Intersectionality: Mental Health Interpreters and Clinicians or Finding the “sweet spot” in therapy

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ABSTRACT
This paper examines the complex and multiple contributions that the mental health clinician, sign language interpreter and Deaf client bring to the mental health context. Building on D-C schema, the author proposes a theoretical framework for understanding the intersection of these factors and the influence on mental health outcomes.

KEYWORDS
Mental health, interpreters, deafness

Introduction

Sign language interpreters and clinicians working in mental health settings face a unique challenge requiring a mutually specific skill set. Interpreters must master linguistic considerations, contextual dynamics, inter and intrapersonal dynamics. Mental health clinicians must master mental health knowledge (i.e. assessment, diagnosis, and treatment interventions), contextual dimensions and interpersonal dynamics. These specific skills must be independently well developed and the interpreter and clinician must also establish an effective relationship to maximize therapeutic effectiveness with the Deaf client.

To many professionals, this type of work appears daunting and they may feel uncertain of best practices. Some clinicians believe that the presence of an interpreter is all that is needed without any adjustment of their own perceptions or behaviours. This type of dated thinking reflects the belief that if everybody performs their own duties no harm shall occur (however, just as importantly, no positive change may be realized) and therefore both professionals work independently of each other. Others currently working in the field may feel “they are a good team” yet have no real understanding why it works and finally, others may realize that more specialized training is needed and attend specialized training programs such as the Mental Health Interpreter Training (MHIT) through...
the Alabama Department of Mental Health, USA. Clearly there are a growing number of sign language mental health interpreters and mental health clinicians who are recognizing the need for and seeking out training venues where these issues can be fully explored and discussed. This paper is for all the following:

- those afraid of doing mental health work with Deaf clients, this paper offers a theoretical base to better understand the dynamics underlying such work;
- those who feel that their role in mental health work is to execute their skill set in isolation, this paper challenges those beliefs providing an alternative way to conceptualize this work,
- those who are currently working well in partnership, this paper offers a theoretical understanding of why and how excellence is both attained and maintained
- and, finally, those who have sought training and want to continue to develop a deeper knowledge base, this paper builds on the current literature in both theory and practice.

**Demand-Control Theory**

The original occupational research by Karasek\(^1\) further developed with Theorell\(^2\) theorized that an individual’s perceived range of control over their environmental situation was a crucial dimension in determining work satisfaction and effectiveness as well as the motivating factor for active behaviour/learning. Specifically, Karasek & Theorell proposed that jobs combining high demands and low control (i.e., high strain jobs) were considered the worst job context for a worker in terms of health/effectiveness. Alternatively, jobs combining high (but not overwhelming) demands as well as high control (i.e., active jobs) enabled individuals to have some latitude or margin regarding how and when to deal with current and new challenges. This combination of high demands/high control facilitated active behaviour in workers, motivated new learning and fostered a sense of mastery, and self-efficacy\(^2,3\). For example, occupations such as firefighter or medical physician are often generally considered to be high-stress jobs. However, these types of occupations as understood within Theorell & Karaseks’ work\(^1\) might not be associated with high rates of stress-related illness if the workers have adequate resources (i.e., education, adequate equipment/materials, related experience, emotional support, and flexibility in decision making) to do their work despite significant job demands. In contrast, when workers in occupations where they are restricted in their response to high demand job situations (i.e., when they had few controls), stress-related illnesses, job dissatisfaction and worker ineffectiveness are at their highest levels.

