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"The Necessary Evil"- An Exploration into the Provision of Sign Language Interpreters in Therapy and its Effect on the Therapeutic Relationship.

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Abstract

The author of this dissertation is a sign language interpreter who works closely with the Deaf community and has become interested in exploring the implications of interpretation in therapy. The aim of the study is to understand the use of the sign language interpreter, while also examining the impact of their presence on the therapeutic relationship. Due to newly established accessibility laws in Ireland, it was necessary to carry out research in order to provide an overview of the current literature surrounding the process that takes place when a Deaf person avails of interpreted mental health services. Language was identified as an essential element in the success of therapy, with the use of a sign language interpreter emerging as the most realistic option when working with a Deaf client. It was established that although a necessary addition for communication purposes, the interpreter brings with them much more than linguistic translation. For this reason, they are identified as the necessary evil. Issues such as translation inaccuracies and triadic relationship problems were found to have a profound impact on the therapeutic alliance, reducing the effectiveness of the therapy. In order to combat these negative effects, techniques such as professional collaboration and implementation of boundaries were discussed, leading to an improved sense of effectiveness. The research concluded with an observation of potential successes when using an interpreter in therapy. However, due to the lack of literature in many key areas, it notes that there is a substantial need for further exploration into this topic.

Chapter 1: Introduction

In Ireland there are approximately 5000 Deaf[1] people who encounter difficulties when accessing services in an equal manner to hearing society members (Comhairle, 2006). However, with the continuous lobbying and increase in legislation, supported by the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) and the Irish Sign Language Act 2017, it may be suspected that this access is on the rise. Current changes like this, as well as my involvement in the Deaf Community, has inspired a passion and curiosity around access issues for Deaf people in relation to mental health services. Irish Sign Language provision by public services has been implemented by such laws, however, with such new establishments, this thesis sets out to examine how these standards are met and what occurs after provisions are applied. Thomas, Cromwell and Miller (2006) argues that the therapist's lack of training in Deaf-awareness leaves them ignorant to the needs of the Deaf community. This implies that although service providers are now obliged to provide access to mental health services, there may still be many unanswered questions around what this access entails and how the therapist ensures and monitors quality within what they are providing.

Sheppard and Badger (2010) state that communication barriers often make it difficult for Deaf people to discuss symptoms of their mental health with healthcare providers. This highlights the need for alternate provisions, however, this dissertations holds an objective to explore and understand the particular choice of a sign language interpreter when providing therapy to a Deaf client. Through engaging with this objective the importance of language within therapy will be understood, while exploring and critiquing alternative methods of communication. A second objective sets out to investigate the implications that the provision of the interpreter may have on the therapeutic process. Using Carl Rogers (1957) core conditions for therapeutic change, the research endeavors to identify

[1] For members who are affiliated with the Deaf Community, the word Deaf is denoted with a big "D" (Jampel, 2010). However, deaf with a small "d" is simply the audiological condition (McCreary & Stebnicki, 1999). Those who are Deaf, do not see themselves as disabled, but a cultural minority with their own language (Corbett, 2003).

the possible barriers which may arise as the therapist strives to express these conditions through a third person. Upon analysis, the study aims to compare the need/provision with the implications, and discover the effectiveness of the triad. Potential risks will be discussed, leading to an exploration of recommendations on how to alleviate such disruption.

In the Republic of Ireland there are no previous studies published on the topic of sign language interpretation in the therapy room. This indicates that this research is a first important step in documenting not just the provision, but the quality and effectiveness of services being provided to the Irish Deaf Community. The paper aims to highlight key issues that may present in an interpreted session, with the hope of giving rise to future research surrounding this topic.

Chapter 2: The Need for Sign Language Interpreters in Therapy

"We could persevere with the interpreter, he could struggle to write his thoughts, or I could learn to sign. Both of the latter two options were much easier said than done".

(Porter, 1999:165).

2.1 Introduction

The aim of this chapter is to understand the need for the sign language interpreter and why it is a common choice when providing therapy to a Deaf client. In order to investigate this, it is necessary to explore alternative options for communication. The choice of oralism and therapists with Irish Sign Language (ISL)[2] will be examined, while highlighting their own associated issues. Finally, this section will explore the choice of applying an interpreter to the situation, with a further aim of understanding their role as the third person in the room.

