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

Steve Hamerdinger & Ben Karlin

Abstract

The use of sign language interpreters in mental health is a subject that has not received a great deal of attention in the literature in recent years. It is critical that interpreters be competent, but not much attention has been paid to other crit ical elements in the therapeutic triad, specifically what is required of clinicians in order to make therapy using interpreters work. This article explores some of those issues and makes specific recommendations regarding how it maximize effectiveness of this approach to bridging the gap between the need for mental health services and the supply of clinicians who are fluent in American Sign Language.

Introduction

In the past two years there has been a growing recognition of the needs of people who are severely and persistently mentally ill and who also have hearing loss. Two ground breaking publications from the National Association of State Mental Health Program Directors (NASMHPD) (See NASMHPD, 2002a and 2002b) have focused the attention of state level mental health authorities on the challenges of serving people who are deaf across both cultural and linguistic lines. This has, in turn, generated many questions as to whether or not interpreters are adequate for providing access. This question has been debated many times, and while an interesting theoretical discussion, does not change the reality that there are far fewer competent clinicians who are fluent in American Sign Language than there are people who need access to mental health services. So the question is not whether we should replace all the interpreters, but rather, how to do we modify the treatment to recognize and accommodate the inevitable intrusion of the interpreter on the process, and, how do we train and evaluate the qualifications of interpreters who work in mental health.

This article will examine several aspects of therapeutic work and attempt to address specific adjustments and accommodations that need to be made for work to be fruitful. Interpreter qualifications and training will be discussed, along with clinician characteristics that are

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necessary to make the work successful. We will present for consideration minimum competencies of interpreters working in mental health. We will also make recommendations for taking advantage of the current political atmosphere in order to get these competencies translated into standards which will help safeguard the right to linguistically appropriate services for people who are deaf.

Can therapeutic work happen with interpreters?

Specialists in the area of linguistic access are often asked if there can be meaningful work in a counseling session when the client and counselor must use a signed language or spoken language interpreter? In our view the answer is a qualified, "yes, but…" Much depends on what is meant by "meaningful work."

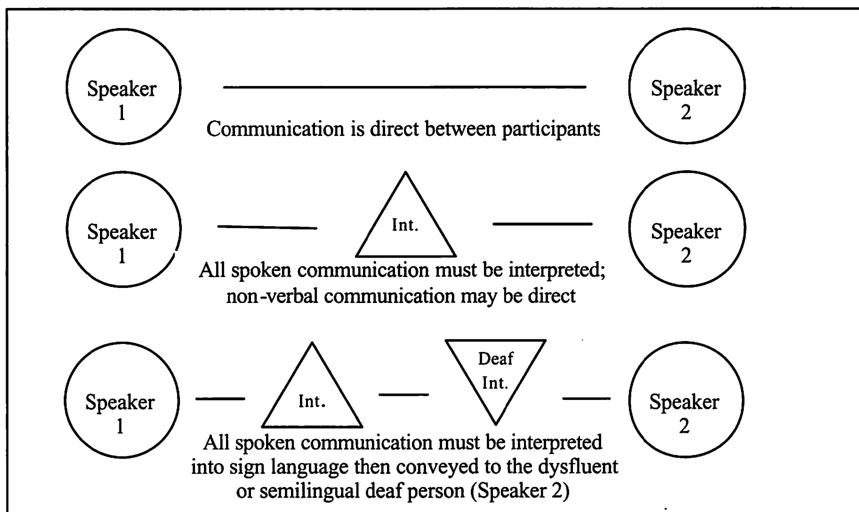
An interpreter is a professional who faithfully renders what has been said in one language into another language. (Bélanger, 2000) A translator works between the written, rather than spoken, forms of two languages. Thus, we can properly say that a deaf person may use a sign language interpreter or, more properly, an interpreter working between English and American Sign Language. A Hispanic person with limited English proficiency may use an interpreter working between Spanish and English.

