**Working with British Sign Language (BSL) interpreters: lessons**

**from child and adolescent mental health services in the U.K**

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**ABSTRACT**

**Background:**

Having good access to information is crucial when attending an appointment with a health professional; for 5% of the world’s population, who have some degree of hearing loss, this is challenging. With the introduction of acts against discrimination in the U.K., there is a responsibility to provide equitable access to services; best practice states that professionals should work with a registered British Sign Language Interpreter. In child and adolescent mental health services, practitioners may work with the deaf child/young person and their families; this presents many challenges. Previous models of interpreting do not lend themselves to this setting; interpreters need to have high levels of language and two-way interpreting skills, imparting detailed information about language and communication demands they face.

**Method:**

The role of the interpreter in the team was audited at two time points using an activity recording sheet; this is integrated with available literature and our clinical expertise.

**Results:**

Based on iterative audits and expert panels to discuss good practice, we have formulated a helpful way of working with interpreters. To enable robust assessments and therapeutic interventions, clinicians and interpreters are required to co-work. We discuss our experiences of helpful practices when working with interpreters including the importance of pre-appointment meetings, co-working during sessions, and debriefing.

**Conclusion:**

We make recommendations for working with deaf children/young people, improving communication with them and their

families, and their experience of services, all of which could potentially improve outcomes.

**KEYWORDS:** Interpreters; child mental health; deafness; communication; access; deaf children; sign language; health services accessibility

**Introduction**

The term deaf in medical terms relates to the hearing status of a person; it is defined according to audiometric descriptors ranging from mild, moderate, severe to profound [1] and affects 5% of the world’s population [2]. Aetiologies are wide ranging from ear infections, diseases, and genetic causes; for many the cause is unknown. The social model of disability views deaf people as a linguistic and cultural minority, with barriers in society disabling the deaf person. Predominately deaf people who use sign language identify themselves as deaf and have a strong sense of belonging to the Deaf community [3, 4] often described using a capital D. In this article, deaf is used to describe deaf people of all hearing statuses, preferred language choices, and cultural identities, though interpreting pertains to the signing population. Deaf children have 2–3 times the rate of mental health problems compared to the general population [5-7]. Some of this increase is likely to be related to having significantly different communication needs in a hearing society [8]. Many users experience starkly poor communicative experiences when attempting to access mainstream mental health services [8-11]. Some users expressed ‘profound concern with communication in therapy’ [8]. This may be one of the factors leading to delay in diagnosis in deaf children, for example of autism [12]. As with any group of children, services have a duty to provide meaningful access to mental health services for deaf clients. One key area is the provision of interpreting [13], which has been a legal duty in the United Kingdom since the introduction of the Disability Discrimination Act 1995. The Towards Equity and Access report (TEA) was published by the Department of Health with the National Institute for mental health in England [14] and addressed key issues surrounding deafness and mental health. It made 26 recommendations for improvements including high standards of communication and good provision of interpreting. Government funding was given to Primary Care Trusts to implement these recommendations, which included increasing the pool of interpreters and providing specialist training for those working in mental health. More recently, NHS England implemented the NHS accessible information standard [15]; undertaking a deaf awareness course is a good step towards increasing understanding for working with the deaf population [11] and many NHS trusts now provide this. However, many health and social care services are not sufficiently prepared for this standard and have great difficulty accessing high-quality interpreters quickly. Here, we discuss best practice and a model of interpreting provision that we have used that works for our deaf child mental health service and the users of that service.