2.2 The Importance of Language in Therapy for Deaf People.

Sieger (2018) outlines many reasons as to why language choice is important in therapy. She emphasises the practical reasons such as clear communication, but also explores language as a method of self-identification. She explains that language is engrained in our experiences, which may be shared or separate us from others. Kaufman (1996:120) supports this statement, explaining that psychotherapy depends directly upon language as "*the bridge between different experiential worlds*". However, Phillips (1996) highlights the stark difference between spoken English and the visual nature of sign language, suggesting that this gap can be quite difficult to bridge. Williams and Abeles (2004) claim that until a way can be found to communicate with a Deaf client, there is a high probability of

[2] In the case of Ireland, the native sign language is Irish Sign Language (ISL). Although treatments may differ depending on how the client identifies (Boness, 2016), this paper focuses on ISL users, and therefore those who are Deaf.

misdiagnosis. Furthermore, he explains that any communication issues within the therapeutic alliance can hinder the relationship, causing the client to drop out, or worse, further perpetuate the clients history of misunderstanding, isolation and oppression (Schirmir, 2001). These issues associated with communication breakdown, highlight the importance for identification of a communication method between a therapist and their Deaf client.

2.3 Oralism as a Method of Communication

According to LeMasters (2003), educational language policies have had a huge effect on Irish Deaf identities. In 1946, signing was banned in schools and replaced by oralism. This was later seen as ineffective and a denial of the culture and language of the Deaf community (Ogbu & Simons, 1998). Signing was re-introduced decades later, however the distinction between generations, particularly around the use of sign or oralism, sent out strong messages as to whether deafness was a normal or abnormal condition. Those who suffered through the oralism stage, were likely to become strong advocates of Deaf Culture, taking an oppositional stance as a result of the oppression that they experienced in school (LeMasters, 2003).

When considering a method of communication with a Deaf client, it may be important for a therapist to be aware of this history. Foster (2018) discusses Hearing Privilege as a term to describe abuse of power dynamics between Deaf and hearing people. If there is encouragement of a Deaf client to become more hearing by lip reading or using speech, the client may feel less human and the therapist may be guilty of this abuse (Whyte, Aubrecht, McCullough, Lewis & Thompson-Ochoa, 2013). If oralism is to be chosen as the main method, it could perpetuate some of the client's history. Ultimately, this could lead to ruptures in the relationship due to the absense of essential therapeutic conditions such as congruence (Whyte et al., 2013; Rogers, 1957). These potential ruptures, along with the statistic that only 30-45% of the English language is discernable through lipreading (Lieu, 2007), leads to the belief that oralism is not the most appropriate method of communication for a Deaf person in therapy.

2.4 The Use of Therapists with Sign Language.

Thomas *et al.* (2006) argue that the therapist's lack of training in Deaf-awareness leaves them ignorant to the needs of the Deaf community. In terms of awareness, Ladd (2003) describes the concept of Deaf culture, bringing with it the many historical pitfalls that have marked the community due to a negative medical perspectives of deafness. He contrasts this with a newer concept of Deafhood, which similarly to motherhood or brotherhood, is used to describe the essence of being Deaf and the rich culture that comes with it. This strong sense of culture, along with a distinctive history of oppression, may raise suggestions over the use of Deaf therapists. Similarly, Woodword (1973) discusses the suggestion of Deaf teachers being used as educators in the community as a means to provide role-models, and in turn, build positive Deaf Identity.

