A MARRIAGE OF NECESSITY (IF NOT ALWAYS AFFECTION): SIGN LANGUAGE INTERPRETING IN MENTAL HEALTH SETTINGS

Working through an interpreter requires a willingness to be flexible on the part of the clinician. Questions may have to be altered, clarified or even discarded in order to reflect linguistic differences between ASL (American Sign Language) and English and cultural differences between Deaf and Hearing cultures. The following suggestions are intended to assist the clinician in this process.

1) It is the responsibility of the clinician (or the agency) to arrange for the interpreter services. This includes identifying a qualified interpreter, coordinating schedules and paying for the interpreter fees (Typical fees are $30.00 - $60.00 an hour, plus expenses). Family members are not appropriate to use as interpreters, regardless of how well they can sign.

2) Sign language interpreters, while knowledgeable in sign language and cross-cultural relationships are not experts in either mental health or Deaf culture. They are not trained to render opinions about a patient's mental status although they can give information about the client's use of language.

3) Clinicians should allow about ten-fifteen minutes before and after the interview to meet with the interpreter and discuss specific language questions or issues related to the interview. This may include specific testing materials or language use information which was observed by the interpreter during the interview.

4) Direct your comments to the client, not the interpreter. Interpreters are bound by the Registry of Interpreters for the Deaf Code of Ethics and will interpret all statements and questions, including phone conversations and comments to other staff.

5) The clinician should introduce him/herself and the interpreter at the beginning of the interview. The interpreter should be seated slightly behind and next to the clinician so the client can maintain eye contact with the clinician (and vice versa) while watching the interpreter.

6) Facial expressions, posture and gestures are all a crucial part of ASL grammar and caution is needed in drawing diagnostic impressions. In addition written English may reflect unusual grammatical structure or poverty of content. Absent knowledge that the client does have fluency in English, this should not be considered clinically significant.

Working with Deaf clients can present an exciting (and frustrating) opportunity for the clinician. The clinician willing to take the opportunity to learn about the Deaf community, language and culture can gain new perspectives and insights not only into their work with Deaf clients but also in their general practice.