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Sign language and interpretation

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Introduction

Many readers will be unfamiliar with the Deaf community, although they will be familiar with people who have a hearing loss. In this article we explain the common historical emergence of Deaf communities and interpreting services. This provides a useful backdrop when thinking of providing services for sign language using deaf people.

We look at research demonstrating sign languages are full human languages that use many of the same neural networks to process linguistic information regardless of the fact it is realized in the visual (rather than auditory) modality. We also look at some research into Deaf people in clinical populations to understand issues experienced by Deaf people.

We explore the role of interpreters within therapeutic settings in general, looking at how they form part of the communication triad or triangle, rather than an interpreted session being seen as an atypical dyad or dialogue. We look at the roles interpreters take on when involved in medical and therapeutic sessions and issues that clinicians may need to be mindful of when working in an interpreter-mediated session.

History of sign language

The Deaf community is a community comprised of sign language using deaf people. These are people with some level of hearing loss (they are deaf) and who use a natural sign language, which could be a national sign language (e.g. Austrian Sign Language – ÖGS, British Sign Language – BSL, etc.) or a regional sign language (e.g. Flemish Sign Language – VGT or French-Belgian Sign Language – LSFB). There is a large amount of endogamous marriage, and as such children of these marriages acquire a sign language as their first language irrespective of whether they are deaf or can hear. These children form part of the Deaf community, as do deaf people who learn sign language in later life (their teenage years or in their twenties) and who socialize within the Deaf community.

This is not a new phenomenon, as deaf people throughout history have desired to seek each other out. The earliest record of Deaf people socializing together can be found in the Survey of Cornwall (Carew 1602) when Edward Bone and another man, “Kempe, not living far off, defected accordingly, on whose meetings there were such embracements, such strange, often, and earnest tokenings, and such hearty laughters, and other

passionate gestures, that their want of a tongue seemed rather an hindrance to others conceiving them, than to their conceiving one another". It is not clear that these two Deaf gentlemen were using a fully-fledged sign language (most deaf children are born to 'hearing' parents and may not have access to a sign language during their early years), although, "Bone was known to modify the complexity of his signing depending on the skill of the person with whom he was communicating" (Cockayne 2003). But the use of 'home sign' systems (Goldin-Meadow 1987) is well documented with recent examples found in Nicaragua (Kegl et al. 1999). The Cornish example does however show the desire for Deaf people to talk to each other and that their common visual experience of the world (Bahan 2008), their use of language and their community draws Deaf people together.

Typically in the Western world Deaf communities emerged with the beginnings of residential education. Much of the dialect difference in sign languages can be attributed to the main Deaf schools in different regions of a country that Deaf children attend (Sutton-Spence and Woll 1999). Schooling traditionally played an important part in socializing within the community and often Deaf people traveled more widely to meet other Deaf people when compared with those from non-Deaf backgrounds with a similar socio-economic status travelling to meet their friends. Deaf identity was often forged within residential school and at the Deaf club (social clubs for Deaf people) (Padden 2007). The emergence of greater access to further and higher education and a broader range of employment is changing the face of the Deaf community, but Deaf people are still coming together and forging a collective identity both locally, regionally, nationally and transnationally (Haualand 2007).

Development of the sign language interpreting profession

Interpreting and translation work is something that can be traced back to antiquity. And for the Deaf community there is a long tradition of family members interpreting so that Deaf people can have access to mainstream institutional activities. One of the earliest references found is in 1684 (Carty et al 2009) where a Deaf husband and other 'hearing' family members provide interpreting for a Deaf woman, Sarah Pratt, to explain her conversion story and be examined on points of doctrine to become a full member of the Puritan church in the New England. In the UK some of the earliest documented provision of interpreting we see is at the centre criminal courts in London (Stone and Woll 2008), where from 1771 we see family, friends, fellow workers, servants' masters and latterly teachers from Schools of the Deaf (known as asylums) giving courts access to the testimonies of Deaf witnesses, prosecutors and criminals.

Institutions have often relied on those in close contact with Deaf people such as friends and members of the family to ensure that institutions can continue doing their job. Similarly, whilst is often teachers and religious workers in Deaf schools that act as interpreters, this does not mean Deaf people are not called upon to provide more culturally sensitive interpreting as core members of the community (Boudreault 2005).

This first example of interpreter training and examining in the UK was via the Deaf Welfare Examination Board (DWEB) in 1928 (Simpson 1991). Whilst this was desirable

at the time there was much criticism in latter years of the lack of autonomy of Deaf people. This system, which tested a number of skills including language and interpreting, continued until 1976 when other pressures came to bear and brought about the creation of a professional sign language interpreter whose expertise was in interpreting. The contemporary interpreter in most countries will be trained and registered (cf. WASLI www.wasli.org) and may undertake further specialist training before working in a therapeutic setting.

Contemporary research

Since the 1960s we have know that natural sign languages (unlike those invented by people to 'help' deaf people) are full human languages with their own rules in relation to phonology, morphology and syntax (see Sandler, Lillo-Martin 2006 for a comprehensive linguistic overview of sign languages). In the main, sign languages exhibit different linguistic characteristics than most indo-european spoken languages, leaving non-signers thinking that an absence of tense or copular demonstrates sign languages are inferior manual version of a spoken language. Like many asia-pacific languages aspect rather than tense is marked, and like many languages of the world there is no copular form.