Leigh and Lewis (1999) explore the advantages of the Deaf therapist. They confirm that because of who and what they are, they have greater awareness of what it really means to be Deaf, and therefore can build a strong alliance with their Deaf client. They offer the example of a client who expressed shame and embarrassment in using sign language out in the hearing world, yet began to internalise the Deaf therapists own comfort with signing and was consequently relieved of this shame. Although this highlights a potentially successful option, Odale (2008) suggests that difficulties arise within particular contexts due to the small size of their Deaf community. In Britain, it was found that many Deaf clients expressed a distaste in using a Deaf therapist, due to issues surrounding familiarity and confidentiality (ibid.). Despite the lack of research, it can be assumed that there is a similar situation in Ireland where the Deaf Community is much smaller than in Britain. In addition to this, when researching Deaf therapists in Ireland, resources were extremely limited with no online presence of their availability. This leads the author to believe that this is not an option due to a lack of qualified Deaf psychotherapists in Ireland. The same issues such as familiarity and confidentiality were apparent when considering a hearing therapist who has sign language, due to the possibility that they would be treating mutilple Deaf clients (Boness, 2016). Again, upon investigation, there was no available information or presence of hearing psychotherapists in Ireland who have fluent ISL.

2.5 The Use of Sign Language Interpreters in Therapy

Sign language interpreters work between spoken and visual signed languages, providing communication facilitation between Deaf and hearing parties (Hamerdinger & Karlin, 2003). According to Brunson and Lawrence (2002), they are trained to be conduits of language who neither add nor subtract information from the primary dyadic relationship. These are trained professionals, who in accordance with their code of ethics, must maintain a strict code of neutrality, impartiality and confidentiality while working (The Council of Irish Sign Language Interpreters (CISLI), 2011). Due to the ISL Act (2017), which states that all public bodies must provide free ISL interpretation to those who need it, it could be assumed that the use of ISL interpreters is increasing within all domains of life, including mental health.

According to De Bruin and Brugmans (2006), the added benefit of using a sign language interpreter in therapy is their ability to understand and communicate the non-verbal aspects of the Deaf client's language such as dialect, signs, and facial expressions, which are not fully understood by the therapist. In the Irish context, qualified ISL interpreters undergo a 4 year training programme (Citizen's Information Board, 2017), after which their skillset may be used to aid the therapist in bridging the gap of communication. Thus, their use ensures that the therapist is not preoccupied by communication breakdowns or an inability to understand (De Bruin & Brugmans, 2006). Hamerdinger and Karlin (2003) argue that using a clinician who signs would be a more optimal situation. However, due to the fact that there are simply not enough to meet demand, they conclude that the use of interpreters will continue to be the most used method in providing mental health services to Deaf people. They describe this as the "necessary evil", which must be approached in a careful manner if there is to be any expectation of success (pg.1).

2.6 Conclusion

This chapter has reviewed the importance of language in therapy, and the implications that the choice of method can have on a Deaf client. Although not the most ideal, it was discovered that a sign language interpreter is the most realistic option in many circumstances. However, the chapter concludes with a stark warning about the proper approach to such methods. The following chapter will explore this warning, giving light to the implications that may arise within the interaction.

Chapter 3: The implications of the Sign Language Interpreter in Therapy

3.1 Introduction

In the previous chapter, an examination took place to understand the need for an interpreter in the therapeutic interaction. In terms of quality, Porter (1999) suggests that working with a sign language interpreter can work well, assuming that everybody understands their role and are comfortable with the process. Although this statement is very broad and could include an array of potential flaws, this chapter will focus on the areas of translation inaccuracy and implications of the triad. These will be explored in order to investigate the effects of the intrusion on the therapeutic relationship.

3.2 Accuracy of Translation.

"Interpreters have to make decisions… their decisions influence the success or otherwise of their linguistic mediation"

(Leeson 2005:52/53).

According to Young and Napier (2019), interpreting is not just inter-lingual practice, but a representation of the Deaf person as a whole. The hearing non-signers are perceiving the Deaf person through the interpreter's tone of voice, lexical choices, and register, with all of these choices conveying meaning explicitly or inexplicitly. Deridda (1976) discusses phonocentrics, stating that a person's speech and sound are simultaneous to their presence and being. Napier and Young (2019) suggest that this can be a challenge for a Deaf person, who for most of their daily lives, may only be known in translation. They argue that with the addition of the interpreter, the simultaneity of expression and being may be lost due to the indirect and bimodal communication method. Vicarious trauma may also be considered when messages are being relayed innacurately. According to DeAngeles (2010:52), the interpreter's alterations can often do more harm than good if they *"censor psychotic, profane or sexual content out of fear, embarrassment or a desire to "protect" the client".*

She states that when interpreting traumatic events, they can often alter, summarise, or leave out essential information due to their own resonance or feelings of being triggered.