A counseling session using an interpreter never produces the *same* work as is done when the therapist and the client use a common language. The Southern District Court in Florida ruled in *Tugg v. Towey* (1994) that providing mental health services through an interpreter is not equal to providing access to therapists who are fluent in a client's language. As a result, the court ordered the Florida Department of Health and Rehabilitation Services to provide services to Deaf patients using signing clinicians. While it is a wonderful goal to have all therapy done by clinicians fluent in American Sign Language, it is impossible to meet this goal any time in the near future. There are simply not enough clinicians able to sign fluently—or bilingual clinicians in other language pairs for that matter —in the United States. Clinicians using interpreters will continue to do much of the work of mental health therapy. Interpreters are, then, a "necessary evil" needed to allow people who are deaf access to mental health services in the foreseeable future. It is important, then, that mental health work using interpreters be addressed as a system issue if there is to be a reasonable expectation of being successful.

The special case of "deaf interpreters"

Questions sometimes arise concerning "deaf interpreters." The phrase, while itself straightforward in meaning, is often misunderstood as being the same as "interpreter for the deaf." Deaf interpreters are people who are themselves deaf. By virtue of native fluency in American Sign Language and training they are able to intervene with semilingual deaf persons, that is, those having minimal language skills or dysfluencies. The deaf interpreter relays messages to and from a secondary interpreter working between English and American Sign Language (See figure 1).

Figure 1. *Comparing monolingual conversation, discussion with an interpreter, and discussion including a Deaf interpreter*



Factors affecting the success of therapy with an interpreter present

The effectiveness of the work depends on a number of factors. The first factor to consider is the interpreter's competence. In order to produce equivalent renditions, the interpreter must be relatively fluent in both the source and target languages. While this seems like stating the obvious, there is a tendency to use interpreters with asymmetric levels of fluency. Put another way, most interpreters are considerably more skilled in one language than the other. We encounter situations where people with native skills in one language have only intermediate

or conversational skills in another and are pressed into service as *ad hoc* interpreters. These interpreters have difficulty producing equivalent renditions in either language because their levels of fluency are significantly unequal. (Maltby, 1999)

The second factor is the interpreter's understanding of the interpreting process. It is a common misconception that someone who "knows how to speak" a language is able to interpret. It is one thing to mentally formulate an expression in a second language and say it. It is quite another to listen to someone else's expression, mentally process its meaning and produce a rendition into a second language that preserves all the original nuance and intent. In simultaneous interpretation this processing must occur while listening to the next expression to be conveyed. In addition to learning the cognitive skills needed to do this, the interpreter also needs to be trained to self-monitor the tendency to "filter" information. Filtering distorts information in clinically significant ways. The major sources of distortion have been identified as deficient linguistic or interpreting skill; lack of knowledge and sophistication in mental health; and interpreter attitudes toward either clients or clinicians. (Marcos, 1979)

Because of the factors mentioned above, it is important for an interpreter to be trained to work in clinical settings. The Department of Justice defines a "qualified interpreter" for Deaf persons as "an interpreter who is able to interpret effectively, accurately, and impartially, *both receptively and expressively*, (emphasis ours) using any necessary specialized vocabulary" (U.S. Department of Justice Civil Rights Division A.D.A. Title III Technical Assistance Manual). The Department of Health and Human Services *Culturally and Linguistically Appropriate Services* (2001, pg 72) standards echoes this guideline for interpreters working with spoken languages. Interpreters must be trained to work in clinical settings and have some understanding of therapeutic processes in order to be called "qualified." The Missouri Department of Mental Health developed guidelines for the minimum competencies interpreters need to function effectively in mental health settings. These competencies are included as Appendix 2. The Alabama Department of Mental Health and Mental Retardation has gone one step further and codified these minimum competencies into what may be the first state standard defining what a qualified mental health interpreter must know. This standard may be found in Chapter 580 3 24 of the Code of Alabama.

In addition to having standards, there must be a mechanism in place to train interpreters to meet the standards. A model program, the

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Alabama Department of Mental Health and Mental Retardation's Mental Health Interpreter Training project, which was based on work pioneered in Missouri (Karlin and Clark, 1998), offers an annual 40-hour training session covering the competencies 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.

