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Occupational Communication

Interpreting for Vocational Rehabilitation Consumers: An Emerging Specialty

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Abstract

This article discusses the role of an interpreter working with vocational rehabilitation consumers in an occupational context with or without a job coach. It describes the necessity of being flexible to the needs of the deaf person and the demands of the work environment. In this situation, the interpreter who takes into consideration the roles of other involved professionals will provide the most effective services to the consumer.

Introduction

You are interpreting for a deaf man who is a Vocational Rehabilitation (VR) consumer. His supervisor gives him a revised time sheet form. The consumer refuses your offers to interpret it, yet he clearly does not understand it all. After reading the consumer's completed form, the supervisor grumbles, "Why did HR hire someone who can't even read?" This situation presents a challenge to even the most seasoned interpreter.

Dilemmas such as this would be best handled by an interpreter who is familiar with the VR system and the variety of consumers VR serves. They can also be addressed by an occupational communication specialist (OCS), the title some Minnesotans have adopted to refer to a job coach who specializes in working with deaf and hard-of-hearing individuals[1]. This article reflects a successful model developed in Minnesota.

In the scenario above, you may be a freelance interpreter with or without an OCS present or you may be a staff interpreter/job coach. Unfortunately, the roles of the interpreter and the OCS are not always clearly distinguishable. They may dovetail, overlap and, ironically, even *conflict* with one another. By not exploring this relationship, we are

[1]Others in this role may be called employment specialists, employment assistants, job trainers, job mentors, job training-accommodation specialists, paraprofessionals, community liaisons, or communication consultants.

doing an injustice to consumers and may unknowingly jeopardize their employment. By understanding these roles, we can:

- Articulate the functions and boundaries of each role.
- Work more effectively with deaf and hard-of-hearing (DHH) consumers, the OCS, the VR system, and the employer.
- Add to our repertoire of marketable skills.
- Learn about some potential "slash" jobs.

To lay the groundwork for this discussion, some explanations of VR, VR consumers, and the OCS's role are in order.

The goal of the VR system is to help people whose disabilities present barriers to employment and teach them how to get and keep jobs. In this regard, the VR system is essentially an extension of the educational system. *In order to qualify for VR assistance, applicants must have demonstrated a need for more than interpreting services*. Not surprisingly, interpreters working with VR clients encounter role and ethical dilemmas shared by educational interpreters.

DHH VR consumers typically possess additional disabilities and/or face barriers which present unique challenges on the job. These may include: developmental and cognitive disabilities, mental illness, chemical dependency, physical disabilities, limited language, transportation and childcare issues, housing problems, financial concerns, and chronic illnesses. These factors sometimes call for a specialized approach to interpreting just as working with deaf-blind and other specialty groups requires adjustments to the traditional interpreting process. Nevertheless, even the most effective interpreting cannot attempt to meet these traditionally-underserved consumers' every need. For that, they need an OCS.

An OCS's mission is to make a job placement profitable for the consumer, employer, *and* co-workers. To plan and carry out effective services, an OCS should study a consumer's file from a holistic perspective, consult with colleagues, and ferret out existing and potential barriers. OCS functions may include: task analysis; intensive skill training for the DHH employee; communication training; revision of written materials to make them consumer-friendly; trouble-shooting and conflict resolution; development and implementation of appropriate accommodations and behavior modification techniques; employer negotiations; cultural mediation; counseling; report writing; hearing loss

awareness training; and teaching sign language to employees. This work is fascinating, rewarding, sometimes frustrating, and always challenging.

Although OCSes and interpreters both "facilitate communication", they facilitate it differently, which may cause confusion. Making things muddier is the fact that many OCSes fill multiple roles, one of which may be interpreting. However, standard practices, as RID advises, suggest that we *not* interpret *while* we are job coaching. Doing so results in inferior performance of both functions. OCSes may even be deaf or hard of hearing, which will affect communication strategies as well.

To the uninitiated, the communication process, as managed by an OCS, *may look like poor interpreting, when, in fact, it is not interpreting at all*. This parallels the roadblocks Deaf people have faced when uninformed people assume ASL is poor English. The communication process as handled by an interpreter may be likened to giving consumers a fish: The interpreter does the communicating *for* the consumers. As handled by an OCS, it is like *teaching participants how to fish*: The OCS teaches participants how to communicate as independently as possible. An OCS is an *active participant* in the interaction. This contrasts sharply with the interpreter's role. Realizing these distinctions may help reduce these discrepancies, ease the interpreting process, and assure issues are addressed appropriately.

