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Introduction

The sign language interpreter plays an important role in making the deaf population accessible to hearing people. That is, while the deaf individual may be able to function adequately with hearing persons, communication with a deaf person often seems difficult, intimidating, and cumbersome to the hearing person. Interpreters are often seen as the solution to the hearing person's discomfort. As such, they are seen as a welcome addition. Apparently, they have not been quite as well received in the mental health setting (Stansfield, 1981), particularly in the case of interpreter-assisted psychotherapy. We think there are reasons why they have not been as well received there: Use of an interpreter in psychotherapy presents unique problems and raises unique issues.

Our goal here is to present one restricted set of issues relevant to mental health interpreting. In this paper we are concerned with certain aspects of the role of the sign language interpreter in face-to-face individual psychotherapy. Specifically, we deal with issues arising in one sort of individual psychotherapy, namely, psychodynamic psychotherapy. In part, we focus on how the interpreter functions within the therapeutic session itself. But we also discuss a role that is thrust upon the interpreter without his or her choosing, namely, that of "transference object."

In particular, we discuss the following: (a) some of the ethical rules and principles governing interpreter practice in any setting, (b) some of the characteristic and naturally occurring processes of psychotherapy, and (c) ways in which standard interpreter ethics present problems for both the interpreter and the psychotherapist in appropriate management of psychotherapeutic processes. We illustrate our discussion of the conflict between interpreter ethics and psychotherapeutic processes with a case example taken from an actual psychotherapeutic interview.

One of our goals in examining these issues is to offer some ideas and suggestions which we have found helpful in our work and which we believe might be incorporated into standard interpreter practice and interpreter training. We feel, however, that some of our notions are controversial in important ways. Therefore, another of our goals is to offer these notions to the field, that is, to both sign interpreters and psychotherapists using their services. That way, the issues might be examined more closely and receive more attention and discussion.

Interpreter Ethics

The current RID Code of Ethics (taken from Caccamisano et al., 1980) states that, among other things, the interpreter shall:

- (a) keep all assignment-related information strictly confidential,
- (b) render the message faithfully, always conveying the content and spirit of the speaker,
- (c) not counsel, advise, or interject personal opinions, and
- (d) accept assignments using discretion with regard to skill, setting, and the consumers involved.

Generally, the purposes for these charges to the interpreter seem fairly self-evident. However, the RID Code of Ethics also offers guidelines which expand upon the principles and explain them more fully. For example, the expansion of (a) notes that a trainer shall not reveal the name, sex, age, or other information about the consumer when sharing actual experiences with a trainee. Nor is the trainer to reveal the city, state, or agency

relevant to the experience.

The general spirit of the charges under (a) through (d) above is two-fold, it see to us: First, the provider of interpreting services needs some sort of assurance that he or she is behaving in an appropriate and professional manner. The provider also needs some sort of protection against inappropriate criticism of the services provided. By faithfully adhering to the RID Code of Ethics and associated guidelines, the interpreter can always be sure of providing appropriate services in a professional manner. Second, the consumer of interpreting services, whether deaf or hearing, needs some sort of protection against intrusions in the communication. The consumer wants assurance that the sort of communication possible is precisely that which would be possible were the two speakers communicating with one another in a common language without the involvement of a third party. Thus, an alternative statement of the guideline under (a) might be formulated as follows: The assignment-related information should remain as confidential as it would had the interpreter not been present.

It is this notion of the non-intrusiveness of the interpreter that we wish to expand upon here. Relevant guideline statements are these:

"Interpreters" are not editors and must transmit everything that is said in exactly the same way it was intended. . . . Just as "interpreters" may not omit anything that is said, they may not add anything to the situation, even when they are asked to do so by other parties involved. . . . The "interpreter's" only function is to facilitate communication. . . . S/he shall not become personally involved because in so doing s/he accepts some responsibility for the outcome, which does not rightly belong to the "interpreter". (Caccamise et al., 1980, pp. 11-13)

The interpreter, then, is not to intrude him- or herself into the communication in any way. In other words, the interpreter is not to influence the communication process. This is a reasonable charge and one with which we are in full agreement. There is an aspect of the process of psychotherapy, however, which forces the interpreter into the role of intruder. It also suggests that the interpreter influences the process of psychotherapy in significant ways. Indeed, it is the very neutrality and non-involvement of the interpreter that fosters and continues that influence. This aspect of the psychotherapy process is the transference relationship, and it is to an explication and discussion of transference that we turn next.

Transference in Psychotherapy

Psychodynamic Psychotherapy

One of the therapeutic mistakes that novice psychotherapists frequently make is this: They think of psychotherapy as a setting where the psychotherapist and the client get together for a series of work meetings. During those meetings, the client describes a set of problems, and the psychotherapist provides counsel, advice, and guidance toward problem solving strategies. This is not a totally incorrect view of psychotherapy. There are certain clients who need such input (e.g., those with limited intellectual functioning or certain major psychiatric disorders). There are situations which call for such work (e.g., crisis intervention, suicide prevention). And there are therapeutic models in which such an approach to psychotherapy is appropriate (e.g., behavioral therapies for well defined problems, certain of the family therapies, etc.). However, for the most part, people (including those who happen to be deaf) have some fairly good problem solving skills, common sense, and advice networks (e.g., friends, family, church, school personnel, medical service providers, etc.). They use these resources in more or less effective ways to manage and cope with, or solve, the problems that arise in their daily lives. For the psychotherapist to imagine that he or she is a necessary component for the solution of the client's problems is rather arrogant and shows an unfortunate lack of respect for the client.

