regarding groups, and where issues can be

directly addressed. (This is in addition to the pre- and post-conferences between the interpreter and the therapist discussed previously.) Actual therapeutic benefit in the group is often limited primarily to exposure to modeling of healthy behaviors and filling time that might otherwise be spent in untherapeutic or even harmful activity. On the other hand, participation in group activities may only give the appearance of providing therapeutic services. Watching others interact naturally and easily may serve to exacerbate the LEP client's feelings of isolation and sense of otherness rather than feeling involved with peers in the group. Thus, actual benefit of participation in a group is too dependent on a plethora of interrelated variables to assume.

We now turn to those situations we have set out as possible scenarios where inclusion of an interpreter in groups may have a therapeutic outcome. The first of these, the lower-level psychotherapy group, is for a small group of severely impaired patients who are in acute care. Their goals are simple: to provide a supportive experience to encourage continuing therapy as outpatients; demonstrate that talking about problems helps identify problems for future work; and, of particular importance to this discussion, to "help patients develop social skills that will permit them to become engaged with other patients on the unit and will serve them well outside of the hospital" (Yalom, 1983, pp 278–279). One lower-level psychotherapy group, the focus group, is suggested as adaptable to long-term treatment sites. One important aspect of the focus group is the participation of everyone present including therapists. Regarding this Yalom writes, "It is important that the leaders be willing to participate fully in all of the group's activities; they must be as engaged and as self-disclosing as they expect patients to be" (p. 285). This may cause a real difficulty for interpreters. Paradoxically, the more training the interpreter has, the more conflict this may cause. As interpreters increase in their sense of professionalism, they come to view themselves as providing a service by allowing unhindered access of interlocutors to one another. They are thus uninvolved in the exchanges they interpret. Indeed, professional ethical codes may require interpreters to avoid self-disclosure regarding any personal opinion[i].

Lectures cannot really be considered as groups in this context. They are more similar to classroom settings than they are to therapeutic groups although the content may be therapy-related. These lectures may be quite brief and address topics such as hygiene, new procedures on a ward, announcements of events, and the like. A group tailored specifically to the needs of the LEP client can also be hardly recognized as a group. Rather it is an individual session with other patients present. These may be confronted together by a treatment team in the case of reproving patients for rule violations. The other patients may be present to recreate an event that has transpired as observed or participated in by the LEP patient. The other types of groups set out to more closely resemble individual sessions where patients are present in physical proximity to one another.

5. *In group therapy, does the presence of an interpreter or translator change the group dynamic? If so, how?*

Again, there is no literature other than the work of Michael Harvey previously referred to, which even begins to discuss this question. It seems reasonable, however, to look to references on group dynamics when new members are introduced or in the face of co-therapists. Rice and Rutan (1987, pp 32–40) identify some of the influences on these dynamics as transferences, defense mechanisms, and object relationships. There is no reason to believe that these dynamics exclude an interpreter who is present in a group.

It has been observed that particularly object relationships are skewed; patients and clinicians have accepted and identified the interpreter with the LEP patient as though they are a single entity. This sometimes leads to confusion over the interpreter's role in mediating talk, rather than authoring original expressions. This can be mitigated by having the therapist introduce the interpreter to the group and treat the interpreter as a colleague or consultant rather than making the interpreter's only relationship to the group and group members dependent on the LEP client's relations.

On other occasions, the interpreter is accorded a role as co-therapist, albeit one with limited scope of concern in the group. This is merely an extension of the comments in the previous paragraph. It is especially recommended in this circumstance that the interpreter and therapist take time to brief and debrief

in connection with groups; that the therapist's intentions for a group session are clear and that the interpreter is free to share observations and ask questions.