According to Rogers (1957), the first condition for therapeutic change is that the therapist and client are in psychological contact, or in other words, are on the same page psychologically. However, if an interpreter has so much power over choices in portrayal, one may wonder how much of the self is lost by the Deaf client. Although sign may be a natural expression of being for the client, it is hindered by the necessity of interpretation in the relationship. The phonocentric perspective, linguistic choices, and vicarious reactions of the interpreter, can reproduce an inequality of person that is being received by the therapist. Therefore, if the therapist is not getting a correct sense of the Deaf person, it could be assumed that this may have serious implications on the ability to achieve accurate psychological contact. Thus, leading to difficulties in providing further conditions such as congruence, genuineness and empathy (Rogers, 1957).

3.3 Implications of the Triadic Relationship.

Roger's (1957:1) emphasises the dyad by suggesting that for constructive personality change "two persons are in psychological contact". He expands by stating the simplicity of this, noting that it is often labelled an assumption. However, this research is not considering situations where there are more than two people in the relationship. Cromwell (2004), argues that by the interpreter simply being present in the room, they become part of the interaction and therefore impact it. At a basic level, their presence has now changed this dyad into a triad (Hoyt, Siegelman & Schlesinger, 1981).

3.3.1 The Therapist-Interpreter Relationship

De Bruin and Brugman (2006) state that this addition to the room adds pressure on the therapist who is now exposed to two people, one of which is not undergoing treatment and is free to observe their skills. The interpreter may have experience in the mental health domain, consciously or unconsciously examining the therapist's performance and professionalism (Levinger, n.d). According to Cromwell (2004), the therapist may feel helpless and de-skilled when encountering these situations. He expands

to include power-struggles between the two, where the therapist who usually holds control over the environment, may be confronted by the interpreter's suggested changes. This may include lighting, seating arrangements, and a slowing down of communication in order to aid the translation. Thus, it may be argued that the interpreter poses a significant intrusion on the therapists regular process, where the intepreter may be perceived as the expert in the room, drawing attention to the therapists shortcomings (ibid.). According to Lenvinger (n.d), if the two professionals compete for this control within the therapy, they may pull the client into their relationship. Consequently, the client's needs are pushed aside in order to meet the needs of others, and therapeutic efficacy is compromised.

3.3.2 The Client-Interpreter Relationship

Levinger (n.d) highlights the possibility of coalitions between the client and interpreter. This may occur due to the potential feelings of closeness which are nourished by the fact that they share a language and a connection to the Deaf Community (Cokely, 2005). However, he expands to suggest that this closeness may also evoke feelings of anxiety and stress. Padden and Humphreys (1988) emphasise how small and close-knit the Deaf community are, noting that interpreters and members of the community are quite likely to know each other very well. This may be particularly relevant in an Irish context where there are 5000 Deaf people, served by an estimated 75 ISL interpreters (Sign Language Interpreting Service, 2017). This could be seen as problematic for a Deaf person who may not want to disclose such personal matter to somebody they have regular social contact with. It may also evoke additional concerns that content will be leaked out to Deaf friends and family (De Bruin & Brugmans, 2006; Napier, 2002).

3.3.4 The Therapist-Client Relationship

According to Cromwell (2004), it is possible that the Deaf person may have feelings of resentment in the fact that they need an interpreter to access a service otherwise freely accessible to hearing. This resentment may then lead to mistrust in the interaction between interpreter and therapist (Stansfield, 1981). Although against the interpreter's code of ethics, it is possible for the client to see the

interpreter as allied with the therapist. This may be heightened by certain elements of the environment such as the seating arrangement. Cromwell (2004) states that when using an interpreter it is most common for the therapist and interpreter to sit opposite the Deaf client in order to provide an optimal view of both, yet one can imagine that this may evoke feelings of being outnumbered within the client. Levinger (n.d) further states that the clients lack of control over what is being transmitted by interpreter to therapist and vice-versa, can put additional stress on the relationship. Furthermore, Antolovi (2017) reports situations of interpreters speaking to clients before and after sessions, almost adopting the role of therapist themselves and providing support. She expands to state that this rapport can destroy the therapeutic relationship, due to the exclusion of the therapist and the potential for them to be perceived as the third person in the room, as opposed to the interpreter. Therefore, it can be assumed that these situations of mistrust, lack of control, and intrusion, may prevent the client in building any relationship with the therapist, thus reducing the effect of the therapy (Porter, 1999).