At the same time, there are individuals who have good problem solving skills, common sense, and support systems, but who are troubled nonetheless. They continue to have difficulty managing their lives or are troubled by uncomfortable emotions that interfere with their lives in various ways. The question in such cases is this: What is it about these individuals that keeps them from using their "life management" skills effectively? What is it that motivates and supports their troublesome emotional states? More succinctly put, the question is, "Why do they have these problems?"

Another mistake that novice psychotherapists make is to assume that the client simply needs to gain knowledge of the reasons for the problems. The mistaken idea is that with such knowledge in hand, clients can simply correct their "errors." They can then go about their lives renewed, refreshed, and armed with the proper skills to manage problems and previously difficult emotions.

Our view is that psychotherapy is much more than advice giving or revelation of knowledge. We believe that psychotherapy is an extraordinarily complex process. It is a process in which clients establish a richly structured relationship with the psychotherapist and then reorganize their experience of themselves and their environment within the context of that relationship. (It should be noted that there are others who would disagree with our views and beliefs.) The assumption is that people have characteristic ways of perceiving themselves and others, and that these perceptions influence their behavior in powerful ways. A further assumption is that these perceptions have deep motivations and complex historical antecedents which are not accessible to one's awareness (i.e., are unconscious) for various reasons. The therapeutic model we are speaking of is psychodynamic psychotherapy. It is important to note that this model does not assume that only the mentally ill or psychologically troubled are influenced by factors outside their awareness. It assumes that each of us has a history which crucially influenced our thinking structures as they were developing, and which continues to influence how we feel, behave, and generally operate in the world throughout our lives. Psychological disturbance is defined by the maladaptive nature or personally troubling experience of those characteristic ways of perceiving oneself and one's world. It is not defined by the presence of such unconscious influences.

How does this rich relationship between client and psychotherapist allow the reorganization of experience and perception? It happens in this way: The psychotherapy client brings him- or herself to that relationship. That is, the ways that the client operates in the world will be reflected in the ways that the client operates within the psychotherapeutic relationship. But there is a difference between the client's relationship with the world and his or her relationship with the psychotherapist. The client's relationship with the psychotherapist is one in which the client can display his or her feelings, thoughts, and behaviors without punishment, without reprisal, without danger--in short, within a safe environment. Because the environment is safe, the client's view can turn inward in such a way that one can examine oneself in various ways, from various perspectives, and with various personal reactions to the material examined.

It is not just the knowledge gained from such examination that makes psychotherapy work. Self-examination, when it is accurate and comprehensive, is an intensely emotional experience. Why? Personal material is unconscious for very good reasons: It is generally emotionally charged in ways that are unpleasant; it may be incongruent with our conscious ways of thinking about ourselves; and it is often in conflict, in certain aspects, with what we must do in the world in order to lead our lives in an acceptable and adaptive manner. It can, in short, be quite dangerous to our sense of self.

The job of the psychotherapist is to make that examination of self as free from danger as possible. Safety is needed so that the emotions that occur as the material is examined do not overwhelm or damage the client. It is the emotional content of the material that in part keeps it unconscious; it is the client's experiencing of those emotions within the therapeutic relationship and without damage to the relationship that allows new emotions to develop. Thus, the psychotherapist does not simply assist in self-knowledge. He or she also provides the environment for a corrective emotional experience.

That is the stuff of psychotherapy.

Transference

We began this portion of our discussion with promise to give the reader an explication of transference. And yet up to this point we have not used the term at all. Psychotherapy is such an exceedingly complex activity that it is necessary to lay a foundation for such explication. In fact, it is so complex that our lengthy discussion must be seen as greatly simplified and not at all comprehensive. Nonetheless, the concept of transference is there within our discussion without being named. It is contained in the statement that clients bring themselves--their histories, their motivations, their perceptions, their characteristic behaviors--to the therapeutic relationship. A more formal definition of transference, taken from a standard text in psychiatry (Kaplan, Freedman, & Sadock, 1980), is the following:

"Transference is a process in which the 'psychotherapy client' unconsciously and inappropriately displaces onto persons in his current life those patterns of behavior and emotional reactions that originated with significant figures from his childhood. The relative anonymity of the 'psychotherapist' and his role as a parent surrogate facilitates that displacement to him 'or her'. The 'client's' realistic and appropriate reactions to 'the psychotherapist' are not transference. (p. 898)

Transference can involve positive or negative feelings and is experienced by the client as realistic and appropriate reactions to the therapist rather than as distortions in his or her own perceptions. It occurs in any psychotherapeutic relationship and effects the course of psychotherapy in various ways. The difference between the therapy model we have presented (i.e., psychodynamic psychotherapy) and other psychotherapies is that in that model the transference is used as a major therapeutic tool.

In its broadest definition, the concept includes four different types of transference: (a) transference of habitual ways of relating, (b) transference of current relationships, (c) transference of past experience, and (d) transference neurosis (Sandler, Kennedy, & Tyson, 1980). We shall briefly discuss each of these in turn. However, we will begin with a distinction between transference and what is generally termed the therapeutic alliance.

