ABSTRACT: Teams of speech-language pathologists, interpreters, and clients were asked to respond to a survey about the characteristics of an effective conference where the results of a speech-language assessment and recommendations were reported. The goals of the project were to describe practices followed by clinicians to ensure that their professional voice was conveyed effectively to the client despite a language barrier and to assess clients’ satisfaction with the information they received. Questions for the speech-language pathologists and the interpreters were similar and pertained to clarity, accuracy of the information conveyed, and issues of confidentiality, clients’ rights, and the dynamics of the conference (what to do if the client seeks advice directly from the interpreter, what to do if the client brings in a bilingual advocate, and what if the interpreter does not agree with what is said). The speech-language pathologists and the interpreters were also asked to provide descriptions of a “good” and “bad” speech-language pathologist and interpreter, and to comment on their reactions to the process of interpretation. A follow-up study was conducted to validate the responses of the speech-language pathologists.

Questions for the client included impressions about how the roles of the team members had been defined, the clarity and the accuracy of the information provided, the team’s ability to understand the client’s concerns, the confidentiality of the information shared, and the general level of satisfaction with the process. The article discusses the clinicians’ responses, compares them to known best practices, and makes suggestions for areas to emphasize in future training for teams of speech-language pathologists and interpreters. Ideas for future research are also outlined.

KEY WORDS: bilingual conferences, interpreters, collaboration
“selected and administered as not to be discriminatory on a racial or cultural basis” and the tests must be “provided and administered in the child’s native language or other mode of communication (Turnbull & Cilley, 1999, p. 21). Assessment includes testing, collecting background information such as health and development history and language use in different contexts, and understanding the client’s specific concerns. When the process is completed, results and recommendations must be reported directly to the client’s family.

When the speech-language pathologist and the client do not share the same language, the process becomes complex for two reasons: There are insufficient numbers of available bilingual speech-language pathologists whose language(s) match those represented within one district or community to meet the needs of a given linguistic group, and there are no certified speech-language pathologists who speak a given language. The latest American Speech-Language-Hearing Association (ASHA) directory of bilingual speech-language pathologists provided names of speech-language pathologists who can conduct services in one or more of 50 different languages (ASHA, 1996). A personal communication with S. Martinez (May 31, 2001) indicated that the variety of languages spoken by clinicians has not increased significantly in the last 5 years. Currently, 1,500 speech-language pathologists and audiologists from ASHA’s membership of 100,000 (or 1.5%) have reported that they can provide clinical services in a language other than English (including sign language). Therefore, collaboration with an interpreter is necessary to communicate with clients and their families whose English language fluency is limited.

The main purpose of this article was to identify current practices followed by speech-language pathologists and interpreters1 that enable clients2 to be full participants in conferences.3 The second purpose was to validate specific information reported by the speech-language pathologist group by sampling and analyzing a larger sample of clinicians. The researcher was particularly interested in documenting clients’ satisfaction with the process and in outlining the strategies used by the clinicians to preserve their professional roles despite their inability to communicate directly with their clients.

This article includes information on clinicians’ competencies needed to conduct conferences reporting assessments when the clinician and client/family share the same language and when the clinician and client/family do not share the same language. The results of an initial study surveying teams of speech-language pathologists, interpreters, and clients to define best practices in communicating information during conferences is also presented. Results from a follow-up study where responses from a larger sample of speech-language pathologists were collected because the initial study yielded very few returns are also reported. The last section of the article discusses areas to consider in the future training of speech-language pathologists and interpreters to enable clients to become more active participants in conferences and to maintain the speech-language pathologists’ roles and responsibilities despite a lack of direct communication with their clients.

COMPETENCIES NEEDED TO CONDUCT CONFERENCES REPORTING ASSESSMENT RESULTS: CLIENT AND CLIENT/FAMILY SHARE THE SAME LANGUAGE

All speech-language pathologists have similar duties, but their scope of practice varies according to their particular setting of employment (e.g., school, clinic, hospital, rehabilitation center) and the ages of their clients. All clinicians’ primary responsibilities include the assessment of various speech and language disorders, treatment for these disorders, and communication with clients, their families, and other professionals who interface with the clients. Kamhi’s (1995) definition of an expert speech-language pathologist is one who has a solid knowledge base of the profession, who follows various needed procedures to evaluate clients’ communication skills effectively, and who applies problem-solving skills. Effective rapport with various persons such as parents, teachers, students/clients, and other professionals is also necessary.