**The use of language in deaf people**

Deaf people are a heterogeneous population and as such may use a variety of communication modalities such as British Sign Language (BSL) and Signed Supported English (SSE), where keywords of an English sentence are signed while the person speaks [16] or an oral/aural approach where a person uses their residual hearing and speech reading to understand and uses speech. On 18 March 2003, the U.K. government recognized: ‘BSL as a language in its own right, regularly used by a significant number of people. BSL is a visual-gestural language with its own vocabulary, grammar and syntax’ [ 16]. The estimated figure of deaf people using BSL as their first or preferred (main) language in the U.K. ranges from 22,000 (2011 census) to 125,000 [17]. For many reasons, it has proven difficult to gain a more accurate figure; it seems likely that deaf people are more or less likely to disclose this information depending on the reason for, and mechanism of, data collection such as accessibility. The Deaf community has its own identity, culture, and history. Deaf people experience the world predominantly visually; du Feu describes this as ‘hearing with eyes’ [11]. BSL is a visual language that has a different grammatical structure than that of English. BSL incorporates many elements such as hand shape, orientation, and location; eye contact; facial expressions; lip patterns; and other non-manual features that convey linguistic meaning beyond simple gesture. Subtle differences in these can change the meaning of a word or phrase. Deaf people are seen as very expressive and people can misread and misunderstand what a deaf person is communicating by a lack of understanding of their facial expressions or body language, or by using hearing norms when describing meaning that does not reflect Deaf cultural norms (for example substantial differences in the use of facial expression). The Deaf community has different social rules and etiquettes compared to the hearing community and this can lead to misunderstandings. Depending on a deaf person’s experience, family background, and schooling, they may use different modes of communication such as oral or SSE (between different modalities) or code mix (use two modalities simultaneously) [18].