3.4 Conclusion

This chapter has reviewed the implications that a sign language interpreter has on the therapeutic relationship. It was found that faults in translation, as well as unconscious processes within the triadic relationship can cause significant ruptures in the therapeutic process. One may conclude with questions around the value of such system if there is so much possibility for flaw. The next chapter will discuss avoidance of such implications and potential solutions for reducing the negative impact.

Chapter 4: Reducing the Impact of the Interpreter on the Therapeutic Relationship

4.1 Introduction

In the previous chapter, there was an exploration into the potential risks that come with the use of an ISL interpreter in therapy. However, in chapter 2, the research outlines the popularity of such use and the consistent need for this application. Taking both of these aspects into consideration, this chapter aims to examine solutions to the problem by highlighting possible measures that can be implemented in order to ensure the highest quality of interaction when working with a Deaf client.

4.2 Reducing the Impact of Translation inaccuracy

"…in the hands of a skilled therapist using a highly qualified interpreter, good work can be done…"

(Hamerdinger and Karlin, 2003:2)

4.2.1 Interpreter Qualification and Training

According to Hamerdinger and Karlin (2003), effectiveness of translation can depend on the qualifications of the interpreter. They state that often there is a tendency for interpreters to be more fluent in one language than the other, which is possible for a native speaker who also has average conversation skills in another language. Yet, this person may be pushed into service and used "as an impromptu interpreter" (Pg.1). In Ireland, although perhaps common in the past, there is hope that this type of occurrence will be eradicated due to the impending ISL interpreter register, currently being developed in compliance with the ISL Act (2017). The act states that…

> "*A court or a public body, in compliance with its obligations under this Act, shall not engage the services of a person providing Irish Sign Language interpretation unless the person's competence has been verified by having been accredited in accordance with an accreditation scheme funded by the Minister for Employment Affairs and Social Protection.*"

All interpreters that are verified under this scheme will hold a 4 year BA (hons) degree in English/ISL interpreting, or an alternatively recognised course (SLIS, 2017). It could be assumed that it is essential for Irish therapists to be aware of this information, employing it where necessary and ensuring they are working alongside a fully qualified interpreter. Thus, ensuring the minimum standards of quality in translation.

Although qualifications may be easy to monitor, difficulties may arise in relation to the level of experience or training obtained by the interpreter in specific domains. According to Hamerdinger and Karlin (2003), distortions of information in therapy commonly occur due to the interpreter's lack of knowledge in the area of mental health and their attitudes towards the client or therapist. Thus, it is essential for interpreters to be aware of the impacts of their distortions through training related to working in clinical settings (ibid.). Salihovic (2008) expanded to state that interpreters working in mental health settings should undergo supervision as part of ongoing training in order to counter-act intrusion of their own feelings. Phelan (2001) emphasises the Department of Health's lack of policy regarding interpreters, and as of now, Ireland still has no apparent guidelines or training programmes for interpreters working in the mental health arena. The only information that could be retrieved is the unwritten rule that ISL interpreters must wait 5 years before entering any type of medical job, including that of mental health. Yet, this does not include any of training or assessment before accepting these types of job (Personal Communication).

The Registry of Interpreters for the Deaf (2007) argue that in order to uphold ethical standards of practice, an interpreter must ensure they have the appropriate training in mental health. However, with the lack of such guidelines and training in Ireland, it could be assumed that Irish interpreters are not capable of doing this. Internationally, organisations such as The Missouri Department of Mental Health, have developed guidelines to aid the understanding of what an interpreter needs to know to work effectively in mental health settings (Included in Appendix A). Although these can be drawn on by interpreters or therapists at their own will, due to the serious implications of translation

inaccuracies, the lack of mandatory training may be observed as a critical gap in the provision of competent ISL interpreters in Irish mental health domains.