In all of these cases, it is assumed that there is continuity in interpreting. Indeed, when there are frequent changes in interpreters, this will have greater impact on the group. There may be changes in age and gender among interpreters which will affect group members differently. The substitution of an attractive young woman for a middle-aged male interpreter will surely not pass unnoticed in a sex offenders group, for example, and has even been used to therapeutic advantage by at least one psychologist.[ii] It is also important to bear in mind that an interpreter produces a rendition of what is said based on his own understanding of what is expressed. Another interpreter's rendition of even the same expression in the same setting may produce a different rendition. Because of this, changing interpreters during the course of therapy will cause texts that are static in English to vary in the target language. Thus texts like the 12 Steps or the principles used in cognitive-behavioral programs will be produced in novel and unfamiliar ways while they are easily recognized by English speakers.

All in all, then, guidance on this issue of impact of an interpreter's presence on group dynamics can be further found in literature relating to the introduction of new members to a group, issues of co-leading therapy, changes in group leadership, and the inclusion of out-group members on in-group interactions.

6. *In group therapy, does the presence of an interpreter or translator change group members' ability to participate in or benefit from group sessions? If so, how?*

This is really two questions. In what ways does the inclusion of an interpreter alter the fundamental nature of a group? Do these changes affect the participation of English-speaking group members?

Aside from the ways already noted in the response to question 5, there are two fundamental ways. The first is that interpreting, if meaningful, will add appreciably to the time a group takes, thereby slowing down the group's progress and cutting the amount of discussion in session. The interpreter must restate everything said in the group. Saying everything twice takes longer than saying everything once.

The second is that the interpreter's presence will be some distraction to the therapist and patients. Rather than viewing this negatively, it can be seen pragmatically as merely broadening circumstances in which the group leader observes patients. How patients incorporate the interpreter's presence into their defense mechanisms is useful to a clinician who is experienced in the dynamics of using an interpreter. Group leaders can also take advantage of the presence of an LEP patient and interpreter to reinforce social skills such as turn-taking and tolerance of diversity.

7. *Is a counselor's ability to assess a client's progress in therapy changed by the client's use of an interpreter or translator?*

The obvious answer is that without an interpreter, the counselor has no ability to assess an LEP client's progress. That said, a skilled counselor who is experienced in using a qualified interpreter, as was discussed in the response to question 1, can still assess a client's progress in therapy. There are still three factors that need to be addressed in considering the progress of LEP clients.

The first is the realization that language barriers affect access to preventive mental health services and diversion resources. This is true in healthcare (Commonwealth Foundation, 2002), and there is no reason to assume it is not equally true in mental health services. The result is that LEP clients are more likely to be more severely impaired by mental illness at the point they come into treatment.

The second is that culture and language differences cannot be ruled out as impacting the time needed for clinicians to be sure of diagnosis and progress toward recovery. Again, we see the correlation to healthcare services. The time spent arriving at diagnoses and the testing done with LEP patients is longer than that of English-speaking patients (Kravitz *et al.*, 2000). This reflects the facts that doctors have no easy way to get confirmation of their hypotheses from LEP patients, and that culture affects the manifestations of disease (Woloshin *et al.*, 1995).

Finally, clinicians unfamiliar with an LEP client's culture and background will have more difficulty determining the client's baseline of function to know when there is recovery. This was addressed in depth earlier in this response.

8.   *What duty of confidentiality do interpreters or translators owe to group members other than their own clients? Could a group counselor (sic?) be called as a witness against a member of the group in court?*

It is the authors' assumption that the above question was meant to ask if the interpreter could be called as a witness against a member of the group in court. However, later in this response we addressed the explicit question in brief. There is ample literature regarding privilege in therapy and limits on confidentiality as applied to therapists that it does not bear in-depth treatment here.

Various codes of ethics have addressed confidentiality in broad terms. Already cited is the example of the Registry of Interpreters for the Deaf Code of Ethics. In Missouri regulations governing the licensing of interpreters (4 CSR 232-3.010) codifies these general obligations.