Part of a clinician’s practice is to report the results of an assessment and recommendations to parents, significant others, and the client (when appropriate) during an individualized family service plan (IFSP) for children under the age of 3, an individual education plan (IEP) for students up to age 22, or a conference for older clients. The process includes five steps (Harman, 2000; Moore-Brown & Montgomery, 2001):

- summarizing and synthesizing the results of the evaluation to identify and describe the presence or absence of a speech-language-communication impairment;
- determining whether the client qualifies for services under the state guidelines or managed care system;
- conveying the assessment results in a comprehensible manner for the client’s family and the client;
- writing goals and objectives that will enhance communication skills, keeping in mind the educational and occupational needs of the client; and
- offering the client and his or her family suggestions on strategies to enhance communication at home and away from the educational or occupational settings.

The success of this process depends on the clinician’s knowledge of the field, but also on his or her interpersonal...
skills, which include confidence, adaptability, enthusiasm, and interest. Andrews and Andrews (2000) suggested that school speech-language pathologists need to show respect to the student’s family as well as curiosity and interest about the student. The use of examples, avoidance of jargon, and adoption of a “both/and” perspective are helpful strategies to clarify the information presented. Listening with empathy and asking parents questions about their views and ideas for intervention enhances their full participation in the process and ensures successful outcomes. These same guidelines can be applied to other settings such as the clinic, hospital, or rehabilitation center. Additional issues to consider include confidentiality (violating this aspect is counter to the Family Educational Rights and Privacy Act [Education Amendments, 1974]) and the assurance that parents and clients understand their rights. The tasks to be performed are challenging even when the speech-language pathologist and the client share the same language. The process is even more complex when the clinician and the client do not share the same language.

In accordance with IDEA, special educators must ensure that all steps of the assessment process are clearly conveyed to the client’s parents. The law stipulates that an interpreter/translator (I/T) is needed to bridge the communication between the professional and the client when there is a language barrier. Therefore, working with an interpreter is necessary in order to convey the information and the decisions made during a meeting (Dennis & Giangreco, 1996; Langdon, 1994; Osborne, 1995). However, best practices on how to conduct meetings of this nature have not been reported extensively except for Fradd (1993), Langdon and Cheng (2002), and Langdon, Siegel, Halog, and Sánchez-Boyce (1994).

A limited number of studies have reported clients’ reactions to the information presented during meetings, but the results are often contradictory. For example, in their study with five Latin American families, Padrón, Wilson, and Zetlin (1996) reported that the parents were unaware of their rights and that they were unsure of their child’s level of functioning. Furthermore, the parents felt intimidated and confused at IEP meetings, but they were reluctant to question the professionals about the curriculum or the teaching methods followed. This feedback was provided even though the conferences had been conducted in Spanish. In contrast, a study with 50 Latino families (Bailey, Skinner, Rodríguez, Gut, & Correa, 1999) found that several families were satisfied with the services provided for their children in an early intervention program. Dissatisfaction was more apparent when the families had no access to materials written in Spanish, or when there were no I/Ts available. Therefore, conveying information about special education procedures and results of assessments in a client’s first language is only one of the steps necessary to facilitate the clients’ understanding and participation of the process. The manner in which the information is transmitted appears to be equally important. Thus, a description of the specific roles and responsibilities of speech-language pathologists or any special educators and those of interpreters is needed to convey accurate and comprehensible information to clients who do not speak the majority language.

### Competencies Needed to Carry Out Conferences Reporting Assessment Results: Clinician and Client/Family Do Not Share the Same Language

The success of an interpreted conference, as it is defined in this article, is based on two levels of interpretation. The first level of interpretation depends on the clinician’s knowledge and understanding of assessment procedures conducted on a client who does not speak the majority language. A second level of interpretation relies on the use of effective strategies to work with interpreters.