**Demand-Control Schema**

Dean and Pollard\(^4\) adapted Karasek & Theorell’s\(^2\) demand-control concept (D-C theory) to better understand the nature of demands and controls within the sign language interpreting profession. The following is a brief summary of their work and the interested reader is encouraged to read the following articles for a more thorough understanding\(^4,10\). Generally, Dean & Pollard proposed that, based on D-C theory, interpreters experience four different categories of job demands: Environmental demands, Interpersonal demands, Paralinguistic demands, and Intrapersonal demands (referred to as EIPI). Environmental demands are interpreting challenges specific to the actual assignment setting (i.e., general nature of the assignment, physical setting such as seating, sight lines, background noise, room temperature, odours, and lighting quality). Interpersonal demands are interpreting challenges specific to the interactions of the consumers and the interpreter (i.e., understanding by all parties of the interpreter’s role, adherence to expected norms, the need to understand and mediate cultural differences, power differences and dynamics, differences in fund of information, and communication control such as turn-taking). Paralinguistic demands are interpreting challenges specific to the expressive communications or the clarity of the actual communicative interactions that the interpreter sees and hears (i.e. heavy accents, voice volume and speed, mumbling, lazy signing styles, dysfluency). Finally, intrapersonal demands are interpreting challenges specific to the internal physiological or psychological state of the interpreter (i.e. the need to tolerate hunger, pain, fatigue, or distracting thoughts or feelings, liability concerns, availability of supervision and support, vicarious reactions).

Within the original Demand-Control theory, Karasek & Theorell\(^2\) proposed the concept of controls to meet demands. Dean and Pollard's D-C schema modified this concept proposing that interpreters respond to the specific demands of the interpreting job with controls. Controls are specific skills, decisions, or other resources available to (or learned by) the interpreter. Controls for interpreters may include constructs such as education, experience, degree of preparation for an assignment, and translation decisions, (e.g., specific word or sign choices or explanatory comments to consumers). There is a temporal nature as to when the interpreter elects to use controls. For example, prior to the assignment, the interpreter has
controls such as education, language fluency, and assignment preparation. During the assignment, the interpreter has potential controls such as translation decisions and post-assignment controls consist of follow-up feedback, emotional support, supervision, and continuing education. Dean & Pollard clarify that their use of the term “control” is as a noun, not a verb, and is preferably referred to as control options as opposed to taking control over a situation. It is not an absolute that control options will always be effective in meeting demands. It is this analysis of the effectiveness and consequences of how an interpreter chooses to respond (or not respond) to a given demand that highlights the use of D-C schema theory during teaching, supervision, workshop or individual self-critiques of interpreting work.

Within a mental health context, interpreters must consider the following:

- Technical skills of two languages (spoken and signed)
- Knowledge of linguistic features (i.e. Vocabulary, sign/word choice)
- Cultural knowledge
- Professional judgment skills
- Experience (or lack of it)
- EIPI interpreting job demands (environmental, interpersonal, paralinguistic, and intrapersonal)
- Interpreting controls (i.e. responses to the job demands)

**Mental Health Clinicians**

Hearing clinicians working with Deaf patients are a diverse group of professionals including psychiatrists, clinical psychologists, psychiatric nurses, social workers, therapists and counselors. Training in mental health seldom includes dedicated learning related to working with Deaf clients and as such many clinicians may feel ill prepared to work in this setting. This lack of training/knowledge likely contributes to clinicians’ reluctance or uncertainty of working with Deaf clients, clinicians working with Deaf clients but failing to recognize that there are indeed differences when working with a sign language interpreter, clinicians feeling frustrated with inadequate progress or change in their Deaf patients, and lastly clinicians working with sign language interpreters successfully yet never really understanding the dynamics contributing to the changes seen in the Deaf client.

Schlesinger & Meadows (1972) used the term “shock-withdrawal-paralysis” to describe the response of some hearing professionals when confronted with Deaf people. Given the hearing professionals are not able to communicate with their voice as per usual, they begin to experience feelings of discomfort and panic. These uncomfortable feelings escalate until the professional begins to withdraw from the deaf person and/or the situation without trying other strategies to communicate effectively. It is evident that this type of reaction precludes clinicians from maximizing their skill set and ultimately affects the efficacy of service. Interested readers are encouraged to read Pollard’s empirical study supporting this concept of shock-withdrawal-paralysis.

All clinicians should have a general knowledge of mental health and each clinician needs to function within their scope of practice. For example, clinical psychologists and psychiatrists are the only mental health professionals in Canada that are licensed to diagnose mental health disorders and medical physicians are the only professionals in Canada licensed to prescribe psychotropic medications. Clinical psychologists have a unique knowledge base in the administration and interpretation of psychological tests (i.e. intelligence, personality, brain functioning etc.) whereas social workers have a unique knowledge base in the provision of services to not only support change in the individual but also within the individual’s social or work environment.