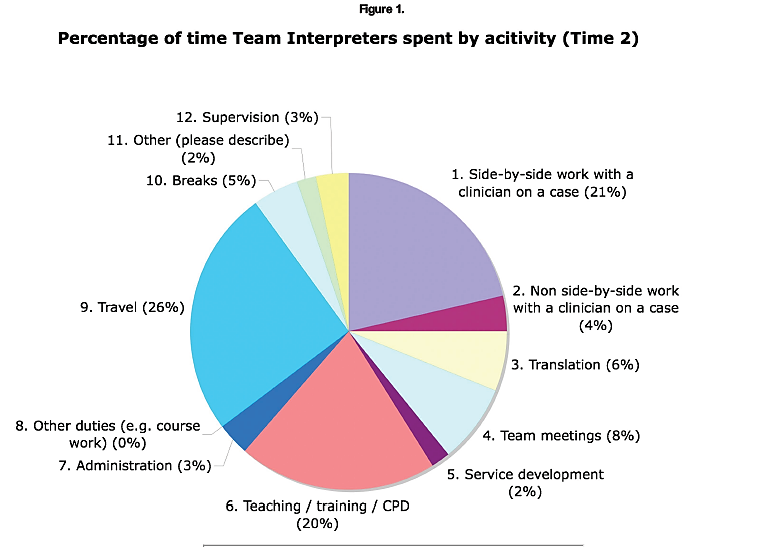
**Models of interpreting**

An interpreter interprets between deaf and hearing people and is booked for both parties. BSL interpreters do not interpret word for word, they ‘transfer meaning’ [19], with the exception of certain settings that may require transliteration [20]. For example, transliterating word for word the language used by a person with autism may show a repetition of a phrase over and over again, despite the fact that the simple ‘meaning’ has been conveyed after the first occasion. This may be important to demonstrate the repetitive use of language. Care needs to be taken with transliteration since it may not be understood by a hearing clinician with a limited understanding of deaf linguistics. For example, in a person with psychosis, there may be impaired language production (such as classifier handshape errors) that needs to be understood in a person’s first language (e.g. BSL or American Sign Language) and complicate any interpretation that is attempted after translation [21]. There are several models that describe how interpreters work with deaf people. This has attracted debate and controversy over the years. The literature can be confusing with many different authors giving a variety of different model names to similar interpreting processes. In brief, the issues often revolve around the role of the interpreter and the relationship to the deaf person and those communicating with the deaf person. Wilcox and Shaffer [22] describe an early ‘helper’ model where a family member, social worker, or church missionary for example interpreted as an advocate for the deaf person. They also describe how this could be disempowering for the deaf person [23]; this is similar to the advocate model [19] whereby the interpreter offers advice and refers to other agencies. This was superseded by the conduit model or impartial model [19] (still sometimes used today), which describes the simple translation of information with little attention to emotional tone or cultural influences on the information being communicated [24]. With this model, the interpreter is described as remaining neutral and detached from the process, interpreting in a mechanistic robotic like manner [25, 26]. There are difficulties with this model that espouses an ‘invisible’ interpreter given the interpreter presence in the interaction. Deaf communities often have strong views about the quality of interpreting, as described in detail by Dennis Cokely [27]. There is currently wide agreement that simple translation is not enough [28], with a concomitant move away from the ‘conduit’ model towards a model where the health worker and the interpreter co-work with one another and develop trust, which is equally established with the deaf person. The interpreter goes beyond conveying the intended meaning to understanding how the message might be understood [29]. A model of ‘communication facilitator’ uses more flexible attempts to facilitate communication and requires a series of skills that are necessary such as good working memory and professionalism [30] and the importance of being keenly aware of the needs of the deaf person and the situation [31]. Others have pointed out the need to understand the cultural differences between the groups and be ‘bilingual-bicultural specialists’ [32]. This recognizes the importance of an interaction between two languages and two cultures [33, 34]. This is a two-way process with interpreters working towards providing an equivalence of ‘meaning’. They are alive to error and misunderstanding and use various strategies for clarification and communication repair. They also negotiate linguistic differences including idioms and metaphors that cannot be interpreted literally, by interpreting them in a way that conveys the accurate meaning for a different culture.

More recently, Dean and Pollard suggest that interpreters should be practice professionals [35, 36]. They assert that factors in addition to linguistics play a part. The additional range of responsibilities includes professional characteristics with intrapersonal, interpersonal, and environmental demands that have to be overcome by the interpreter.

**Working with interpreters in CAMHS**

In March 2012, the service conducted an audit [37] to gain greater clarity on the role of the employed team interpreter, set standards, and expound the working relationship between interpreters and clinicians. The interpreters’ activity was recorded using a quarter-hourly time audit sheet at two time periods (T1 and T2) to see if there was consistency of activity over time. The time sheet was adapted from one used by generic CAMHS in consultation with the service manager and interpreter lead. A 100% return rate was recorded from the interpreters, with 73% (T1) and 42% (T2) from staff members in the service. Figure 1 shows how the interpreters spent their time at work (T2) [37, p.4].



In both T1 and T2, staff members who completed the questionnaire worked with interpreters on average 7 times (minimum 1 time and maximum 15 times) during the week being surveyed. The two most frequent ways of working together were during side-by-side sessions and during team meetings, where interpreter’s comments are proactively sought. Interpreters are co-workers working closely [38] in a transparent and overt way [39-41] in collaboration [42] with the multi-disciplinary staff members in a ‘team around the child’ approach [40, 43]. This enables the child and family to fully participate in the assessment in partnership with the clinician [44], and it enables the clinician to gain in-depth information about the children, adolescents, and their families. Interpreters should not try to make sense of language that is not clear and relay any dysfluency to the clinician, thus preventing misdiagnosis [21] and highlighting the need for possible further assessments such as cognitive or specific language impairments. The interpreter is at times a cultural broker; they reframe information to mediate cultural and linguistic differences, educational differences such as literacy problems, and fund of knowledge gaps [45]. They take into account the impact of belonging to a minority group or the barriers faced by deaf people in society, thus enhancing the clinical cultural competencies and understanding of the deaf person, which may lead to different outcomes [46]. It also includes taking into account issues of transference and countertransference, while ensuring that the clinician maintains clinical responsibility for the therapeutic work [40]. Interpreters working in this setting must be qualified, registered with The National Register of Communication Professional working with Deaf and Deafblind People (NRCPD) [47], 48, trained in mental health interpreting, and have knowledge of working with children and adolescents. We recommend only those with three years post qualification experience and additional training for this field to be contracted [11]. There is a growing availability of training ranging from online webinars to advanced certificates in mental health and deafness [49]. This guarantees a minimum professional standard. Interpreters not only need knowledge, skills, and experience of working in mental health but also with working with deaf children and are comfortable in this setting. They need a repertoire of sign language that enables them to attune to the language [41] used by the child and their family; if they are unable to do this, they should be honest and state this, asking for a replacement interpreter or the assistance of a deaf interpreter [50]. When we meet a child and family, it is important to carefully consider the needs of the child and family members. The clinician will need to have an understanding of the interpreter’s role before they begin working together and establish a mutual agreement to be open to discuss any issues that arise while doing their jobs co-working as respective professionals [51]. The interpreter is not a co-therapist and will direct the communication to the clinician [19, 41,50]. A clinician should work with the same one or two interpreters for all sessions to provide important continuity for any given family, build trust, rapport, and confidence between all parties, aiding the therapeutic process [40,51].