The therapeutic alliance. The therapeutic alliance is that part of the client/psychotherapist relationship which is based on the client's conscious and unconscious wishes to cooperate with the therapist, to overcome resistance to the relationship and the material uncovered within that relationship, and for understanding and help with internal difficulties. It involves a basically trusting and positive attitude towards the therapist. And it is this trust which allows the client to tolerate difficult experiences in the therapy (e.g., anxiety, painful emotions, confusion, etc.) in order to attain therapeutic change. It also allows the client to tolerate interpretation of resistance and counterbalances one of the most common manifestations of resistance, namely, the wish to leave treatment. It differs from transference in that the alliance is more reality oriented. Although it may be colored by neurotic elements and past experience, the alliance is not based on these. Rather, it is based on: (a) a psychotherapist's and client's common goal of helping the client struggle with conflicts, and (b) a more or less clear understanding that the therapist is a professional trained to help people with such difficulties.

The transference, both positive and negative, is what the client and psychotherapist look at in therapy; the therapeutic alliance is what allows the client to look at the transference. With this distinction made, we can return to the four general types of transference.

Transference of habitual ways of relating. This type of transference is based on early relationships and reflects those relationships in the stylistic aspects of how one

relates to other people. For example, one might have a consistent tendency to placate authority figures or, conversely to rebel against authority figures. These stylistic aspects constitute a generalized mode of functioning that is chronic and habitual. They are generally acceptable to the client because they are not so emotionally charged. And, they are also generally not all that disruptive of daily functioning. In this sense, transference of habitual ways of relating is neither helpful nor destructive to the psychotherapeutic process, for the most part. This is because such transference is neither dangerous nor connected to disturbing emotions, and also because it is not specific to the therapist or to the therapeutic relationship. Rather, it is directed to everyone in the client's environment. It nonetheless flavors the therapeutic relationship and usually must be addressed as an issue within the therapy.

Transference of current relationships. Transference of current relationships occurs when there is a "spill over" of emotions and behavior in the therapeutic relationship which are related to current events and relationships in the client's life. For example, a male client might be experiencing difficulty in his relationship with his wife. He may be very angry with her but, for various reasons, be unable to manifest that anger towards her. The acting out of that anger in the treatment sessions is a transference which can occur for various reasons. It can occur in part because the anger is significant in the client's current experience. It can also occur in part because the consultation room provides a safe, confidential, and accepting environment for display of behaviors and emotions that would be unacceptable in his home with his wife.

Transference of past relationships. This type of transference is one of the most powerful features of psychotherapy. The concept refers to past impulses, wishes, memories, and fantasies that become manifested in the therapeutic relationship because the work done in treatment revives and stimulates them. Past experience and earlier patterns of emotion and behavior thus stimulated get reenacted in the therapeutic relationship. These reenactments also contain earlier feelings and a repetition of earlier consequences (e.g., depression, trauma, feelings of abandonment, etc.). The therapist, being the target of such transference (or, as we shall term it, the transference object), is seen by the client as being more specifically involved with the feelings, and more specifically the source of the feelings, than in the transference phenomena previously described. An example can be found in our case presentation below where the client, who was looked down upon and discounted by his parents, saw the psychotherapist as looking down on him and discounting him, and responded to the therapist with fury and rage.

Transference neurosis. Finally, there is the transference neurosis. This is a type of transference that perhaps occurs in its purest form only in psychoanalysis. It is a special case of transference which reflects major conflicts between unconscious elements. For example, an analysand (i.e., a psychoanalytic client) may have an unconscious wish for dependence and nurturance, that is, to be taken care of as an infant would be. A caretaker from the analysand's early childhood, however, may have punished dependent-behavior by anger, rejection, and withdrawal of love. The analysand, then, might have an unconscious fear of dependency which is in conflict with the wish and need for dependency. In a transference neurosis, this conflict might be reflected in the following way: Each time the analysand reports dependent behavior to the analyst, he or she perceives the analyst as angry and rejecting, and attacks the analyst for not being sufficiently caring and concerned. This perception occurs even though the analyst's behavior has remained unchanged (i.e., the same as when the analysand perceived the analyst as pleased, accepting, and caring). Thus, the transference neurosis is an externalization of major unconscious conflicts acted out within the therapeutic relationship so that the conflict is experienced by the client as being between him- or herself and the therapist. Since this paper is about psychotherapy and not about psychoanalysis, a more detailed account of transference neurosis is beyond the scope of this work.

Related Concepts

We have explained what transference is, and have also said a little about how it is used in treatment. There is more to be said, however, and in order to round out

discussion, the balance of this portion of the paper is devoted to three related concepts: (a) the stimulation of transference within the therapeutic relationship, (b) the therapeutic use of transference and the transference reaction, and (c) countertransference.

Stimulation of transference in the therapeutic relationship. Transference is stimulated within the therapeutic relationship not only because the client brings his or her history and past experience to that relationship, but also because the psychotherapist takes on a particular role. In ordinary relationships, both partners reveal themselves in ever increasing ways and become increasingly reality oriented in their perceptions of each other. An example familiar to just about everyone can be found in the experience of romantic love of the "love at first sight" variety. When two people experience an immediate or nearly immediate attraction for each other, the intense and powerful feelings that surround such attraction are generally quite unrealistic. That is, although the feelings themselves are valid and very real, they are not actually based on objective perception and knowledge of the love object, but rather on the needs, wishes, fantasies, and so forth, of the experiencing individual. Indeed, it is the very lack of objective perception and knowledge that allows such feelings to arise. With increased contact with, and knowledge of, the love object, emotional responses to the object generally become increasingly reality oriented--so much so that the person may come to wonder what it was that he or she ever saw in the other in the first place, or wonder how he or she could have ever felt such love. Such feelings are a kind of transference, a very pleasant kind, indeed, and one which is possible because the transference object is so unknown and ill-defined.