Working with Deaf clients within a mental health context definitely requires specialized knowledge similar to working with any other special population such as pediatrics or geriatrics. Within the field of deafness there are key constructs that are critical to mental health. One important construct for the clinical worker to understand is the etiology of the deafness as this may influence both the development and outcomes of psychological disorders. For example, meningitis in the early years of childhood may result in both deafness and learning disorders. Another important construct is the early acquisition of an accessible language. When language is not successfully acquired within the critical stage of childhood brain development, the clinician and interpreter may be working with a deaf client who presents with language delays or dysfluency (oral and signed). Language dysfluency may be present in oral deaf persons such as peculiarities with their spoken language or in culturally Deaf persons as evidenced by peculiarities with their signed language with tremendous implications for mental health. A third construct is the worldview of the Deaf client or cultural orientation. Individuals who consider themselves culturally Deaf who use a signed language with a history of Deaf social mores and traditions differ from those who may consider their deafness to be a medical deficit and disability. This difference in client worldview is an important construct for the clinician to understand in
terms of the client-therapist relationship. And finally, deaf individuals are more vulnerable to the development of some mental disorders related to issues of isolation, loneliness, unemployment, lack of family and community support, and literacy issues. Interested readers are referred to the following sources for specific knowledge related to the mental health of Deaf children and adults.14-20

Adapting Dean & Pollard’s D-C schema to clinicians suggests that mental health clinicians face clinical demands rather than interpreting demands when working with Deaf clients. These include Environmental demands, Interpersonal demands, Continuum of care (rather than paralinguistic demands facing interpreters), and Intrapersonal demands (referred to as EICI). Environmental demands are similar to the interpreting environmental challenges and are specific to the actual assignment setting (general nature of the assignment, physical setting such as seating, maintaining eye contact with the Deaf client rather than the interpreter). Interpersonal demands are also somewhat similar to the interpreting challenges and are specific to the interactions of the consumers and the clinician (thorough understanding by all parties of the clinician’s role and scope of practice, the need to understand and mediate cultural differences, power differences and dynamics, differences in fund of information, and communication control such as turn-taking). Instead of paralinguistic demands, mental health clinicians face challenges specific to the continuum of mental health care. This refers to the wide range of comprehensive services necessary for competent care (i.e. assessment, diagnosis, therapy, counselling) and related issues such as the validity of commonly used mental health tests in sign language, lack of standardized norms, and unfamiliarity with clinical presentations such as auditory hallucinations in psychosis. Finally, intrapersonal demands are again similar to the interpreting challenges specific to the internal physiological or psychological state of the clinician. These may include liability concerns, availability of supervision and support, vicarious reactions, distracting feelings and internal thought such as “does the Deaf patient really understand what I am saying?” or “Does the Deaf client have more of a relationship with the interpreter than me?”

The mental health clinician, similar to the interpreter, has a variety of controls that may be used to meet the clinical demands. Controls for mental health clinicians may include constructs such as educational level, availability of supervision, peer feedback and support, degree of specialization in a particular area, continuing education, experience and formal support from a licensing regulatory body. Similar to the interpreter, there is also a temporal nature regarding when the clinician elects to use these controls.

Within a mental health context working with Deaf clients and interpreters, clinicians must consider the following:

- Technical skills within individual scope of mental health practice
- Knowledge of mental health (i.e. etiology, definitions, assessment, treatment interventions)
- Cultural knowledge
- Professional judgment skills
- Experience (or lack of it)
- EICI clinical job demands (i.e. environmental, interpersonal, continuum of care, and intrapersonal)

**Deaf Clients**

The Deaf client brings a number of considerations to the mental health context. Firstly, there is the presenting mental health issue that is the reason for the meeting. Mental health issues may present differently in Deaf clients than in hearing clients. For example, a hearing adult presenting with depression may show a slowed or dulled affect as reflected in their speech patterns as evidenced by slowed speech, fewer facial expressions, or fewer utterances. A Deaf adult presenting with depression, however, may appear to the hearing clinician as quite animated and engaged in the signed conversation leading the clinician to dismiss depression as a possibility. However, that animation may be a direct function of the signed language rather than a true expression of the patient’s state of mind. A thorough understanding of the differences in clinical presentation of symptoms in Deaf patients is essential to an accurate diagnosis and treatment plan. In addition, the clinician needs specialized knowledge of which assessment tool to use and how to properly use it. For example, Pollard5 outlines the appropriate use of the Mental Status Exam with Deaf patients and Chovaz21 discusses the importance of cultural and linguistically appropriate assessment of Deaf children with Tourette’s Disorder.