Factoring in clinician experience and competence

Assuming the interpreter is qualified to work in the clinical setting, the third factor influencing the process is the experience and skill of the therapist related to working with the interpreter. Therapeutic processes are very different when working through a third person rather than one-on-one with the client. These differences require the therapist to both know processes and appreciate what occurs in the session and to be willing to adjust for these differences. Michael Harvey (1982, 1989) has written extensively on making use of sign language interpreters in therapy sessions and explains some basic changes in approach that are necessary in order to make interpreted sessions effective. Therapists must be aware of, and alert for, culturally-embedded information (Glickman & Harvey, 1996). If therapists do not have a sophisticated level of cultural awareness or cross-cultural expertise, such information may be misunderstood as symptomatic or diagnostically significant.

Therapists are not always conscious that including an interpreter alters the nature of the patient-therapist relationship. There is no longer a dyad. There is a third person in the room bringing his or her psychological baggage into the session—baggage that may subtly influence interpretation (Temple, 2002). A skilled clinician teamed with a highly qualified interpreter continually monitors for such shading and skewing of the message. The difficulty lies when the therapist is not experienced in using interpreters and is unaware of the effect of the interpreter on the therapeutic relationship. Consideration of alliances becomes 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 therapist trust the interpreter and the interpretation? Being unprepared to deal with these dynamics will make the counselor's work less effective.

The presence of an interpreter creates opportunities for transference and counter transference that do not exist in dyads. In this respect, a skilled therapist using a highly qualified interpreter can do good work together—work that is not possible using any other approach.

Further, the presence of an interpreter, especially when the clinician is skilled in using interpreters, makes the "deaf/hearing" difference more figural (Harvey, 1989). By this we mean that the communication differences are brought to the fore, instead of remaining ignored in the background. Issues and problems caused by the failure to have effective communication in other settings can be dealt with up-front. Finally, it is a powerful and unspoken acknowledgment of acceptance of diversity when the interpreter is viewed as serving both the therapist and the client: "The interpreter is here for us" instead of "you use an interpreter."

The impact of culture and language on assessment

The effectiveness of therapy sometimes depends on the accuracy of the initial assessment done by the clinician. Research in cross-cultural counseling indicates that when there are cultural differences between a client and clinician, the quality of assessment is highly dependent on the clinician's general cultural competency (Sue, 1981, p. 27). Less clear is how an interpreter affects the assessment process when there are cultural and language differences. 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 the client's cultural norms. As discussed earlier, 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. If the relationship is inadequate, or the interpreter is not highly competent, the assessment is suspect. If, however, a highly competent interpreter, skilled in working in mental health, is teamed with a clinician who is comfortable with and knows how to make effective use of an interpreter, confidence in the assessment can be considerably higher.

On the other hand, if the clinician is not familiar with the culture of the client, expressions, mannerisms, and behaviors all can be misinterpreted. 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, cultures are not monolithic. Within every cultural group there are different strata. Values and communication styles are influenced by socio-economic, age, gender and religious differences. These differences all impact on such subtle things as word choices and conceptual constructs (Solomon, 1997). They also impact how the client presents to the therapist. People within the same language

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groups but different cultural groups may engage the therapist with eye contact, while others avoid it. Whether a person sits open or closed, near or far, casual or anxious may all be part of class and social differences, which are culture-bound. Non-verbal communication markers are often culturally embedded as well. Effective cross-cultural therapy relies on thorough understanding of these differences. To quote Ridley, *et al.* (1994),

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

Viewing deaf people within the context of their culture is at least as important as assuring linguistic access. Compared with people speaking, deaf people signing appear very animated and emotional. They use facial expression, body movement and other non-verbal markers to convey a great deal of linguistic information. "Flat affect" means something very different among people who are primarily users of ASL. The clinician who is not aware of what is normal when communicating with Deaf people runs a significant risk of over- or under-diagnosing. 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 frequently result in non-therapeutic outcomes. As did Ridley (1994), we can justly ask, "How can the therapist perceive what is abnormal until the normal is fully grasped?" (*Ibid.*)

Trusting clinical skills and judgment is problematic any time a therapist is working cross-culturally. It is particularly troublesome when there is a language barrier present as well (Sue, 1981, pp. 27, 32). Clinicians need to be cognizant of the various factors affecting their clinical judgment and weigh the impact of those factors before determining that their assessments are accurate. Some factors are intrinsic to the clinician; others are extrinsic. Some intrinsic factors include the level of cultural competence, experience working with people of the other culture, experience in working through interpreters, ability to sort out personal biases related to the other culture, and comfort with

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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.