Psychotherapists are also rather ill-defined. They reveal very little of themselves in the way of history, reactive behavior, thoughts, or feelings, except where such revelations can be used therapeutically. They do not take this general stand to be secretive or unauthentic. Rather, they seek to remain somewhat ill-defined precisely because such lack of definition stimulates transference within the client. The more defined and real the therapist becomes, the more objective and reality oriented become the client's perceptions of the therapist. The transference is then diminished, and the therapeutic relationship becomes more like a friendship.

The therapeutic use of transference and the transference reaction. One might ask why this should be a problem. Why shouldn't the psychotherapist and client be friends? The answer lies in the therapeutic use of the transference. The client is not in the consultation room to better know and understand the therapist; clients are in psychotherapy in order to better know and understand themselves. It is by looking at the transference that the client may come to better know and understand his or her own perceptions, emotions, and history. This is because transference is a reflection of the client's self rather than of the psychotherapist. It is the major tool that both client and psychotherapist use to make sense of the difficulties that brought the client to the consultation room in the first place.

The transference feelings are manifested in what is termed transference reactions. For example, in the case described below, the client had a powerful reaction to a fairly minor error made by the interpreter during the course of an interpreter-assisted therapy interview. The client's behavior was seen as a transference reaction, as an inappropriate displacement of hostile feelings toward the therapist onto the interpreter. The client's reaction, as shall be seen, gave a great deal of information to the therapist. And it also provided material for client and therapist examination that was immediate, spontaneous, emotionally relevant, and profoundly important. By working through the transference (i.e., by experiencing it fully with all of its emotional concomitants, by understanding it, and by mastering those associated emotions), the client is better able to handle such emotions and the events which stimulate them.

Countertransference. The last concept for discussion here is that of countertransference. This term refers to the transference that the psychotherapist him- or herself injects into the therapeutic relationship. Although the therapist ideally is

objective, stable, psychologically intact, and in control of his or her emotions and behavior, it is nonetheless true that in any psychotherapy there are at least two human beings in the room. Transference is not a reflection of pathology; it is a reflection of one's humanity. And the psychotherapist has a history, an unconscious, and a set of conflicts, too.

True countertransference occurs when the therapist responds to the client and to the therapeutic relationship from an unconscious place. It is troublesome because it can lead to the therapist making interventions that are motivated by his or her own dynamics rather than the therapeutic needs of the client.

Such feelings must be clearly differentiated from the various feelings that arise in the therapist as a response to a particular client. An example of the former, the countertransference reaction, might be reflected in, say, the therapist's reacting in a punitive way to some sexual behavior on the part of the client because the behavior stimulates similar, but unacceptable and unconscious, sexual feelings on the part of the therapist. The latter class of therapist reactions are based on a reality based experience of the behavior of the client. For example, the therapist may find him- or herself always feeling disorganized and overwhelmed in dealing with a particular client in ways that are not a reflection of countertransference or lack of ability, but rather a reflection of the client's being disorganized and overwhelmed.

In this way, the psychotherapist uses him- or herself as a sort of barometer or testing device. If the psychotherapist reacts in a consistent way to a client, and that reaction is not a countertransference reaction, then it is likely that others in the client's environment have similar reactions. Obviously, such reactions can be very useful and informative.

It should be clear that, owing their unconscious sources, countertransference reactions are very difficult for the psychotherapist to distinguish from those reactions which are reality based, useful, and therapeutic. That is why responsible and ethical psychotherapists establish an ongoing supervisory relationship with colleagues in which the therapist can share his or her work, reactions, and thoughts for objective review. We will have more to say about ongoing supervision in our discussion of the role of the interpreter in psychotherapy.

Transference in the Interpreter/Client Relationship

Introduction

Although it might not be immediately apparent from our discussion above, the notion of transference relationship and transference object implies something about the interpreter's role in psychotherapy. It suggests that the interpreter, by his or her very presence in the consultation room, might "add to the situation" in important ways.

We have explained how ambiguity and lack of definition in the psychotherapist encourages transference in the client. The interpreter, because he or she reveals so little personal material in the way of thoughts, feelings, reactive behavior, and history, is quite as ambiguous and ill-defined an object as the psychotherapist. Moreover, while the client is encouraged in developing a transference relationship with the psychotherapist by the inherent dependency of being a client in psychotherapy, it must be remembered that he or she is also depending upon the interpreter in crucial ways as well. It would seem, then, that the interpreter is a very likely transference object, perhaps as likely as the psychotherapist. We believe that the interpreter is a very frequent transference object.

Case Presentation

We can now turn to a particular case example in which the interpreter in fact did become a transference object and played a significant role in the process of

psychotherapy. In presenting this case, we are ourselves violating some of the ethical guidelines of the RID Code of Ethics because it is known that we work for the University of California Center on Deafness in San Francisco and because we intend to reveal certain aspects of an interpreting situation and of the consumers of interpreting services. The amount of information we reveal, however, is within the limits governing our agency and the practice of psychotherapy, and both psychotherapist and interpreter were staff members of the Center on Deafness and, therefore, subject to that agency's guidelines.

The client in question is a deaf male in his thirties who complained initially of relationship problems in both his personal and professional life. He was seen over a period of several months by a hearing therapist who used the services of a CSC interpreter on staff. As might be imagined, the interpreter had a great deal of experience working in mental health settings.

