Interpreters and Speech Pathologists : Some Ethnographic Data

Elizabeth Clark, Charles Sturt University, Australia

Australia is a multilingual and multicultural society in which approximately 20% of the population speaks English as a *second* or *other* language (Australian Bureau of Statistics, 1991) and over 250 languages are in current use (Clyne, 1990). This mix of languages and cultures presents a considerable challenge for speech pathologists as they attempt to assess and treat speech, language and communication problems in patients from non-English speaking backgrounds (hereafter NESB). As with many other professional groups in Australia, speech pathologists do not reflect the range and mix of language and cultural backgrounds of the population as a whole. The fundamentally monolingual nature of the profession means it is often necessary for speech pathologists to work with interpreters when providing services to NESB patients.

Interpreting within the domain of speech pathology is a demanding area for interpreters, as speech pathology assessments can place considerable linguistic and ethical demands on interpreters. It is not uncommon for interpreters to be called upon to do more than simply interpret for the NESB client and the speech pathologist. Often a speech pathologist will ask an interpreter to become involved in some type of *analysis* of the client's responses, in order to identify deviations from the language norms of the patient's community which might lead to a diagnosis of a speech or language impairment. This situation is a complex one for both the interpreter and the speech pathologist, fraught with potential for misunderstanding and confusion over roles and responsibilities.

This paper will explore the context of interpreted speech pathology assessments from the perspective of a group of interpreters and speech pathologists based in Melbourne, Australia. After outlining some of the features of this complex context, the discussion will focus on the degree to which there is a shared understanding of the respective *professional roles* . Some recommendations regarding future collaboration and research will also be made.

Background

It is important to understand the broader context of health service provision within which the interpreters and speech pathologists work together. Before discussing the data from my recent research, I would like to present some brief comments to help contextualize the situation in Melbourne, Australia.

In Australia, 'multiculturalism' was adopted as a policy platform at the federal level in the 1970's., and has generally received bipartisan political support since that time. There is growing concern, however, about the ability of many service sectors to respond to the social justice implications of this policy, particularly in terms of providing services that fully meet the needs of people from non-English speaking backgrounds (Pauwels, 1991b; Lee, 1990). This is particularly so in the health sector, with a number of reports attesting to the difficulties catering for the health needs of minority and specific groups in society (Galbally Report, 1978; McClelland, 1991; Migrant Health Unit, 1989; Pauwels, 1995).

Strategies used in Victoria to address inequities in the health sector include the provision of health-related information in community languages, the employment of migrant health officers in various health facilities, and the extension and development of interpreting services within the health sector such as the Central Health Interpreting Service (CHIS) and the Telephone Interpreter Service (TIS).

While these strategies have resulted in significant improvements in health care to NESB patients, inequalities in access to, and standards of, service provision to NESB patients continues to be a source of concern (Intercom Consulting, 1997). Victoria is fortunate to have a specific health interpreting services, but the availability of appropriate interpreters in the health system is still quite variable (Gentile, 1991) and health professionals generally have limited training in working with interpreters (Pauwels, 1990).

Interpreting for Speech Pathology

Our knowledge of the *language issues* inherent in encounters between monolingual English-speaking health professionals and NESB patients has been informed by a wealth of research into cultural differences in health care (Cox, 1987; Ryan, 1991; Pauwels, 1995) and doctor-patient interactions (Byrne & Long, 1976; West, 1984; Buttny & Cohen, 1991; Cicourel, 1992). To date there has been little linguistic research into patient encounters with allied health professionals including speech pathology encounters.

Gentile (1996) outlines the linguistic issues facing interpreters involved in speech pathology assessments, in particular the importance of the finely grained analysis that is required in speech pathology. In addition to a well developed understanding of the linguistic dimensions of both the target languages, speech pathologists also expect a

thorough understanding of the communication and interaction 'norms' of the patients language community.

Ethical issues are at the heart of concerns about the role of the interpreters in various contexts, including speech pathology (Gentile, 1996; Hale, 1996). The interpreters code of ethics specifically cautions against making judgements about the NESB client's use of their mother-tongue (Frey, 1990), yet an *evaluation* of whether mother-tongue skills are 'normal' or 'disordered' is precisely what a speech pathologist needs in an assessment in order to determine the extent of any language impairment. Indeed, the diagnosis of 'disorder' relies primarily on the degree to which a patient's speech or language varies from the norms within a language community (Hand, 1991).