**Before a session begins**

Before the clinician meets the deaf child/family, it is good practice to have at least a 15-minute pre-appointment meeting with the interpreter. Our experience in Deaf CAMHS has found the points for discussion in Table 1 to be key to ensuring a good co-working relationship between the clinician and the interpreter. When therapy spans several sessions, a clinician will become more comfortable and confident working with an interpreter and deaf peoples.

**Table 1. Pre-appointment meeting between clinicians and interpreters.**

|  |
| --- |
| * Items to discuss can cover: |
| * Introducing the interpreter? (courtesy) |
| * Who will explain the role of the interpreter? (clarity to process and confidentiality) |
| * Arrangement of practical aspects such as seating and lighting (deaf awareness). |
| * Aims of the session (orientation). |
| * The communication goals of the clinician. |
| * Any special information about the child or family’s needs (special needs). |
| * Any other relevant information from the child’s case notes, such as medical conditions (technical terms), communication mode, and family members names (background). |
| * What did or did not work in the previous session, e.g. use of metaphors, visual resources. Is pre-educative work required for example before anger management work, the child may need to develop general emotional literacy. |

**During the session: challenges and tasks**

**Language and communication issues**

A deaf child may have a limited vocabulary and language delay, for example because of late diagnosis of deafness or limited access to communication. Deaf children and young people may be in an educational setting that ranges from an oral approach (using amplification, listening, and lip reading) to being taught in BSL, or any mixture of these. This needs to be shared with the interpreter before an appointment to enable full preparation. The clinician and interpreter have to be very sensitive regarding the communication needs of the child and family, and respect the communication choices they make (avoiding political stances). The interpreter needs to be flexible while interpreting, as the child may not use BSL as proficiently as a deaf adult. They may use their voice, which may not be very understandable. They may also have some signs that are particular to their home (signs the family have created) or their school and ‘developmentally immature signs’ [41, p. 87]. An interpreter would not correct their use of language or any particular signs used, but may instead seek clarification, and during interpretation (or afterwards in the debrief session) explain to the clinician what they saw.

**Explaining how to work with the interpreter**

An appointment can be the first time a family and their child has worked with an interpreter. Many children do not fully understand the concept of confidentiality, what an interpreter does, and how they work. Time should be taken to explain how the room is set up and how the interpreter will be working, including reassurance about confidentiality. It should usually be possible to let a family know the name of an interpreter before the meeting and some families may opt for an alternative if they know the interpreter personally or work with them in another setting such as their workplace.