The client was bright, well-educated, responsible, and generally handled many aspects of his life in an adaptive manner. He had, however, experienced consistent difficulties over a period of two decades because, in his words, "people do not understand deaf people." With exploration of his complaints in some detail over a period of several weeks, it was revealed that he would have angry, at times uncontrolled, temper outbursts in response to what he perceived as "put-downs" or patronizing behavior coming from others, or to violations of his rights.

While he was apparently often correct in his perceptions, his own behavior was frequently excessive, difficult to understand, and frankly intolerable to those around him. As a consequence, he had lost many friendships in the deaf community, had lost important affectional relationships, had lost important training opportunities, and had severe vocational problems. He felt, and was in fact, isolated, uncared for, and unappreciated for his abilities and accomplishments.

The client had a troubled family history. He had been abandoned by his natural mother to institutional care at birth and was placed in foster care at age 17 months. He remained with the same foster family throughout his childhood and adolescence, but he was never treated as an equal member of the family as the foster parents' natural children were. He remembered that he had always felt inadequate, unacceptable, and damaged in his foster parents' eyes.

It is likely that such a tenuous position in the family was a source of great distress and pain for the client. It is also likely that he protected himself from such emotional assault. He achieved this sense of being protected by not fully connecting his natural childhood needs for nurturance and dependency onto a set of parents who seemed unwilling or unable to meet those needs.

At the same time, the client was blocked from completely rejecting of his foster parents' behavior and emotional separation from them. The family was the only available source of emotional support that he had. Thus, he was forced to suppress his negative feelings and aggressive drives in order to maintain what little emotional supplies were available from the family.

This situation created in the client a deep sense of isolation and lack of self-worth along with an unsolvable conflict: He had the natural needs of a child and a correlated drive to meet those needs with closeness and dependency. However, closeness and dependency with his foster parents was punished by their relative rejection of him and their refusal to provide him a secure place in the family. This in turn created a drive to avoid such danger by distance from, and lack of connection to, others. In short, his childhood was a "damned if he did, damned if he didn't" situation. If he sought connection with his parents, he placed his fragile sense of self in the hands of people who could not be trusted to treat it with respect and care. If he protected his fragile sense of self by refusing connection with his parents, he condemned himself to ever increasing fragility, for it is only in the acceptance and love from others that a child comes to know and trust his own worth.

This conflict, which was fully outside of his awareness, was played out in many ways throughout his adult life. He would feel unloved and needy and would approach others for support and care; as others moved closer to him, and he closer to others, the unconscious conflict would stimulate deep feelings of danger and threat. He would then experience an impulse to drive the others away, to protect himself through isolation. In terms of the framework developed above, he transferred significant emotional responses connected to the earlier relationship with his foster parents (where such responses were actually adaptive) onto new relationships in his adult life (where such responses most often were maladaptive). He accomplished this "driving away" by his excessively hostile behavior, which assured that others would reject him. He then would physically escape from the situation by running away (i.e., to another job, another school, another state, another relationship, etc.).

The client initially entered therapy in response to a crisis. As the crisis was resolved and he received some support from the therapy, his motivation for serious work and insight development diminished. It became clear that he saw the psychotherapy as an arena in which he could fortify his attribution of his problems to the notion that "people don't understand deaf people." In particular, it was important for him to convince the psychotherapist that all of the other people with whom he had problems were in the wrong and guilty while he himself was innocent, abused, and misunderstood.

The client resisted the interpretation that he himself might be adding something to his difficulties. In fact, when the psychotherapist would suggest ways in which his own behavior might have influenced how others reacted to him, he would claim that the psychotherapist either did not understand the situation or did not understand deaf people. Thus, it was impossible to use the client's prior experiences as a tool to help both psychotherapist and client explore the client's deep, persistent, and pervasive relationship problems.

It was felt that the problem could be addressed only through the transference relationship. The psychotherapist knew that he would make no progress by arguing about the meaning of the client's past behavior. Both psychotherapist and client needed some immediate and tangible experience to examine. The client's transference onto the therapeutic relationship of similar feelings of closeness and fear of that closeness could provide that immediate and tangible experience. The expectation was that as the relationship between the psychotherapist and the client grew, and they became increasingly close, the client would experience a sense of danger and consequently come to feel that the actions of the psychotherapist put him down, patronized him, and violated his rights.

Obviously, it was necessary for the psychotherapist to remain neutral and not to behave in such a way that the client could objectively view as a violation of his rights, as patronizing, or as diminishing of his sense of self. Only by maintaining such neutrality could the psychotherapist assure that such feelings in the client were based on transference, and thus be able to offer him an immediate and safe forum to explore the meaning of those feelings.

Unfortunately, the client's goals conflicted with those of the therapist. Because it was important to the client to present himself as controlled, rational, and pleasant (so that the psychotherapist could see that it was others who behaved incorrectly), he would not allow himself to manifest his powerful negative feelings or to follow his impulse toward angry behavior as he felt himself move closer to the therapist.

The situation continued for several months with little progress made in psychotherapy other than the establishment of a fairly trusting relationship between psychotherapist and client and, incidentally, between interpreter and client. And as expected, as the relationships became closer, they became more dangerous to the client. He would seek to distance himself and change the focus or established procedures of the therapy in small ways that are not important to recount here. Major topics in therapy during this time included plans for a new vocation, the client's living arrangements, and details of the client's history.