4.2.2 Therapist Awareness

> *"How can the therapist perceive what is abnormal until the normal is fully grasped?"*
>
> (Ridley, Mendoza, Kanitz, Angermeier, & Zenk, 1994)

Harvey (1982,1989) argues that accuracy is not only the responsibility of the interpreter, but also the therapist who must be aware of, and appreciate what is going on in the sessions. Aside from linguistic challenges, he claims that in the case of culturally embedded information, everything is not always readily perceptible through interpretation. This requires an additional level of awareness which the therapist must embark on themselves, including knowledge of factors asscociated with culture, disability and language (Boness, 2016). According to Hamerdinger and Karlin (2003), if the therapist is culturally aware, it will avoid misinterpretations of the Deaf client's mannerisms, expressions and behaviours. For example, a Deaf person commonly uses strong facial expressions and body movements as part of the linguistic markers within their language. Although a very normal aspect of ISL, this may look very animated to the unaware therapist, leading to a risk of misdiagnosis (ibid.). Therefore, it could be argued that an understanding of these cultural differences is key in accurately identifying the self within the client. This may lead to a deeper understanding of their being, and facilitate the building of a genuine therapeutic relationship (Napier & Young, 2019; Boness, 2016; Rogers, 1957).

4.3 Reducing the Negative Effects of the Triad

According to Levinger (n.d), it is important for the therapist to recognise the unconscious processes that are at play within the triad. This awareness reduces the destructive effect, and can be used to increase the positive. He explains that the system should work like a triangle. For the relationship

between the therapist and client to be effective, the other two sides connecting interpreter and therapist, and interpreter and client, must also be strengthened and reinforced.

4.3.1 Collaboration Between the Professionals

According to DeBruin and Brugmans (2006) the biggest issue between the therapist and interpreter is confusion around role conception. They claim that codes of conduct which outline the interpreter's role are very useful in general settings, yet are not always workable or desirable in mental health practice. The interpreter's choices impact heavily (Napier & Young, 2019), hindering their ability to abide by rules of neutrality or impartiality. He offers the example where an interpreter intruded by explaining the purpose behind certain therapeutic interventions to the Deaf client. Although the interpreter was trying to provide a clear message as to what was going on in the room, this elaboration was not the therapist's intention. When the therapist asked the interpreter to stay after the session to discuss the effects of such actions, the interpreter deemed it unnecessary as the job he was commissioned to do was complete.

In order to avoid this type of role confusion or conflict, DeBruin and Brugmans (2006) advise that the team should apply a collaborative approach. To do so, Cromwell (2004) recommends that the professionals meet prior to the first session in order discuss any issues, including clarifications on the interpreters role, the therapist's expectations, and an agreement on how they will deal with misunderstanding during the sessions. In support of this, Levinger (n.d) advises that the two professionals maintain this closeness, acknowledging that they depend on each other for the work to be effective, and continuing to meet on a regular basis in order to review the effectiveness of the system (Stanfield,1981). By doing such, this will reduce competitiveness and the potential for tension or friction throughout the therapy. Thus, lessening the possibility of detriment to the therapeutic process (DeBruin & Brugmans, 2006).

4.3.1 Interpreter-Client Boundaries

In chapter 3, the paper discussed issues of confidentiality within the Deaf community considering its small size and the fact that interpreters themselves are often quite involved (Padden & Humphrys,1988). In order to combat this, Cromwell (2004) states that the ethical position of the interpreter should be made very clear to the client in the initial session. For example, CISLI's Code of Ethics (2011) states *"Members will respect the privacy of consumers and hold in confidence all information obtained in the course of professional service".* Emphasis of this may alleviate any concerns that the Deaf person holds around confidentiality (Cromwell, 2004). Although there are no official Irish protocols to guide how the interpreter and client interact outside of the therapy room, agreements have been put in place on an individual basis. For example, one interpreter agreed that they would not accept interpreting jobs in the client's workplace until a year after the therapy ceased (Personal Communication). Thus, allowing the client to feel less exposed and aiding them to express themselves more freely.