**Linguistic understanding and interpretation issues**

Issues may arise from differences in life experiences and general knowledge (with deaf children or families often having less of a ‘fund of information’ to draw from [52]. Socio-emotional awareness may be delayed in some deaf children [53]. Many metaphors in BSL are different from those in English. The interpreter can advise if particular concepts or phrases are culturally and linguistically difficult to use or translate. The interpreter will be able to advise any communication difficulties (for example if a deaf person is not understanding what is being explained), which is important clinical information, using interpreting tools/strategies to highlight any unusual signs, state when they have not understood what is signed, and if the language used is ambiguous or nonsensical. If the interpreter has added an explanation to their interpretation to make a concept or phrase more explicit, they should tell the clinician that this has happened; it is important that the clinician is aware of the client’s use of language and understanding, for example has the deaf child used what local deaf clinicians refer to as the ‘deaf nod’ to cover the fact they are not understanding; therefore, it is imperative that the interpreter checks whether the deaf person has understood [41]. Some phrases or concepts may need to be reworded or structured to be linguistically and culturally relevant to a deaf person’s experience.

**Visual aids**

Another significant difference between deaf and hearing people is the level of written English used, as English is often a deaf person’s second language. BSL has a different word order, grammar, and syntax from English. A general requirement in England is to achieve five General Certificates of Secondary Education (GSCEs) graded A–C; this is also used as an indicator for school performance. Of Deaf children, 37% achieved 5 GCSEs A–C compared to 69% of their hearing peers [54] and many deaf young people will be several years behind in reading English on leaving school [55]. With this in mind, there is a duty to provide information in an accessible format [15]. Any written information (appointments, copies of letters, etc.) should be written in plain English. This means straightforward phraseology without sub-clauses using clear and commonly used words, and limited use of English metaphors or double negatives. Sometimes, it is appropriate to provide a video (DVD) of the interpreter interpreting the clinician reading the material (e.g. an assessment letter) [13,15]. Some clinicians use communication props [45] as a visual representation of the information such as using pictures, photographs, or role-play [6] to help communication. For example: when explaining meningitis the clinician may use pictures and/or anatomical models.

**Deaf interpreter/relay interpreter**

For some deaf children and families, an additional deaf interpreter may be needed. These are people who are native BSL users and are trained to work alongside hearing BSL interpreters [56]. If a deaf child or their family’s language use is not within the usual developmental milestones for BSL (for example BSL is not their first language, or they are from another country), if they have significantly delayed language skills, have minimal language skills, or idiosyncratic language [41], then a deaf Interpreter can attune to their use of language due to their knowledge of sign language, shared lived experiences, and culture; therefore, they relay information meaningfully, making adjustments for example to account for ‘native accent/regional variances’ [57]. Some may have language impairments, find it difficult attending to information, or difficulties with turn taking. All of these require awareness from interpreters. In a similar way to generic CAMH services with bilingual workers [58], who may be able to assist with communication and offer advice regarding community and culture, National Deaf CAMHS has Specialist Deaf Outreach Workers and deaf Family Support Workers who provide a deaf perspective [11,59]. These professionals may also work in a way similar to that of a relay/deaf interpreter. They may also work directly with families, for example providing help with engagement and trust, deaf identity work, emotional literacy, or emotion management sessions.

**Children as interpreters**

It is common for deaf parents to ask their hearing children (Child of Deaf Adults (CODAs)) or other members of the family to interpret for them. They therefore feel obliged to act as language brokers [60]. This is not good practice and raises a range of difficulties [41,61]. Role reversal may cause problems with family dynamics and can create power imbalances within the family system [62]: dependency, burdening a child with additional or adult responsibilities, giving them information that is not developmentally appropriate (for example in court or hospital), or exposing them to information that causes internal conflicts [63]. This is not uncommon in medical situations [64] and can lead to high levels of anxiety in the child. Similarly, family members may misinterpret because of lack of understanding or preconceived ideas about what may be relevant or important, therefore moderating the information exchanged [41]; they may also give their own opinions and act in a prejudiced way [65]. Clinicians should be providing the appropriate communication support (including interpreters) to ensure this does not happen in their clinical encounters; hence, patients will have the freedom to talk, and they are free to be themselves. Ultimately, they are not putting themselves and the patient at risk [19].