Ethnographic Investigation into Interpreted Speech Pathology Assessments

Sjardin (1990) identified a number of areas of difficulty for speech pathologists working with interpreters, using a questionnaire circulated via a national professional newsletter. This study extends that line of enquiry, clarifying and examining the types of difficulties that are experienced by speech pathologists *and* interpreters using an ethnographic framework for data collection. Ethnographic methodology provides for the collection of information about language and behaviour from a variety of sources and involves both description and explanation of observed behaviour with a focus on the participants' own interpretations of what actually happens in an interaction, enables the salient features of a particular context to be defined and explored (Saville-Troike, 1989)

Data for the entire project included extensive interviews and observations as well as detailed analysis of recorded speech pathology assessments and various written texts. This paper will focus on the interview data only.

Interview Data

Interpreters were selected from the Central Health Interpreter Service (CHIS), a service funded by the Victorian Government. The sample of interpreters included both contract and sessional staff. Speech pathologists were selected from four major public hospitals in the Melbourne metropolitan area. These hospitals provide services to a broad range of ethnic communities as well as representing both acute and rehabilitation services.

All subjects indicated that they had, in the past, experienced some degree of difficulty working with members of the respective *other* professional group during the assessment of NESB adults. Close scrutiny of the interview data showed that these difficulties could be grouped around six major themes:

a) the *training* received by both professional groups;
b) the establishment of *rapport* between the participants in the assessment;
c) the availability of *appropriate resources*[1] for speech pathology assessment and treatment;
d) the degree to which speech pathologists felt *comfortable* with different languages and cultures;
e) the use of *family members* as interpreters;
f) the *roles* each professional assumes in an assessment session, and the extent to which there is a shared understanding of each others role.

The analysis of data pertaining to all six of these themes revealed some interesting results, but given the dimensions of this paper I would like to focus on the theme of *professional roles*.

Professional Roles

Successful collaboration between two professionals is dependent on many factors, not least of which is the understanding each has of their own role and expertise in relation to that of the other. Detailed analysis of the interview data shows there was both *consensus and confusion* over the respective roles of speech pathologists and interpreters in an assessment context.

The Role of the Speech Pathologist

Not surprisingly, there was consensus that the speech pathologist should be the person 'in control' of an assessment session, in accordance with their expertise and professional responsibility in the medical context.
Furthermore, this sense of control is evident in the behaviour of speech pathologists: they are responsible for booking the interpreter, for determining what information the interpreter receives about the patient and for deciding what tools will be used to assess the patient. Further, they instruct the interpreter about tasks to be undertaken, about the aspects of speech or language to focus on, in addition to generally setting parameters for accuracy and conduct within which the interpreter is expected to work.

As the interpreter in the following extract points out however, speech pathologists do not always appreciate their role as 'controller' of the session (line 1), sometimes put the responsibility for the session back onto the interpreter (line 3) which can have a negative impact on patient care (line 7).

Extract 4.13

1In	?	Now some don't know that they are controllers of the interview
2		and they let go and they leave the interpreter- Put all the

[1] Apart from the bilingual aphasia batteries developed by Paradis (1987) , there are few resources for assessing non-English speaking patients in Australia.

3 emphasis and work on the interpreter. Not because they want
4 to do that but because they say “Well I’m not very familiar
5 ? with this person, let the interpreter do it” more or less. That
6 is not a very positive result for the patients’ care because
7 ? treatment has to be equally accessible to this person and I
8 don’t think it happens just like that and I think you have to put
9 a bit of effort into it to get the results if you really care.
10

The lack of familiarity with diverse languages and cultures (Line 5) is a critical factor in speech pathologists’ *perceptions* of their ability to effectively control an interpreted assessment session. Ambivalence about extent of their control relates directly to the fact that what they are professionally interested in, namely language and interaction skills, is not *directly* accessible to them. They must act upon second-hand data, which often does not contain the nuances of direct communication, particularly the subtle hesitations and repairs that can signal possible speech and language disorders.

This ambivalence about the extent to which it is possible to truly ‘control’ interpreted sessions is reflected in the mixture of hesitancy and certainty with which the following speech pathologist describes her role in relation to the interpreters roles.

Extract 4.14

1 R How would you describe your role? What are you
2 responsible for and what are they responsible for?
3 Sp ? Yeah, I guess- I sort of feel like I am the boss. Um- (0.3) and
4 ? firstly they are responsible for giving me- for doing that
5 interpreting and then, as I said it’s an added bonus if they
6 ? give me information that I will probe for.

