Diversity in Deaf Mental Health: Developing Clinician-Interpreter-Client Teamwork

Kathleen S. Friedman, LCSW, CSC
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Educational Learning Objectives

Participants will be able to identify:

• Interpreter-clinician-client teamwork - roles, controls, strengths, challenges
• Demand sources interpreted mental health settings
• Efficacy of interpreted communication/services
• Differences in spoken/signed interpreted services
• Theory/practice demonstrations - case study/role play
The purpose of this position statement is to acknowledge and emphasize the importance and need for direct communication, sensitivity to cultural affiliation, and sensitivity to the psychosocial impact of hearing loss in the delivery of mental health ... services to people who are deaf, hard of hearing, late deafened and deaf-blind...
NAD recommends:
for estimated 28,000,000 individuals w/hearing loss in U.S.:

• Mental health services should be provided using culturally, linguistically affirmative approaches
• Should be referred to specially trained providers when/where possible
• Positive therapeutic process includes facilitating the acceptance of hearing loss as integral, potentially valued part of individual; understanding, respecting communication choice, family needs...

https://www.nad.org/about-us/position-statements/position-statement-on-mental-health-services/
Culturally and linguistically competent provider skills include ability to...

- Communicate directly with deaf/hard of hearing individuals, frequently requiring fluency in American Sign Language, signed/visual communication systems
- Appropriately use services, adaptive technology as identified, used by consumer and family members, inc. qualified/certified interpreters, assistive listening devices, captioning services
- Awareness of cultural, linguistic differences, psychosocial impact associated with hearing loss

https://www.nad.org/about-us/position-statements/position-statement-on-mental-health-services/
Dyadic Systems View of Communication
Parent-Infant Social Interactions Framework

- Primary task – communication- understand messages of other – modify own action - meet needs of other
- “Getting into sync” process - person acts responsively to actions of others in communication
- Parent - greater range, control, behavioral flexibility
- Child’s functional development - first social (between people), then individual (inside child)
- Mutual recognition of entering into each other’s field of perception establishes system of communication

Foundations for Relating, Communicating, Thinking

• **Shared attention, regulation** - 0-3 months — calm interest in, purposeful responses to sights, sound, touch, movement, other sensory (looking, turning to sounds)

• **Engagement, relating** – 2-5 months – growing expressions of intimacy, relatedness (gleam in eye, joyful smiles initiated, sustained)

• **Purposeful emotional interactions** – 4-10 months- range of back/forth interactions, w/emotional expressions, sounds, hand gestures, etc., used to convey intentions

Foundations for Relating, Communicating, Thinking

• **Long chains of back/forth emotional signaling, shared problem solving (joint attention)** – 10-18 months – many social, emotional interactions in a row used for problem solving (showing parent a toy)

• **Creating ideas** -18-30 months – meaningful use of words, phrases; interactive pretend play w/caregivers, peers

• **Building bridges between ideas: logical thinking/connections between meaningful ideas** - 30-42 months ("Want to go outside because I want to play")

Demand-Control Theory: Application to Sign Language Interpreting

Demand-control theory – method of analyzing

• Occupational stress

• Reduction of stress-related illness, injury, burnout

High Control

<table>
<thead>
<tr>
<th>Low Control</th>
<th>High Control</th>
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<tr>
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- **IV Low Strain**
- **III Passive**
- **I Active**
- **II High-Strain**
Quick Guide to Working with Interpreters in Mental Health Settings

Clinician Responsibilities

• Aly with patient – speak in the first person
• Pre-post collaborative sessions with interpreter
• Identify communication/cultural differences/similarities
• Identify communication plan
• Maintain control of communication
• Register matching – source and target languages
• Check with patient for preferences
• Check with patient for understanding
• Check with patient/interpreter for pace
• Ask clarifying questions of patient
• Practice “teach back”
Clinical Teamwork Strategies/Controls

Pre-session briefings

• Appointment purpose; session goal
• Clinician familiarity - Deafness, interpreted sessions, patient(s)
• Interpreter familiarity – mental health processes, knowledge/understanding of the patient
• First session? Ongoing? who will be present
• Patient background – age, referral reason, language/communication used
• Symptom expectations- potential differential diagnoses

Clinical Teamwork Strategies

Post-session de-briefing
- Cultural, language issues presented, not expanded on during session
- Possible interpretations of language that could be understood differently
- Therapeutic-related questions about session
- Self-disclosure/vicarious trauma, effect on communication
- Questions, concerns clinician has re: session
- Issues regarding process – pace, turn-taking, etc.

Environmental Demand Sources

• Nature, setting of assignment
• Seating arrangements, sight lines
• Visual distractions, background noise
• Room temperature, odors, lighting quality

Intrapersonal Demand Sources

- Dynamic nature and intensity of event
- Transference and countertransference
- Vicarious reactions
- Safety concerns

Intrapersonal Demand Sources

• Physiological responses and distractions

• Doubts or questions re: performance

• Availability of supervision and support

• Anonymity, isolation, confidentiality

• Liability concerns

Interpersonal Demand Sources

• Power and authority dynamics

• Oppression, dishonesty, unfairness, etc.

• Communication control, e.g., turn-taking

Interpersonal Demand Sources

• Parties’ understanding of interpreter’s (each others’) role

• Parties’ adherence to expected role norms

• Communication directed to the interpreter

Linguistic Demand Sources

• Language and communication assessment

• Communication modality and language fluency

• Sign volume, speed, sign space

• Communication clarity

Demand- Control Example

- http://healthcareinterpreting.org/tag/asl-videos/
Case Study/Role Play

• Clinical settings of participants

• Nature of service provided

• Provider’s discipline
Bibliography


Bibliography


- http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf


- Miletic, T., Minas, H., Stolk, Y., Gabb, D, Klimidis, S., Piu, M., Stankovska, M., (2006), Improving the Quality of Mental Health Interpreting in Victoria, Victorian Transcultural Psychiatry Unit.


Bibliography

• http://www.ada.gov/2010_regs.htm

• http://www.lep.gov/13166/eo13166.html

• https://www.nad.org/about-us/position-statements/position-statement-on-mental-health-interpreting-services-with-people-who-are-deaf


• Piu, Marie (2006), Victorian Office of Multicultural Affairs; Mental Health Branch, Department of Human Services, Victoria, Australia