The suggestions below should help the interpreter prepare for an assignment with a VR consumer.

- **Do not make assumptions.** Do not assume interpreting at a dishwashing job will be simple merely because the job itself may seem simple. The consumer and unique circumstances can complicate your work. For example, the consumer may have been repeatedly fired from past jobs for evangelizing. The OCS may or may not be at liberty to share this with you. This could make for a tense, difficult encounter and might raise sticky interpreting issues.
- **Gather background information.** Ask about communication preferences, other factors that might affect communication, the setting/topic, and the roles of others involved. If the OCS is deaf or hard of hearing, ask how to best accommodate his or her particular needs.

- **Clarify the OCS's goal.** Knowing the OCS's goal will guide your role as a team member. Examples:
  - ***OCS's GOAL:*** To teach consumers to communicate directly with one another.
    WHAT YOU MIGHT EXPECT: At some point the OCS will likely ask that you suspend your interpreting so s/he can assist consumers as they practice communicating directly with one another. The OCS should still make sure the DHH consumer knows everything that is happening, *but some of this may occur one-to-one when you are not there.*
  - ***OCS's GOAL:*** To mediate a dispute.
    WHAT YOU MIGHT EXPECT: To defuse a volatile situation, the OCS may interrupt, take the parties aside individually, and collect information necessary for reaching a resolution. The OCS may also take this opportunity to teach both consumers how language and cultural differences can lead to misunderstandings.
  - ***OCS's GOAL:*** To set behavioral expectations of the consumer and outline consequences for noncompliance.
    WHAT YOU MIGHT EXPECT: Perhaps the OCS and the employer have issued several warnings about unacceptable behaviors. Paradoxically, the OCS must advocate for *both* the DHH consumer *and* the employer and strive for a win-win situation. If a consumer is clearly incapable of performing a job despite appropriate accommodations and adequate training, the OCS must support–and sometimes even encourage–the supervisor to fire the client.

- **Know your boundaries.** You may be the only one present who can provide referral and resources. Regardless of your intentions, though, should you provide more than superficial advocacy you could be compromising the ongoing efforts of the VR counselor, OCS, employer, therapist, social worker, parole officer, and others who may be working with the consumer.

  If you are interpreting with an OCS present, the OCS is responsible for providing resources, guidance, and advocacy so you should remain entirely in the interpreter role.

- **Keep learning.** If possible, debrief with the OCS after the assignment to determine what did and did not work. Continue to learn as much as you can about the OCS's role and how it interacts with and affects yours.

Unfortunately, the OCS field is in its infancy, much as the field of interpreting was in the 1960's. Extensive training programs, national organizations, and a licensing body have yet to be established. OCSes are often drawn from the ranks of interpreters, because they already possess communication skills and understanding of hearing losses. But interpreting skills alone are not a prerequisite nor are they adequate for working as an OCS. It takes a myriad of skills and personal attributes to make an effective OCS–traits that deaf, hard of hearing, *or* hearing individuals may possess.

The more we learn about this field, the more complexities we discover, just as our understanding and appreciation of ASL and interpreting have grown over time. If you relish variety, appreciate the rich tapestry of human nature, and are energized by a good challenge, interpreting for VR consumers may appeal to you. By continuing to learn about and respect each of the roles, we will be advancing both the interpreting and OCS professions, increasing our job opportunities, and opening more employment doors for deaf and hard-of-hearing consumers.

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Book Review

Mental Health Care of Deaf People: A Culturally Affirmative Approach

Neil Glickman and Sanjay Gulati (2003)

Lawrence Erlbaum Assoc.

In 1955 Franz Kallman opened the first psychiatric treatment unit for the deaf at the New York State Psychiatric Institute. Along with fellow psychiatrists John Rainer and Ken Altshuler, and psychologist Hans Furth, this pioneering program opened the door to specialty mental health services for deaf people. It was followed by Luther Robinson's program at St. Elizabeth's Hospital in Washington D.C. in 1963, and by the program co-founded by MacCay Vernon, Roy Grinker and Eugene Mindel at Reese Hospital in Chicago in 1966. These programs, along with the San Francisco Center on Deafness, established by Hilde Schlesinger and Kay Meadow in 1966, collectively produced most of the published work on mental health and deafness over the next decade. While unquestionably moving the field forward, it was nevertheless troubling that the pervasive view was that deaf people were prone to mental illness by virtue of their deafness. Surdophrenia was not an uncommon diagnosis of the time.