During one session at the end of this period, however, the client made a great shift in plans he had been developing over the previous weeks and announced his intention to move to another part of the country. The psychotherapist made a rather minor interpretation of this shift in plans as a way of escaping the difficulties and isolation that had arisen for him in the preceding months. He also pointed out several other times in the client's past when similar events had occurred and served the same purpose in the client's life. The therapist was also attending to another function of such a move, namely, to end the every closer (and thus ever more dangerous) relationship with the therapist. He did not interpret this function to the client.

The client's face flushed in anger, and he had to pause to regain his control. He then stated that the therapist was mistaken. The psychotherapist sensed that the danger the client had been experiencing was finally surfacing. Thinking that perhaps the opportunity to explore the transference feelings had arrived, he suggested that the client might be angry with his interpretation. The client insisted that he was not angry; he was only pointing out how the interpretation was incorrect and displayed a lack of understanding of deaf people. The session ended with no further progress being made.

At the very next session, the client started off by bringing up the interpretation again. He was in much better control, had formulated some convincing arguments to support his position, and was impervious to alternate ideas. He nonetheless remained agitated and upset. At this point in the interview, the interpreter made a minor error in his signing. The client did not understand the interpreter's communication and asked him directly and in a very angry manner what he was saying. The interpreter tried to clarify his communication; however, the client (perhaps purposefully) had difficulty understanding the clarification. The client then launched into a tirade at the interpreter, telling him that "that's not the way to make that sign to a deaf person." He then asked the interpreter if he had CSC certification.

While there was a miscommunication, and the client was certainly well within his rights to ask for clarification and for a statement of the interpreter's qualifications his behavior seemed excessive for the situation and sadistic toward the interpreter. It seemed, in fact, precisely the sort of behavior that had brought the client into therapy in the first place. The therapist also noted that the behavior had followed closely upon difficulties the client was experiencing with the him. For this reason, the psychotherapist assessed them as being part of transference feelings which really had himself as the object rather than the interpreter. Display of such feeling toward the psychotherapist was too dangerous, so the client displaced them onto the interpreter.

The psychotherapist was placed in a dilemma. He was aware that the interpreter was suddenly involved in the therapeutic process in a way neither he nor the interpreter had planned for. He was also acutely aware of the RID Code of Ethics and its charge that the interpreter not become involved. And finally, he was aware that a significant event had occurred that had been anticipated for months and that might not occur again for several more months. Moreover, there was a great danger of the client terminating therapy: The sudden decision to move was (at least in part) an acting out of the the resistance to the growing closeness of the therapeutic relationship. If resistance is not addressed in therapy, there is great danger of premature termination, particularly with a client whose general mode of operation is to run away from difficulties. Exploring the attack on the interpreter with the client would necessarily involve the interpreter in "unethical" ways (particularly since it was likely that the client would want to bring the interpreter into the discussion). But not exploring the event would be countertherapeutic and not in the client's best interests: Not only would it necessarily delay progress in therapy,

Here's what happened: The psychotherapist turned to the interpreter and asked him to sign everything he said. He then said that he was going to do something that might be uncomfortable to the interpreter, and that if the interpreter did not think it appropriate, he should stop him. Then he asked the client how he imagined the interpreter might feel after what had just occurred. The client stated that he had the right to ask about the interpreter's qualifications. The psychotherapist agreed that he had such a

right and suggested that he even had in some sense a duty to insure that his interpreter was sufficiently qualified. But he also pointed out that that was not an answer to the question, which was about the interpreter's possible feelings. The client could not bring himself to answer, but responded with statements such as, "I don't care if it made him angry; if he feels hurt, that's his problem, not mine; he shouldn't get upset if I ask about his CSC." The psychotherapist then said that it seemed that the client imagined that the interpreter might feel angry, hurt, and upset. The client then turned to the interpreter and asked him how he did feel. The interpreter, in violation of his own code of ethics, said that he had felt angry and had wanted to "just get through the session and be done with it." The psychotherapist then, in a supportive manner, said that he was glad that the event had happened because finally there was something that both he and the client were a part of and could look at together.

The general treatment course and the specific event outlined above reflects a complex psychotherapeutic process. That process can be described as follows:

1. The client initially formed a tenuous therapeutic alliance with the psychotherapist which enabled him to discuss painful situations and continue in treatment despite his difficulty in tolerating even gentle confrontation of his beliefs and behaviors.
2. As the relationship between psychotherapist and client grew more close, the client began to experience strong unconscious wishes to be dependent on and nurtured by the psychotherapist.
3. The dependence wishes in the client activated strong unconscious fears of assault on his self integrity by being rejected and discounted (as he was by his foster parents).
4. The conflict defined by (2) and (3) gave rise to wishes to escape from the relationship, to sacrifice his dependency needs in the service of ego integrity (again,—as he had with his foster parents).
5. He defended his integrity (a) by denial of interpretations made by the psychotherapist and (b) by minor attempts to shift the focus and procedure of the psychotherapy. In this way, he could control or escape from the painful aspects of the therapy while maintaining continued (though reduced) contact with the psychotherapist.
6. As his defenses against the psychotherapist/client relationship failed (i.e., as he grew more dependent on the psychotherapist), he formulated plans to leave the area and thus escape the dangers of the relationship (a form of transference acting out, limited in this case since usually he would precipitate his own rejection by hostile action prior to leaving).
7. When the psychotherapist interpreted the plan for leaving, the patient lost control of his impulses to act out the transference in a limited way and experienced powerful hostility toward the psychotherapist.
8. Direct attack on the psychotherapist would endanger the position the client had taken throughout the psychotherapy, namely, that the problems that he had had in the past were due to the failings of others. Therefore, he directed his transference acting out onto the interpreter.

