

## Working with Interpreters/Translators

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As the population from a variety of cultures and language groups grows in this country, clinicians are faced with the challenge of providing services to persons with aphasia and other communication or swallowing disorders in languages other than English, or in languages in which they may not be fluent. This is where the use of an interpreter/translator comes into play. While services are best provided by a clinician that speaks the language of the patient, this match is not always possible. For example, in speech-language pathology the American Speech-Language-Hearing Association reports that less than 4% of the membership self-reports as bilingual. In this country, over one third of the population speaks a language other than, or in addition to, English. This is a similar situation for the professions of psychology, social work, nursing and medicine.

This article will discuss matters related to using interpreter/translator to provide clinical services to persons with aphasia that communicate in a language other than English, or a language other than that spoken by the clinician. Understanding cultural factors involved in this exchange, as well as the difference between interpreters and translators will be introduced.

### CULTURE

The notion of culture is a broad one. Basically, everyone has one. Battle (2002) defines culture as “the behavior, beliefs and values of a group of people who are brought together by their commonality... [it] is the lens through which one perceives the world... speech, language and communication are embedded in culture” (p.3). Today’s clinician must accept and fully incorporate the notion that everyone has a culture, in order to be able to provide culturally appropriate services. Furthermore, culture goes beyond race and ethnicity. It is up to the practitioner to define culture more broadly and include not only ethnicity, but also religious beliefs, lifestyles, special interests, choice of supermarkets, etc. (Riquelme, 2007). In efforts to improve treatment outcomes, medical training centers are introducing the concept of *cultural humility* as distinct from cultural competence. According to Tervalon and Murray-Garcia (1998) “cultural humility incorporates a lifelong commitment to self-evaluation and critique, to redressing the power imbalances in the physician-patient dynamic, and to developing mutually beneficial and non-paternalistic partnerships with communities on behalf of individuals and defined populations.”

In 2004, the American Speech-Language-Hearing Association (ASHA) approved a practice document entitled, "Knowledge and Skills Needed by Speech-Language Pathologists and Audiologists to Provide Culturally and Linguistically Appropriate Services" authored by members of its Multicultural Issues Board. This document outlines the knowledge and skills that clinicians must strive to develop in order to provide unbiased and culturally appropriate services. It also acknowledges the need for lifelong learning. It lists competencies needed to achieve cultural competence, such as sensitivity to differences, understanding the influence of culture on service delivery and the need to advocate for and empower consumers, families and communities at risk for communication, swallowing or balance disorders. Some of the cultural factors to understand when working with limited-English speaking patients are: increased respect for individual differences within and between groups (e.g., family structure and roles, approach to disability and rehabilitation); separation of the effects of culture from the effects of socio-economic status; understanding the patient's sociocultural belief system; greater caution in interpreting and generalizing findings; greater caution in the use of formal tests; and awareness of differences in interpersonal relating (ASHA, 2004).

#### DEFINITION OF INTERPRETER/TRANSLATOR

The clinician employing the services of an interpreter or translator should be clear on the difference between the two, as well as the role this person plays in the assessment, treatment and counseling services being provided. An *Interpreter* is known as a person specially trained to transpose oral or signed text from one language to another. A *translator* is a person specially trained to transpose written text from one language to another. The clinician will likely use the services of an interpreter most frequently.

Interpretation may be consecutive or simultaneous. The former involves transmitting segments of a speaker's message while the speaker pauses for the interpreting to take place. The latter involves interpreting the message from one language to the other without lag time (Langdon, 2002, p. 3).

#### Selecting the Interpreter/Translator

Not every bilingual person has the ability to be an interpreter or a translator. In addition to proficiency in two languages, Langdon and Cheng (2002) state that other necessary skills include: ability to say the same things in different ways; ability to shift styles; ability to retain chunks of information while interpreting; and familiarity with medical, educational, and professional terminology.

Ideally, the interpreter should not be a friend or family member. The information being interpreted may be misunderstood, relayed inaccurately, or omitted (Riquelme, 2002). The interpersonal dynamics between the patient and the interpreter cannot be underestimated either. All these factors may ultimately influence the quality of the interpretation, and hence the clinician's ability to

diagnose or treat a communication or swallowing disorder. Finding the right balance between the communication disorders professional and the interpreter takes practice, and is further complicated by the need to include the patient in the triad, as the clinician would with any other patient s/he provides services to. The clinician is cautioned not to underestimate this delicate process.

#### WORKING WITH THE INTERPRETER

The ideal situation is to use a professional interpreter. This is an individual with national certification in interpretation/translation acquired through formal education, usually a minimum of a Master's degree. The professional interpreter is expected to maintain neutrality, respect confidentiality, interpret faithfully and participate in ongoing learning and remain flexible (Langdon, 2002). When a professional is not available, the next best option is to access the facility's language bank. The last resort would be to use a family member. The following outline should serve as a guide for collaboration with any interpreter, whether professional or not.

##### *Before meeting with the patient:*

The speech-language pathologist or audiologist should meet with the interpreter before the scheduled session with the patient.