Clinicians' perception of what is normal or abnormal is often shaped by factors of which they are unaware. Wright (1983, pp 32-39) explains how the *Spread Effect*—the power of a single attribute to invoke a list of characteristics—affects therapists' interactions with clients from different backgrounds. Typically, a negative attribute (as in the cases of deafness or the inability to speak English) will lead to negatively evaluating the client, whereas a positive attribute (affluence, attractiveness, or gender similarities, for example) tend to invoke more positive views of the client. The effect is subtle, unconscious, and insidious.

Unintentional bias like this occurs any time there is cross-cultural interaction. The literature is replete with examples of this with limited English proficient populations. A good treatment of this effect can be found in Kaufert (1997). Dickert (1988) conducted a study examining attitudes of professionals working in psychiatric settings regarding 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 general programs. What was surprising was that specialized staff still thought of deaf clients as more impaired than hearing clients in the same treatment setting (See also Freeman, 1989).

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

The therapist-interpreter team

Counselors and interpreters need to view themselves as a seamless team, together working toward specific therapeutic goals. This means that the therapist needs to see the interpreter as a colleague rather

than as an intrusion into the therapeutic relationship—a person, then, not a machine merely serving a communication function and having no other impact on therapy. While interpreters do not interject comments or opinions into their interpretation, they do have salient observations. This is particularly true of 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 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 is 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 clinical sessions. These pre- and post-conferences, discussed by Stansfield (1981) and Harvey (1989), have been elaborated upon by several other authors. The practice is now considered the norm for professional collaboration in most settings where interpreters work.

A pre-conference allows a therapist to brief the interpreter about therapeutic goals for that session and to give background information that may be necessary for accurate translation of concepts raised in therapy. The value of pre-conferencing is underscored by the example of social learning approaches to severely mentally ill patients in an inpatient setting. Removing all reinforcers for a client's targeted behavior may be used as a technique for extinguishing it. If the behavior is particularly bizarre, an uninformed or ill-prepared interpreter may wonder why it is being ignored. This can result in unintentional undermining of the intervention.

Debriefing after a session, or post-conferencing, allows the interpreter to share information 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 that did not rise to the level of obvious dysfluency but nonetheless was remarkable. Changes in affect, style, speed, changes in word choice or register—all represent things that few clinicians without special background experience or training would notice.

This close collaboration will surely be noticed by the client. It may give rise to questions of the interpreter's role; whether the interpreter and therapist are teamed against the client; whether the interpreter is

likely to spread client-related information in their shared community. These issues are emotionally laden. As such they are also clinically rich with therapeutic potential—if the clinician is able to skillfully make use of them.

Interpreters, however, are often surprised that these issues arise. They are trained to think of themselves as "neutral," having a non-participatory stance with regard to the interaction. We are beginning to understand that neutrality in interpreting is a myth. (A thorough treatment of this topic can be found in Metzger, 1999). In reality the interpreter is allied with either one participant or the other. In community interpreting assignments, this alliance is most often with the deaf person. Even in the medical setting, the alliance is usually skewed toward the person who is deaf. This skew is potentially inimical in a mental health setting. The client may split the interpreter and clinician, playing one off the other. There are issues of transference—and more importantly-counter transference. The interpreter may bring issues of codependence to the session. All of these can subtly undermine therapy. The only workable solution is for the clinician and interpreter to work together as a clinical team. Only in that case will the work move toward the specific therapeutic goals. It is critical that the alliance be between the interpreter and the clinician to be therapeutically productive. The consistent use of pre- and post-conferencing helps ensure this happens.

For therapy to be successful, the clinician must be able to assess progress. When working with a deaf client the inability to communicate directly with the client has significant impact on the clinician's ability to control the process of the work. Without an interpreter the counselor has minimal ability to assess the client's progress. With an interpreter, the clinician has to assess whether the progress shown is that of the client or the interpreter. That said, a skilled counselor who is experienced in using a qualified interpreter is in a better position to assess a client's progress in therapy than without the interpreter. There are three factors, however, that need to be addressed in considering the progress of clients who are deaf, or any client who has Limited English Proficiency (LEP), for that matter.

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 clients who are LEP are likely to be more severely impaired by mental illness at the point they come into treatment.