The use of word "boss" does more than signal the speech pathologist’s ‘control’ of the session, implying an employer/employee relationship between the two professionals. The preceding phrase ("I guess I sort-of feel") points to a lack of confidence, however, in claiming such a position. These comments also serve to highlight the dual nature of the interpreters position, namely both professional peer *and* ‘quasi-assistant’: potentially another reason for the ambivalence that a number of speech pathologists reported in relation to working with interpreters.

Further analysis of this extract raises a further dimension for this ambivalence. The self repair in line 4, where “giving me-” is replaced by the word “doing”, gives an insight into the way the process of interpreting is viewed by this speech pathologist. The words, “giving me”, frame the act of interpretation as a static ‘thing’ which can be ‘given', whereas “doing” more accurately reflects the dynamic nature of interpreting. Few of the speech pathologists interviewed appreciated the dynamic complexity of interpreting. This resulted in unrealistic expectations and meant that speech pathologists often experienced difficulties defining appropriate parameters of performance for the interpreter.

The Role of the Interpreter

The role of the interpreter was generally described in two distinct parts, as it is in the extract below. One component relates to the *transmission of information* between the speech pathologist and the patient (line 3), and the second to determining the '*cultural appropriateness'* (line 7) of test materials.

Extract 4.15

1 Sp Well, I see the interpreter's role as giving the- >I think they've
2 got a two fold role - obviously they've got to get the
3 ? **information** across to me and the patient< ... I would be
4 surprised if they didn't have to modify some of the
5 information that I gave them... but its important that they give
6 that feedback to me... I think they need to play a role in
7 ? terms of, I suppose, that **'culturally appropriate-ness'**
8 and also give feedback in terms of their ability to interpret the
9 information accurately... so they need to be able to tell me
10 "No, it won't go across to them as you want it to" but I also
11 see my role as letting them know that the information that
12 I'm giving them needs to be as I say it and if it's not then I
13 need to know that. I s'pose that's what I see the **main role**
14 ? as. And in terms of assessment we need that accuracy of
15 information from a language and speech point of view as well.
16 And I also think that getting **feedback** from the patients
17 ? about whether they are stressed or not is quite important as
18 well."
19

The use of the phrase 'main role' (line 14) indicates that there may well be a hierarchy of roles - both major and minor. Indeed this speech pathologist goes on to define another role for the interpreter - getting feedback from patients about their emotional state (line 17). The following extract provides a clearer definition of the multi-faceted role of the interpreter, which is equated with being a "chameleon" (Line 22). Different components of the interpreters role are presented in the order of performance within the speech pathology assessment session. The first role is usually the *translation of written texts*, followed by the provision of feedback on *cultural appropriateness* of materials during the briefing stage of the session. Then follows the *transmission of information* between the patient and therapist during the actual assessment phase, and finally some degree of *analysis* in the debriefing stage of the session. The final few lines of this extract, where speech pathologist realizes the complexity of the task expected of the interpreter, are a good example of the potential for personal and professional reflection which involvement in research projects can give practitioners.

Extract 4.16

1 Sp Um:: (1.2) I try to-(.)um:: (2.1) In a way- like in a lot of
2 ? testing I almost try to act as if the interpreter's not there?
3 ? You know what I mean?
4 R Yeah , right.
5 Sp As if they are interpreting purely - ( ) so that's what- I
6 R ?yeah

7 Sp ? suppose- I mean their role changes. (0.3) Like I come in and
8 they'll need to interpret what is written before them and give
9 me feedback on if that's culturally biased or not=
10 =Yeah=
11 R =And then I expect them to do a pure translation of what I
12 Sp say and- and what the patient says and then I ask them
13 you know (.)"Did they say the right words? Did they say
14 jargon? Were the sounds in the right order?" so then I ask
15 them- I'm basically asking them (.)to:: (.) um analyse =
16 =Hmm=
17 =not in order to diagnose but in order to describe (.) patterns
18 R of things that happen.
19 Sp Ok
20 So (.) really they have to be quite a little chameleon (0.9)
21 R don't they?
22 Sp Have you talked about that (.) quite- I mean have you ever (.)
23 talked through those different roles quite specifically?
24 R No, I've never really thought about them in that light >except
25 for now.
26
27 Sp
28

Notwithstanding the confusion in the use of the terms 'interpret' and 'translate' in this extract, this subject identifies the *analysis* of the patient's speech/language as a facet of the interpreters role which is equally as important as the other facets, and established a connection between description and analysis which I will address again later. Furthermore, this description indicates that the generally accepted notion of an interpreter, as someone who simply facilitates the transmission of information between two people unable to communicate in a common language, does not match the expectations speech pathologists have of interpreters in an assessment context. This mis-match in expectations can be seen more clearly in the more judgemental language of the following extract.