As with spoken languages, sign languages use the body to produce language. The articulators for speech are in the main unseen (the larynx, vocal tract, velum, tongue, etc.), whereas the articulators for sign languages are visible (hands, head, eyebrows, lips, etc.); the fact that humans have two hands also results in sign languages being able to exploit simultaneous constructions with different hands representing different linguistic units. Spoken languages have high temporal resolution with acoustic events being perceived and sign languages have high spatial resolution with visual events being perceived. Whilst the signer must be in view of an interlocutor a speaker need only be within earshot. And the feedback systems for the different modalities are different in that the one hears the spoken language one produces as others hear it; with signers what they see other signers produce and what they see themselves produce is different.

Both speakers and signers also produce gestures alone and with accompanying language; as manual gestures occur in the same modality as sign languages these gestures occur consecutively rather than simultaneously as with co-speech gesture. And there is evidence that even though the forms of some signs appear to be very similar to gestures there representations are stored differently as language (the signs) and gestures (the pantomimic demonstration of action) (see Marshall et al. 2003).

The processing of sign language

Recent research on signing deaf people and non-signing speakers has allowed us to understand in more detail where the brain processes different aspects of language in general and whether the visual modality affects where language is processed. The evidence supports the analysis that sign languages are processed with many of the same neural correlates of speech (the left perisylvian regions, MacSweeney et al. 2008) and these can rightly be thought of as language processing areas rather than speech processing areas. There are, however, some modality affects, and Emmorey (2002)

comprehensively documents similarities and differences for sign language using deaf people.

Evidence of signing and therapeutic needs

One of the issues experienced by Deaf people within therapeutic sessions is the lack of specific treatments or specific services for those with neurological impairments. In many cases it may be that Deaf people (in the UK at least) are not referred to speech and language therapy and that teams are ill prepared to deal with sign language using deaf people (Marshall et al. 2003). There is evidence, however, that after strokes Deaf people experience the same types of language processing issues (such as sign anomia and other types of aphasia) that spoken language users experience and that there is dissociation between gestures and sign language (Marshall et al. 2004).

It is also important to recognize the heterogeneity of the Deaf community and their residual hearing. As shown above identity is forged by attending Deaf schools, Deaf clubs and interacting with the Deaf community. This does not mean that all members of the community have equal levels of hearing loss. This can result in differing experiences of illness including psychosis where 'voice-hallucinations' can be experienced with a variety of perceptual characteristics ranging from nonauditory voice with subvisual perception of voice-articulators in the mind's eye to voice and true visual, olfactory, gustatory and tactile phenomena (Atkinson et al. 2007).

Interpreter-mediated therapeutic sessions

More often than not services are not established to deal with the specific needs of the Deaf community. In health care, psychiatric services and talking therapies, Deaf people often access support via an interpreter and in cases of complex need (such as cognitive impairment, developmental impairment and severe mental distress) Deaf interpreters often work alongside 'hearing' interpreter colleagues (Boudreault 2005). Although many non-interpreters view interpreters as machines (in the loose sense that interpreters will provide a verbatim rendering of one language into another), as human beings involved in an interaction interpreters do more than just render language. We have known for some time that interpreters within an interaction are trying to judge the most effective ways of understanding and rendering meaning (both in linguistic and cultural terms) (Roy 1996). We also have known that interpreters often try to manage interactions (Wadensjö 1998) and that interpreters do not take a neutral stance when interpreting (Metzger 1999).

These issues are somewhat compounded within the therapeutic setting when it may not be clear to the interpreter what information is of importance to the therapist and the different therapeutic strategies that are being adopted. And interpreters can often be seen within institutions as language specialists, culture specialists, patient advocates and sometimes as institutional therapists; these conceptualizations can be problematic (Drennan et al. 1999). Bot (2005) has undertaken a comprehensive analysis of the work of interpreters for asylum seekers and refugees in the Netherlands within a mental health care setting. Here we see that strategies that interpreters employ in other settings are also applied to the therapeutic domain. It is evident that interpreter-mediated therapy is a

complex area, as interpreters are human their renditions may diverge from the accounts given by the other interlocutors and this commonly influences therapeutic sessions.

Working with sign language interpreters for better outcomes

When working with interpreters it is clear from Bot (2005) that the most successful sessions occur when interpreters have a basic understanding of the professional domain they are working in and for the other professionals to know how to work with interpreters. In fact, those working in diagnosis may need to brief interpreters so that they understand the goals of the interactions as well as the roles and functions of those within a multidisciplinary team (Hsieh 2006).

One useful framework that is being used within mental health settings is demand-control theory as applied to sign language interpreter training (Dean et al. 2001). Here we see how interpreters can best prepare themselves to work within a variety of settings. By being familiar with how interpreters prepare themselves, considering them part of the team and enabling them to understand the interactions they are to become a part of, interpreter-mediated therapy can become more successful.

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