Additionally, section 209.339.1 RSMo states,
> *"A person who interprets a conversation between a person who can hear and a deaf person is deemed a conduit for the conversation and may not disclose or be compelled to disclose by subpoena, the contents of the conversation which he facilitated without the prior consent of the person who received his professional services."*

If the purpose of group therapy is for the participants to learn from one another's shared experiences, there is a strong argument that an interpreter is not just there to interpret between the deaf person and the therapist/group-leader, but to interpret for all of the group participants. In this case, the "conversation" is taking place between the entire group and the contents of that conversation are protected and may not be disclosed. However, the statute only says *"may not be compelled to disclose by subpoena."* It does not address whether a court order would be sufficient to compel disclosure, and there are no cases citing this statute that give guidance on that issue.

Additionally, there are two exceptions to the general rule stated above. A court may order disclosure to provide evidence in proceedings related to criminal charges. Therefore, if a member of a therapy group makes a disclosure about a criminal act, any member of the group, including the interpreter, may thereafter be ordered by a criminal court to testify about what was said. Additionally, the interpreter may have to disclose the contents of a conversation in a proceeding related to allegations that the interpreter was practicing interpreting without a license or was practicing beyond their level of competence. The former exception appears to be more likely.

It is noteworthy that Missouri statute protects only interpreters working to facilitate communication between people who are deaf and people who hear.[iii] Interpreters working in other language pairs do not enjoy the same level of protection in the law. Whether this protection can be extended by logic is an argument that has not been tested in court. Indeed, the authors know of few court cases testing whether an interpreter can be compelled to divulge the contents of an interpreted conversation. None of these cases dealt with group therapy issues.

Regarding the question about group counselors, the answer depends on the credentials of the counselor—he may have either a professional (i.e. licensing) or ethical duty of confidentiality to those he counsels. However, many counselors fall into the category of persons required to report certain forms of child, adult and elder abuse (see §§210.115 & 660.255 RSMo). The duty to report may reveal the counselor's identity and lead to his being called as a witness at a hearing. It is not possible to say with 100% certainty that anything   said   to   a   counselor   is   protected,   even   from   the   court,   by   a   privilege.

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Appendix A

Minimum Competencies for Interpreters in Mental Health Settings

This document refers to four levels of knowledge: exposure; awareness; familiarity; and understanding.

- Exposure is having some knowledge of a field's existence and its place in the setting and, possibly, some of the vocabulary used in the field.
- Familiarity is having actual experience with a field and/or practitioners in that field.
- Awareness goes beyond familiarity in that it also includes beginning to internalize the information regarding a field and to have begun thinking through how it affects one's professional and personal behavior although it does not necessarily include having resolved issues raised.
- Understanding is having sufficient knowledge of a field to be able to explain the discipline, including its limits and its relationship to other disciplines.

Commensurate levels of competency are: exposure; familiarity; awareness; and demonstration (or compliance).

1. *PROFESSIONAL COMPETENCIES/KNOWLEDGE*
    1.1. **Understanding of Missouri Interpreter Certification System Requirements** (For Sign Language Interpreters only)
        1.1.1.   Understand requisite skill levels and their rationale
        1.1.2.   Hold MICS Intermediate Certification or higher
        1.1.3.   Understand Mentoring and Supervision

    1.2. **Demonstrate Interpreting Methods and Appropriate Use**
        1.2.1.   Simultaneous Interpreting
            1.2.1.1.   First Person
            1.2.1.2.   Third Person
        1.2.2.   Consecutive Interpreting
            1.2.2.1.   First Person
            1.2.2.2.   Third Person
        1.2.3.   Narrative Interpreting (Third Person)

    1.3. **Familiarity with Mental Health Issues**
        1.3.1.   Psychiatric Services / Mental Illness
            1.3.1.1.   Awareness of Psychopathologies
            1.3.1.2.   Familiarity with Assessment Methods
                1.3.1.2.1.   Understand Impact of Signing on Assessment
                1.3.1.2.2.   Understand Impact of Culture on Assessment
            1.3.1.3.   Exposure to Treatment Approaches
        1.3.2.   Addiction Services
            1.3.2.1.   Familiarity with Addictions
            1.3.2.2.   Familiarity with Assessment Methods
            1.3.2.3.   Exposure to Treatment Approaches
                1.3.2.3.1.   Inpatient
                1.3.2.3.2.   Outpatient
                    1.3.2.3.2.1.   Self-help and Support groups
        1.3.3.   Dual Diagnosis
            1.3.3.1.   Exposure to Mental Retardation and Developmental Disability
            1.3.3.2.   Awareness of the difference between Interpreting and . Communication Assisting/Language Intervention