**Multiple cultures**

Deaf children may have a strong Deaf identity or may identify more with the hearing community. Often families who have not explored the impact of their deafness on their child’s identity may be experiencing difficulties and frustrations. Information about language or culture may be sought from a variety of sources/professionals (Table 2).

**Table 2. Useful resources when working with deaf children.**

|  |
| --- |
| Action on Hearing Loss: <https://www.actiononhearingloss.org.uk> |
| Adult Services; transition to adult mental health services, e.g. John Denmark Unit |
| Audiology Departments |
| British Deaf Association ([www.bda.org.uk](http://www.bda.org.uk)) |
| British Society for Mental Health and Deafness ([www.bsmhd.org.uk](http://www.bsmhd.org.uk)) |
| Education; Teachers of the Deaf |
| National Deaf CAMHS (<http://www.leedsmentalhealth.nhs.uk/our_services/Specialist-LD-Care/National_Deaf_CAMH>) |
| National Deaf Children’s Society; Family Liaison Officers ([www.ndcs.org.uk](http://www.ndcs.org.uk)) |
| National Register of Communication Professionals for Deaf Blind People ([www.nrcpd.org.uk](http://www.nrcpd.org.uk)) |
| Plain English Campaign ([www.plainenglish.co.uk](http://www.plainenglish.co.uk)) |
| Sign Health; Counselling ([www.signhealth.org.uk](http://www.signhealth.org.uk)) |
| Social Care: Social Workers for the Deaf |

Families may be constituted by multiple cultures. It may sometimes be necessary to have a BSL interpreter working in tandem with another oral language interpreter. The importance of planning in this situation becomes keener in order to enable a successful meeting.

**Family dynamics**

Family dynamics and family relationships [66] add another dimension to be considered. Families are a mix of people who have their own identities, personalities, beliefs, and goals. In some circumstances, the deaf child may feel left out of their family. Lack of communication, access, and deaf awareness are some of the reasons for this. Deaf children often miss out on the little things that we can take for granted, such as incidental learning of language [67] or social and emotional information [59], for example by overhearing the opinions, emotions, or disagreements of others. Often when an interpreter is brought in to a session, communication lines are opened and family members are able to communicate and express their thoughts and feelings to one another. Such differences in access to family communication may be a change in everyday experiences for some members of the family, particularly if communication is usually largely needs led and functional within a family. It may also be a surprise. Some children may sign at school but be more oral at home. We have seen several examples where parents say they do not need an interpreter but the child may be fixed on them if present.

**Deaf awareness**

Many hearing people may lack deaf awareness (a clinician or a family member). This may include simple but important things such as talking with hands over the mouth or while moving around the room, multiple people talking at the same time, or poor lighting. Children may be so used to this that they do not comment on it, but professionals can draw attention in a constructive way to demonstrate good practice. Similarly, a deaf parent may have a lack of ‘hearing awareness’ and may make assumptions about hearing experiences.