The test of such an analysis is, of course, in how the psychotherapy proceeded from that point. The proof of the pudding is in the eating. The psychotherapist said that while he could acknowledge the client's right to question the interpreter's skills, he felt that the client's strong feelings had much more to do with his feelings about the psychotherapist than with the interpreter. He asked the client how he was feeling about him. The client, in contradistinction to the consistent

stand he had taken throughout the psychotherapy up to that point, said that he felt the psychotherapist looked down on him, thought himself better than him, and expected the client to agree with everything he said and to comply with every suggestion. The psychotherapist asked him if that was what he had felt about his foster parents, and the client said that it was. He went on to rail against professionals who work with deaf people and how they never understood the deaf person (remember that the interpreter was also a professional working with a deaf person). The therapist asked the client if he felt he was being misunderstood now, and the client said that he did. The balance of the session was spent in examining these feelings. Thus, it turned out that the event described offered the first significant break in the client's resistance and the first substantial movement in the course of psychotherapy.

Case Implications

We have offered this extensive description of the case not to train the reader in psychotherapy, but rather to give some sense of the complexity inherent in psychotherapeutic treatment. We have also attempted a description of how intimately involved with the therapeutic process the interpreter can become. It is fine for the psychotherapist and the interpreter to say, following the RID Code of Ethics, that the interpreter will not become involved with the client--in effect, "Thou shalt not transfer onto the interpreter!" But who tells the client? And even bringing this issue up with the client in an effort to limit its consequences would be ineffectual; remember that transference is an unconscious process not accessible to the immediate awareness of the client.

The interpreter, who had a mutually trusting and respectful relationship with the psychotherapist as well as a great deal of experience with and knowledge of psychotherapeutic processes, behaved in a manner absolutely appropriate to the therapeutic needs of the client and to the situation. The feedback that he gave to the client (at the client's request), was authentic and was not punitive, even though it was likely difficult for the client to receive. And his stand toward the client (his client as well as the psychotherapist's) remained helpful and professional in tone throughout the session and, incidentally, in subsequent sessions. However, he had clearly violated well established ethical principles of his profession.

Was it simply that he was very insightful and sensitive, thus able to allow the intrusion on his non-involvement and able to provide accurate and authentic feedback to the client? In part, yes. But more importantly, the interpreter and psychotherapist discussed the case regularly (again, an ethical violation) and had in fact expected the session described above to present some difficulty. They had spent a few minutes preparing together for the session, and the psychotherapist had said that he expected the client to act out against him in some way because of the difficulties in the immediately preceding session (acting out toward the interpreter was not expected). In other words, they had established a working relationship in which the interpreter was seen by himself and the psychotherapist as part of the treatment team, not as an intrusive but necessary addition to be tolerated. He took the position that interpreting in this psychotherapy setting was unlike interpreting in a classroom, court, medical office, or indeed, almost any other setting. He took the setting to be, rather, one in which the best interests of his client may not be easily discerned and may not be adequately supported by a rigid set of principles seeking to provide protection to his customers in the broadest range of situations possible. He operated as a professional in the best sense of that word.

Interpreter Role, Training, and Ethics

We think that there are important points implied in our discussion of psychotherapeutic processes, of how the interpreter can become involved in those processes, and of an event wherein the interpreter's choice not to maintain an uninvolved stance helped forward the best interests of the client. The points are

relevant (a) to the role of the interpreter in any long-term, psychodynamic psychotherapy, (b) to the nature of the RID Code of Ethics, and (c) to the training of interpreters.

The Interpreter as a Member of the Treatment Team

We have suggested that interpreters working in the context of psychotherapy do not really have the choice to be involved or uninvolved. That choice is left up to the psychotherapy client, and it is a choice the client may make at an unconscious level. When such involvement occurs, the interpreter's choices are quite limited: (a) He or she can use it in the best interests of the client or (b) can deny that the involvement occurred. We think the former choice is more appropriate. What is chosen is something that might be termed "controlled unethical behavior." What is avoided is unaddressed countertransference reactions on the part of the interpreter. That is, whenever the interpreter in fact becomes involved with the client, there is a great danger of countertransference reactions which could affect the way that the interpreter does his or her job. By allowing such involvement to be open and available for discussion, one also allows a forum where such countertransference possibilities can be explored and corrected, if necessary.

Are we suggesting, then, that the interpreter is appropriately seen as a sort of co-therapist who can make interventions and work out the therapeutic issues with the client during a course of treatment? Our answer to that is an emphatic "no." Psychotherapy, when it is really done well, is a powerful and risky business that requires of its practitioners years of training and even more years of experience before they can be said to be top-notch professionals.

Rather, we are suggesting that the interpreter ideally is an adjunct member of the treatment team, which may include a psychiatrist for medication, other medical service providers, a social worker for social service coordination, a vocational rehabilitation specialist, and so forth. The primary coordinator of services, however, must be the psychotherapist. In part, the superordinate status of the psychotherapist is necessary in order to foster a unified and cohesive treatment approach. One person must have ultimate responsibility for the course of treatment. And it is generally true that the psychotherapist is privy to the broadest range of information about the client. More important, however, is this: In any course of psychotherapeutic treatment, there are multiple points at which choices for future direction of treatment must be made. Often there are several "right" choices that can be made. In our opinion, however, it is never right or helpful to the client for one member of the treatment team to choose a direction different from another member. We see it as necessary, then, for one person to have the final say--to "call the shots," as it were. If the interpreter is to use his or her involvement with the client in an appropriate way, it must be under the leadership of the psychotherapist.