In 1972 Hilde Schlesinger and Katherine Meadow published *Sound and Sign*, perhaps the first scholarly book to propose that there was a cultural element to providing mental health services to the deaf. Meanwhile, Dr. Alan Sussman was making a reputation for himself by treating patients with mental illness from the radical (for the time) construct that their mental illness was not caused by deafness. In 1977 he likened himself to "a voice in the wilderness" because the concept of mental health services geared to the deaf was so new, so radical, that is was outside the ability of many people to conceptualize anything remotely approaching "culturally and linguistically appropriate services. He argued that failure of therapy said more about the clinician's clinical skills than about the deaf person.

Over the years the delivery of mental health services to people who are deaf morphed into something that more closely approximates the outcomes that hearing consumer's experience. Things picked up speed

in the 1980s beginning with the evolution of services in New York culminating with the establishment of the deaf program at the Fountain House, one of the first psycho-social rehabilitation programs to take a cultural view of deaf people. This was followed closely by the Thresholds project in Chicago. At the same time, Michael Harvey was challenging previous conceptions of systems therapy and proffered a therapeutic approach that normalized deafness, per se, within the parameters of social systems.

Around this time a new voice emerged on the scene, a voice that later would take the cultural view of deafness to new levels of understanding and application. Drawing from his own experiences, Neil Glickman formulated what he calls a "culturally affirmative" approach to mental health service. After publishing numerous articles and authoring several book chapters, Glickman teamed up with Michael Harvey to edit the essential *Culturally Affirmative Psychotherapy with Deaf Persons* (Lawrence Erlbaum Associates, Publishers, 1996). Critically acclaimed, this book became an instant addition to the knowledgeable deafness professional's "must have" list.

When rumors that Dr. Glickman was working on a follow up that would be even more practical in orientation there was palpable excitement. If this book was anything like the previous volume, it would be a winner. We are not disappointed. With the publication of *Mental Health Care of Deaf People,* Glickman and his collaborator, Dr. Sanjay Gulati, have written an indispensable follow up to Glickman and Harvey's seminal work. Clearly written, thoughtfully laid out, and chock-full of helpful, practical ideas that work in the real world.

What sets this volume apart from its predecessor is the practicability of information. Where the older volume was more theoretical, this vital new work presents clear and practical suggestions for how to provide services. Of particular note is coinage of the phrase "psychologically unsophisticated" deaf persons. This term is given to individuals we think of under various other labels - none of them very positive - such as "low-functioning," "minimal language skills," and the frustratingly tenebrous "traditionally underserved." Far from being offensive, we find the term to be quite descriptive, if perhaps a bit disconcerting, to the layman.

In fact, more than any other volumes we have reviewed to date, Glickman and Gulati have provided concrete suggestions for working with alingual or dysfluent deaf people. Using case studies to illustrate tried and proven techniques, they lay out ways to provide affirmative

treatment to the most reticent and treatment resistant people in our service.

Specialty services are not neglected in this volume either. Substance abuse is addressed by the ubiquitous team of Guthman and Sandberg, and, delightfully, children's programming is addressed by Vreeland and Tourahgeau. The addition of a chapter on sexual offenders by Lemere is a welcome contribution as well.

Gulati discusses his experiences as a deaf clinician in the epilogue. His insights are valuable to the reader both for his forthrightness and for his particular perspective as a late-deafened psychiatrist. This is sure to be a thought-provoking chapter and, one hopes, the source of many coffee-klatch conversations when other deaf professionals gather.

As vital as all of the preceding is, in our opinion the most practical thing in the book is Krajnak's "Skill Cards" on the enclosed CD ROM. For anyone who has ever longed for a better way to communicate with dysfluent deaf people, this tool is manna. Simple, straightforward, sometimes humorous, and always helpful, the illustrations by Krajnak will become a principle item in the arsenal of techniques this book will give the practitioner. We use them in our work here in Alabama and actively teach our communication specialists and intermediary interpreters (CDIs) how to make use of them in their daily work.

For anyone who works actively providing mental health service to people who are deaf, this book provides the benchmark by which they can measure the success of their labors. For people who administer mental health programs that serve the deaf, this book is one of the most important publications in the past 20 years. If the deafness and mental health professional could have only one book on their bookshelf, this should be it, preferably well-worn, dog-eared, and falling apart from the frequent use made of it.

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