Extract 4.24

1 Sp ? Some interpreters I've found to be a lot more thorough and
2 really keen to give you that information and others might say
3 "That's fine - there are a few slight mis-articulations or a little
4 bit of slurring but no, no he's fine". Sort of very vague- and
5 ? perhaps they see their role as they've just interpreted for me
6 and their job's over. They don't really understand the
7 importance of the work in clarifying the information after the
8 ? session."

The clear impression here is that interpreters who are not 'keen' be involved in 'analysis' in the debriefing stage of the session are not 'thorough'. The concern that interpreters felt about engaging in any form of 'analysis' is, however, entirely appropriate given that they have no training into the parameters of language

behaviour that may be relevant in a speech pathology assessment context. The comment that interpreters don't seem to appreciate the importance of clarifying the information gained in the assessment session was not borne out by data from interpreters, as the following comments show.

Extract 4.25

1	R		Yes, because there's almost no point in having an interpreter
2			if you don't also have that debriefing.
3	In	?	It's so:: important. I think it's almost mo::re important in
4			speech than in any other field.

The most likely cause of this mismatch in perception and expectation appears to stem from different ideas of what is 'description', 'analysis' and 'opinion'. Speech pathologists appear to use the term 'analysis' to encompass *description* of patterns of communication as well as *clarification* of the degree to which speech and/or language is within 'normal limits' for the mother tongue. Interpreters seem to take the term more literally, focusing on connotations of 'opinion' within the broader spectrum of 'analysis'. In a medical context (ie 'Get a second opinion"), opinion is more closely linked to making a judgement or diagnosis and most interpreters rightly refuse to enter into such dangerous ethical areas.

The extent of interpreter concerns about inadvertently giving opinions is clearly seen in the following extract:

Extract 4.27

1	R		Have they ever asked you for your opinion?
2	In		They do. (0.7) That's another thing I don't like about, um I
3		?	don't know what they are looking for so I don't know- I'm not a
4			speech pathologist- I can't give my opinion. Um I can
5		?	comment, like I mean if they ask me to watch their speech if
6			it's grammatically correct I can comment on that.
7			So the difference to you then between what's comment and
8	R		what's opinion is that you can comment on what they've
9			asked you to look for=
10			=Yes=
11	In		=but anything else would be giving your own opinion=
12	R		=Yeah. And it may be VERY wrong.
13	In	?	

This interpreters concern is that by commenting on anything other than what the speech pathologist has specifically asked her to 'watch', or listen for, she would be guilty of giving a personal opinion. The strength of 'VERY' (line 13) in conjunction with the conditional 'may' reflects a fear that her personal opinions, lacking the training of a speech pathologist, could easily be wrong. In turn, this could result in the inappropriate treatment of that patient.

In addition to the central issue of how respective roles were defined and managed within an assessment session, a number of factors which impact on the actual *performance* of these roles were also identified during the interview process. These factors, which are relatively self explanatory, included :

a) the extent of shared understanding of aims and methodology,
b) the time allocated to the assessment,
c) the accordance of professional respect, and
d) the complexity of interpreting incoherent speech and/or language.

Conclusions

The interviews carried out with speech pathologists and interpreters clarify and extend the range of difficulties which had previously been identified (Sjardin ,1990) as affecting the working relationships of speech pathologists and interpreters. Limitations in the training of both professional groups are compounded by a lack of familiarity and confidence with diverse languages and cultures on the part of most speech pathologists. The ability to establish rapport with both patient and interpreter has a significant effect on all participants in an assessment. The current lack of assessment and treatment resources in languages other than English is also an issue.

Most importantly, however, detailed analysis of interview data showed that the respective roles of speech pathologists and interpreters are not always clearly understood. Moreover, it seems that mismatched expectations can result in confusion and frustration which can have a negative impact on the management of NESB patients.

Training of both professions (interpreting and speech pathology) is one means of improving the outcomes of interpreted speech pathology assessments. All interviewees felt that current professional development programs appear to adequately address *basic principles* of collaboration, though was broad concern that future education programs address the complexity of roles and expectations more directly. Furthermore, such programs should use recorded, real life examples rather than role plays as the former allow for more opportunities for discussion and reflection. Of paramount importance is the explicit negotiation of what the interpreter's role should be in the 'analysis' of a patient's language skills, including discussion of the difference between *describing* the patients communicative behaviour and *evaluating* those behaviours in relation to the norms of the relevant language community.