Secondly, there is the consideration of possible language delays, deprivation or dysfluency that will directly impact upon the mental health dialogue. In some instances with significant language issues, the interpreter may recommend the use of a Deaf interpreter (DI) who may be better able to both receptively and expressively communicate with the Deaf patient. This, however, introduces yet another member into the “therapeutic dyad” meaning the clinician needs to consider the implication of this and how best to manage it.

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Thirdly, the clinician must be mindful of the possibility that the Deaf person may have prior negative experiences in physical or mental health care settings. This may change the dynamics introducing mistrust, confusion or hostility towards the clinician. Alternatively, this may be the Deaf person’s first time accessing health care, given the logistics and deterrents present in navigating through a hearing system. To that end, there may be considerable uncertainty regarding the purpose for the meeting, terminology, and expected roles. In some cases Deaf individuals may not be aware of their own family medical or psychiatric history given the language differences that exist between some hearing parents and their deaf children.

And lastly, clinicians need to be astute in separating cognition from language deprivation, restricted experiences, and limited opportunities for a typically developed fund of information. Past residential school experiences, limited language exposure, and minimal opportunities for incidental learning may all combine to result in mistaken clinical presentations of lowered cognitive ability.

Deaf clients bring a number of factors to the mental health setting including:

- Mental Health Issues
- Language fluency
- Dysfluency
- Language deprivation
- Fund of Information
- Affect
- Orientation
- General cognition
- Psychosis
- Past experiences

The Triad

Trainees in mental health usually learn about the therapeutic dyad. A therapeutic dyad refers to a clinician and a client in an interactional type of situation within a mental health context. Much has been written about the importance of the therapist-client relationship yet what happens when this becomes a triad? How do two professions, each with their own set of demands and controls, work within the mental health context of their Deaf client? How does each professional maximize their own unique, separate and specialized tools yet still respect and acknowledge the contributions the Deaf client brings to the triad? How can professional goals be mutually supportive yet still true to their own scope of practice? This paper proposes that the skill sets and perspectives of both professions will be best understood and utilized within a formal, integrated set of principles or theory. It is only within such a unifying theoretical framework that both professions can explain and teach about phenomena such as interpreter and clinician demands and controls. Use of a theoretical framework provides both professions with a systematic and rigorous way to conceptualize, operationalize and measure salient constructs integral to the goals of the mental health context.

Intersectionality Theory

The mental health care system should be concerned with potential sources of inequities such as race/ethnicity, age, disability, gender, political views, and social identities. To be truly effective though the mental health care system should go beyond just awareness of these dynamics and in fact critically understand the effects of these variables on the overall outcomes of therapy. This, however, has proven to be difficult with issues of how to define, measure and operationalize these constructs.

In the past, most theorists made the mistake of examining only one variable at a time rather than the matrix effects of social categories. For example, in the 1980’s the feminist work was challenged for its predominant focus on gender as the single point of inequality. At that time, critical race theorists examining society and culture specifically within the intersection of race/ethnicity, education, law, and power proposed that it was not just gender alone that was the root of all inequality for women. Feminist and critical race theorists then developed analytic approaches in attempts to better understand the effects of these multiple variables of social membership. This line of thinking eventually produced intersectionality theory with the basic premise that individual human variables work in groups rather than in isolation. The central argument in intersectionality theory is that it is the intersection itself that causes or produces the actual inequity or oppression and that furthermore one cannot truly understand the dynamics through the study of only individual variables.