According to Levinger (n.d), it may not be possible to stop unconscious processes within the triad, but the awareness of such will reduce some of the destructive effects. Furthermore, by applying the above techniques it may be argued that partial sides of the triangle are strengthened, allowing more opportunity for the client and therapist to build and maintain a real and genuine relationship where core conditions can be shared (ibid.)

4.4 Conclusion

This chapter has considered the impact of the interpreter, while simultaneously offering suggestions and solutions for the alleviation of such. It was discussed that in order to provide high quality therapy, there is much to be considered such as qualification and training levels of the interpreter, as well as collaborative and boundaried relationships within the triad. With the application of such skills, it was found that therapeutic conditions can be conveyed and the system can potentially be effective.

Chapter 5: Conclusion

The aim of this dissertation was to explore the effects of a sign language interpreter on the therapeutic relationship. In order to situate this work, international research in Deaf studies was considered, alongside Ireland's relevant statistics. Using Carl Roger's perspective on the therapeutic relationship, the effectiveness of the therapy was analysed through the discussion of potential implications of the intrusion. The research then examined the possible techniques that could be applied in order to reduce destructive effects within the process.

It was found that language is essential in therapy, particularly for a Deaf person who may have suffered lifelong experiences of misunderstanding. The option of oralism was considered, however it was noted that there may be negative consequences for this choice due to the history of oppression endured by the Deaf community. The research continued by looking favourably upon the use of a Deaf therapist who would be capable of sharing amongst the culture of the client. However, issues of confidentiality and familiarity were raised due to the small size of Ireland's Deaf community. Further complications were noted when this option seemed currently impossible due to a lack of Deaf psychotherapists in Ireland. While it was highlighted as not the most optimal of choice, it was found that a sign language interpreter was deemed the most realistic option. Their role as a conduit of language was discussed, understanding that they are professionals who are brought in to bridge the gap of communication between the hearing therapist and their Deaf client.

The interpreter was identified as the necessary evil due to the fact that they are important for the interaction, but bring with them many potential implications. It was established that while working in the mental health domain, interpreters are not simply conduits of language. Their linguistic choices and own unconscious processes were found to have potential implications on the accuracy of translation. As a result of this, the therapists perception of the Deaf client risks being skewed, thus hindering basic levels of psychological contact and and impeding the provision of conditions such as empathy and congruence. Furthermore, the altering of the dyadic relationship into a triadic one was

found to arouse unconscious defences amongst all parties, leading to power struggles, coalitions and feelings of mistrust. Ignorance of these defences were seen to cause ruptures within the relationships, ultimately leading to a potential breakdown of the therapeutic relationship between therapist and client.

In order to reduce these destructive effects, the research discussed precautions that can be implemented in order to ensure successful execution of the therapeutic relationship while using an interpreter. Translation inaccuracies and interpreter qualification and training levels were examined and it was concluded that the therapist can avoid certain implications by ensuring a minimum standard through an upcoming accreditation register. However, a significant gap was idenitified in the provision of training for ISL interpreters working in mental health domains. The effect of the therapist's own awareness was then explored, noting that in order to be receptive of all elements of the process and achieve true congruence with their client, they too require a level of Deaf cultural knowledge. In terms of the destructive effects of the triad, professional collaboration between the therapist and interpreter was found to be effective. This included an initial clarification of roles, agreed methods around misunderstandings, as well as a maintained closeness throughout the duration of the sessions. Client and Interpreter boundaries were also noted to be effective in reducing concerns of closeness or coalition, suggesting that these can be implemented through emphasis of interpreter ethics and agreements regarding external interactions.

This research gives hope for effectiveness of therapy through the use of an interpreter, providing all participants understand the potential implications. However, future research would be beneficial in truly understanding these effects on a national level. Ireland has yet to ask its therapists, interpreters, or Deaf community of their personal experiences when engaging in this type of process, which has left a huge gap in knowledge around the procedures that take place in this country and how effective they are. This area that has been neglected thus far, holds the potential to provide deeper insights into the quality of mental health services that are being provided to the Deaf community of Ireland.

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Appendices

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