The second is that culture and language differences impact the time needed for clinicians to be sure of diagnosis and progress toward recovery. Again, we see this in healthcare services and clinical experience shows this to be true also in mental health services (NASMHPD, 2002b). The literature documents that more time is spent arriving at diagnoses and the testing done with patients with LEP takes longer than is spent with English-speaking patients (Kravitz *et al.*, 2000). This reflects the facts that doctors have no easy way to get confirmation of their hypotheses from patients with LEP, and that culture affects the manifestations of disease (Woloshin *et al.,* 1995). It requires no great stretch to see applicability of these findings to deaf people.

Finally, clinicians unfamiliar with a deaf client's culture and background will have more difficulty determining the client's baseline of function to know when there is progress toward recovery. We have already addressed the need for therapists to be open to and knowledgeable about their clients' cultures.

Confidentiality

Frequently questions arise as to how the introduction of an interpreter in a group setting changes the expectation of confidentiality and the interpreter's obligation to the members of the group. As there is ample literature regarding privilege in therapy and limits on confidentiality as applied to therapists, it does not bear in-depth treatment here. For the interpreter, however, various codes of ethics address 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.*

Often group therapy situations raise interesting conundrums. What is protected or privileged in groups can be very confusing for an interpreter. 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."* According to M. Johnston, Assistant General Counsel, Missouri Department of Mental Health, (personal communication on October 2, 2002), 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.

There are two exceptions to the general rule of confidentiality cited 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 licensure or ethics inquiry.

It is noteworthy that Missouri statute protects only interpreters working between people who are deaf and people who hear. (This same section of the statutes protects conversations transmitted through a dual-party telephone relay service. As a practical matter, conversations transmitted this way are, for all intents and purposes, totally confidential; relay centers do not log the contents of conversations and no record is keep other that what is needed for billing purposes.) Interpreters working in other language pairs do not enjoy the same level of protection in the law.

One final caveat is needed. The authors' experience with the confidentiality issues is limited to Alabama and Missouri. The statutes and regulations cited in this article are law in those respective states and have no bearing anywhere else. Further, the authors make no claim to legal expertise and offer no legal advice. As always, the reader is advised to seek counsel regarding laws applicable in their state.

Recommendations

So what, then, can we determine from what has been learned. We feel there are several specific things that can be implemented as broad policy initiatives that would have immediate and dramatic impact on the quality of mental health services being delivered through the use of interpreters.

First, state mental health authorities should adopt a formal guideline defining a qualified mental health interpreter. These guidelines

should have specific training and experiential expectations. Alabama code is an excellent model to follow.

Secondly, clinicians need to understand the dynamics of introducing an interpreter into the therapeutic process and need to have specific knowledge of the cultural background of the deaf client. Superficial awareness of cultural diversity is not enough to assure that the clinician can monitor the effects of the intrusion of an interpreter on the process. This, in turn, creates a need for formal training of clinicians in using interpreters when working with deaf people.

Thirdly, it must be recognized that the work done through an interpreter will be qualitatively different from the work done without an interpreter. This is not necessarily a bad thing, but all parties must recognize that it is happening and adjust treatment goals accordingly.

Finally, it is imperative that the clinician and interpreter view themselves as a team working collaboratively to achieve a specific therapeutic goal. Both professionals must consider themselves equals, allied together to accomplish what neither can do alone.

Conclusion

We have built on the base of published literature our own experiences, along with anecdotes from colleagues to present a framework for successfully providing mental health services through interpreters. This framework includes the need for culturally competent clinicians and qualified interpreters working cooperatively to provide these services when needed for deaf and other less English proficient individuals. We also assert that mental health authorities need to take an active role in defining what a qualified interpreter is.

It is our hope that this article will be of assistance in planning and delivering treatment that is effective for deaf patients. We believe that with the wise marshalling and directing of scant resources it is possible to successfully treat members of these underserved populations. We also believe, however, that consumers who are deaf deserve competent, not just adequate, mental health service.

Appendix A
Minimum Competencies for Interpreters in Mental Health Settings (Missouri Department of Mental Health)

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 Counter transference in the Interpreter
3.5.3. Familiarity with Transference to the Clinician or to the Interpreter

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