- Both parties will be able to discuss the purpose of the session, nature of the case, format and goals for the session.
- They will agree on the best physical arrangement for the session.
- Good rapport should exist between the clinician and the interpreter, especially in view of possible communication problems that may arise during the session.
- The interpreter should also be made familiar with the protocols and test batteries to be presented, and the need to interpret verbal output as close to the original as possible (e.g., identifying agrammatism).
- The clinician should also plan for a longer session, so as to allow time for the interpreting process, and subsequent meeting with the interpreter.
- The clinician should also brief the interpreter on the different types of speech and/or language disorders that may be present. This will allow for a more collaborative approach to diagnosing the disorder, or providing treatment for its amelioration.

It is also important to highlight the reduced number of assessment batteries or treatment materials available in languages other than English. In the author's experience, most of the materials available in other languages are usually quite basic, and appropriate for persons with more severe aphasia, for example. When working with a right hemisphere impaired individual, for example, materials available in non-English languages are almost non-existent. In this case, the services of the interpreter or the translator take on an added role. For patients with cognitive-linguistic or right hemisphere disorders, the clinician may need to ask the interpreter or translator to adapt some materials, not to simply translate them. Idiomatic expressions cannot be translated from one language to another

and be expected to keep their meaning. Furthermore, many idiomatic expressions are culturally based, and do not translate well.

*During contact with the patient:*

- It is extremely important that the clinician talk to the patient, as if the patient could speak his/her language.
- The clinician should maintain eye contact with the patient, not with the interpreter. Use of the second person is also important (e.g., "Tell me what brought you to the hospital," rather than "Ask them why they were brought to the hospital").
- It is also important for the clinician to avoid using technical language.
- S/he should also be clear with the patient as to the purpose of the session, and explain the need to use an interpreter.
- While the session is progressing, the clinician must not only be aware of the data being gathered, but also of the patient's reactions to the questions or situations that arise.
- At the end of the session, the clinician should summarize any decisions or recommendations that have been made.
- The clinician should encourage the patient to ask for explanations or clarifications.

*After the session is over:*

- The clinician should feel comfortable discussing any cultural or linguistic issues that may have arisen during the session.
- The information obtained during the session should be reviewed and discussed jointly.

## WORKING WITH THE TRANSLATOR

The clinician may be in need of two types of translation: prepared or sight.

*Prepared translation* involves preparing a written version of any type of document. *Sight translation* involves providing a spoken translation while reading a written document (Langdon, 2002).

## RESPONSIBILITIES OF THE CLINICIAN WHEN USING AN INTERPRETER/TRANSLATOR

While the clinician may need the services of an interpreter or a translator, s/he is ultimately the professional responsible for the appropriateness of the service being provided, be it an assessment, treatment, or a counseling session. Therefore, the clinician must still strive to: have knowledge about bilingualism and patterns of linguistic recovery; continue to update knowledge through continuing education; adequately prepare the interpreter/translator; and document successful strategies in working with the interpreter/translator.

## MODIFYING TESTING PROCEDURES

When working with adults, clinicians often use a combination of formal and informal test protocols. While formal materials may be formally translated,

caution should be taken as to the need for adaptation of the material. For example, in a battery designed for persons with right hemisphere dysfunction, tasks to assess cognitive flexibility and integration may include the explanation of idiomatic expressions. These may be meaningless upon translation to another language (e.g., “Her father hit the roof.”), unless adapted accurately.

The examiner should also be aware that testing will take longer, and s/he may need to spend more time developing a relationship with the patient. Certainly, the examiner should reword instructions, as needed, and record all responses for later analysis. The examiner should also accept culturally appropriate responses and make sure culturally appropriate pictures and themes are being employed (adapted from Kayser, 1995).

It is also important to note that the recommendations to be made will impact the patient’s ability to participate in cultural traditions. In general, recommendations should be formulated jointly with the patient, in efforts to ensure appropriate follow-up.

#### UNDERSTANDING TREATMENT

In reality, the use of an interpreter/translator for treatment sessions may be a bit more difficult, as per the need to coordinate schedules with the patient, speech-language pathologist or audiologist, and the interpreter/translator. This is certainly not impossible, however, and should not be an excuse to not provide appropriate services. At all times, the clinician should be aware of the influence of culture on communication and swallowing. The clinician should not assume that everyone understands treatment sessions and/or the need for follow-up at home.

It is also important to understand that treatment with an interpreter presents further challenges when needing to address the many nuances of language production. For example, when working with a patient with a Nonfluent Aphasia, the cuing hierarchy is often based on the patient’s output. This may be difficult for a clinician to develop when working with an interpreter.

#### PARTING THOUGHTS

Although language matching of the patient and clinician is not always possible, it is the clinician’s responsibility to ensure the best outcome for the patient. Demographic trends continue to show an increase in persons from diverse backgrounds in this country, and societal attitudes are changing towards greater respect for the inherent diversity in our world. Our multicultural and multilingual society, as well as our ethical and moral standards, require clinicians to provide the best services possible with excellent professional expertise, cultural humility and cultural and linguistic competence so as to achieve the best possible outcomes for all persons with communication disorders.

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