This role implies several things: First, it implies that the therapist and interpreter, as well as other members of the treatment team, must have a relationship which provides an opportunity to work out disagreements, to share information, to decide on the direction for treatment, to provide mutual support, and so forth. Such a relationship fosters cooperation and assists the psychotherapist in his or her leadership role. Second, it implies that the interpreter is subject to the same dangers that the psychotherapist is subject to (i.e., of injecting his or her own countertransference issues into the treatment, of managing the transference inappropriately, etc.). Just as the psychotherapist should seek ongoing supervision with respect to these issues, so ought the interpreter. Finally, it implies that the interpreter who chooses to do mental health interpreting ought to share some of the professional values, theoretical concepts, technical vocabulary, and procedural knowledge of the psychotherapist. In short, the interpreter and psychotherapist ought to "speak the same language." (This notion has obvious training implications, which we discuss below.)

There is another obvious answer to the dilemma we have presented. One could not include the interpreter as a member of the treatment team, or as a consistent element in therapy. The psychotherapist could use different interpreters on a revolving basis. That way, a transference relationship between the client and interpreter would have no opportunity to develop. Unfortunately, such moves would introduce a very chaotic and unstable element to the therapy. And part of psychotherapy is precisely to provide a consistent, stable, and safe environment for the client to do his or her work.

Ethical Implications

We think that the RID Code of Ethics needs to be looked at carefully with respect to its appropriateness in dealing with the issues arising in the psychotherapy setting. Each of the statements we outlined at the beginning of this paper is problematic: We have seen that keeping assignment-related information strictly confidential is a knotty issue in a setting where the work done must be discussed with others (i.e., other treatment providers, supervisors, etc.) We have seen that rendering the message faithfully and conveying the content and spirit of the speaker can be a herculean task when some of the content and spirit of the speaker is unconscious and covert. We have suggested that not interjecting personal opinions can be countertherapeutic in the psychotherapy setting, in certain cases. We would also suggest here that such strict neutrality is destructive to the sort of cooperation and sharing of information between psychotherapist and interpreter necessary for providing the most appropriate services to the client. And finally, we submit that if one does not have appropriate training and experience, or is not willing to take on the unique interpreter role demanded by the psychotherapy setting, then one ought to exclude interpreting in psychotherapy settings from his or her practice. Only thus is one using discretion with regard to skill, setting, and the consumers involved.

Training Implications

If interpreters are to take such an expanded role in the context of interpreter-assisted psychotherapy, how are they to be trained for that role? We have investigated several interpreter training programs across the country. We found that, in the main, mental health interpreting is not specifically addressed in their curricula, though it may appear as a topic in an ethics course or a multi-topic seminar. It seems as though most interpreters can complete their training and receive certification with no didactic presentation of the special issues relevant to mental health interpreting in general, or interpreter-assisted psychotherapy in particular. We also found that training practica in most programs did not include placements in mental health settings. This means that most interpreters do not receive practical training experience in mental health settings. Obviously, the issues that we have presented in this paper reflect our belief that the standard training most interpreters receive is insufficient to meet the needs of mental health interpreting.

We found one shining counterexample, however. That counterexample was the health service interpreting program offered by St. Mary's Junior College in Minneapolis. The St. Mary's program takes practicing interpreters and provides them with advanced training for interpreting in health service settings, including mental health service settings. The curriculum includes an 11-week course in mental health interpreting that covers such topics as theories and techniques of psychotherapy, psychological tests and measurements, psychopathology, epidemiology of mental disturbance, special interpreting techniques, relationship to other service providers, and ethics. Students also receive 30 hours of practicum training in a mental health setting. We were quite impressed with the program and believe it could provide a model for other institutions seeking to provide good interpreter training.

Another means for providing such training is potentially offered by the mental

health agencies themselves. Our agency offers in-service training for staff and both a formal and an informal peer supervision network. Members of the interpreting staff regularly participate in training and research activities and discuss cases with the clinical staff. Such activities in any agency could provide the foundation for a more formal in-service training program wherein experienced interpreters are given didactic and practical training in mental health interpreting and ongoing supervision of their work subsequent to the completion of training.

Concluding Remarks

We have attempted here to present what we feel are important issues and problems regarding the appropriate functions of the interpreter in the psychotherapy situation. We have also suggested some possible solutions to those problems, all of which point to an expanded role for the interpreter. We do not claim to have offered fully satisfactory solutions, however. Rather, our purpose has been to stimulate discussion of the issues within the separate fields of psychotherapy and interpreting. A comprehensive discussion of the role of the psychotherapist in mental health settings would necessarily address multiple issues, some of which have been addressed by Stansfield (1981):

"When therapists need to know information about deafness, language, and communication, should the interpreter comment . . . ?

"Should the interpreter be in charge of arranging the seating?

"Who should clarify unclear communication from the client?

"How should the interpreter handle comments made to him directly by the client?

"How can the interpreter deal with his feelings about how the therapist is handling the session?

"How should the interpreter assess the client's communication before the session?

It is beyond the scope of this paper to address all of the issues in mental health interpreting, but it is not beyond the scope of the field. We expect that both interpreters and psychotherapists will debate these issues in the future, as they have been for some time now. What we are suggesting is that mental health interpreting must be seen as a specialty area of general interpreting. And as such, it requires special experience, training, and standards of professional conduct.

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