1.4. **Familiarity with Mental Health Systems**
    1.4.1. Ability to Identify Care Providers
        1.4.1.1. Identify Mental Health Disciplines
        1.4.1.2. Familiarity with Milieus and Settings

1.5. **Understand Role of Professional Consultant**
    1.5.1. Understand Professional Boundaries of Interpreters
    1.5.2. Awareness of Confidentiality and Privilege, including at a minimum: Abuse Reporting, Duty to Warn, and Protections Specific to MO Statute.

2. *CULTURAL COMPETENCIES/KNOWLEDGE*
2.1. **Demonstrate Cross-Cultural Competencies**
    2.1.1. Understand Impact of Stereotypes
    2.1.2. Awareness of Constructs of Deafness
        2.1.2.1. Majority/Minority Cultures
        2.1.2.2. Pathological Models
    2.1.3. Understand Cultural Views of Mental Illness, Mental Retardation/Developmental Delay and Addiction

2.2. **Understand Impact of the Interpreter in the Milieu**
    2.2.1. Understand Sociological Impact
    2.2.2. Understand Impact on Treatment Dyad

3. *CONDUCT COMPETENCIES/KNOWLEDGE*
3.1. **Understanding of Personal Safety Issues**
    3.1.1. Understanding of At-Risk Conduct
    3.1.2. Understanding of Personal Boundaries
    3.1.3. Awareness of De-escalation Techniques
    3.1.4. Awareness of Universal Precautions

3.2. **Demonstrate Professional Boundaries and Judgment**
    3.2.1. Demonstrate Professional Collaboration in Pre- and Post-Conferencing

3.3. **Demonstrate Ability to Assess Effectiveness of Communication**
    3.3.1. Demonstrate Ability to Appropriately Match Interpreting Method with Client and Setting
        3.3.1.1. Understand Impact of Emotionally Charged Language
    3.3.2. Demonstrate Ability to Discuss Unusual or Changed Signing
        3.3.2.1. Demonstrate Ability to Convey Information Without Alteration
        3.3.2.2. Demonstrate Ability to Convey Emotional Language Without Escalation
        3.3.2.3. Demonstrate Ability to Convey Ambiguous, Emotionless Language
        3.3.2.4. Demonstrate Ability to Isolate Peculiar Features of Eccentric Language Use

3.4. **Demonstrate Ability to Read and Record Documentation**
    3.4.1. Awareness of Protection of Confidentiality
    3.4.2. Awareness of Personal Records as compared with Records Shared with Other Interpreters and Other Professionals

3.5. **Awareness of Personal Mental Health Issues and Maintenance**
    3.5.1. Understand Personal Issues Impacting on Interpreting Process
    3.5.2. Awareness of Countertransference in the Interpreter
    3.5.3. Familiarity with Transference to the Clinician or to the Interpreter

Endnotes

[i] This is one of the tenets promulgated by the Registry of Interpreters for the Deaf in its Code of Ethics. The third point reads: "Interpreters/transliterators shall not counsel, advise or <u>interject personal opinions</u>." In Missouri this has been codified in 4 CSR 232- 3.010 (8). As a result many interpreters will refuse to answer even benign questions raised in the context of the focus group. Samples of these questions and related activities are presented in Yalom (1983), pp 290–304.

[ii] Robert Steele at St. Louis Psychiatric Rehabilitation Center used this technique in order to uncover the differences in how a deaf sex offender related to each gender.

[iii] This same section of the statutes protects conversations transmitted through a third party telephone relay service. As a practical matter, conversations transmitted this way are, for all practical purposes, totally confidential as the relay centers do not log the contents of conversations and no record is keep other that what is needed for billing purposes.