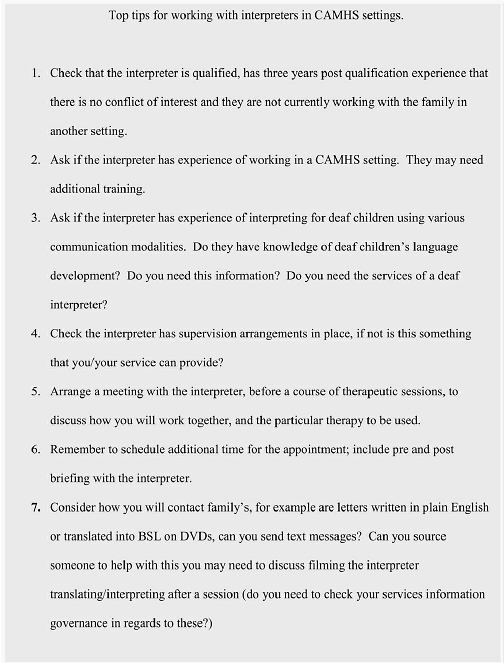
**After a session**

After the session, the clinician and the interpreter should have an opportunity to debrief, away from the child and the family, as part of their co-working relationship. Issues such as transference, counter-transference, projection, and displacement such as families projecting supressed unresolved feelings about having a deaf child on to the interpreter may need to be discussed [21,68]. There are frameworks available such as the demand and control schema [36] that cover environmental, intrapersonal, paralinguistic, and interpersonal aspects of an assignment. An interpreter should have the opportunity to express any element of the session that leads to strong emotions to enable its diffusion and limit the effects on the interpreter [19,69], for example an interpreter may experience strong feelings if a family member is not deaf aware and this is causing frustration and upset for the deaf child. This ‘barometer’ is a useful way to hear how the communication flowing through the interpreter made them feel, as it gives an insight into how the clients were feeling. Research shows that interpreter mood can affect the interaction [70]. Similarly, the interpreter may be affected by the content or process of the session. These strong emotions can be transmitted back to the clinician to better understand the child’s predicament [40]. Interpreters should seek clinical supervision to explore their professional practice and any issues that have arisen in the same way their health professional colleagues would; this can be provided in-house or via trained interpreter supervisors [39,40,71].

**Future developments**

NDCAMHS interpreters Ackroyd and Lafferty are developing a new model for interpreters working in a child mental health setting [72]. The Kaleidoscope model recognizes the multiple active roles interpreters have in the communicative process [23] and their need to be using a range of skills simultaneously. Working with deaf children and their families requires further consideration of the systemic context [73], families’ mode of communication, the child’s developmental stage, language acquisition, idiosyncratic language skills [21], and cultural identity. Children are developing and negotiating their way into the wider world. It is important that the interpreter is aware and sensitive to this, respectful of this journey and that they have good interpersonal skills. It calls upon interpreters to consider the following important elements: co-working, alliances, the interpreting process, self, and the effect of their presence. All parties impact on the interaction and it recognizes this [74]. The model advocates the need for reflection and supervision [40,71], with clinicians and peers (e.g. supervision groups). As we move through the steps of evidence-based practice, a service evaluation is taking place to look at the contributions an interpreter makes to the clinical team. An evaluation of the deaf children, young people, and family’s experience of working with interpreters in this way is needed (Figure 2).

**Figure 2. Top tips for working with interpreters in CAMHS settings.**



**Summary and conclusion**

The interpreter audit identified team interpreters as undertaking tasks beyond that of ‘just’ interpreting and positions them as part of the multi-disciplinary team. NDCAMHS (Northern Arm) has developed a model of working with interpreters over the last five years. It takes into account the needs of the child, family, clinician, and the interpreter. It starts from the recognition that communication in a deaf mental health service is a primary concern. For interpreters to work effectively, they need to be of a high standard, respectful of the independence and autonomy of the deaf person, and have experience of working with child mental health services paying attention to the developmental needs of the child. They need to be able to accommodate a wide range of needs and communication styles; this is augmented by the interpreter’s ability to modify their register, paying close attention to conveying meaning in both directions including cultural information, taking into account cultural and linguistic differences. The interpreter can also provide live deaf awareness for the hearing professional and hearing awareness for the deaf person. Interpreters in clinical settings should have supervision arrangements in place. This method of working recognizes the multifaceted role of the interpreter to work flexibly with the clinician and the client (child and family), to empower them, and facilitate a successful clinical encounter. A key element to this way of working is an understanding the role of the interpreter as part of the therapeutic team. This does not confuse the role of the interpreter with the role of the clinician; rather, it explicitly acknowledges the particular skill set and knowledge and gives permission for these to be utilized within a whole team approach for the benefit of the children and young people. For this to work effectively, there needs to be clarity throughout with respect to purpose and process; therefore, preparation and debrief are essential elements of the model.

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**Disclosure statement**

No potential conflict of interest was reported by the authors.

**Notes on contributors**

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