One of a number of practical suggestions which arose from the interview data was that some kind of 'proforma' document be developed, to act as both a reminder of respective roles and responsibilities as well as providing a means by which professionals could reasonably sit down and negotiate areas of potential confusion

or conflict. Such areas include the type of interpreting methodology to be used, the range of possibly salient features that may be present in the patient's communicative behaviour which the interpreter may need to remain alert for, as well as the extent to which an interpreter feels qualified to engage in 'analysis' of the data in the debriefing stage of the session.

Interpreting for speech pathology is always likely to be a complex and demanding task. This study has ways that collaboration between speech pathologists and interpreters could be enhanced, thus improving speech pathology service provision to our multicultural community in the future.

Bibliography

Australian Bureau of Statistics (1991) *Census of Population and Housing.* Canberra: Australian Bureau of Statistics.

Buttny, R. and Cohen, J. (1991) The Uses of Goals in Therapy. In K. Tracy (Ed) *Understanding Face to Face Interactions.* New Jersey : Lawrence Erlbaum Associates

Byrne, P. and Long, B (1976) *Doctors Talking to Patients*. London : HMSO Publications

Cicourel, A (1992) The Interpenetration of Communicative Contexts : Examples from Medical Encounters. In A. Duranti and C. Goodwin (Eds) *Rethinking Context* Cambridge : Cambridge University Press

Clyne, M. (1991) Australia's Language Policies : Are we going backwards? *ARAL Series S*, No. 8, pp 3-22

Cox, D *(1987)* 'Multiculturalism in Health and Welfare' in Yee, H.M. (ed) *Aboriginal and Multicultural Conference: Selected Papers.* Gippsland Institute of Adult Education.

Frey, R, Roberts-Smith, L. & Bessel-Browne, S. (1990) *Working with Interpreters in Law, Health and Social Work.* Perth : National Accreditation Authority for Translators and Interprets

Galbally, F. et al (1978) *Migrant Services and Programs: Report of the Review of Post-Arrival Programs and Services for Migrants*. Canberra: Australian Government Publishing Service.

Gentile, A. (1991) Working with Professional Interpreters. In A. Pauwels (ed) *Community Language Skills for Health Professionals*. Melbourne: Monash University.

Gentile, A., Ozolins, U., & Vasilakakos, M. (1996) *Liaison Interpreting* Carlton: Melbourne University Press

Hale, S. (1996) Pragmatic considerations in Court Interpreting. *ARAL 19, 1*

Hand, L. (1991) Bilingualism : Issues for Speech Pathologists*. The Australian Communication Quarterly*, Summer Edition.

Migrant Health Unit (1989) *Multicultural Health: Proceedings of the First National Ethnic Health Policy Conference.* Adelaide: South Australian Health Commission

Paradis, M. (1987) *The Assessment of Bilingual Aphasia*. New Jersey:Lawrence Erlbaum Associates Inc.

Pauwels, A (1990) *Health Professionals Perceptions of Communication Difficulties in Cross Cultural Contexts.* ARAL Series 7. .

Pauwels, A (1991a) The Problems of Relying on Non-Professional Interpreters. In A. Pauwels (Ed) *Community Language Skills for Health Professionals*. Melbourne : Monash University.

Pauwels, A (1991b) Language, Culture and Health Care. In A. Pauwels (ed) *Community Language Skills for Health Professionals*. Melbourne : Monash University.

Pauwels, A. (1995) *Cross-cultural Communication in the Health Sciences: communicating with Migrant Patients*. South Melbourne: MacMillan Education, Australia

Intercom Consulting, Plimer, D. and Strategic Data (1997) *Issues and Options Paper for the Review of the Funding and Management of the Language Services System* Melbourne: Victorian Government

Ryan, J. (1991) *Cross Cultural Attitudes of Parents of Language Disordered Children* (Masters Thesis)

Saville-Troike, M. (1989) The Analysis of Communicative Events. In Saville-Troike *The Ethnography of Communication: An Introduction* (2nd ed.) Oxford : Basil Blackwell.

Sjardin, H. (1991*)* Speech Pathologists Working with Interpreters. *Australian Communication Quarterly.* Summer Edition.

Sjardin, H. (1995) *Bilingualism and Aphasia : An Australian Perspective* Paper presented at the International Symposium on Communication Disorders in Bilingual Populations. Haifa, August 6-10,1995

West, C. (1984) *Routine Complications: Troubles with Talk between Doctors and Patients.* Bloomington: Indiana University Press.