There is value in re-examining the complex interplay of factors inherent in the demands/controls of the ASL mental health interpreter and the mental health clinician within the framework of intersectionality theory. The first point of intersection is usually when the interpreter meets the Deaf client. This often takes place in the clinician’s waiting room. At this initial intersection some level of interaction often occurs as both individuals share a signed language. This can be beneficial as the interpreter then is given an opportunity to assess particular demands and plan for specific controls. For example, at that initial intersection the interpreter may realize that the Deaf client
has significant language dysfluency that may require a different language register. However, this initial intersection can also be problematic if the Deaf client begins to share their reason for the mental health visit or perhaps even more worrisome if he/she engages in a description of symptoms. This is a demand that if not met with a successful control may jeopardize the actual mental health appointment, create significant discomfort within the interpreter and cross over professional lines of competence. In addition, given the relative small Deaf community in most cities, the interpreter and Deaf individual may have met or worked together before. This maybe advantageous in terms of familiarity, yet also may result in a demand in terms of bias relative to their shared history. Recognizing that this point of intersection may trigger some concerns has prompted some clinicians to provide different entry doors for the interpreter and client.

The second point of intersection usually takes place when the clinician brings the interpreter and Deaf client into the case room, or arrives in the room where they are waiting. At this point, the interpreter and the clinician are the individuals who share a language and usually some form of communication ensues. This again may be advantageous as it allows the interpreter and clinician to assess mutual demands and controls. However, this may be detrimental if it occurs in front of the Deaf client as it may be perceived wrongly (i.e. they are talking about me) or it may be done hurriedly so as not to detract time from the actual appointment. It is likely more helpful if this intersection took place at a different time/date or alternatively in a physically different location from the Deaf client and be built into a lengthened time slot.

The third intersection takes place when the clinician meets the Deaf client. At this point in time, the demands experienced by clinicians may vary. The inexperienced clinician may feel nervous about the dynamics and only make eye contact with the interpreter using phrases such as “tell her....” rather than engaging in direct interaction with the Deaf client. It is also at this third intersection that the clinician who has learned a little bit of sign language may attempt to use rudimentary signs. Although most Deaf patients welcome any degree of sign from the clinician while continuing to rely on the interpreter, this point of intersection needs to be sorted out to avoid communication confusion. Other demands may include clinicians feeling unsure that the Deaf client is really understanding the message (an intrapersonal demand) and starting to use their own voice louder and more emphatically (an ineffective control option).

The degree of overlap with the first, second and third points of intersections will vary according to individual and situation. It is essential that the clinician and interpreter be aware of demands and respond proactively with controls at these points of intersection. This paper, however, proposes that it is actually the complex intersection itself of clinician, interpreter and Deaf client (and all the multiple variables contributed by all three individuals) where the richest therapeutic change will occur. This critical intersection (see Figure 1) or sweet spot of therapy potentially (and hopefully) occurs in every mental health meeting or interview although it is perhaps not recognized as the most important intersection. It is here where change is enabled, inequities happen or oppression occurs. This critical meeting of so many constructs exemplifies intersectionality theory as it is suggested that it is the intercommunication of these variables that may significantly influence mental health outcomes.

**Figure 1. Critical Intersection – Sweet spot of therapy**

For example, the Deaf client may present with a moderate depression. The clinician may be very knowledgeable about cognitive behavioural strategies to change distorted thought patterns contributing to depression. The interpreter may be very adept in the technical skills of interpreting between a spoken and signed language. Despite all this, why does the experienced clinician feel so frustrated? Why does the normally technically savvy interpreter feel like she is inept? And most importantly, why is there no improvement in depressive symptoms in the Deaf client? Rather than throw the baby out with the bathwater, the theoretical principles of intersectionality would suggest that the clinician and interpreter singly and mutually consider and define the contributions each bring to the mental health context with particular attention to the synergy that results at the point of intersection.

As professionals we are at the point where intersectionality theory moves beyond faulty thinking or inadequate understanding (“we just work well together”) by facilitating both professions to operationalize, evaluate and improve upon the process of their work as well as the
outcomes. Although this paper provides a framework for understanding the complex interplay of factors that results from the many different variables inherent in the mental health triad, the real challenge is for future clinicians, interpreters and researchers to better operationalize these variables so we can truly measure and thus improve outcomes. With a growing emphasis on evidence-based health practices, there is an increasing urgency for empirical research to underpin and legitimize diverse practices with scientifically produced knowledge and data.

References
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