**First Level of Interpretation of Assessment Results on a Client Whose First Language Is Other Than English**

Moore-Brown and Montgomery (2001) listed specific competencies for speech-language pathologists who work with multilingual clients. These competencies include understanding second-language development and acquisition issues, conducting non-biased assessments (taking into account the client’s culturally different experiences), and collaborating with interpreters. Best practices suggest that the speech-language pathologist takes into account six areas when reporting the results of an assessment: limitations of tests even when they were normed and administered in Spanish (where a greater number of normed tests are available); observations and feedback provided by the client’s family, teachers, or coworkers over time; health and early development history; the client’s experiences in using and learning each language; experience with testing in general and the family’s level of acculturation and rearing practices; and understanding of language and learning disabilities (Kayser, 1995; Langdon, 2000; Langdon & Cheng, 2002). In their multicultural assessment chapter, Suzuki, Ponterotto, and Meller (2001) indicated that an assessment should be one where “there appears to be greater understanding of merging qualitative and quantitative measures and procedures in many areas of assessment” (p. 571). Additionally, generating and creating various clinical hypotheses based on the findings and the cultural background of the client must be considered (Ridley, Hill, & Weise, 2001).

The limitations of normed tests on multilingual individuals have been long debated in the literature and will not be discussed in depth in this article. The reader can refer to sources such as Battle (1998), Hamayan and Damico (1991), Langdon and Cheng (1992), and Valdés and Figueroa (1996).

Reliability and validity measures are violated when tests are adapted, translated into another language, or administered by other than certified personnel. Also, test results have a very limited value when planning strategies for intervention. They provide a general overview of the client’s performance during one time, and they are based on only one, or a very limited number of, tasks. Therefore, the results of tests need to be supported by observations...
and feedback from persons who have known and have worked with the client. To gain a more realistic picture of multilingual clients’ strengths and challenges, Hammer (1998) suggested that the speech-language pathologist work with families from the initial stages of the assessment to better understand the family’s “perspective, values, priorities, interpretation of events and decision-making process” (p. 9). Reading literature on various cultures, observing relationships and interactions within the family’s community, and reviewing reports from community agencies are helpful ideas to expand the speech-language pathologist’s skills in conducting and interpreting results of a non-biased assessment. Additional factors to consider in assessing a possible language/learning disability must include the family’s experience in accessing different institutions, their degree of acculturation, their child-rearing practices, the role played by the extended family, and their communication styles (Goodz, 1994; Hammer, 1998; van Kleeck, 1994).

Learning about the family’s knowledge of disabilities and their implications for the client’s life should be part of a conference and follow-up treatment plan (Dennis & Giangreco, 1996; Harry, 1992; Langdon, 1992). Understanding the interpretation of “intelligence” by various cultural groups should be considered as well. For example, Okagaki and Sternberg (1993) found that Latino parents often conceptualized intelligence as meaning social-competence skills, whereas Asian parents, like Anglo parents, gave more importance to cognitive skills. Ultimately, the assessment should be conducted by following a non-biased paradigm but, very importantly, the manner in which the data are interpreted and reported should be considered (Barrera, 1996). If the speech-language pathologist refers to these six areas, the final report of findings can be conveyed in a much clearer and accurate fashion during a conference.

Second Level of Interpretation of Assessment Results on a Client Whose First Language Is Other Than English

A second level of interpretation is needed when the speech-language pathologist collaborates with an interpreter because the information is not conveyed directly to the client but is filtered through an interpreter. The process can be accomplished successfully when all parties involved (including the client) have a clear understanding of their roles and their responsibilities.

The process of interpretation. Translations of oral and written messages from one language to another have been practiced since ancient times. The profession of international conference interpreting evolved shortly after the conclusion of World War I because French (the traditional language for peace negotiations) could no longer be used in view of the United States’ involvement in the war. Initially, bilingual military personnel were assigned the task of interpreting the information. Subsequently, a greater need for communication among linguistically different nations resulted in the establishment of specialized schools to train interpreters for international conferences. These schools were originally founded in Europe (Switzerland primarily in the 1920s) and, later on, in the United States (Georgetown University, Monterey Institute of Languages). The profession of conference interpreter was thus established and recognized and was followed by the profession of deaf interpreter. However, limited professional recognition has been granted to interpreters who work in other professions such as law or medicine, and even less to those interpreters who collaborate with special educators, psychologists, speech-language pathologists, or audiologists. The majority of those interpreters receive limited formal training, and often no training at all. Several do not hold steady positions within the agencies or school districts that employ them. (For details on the history of interpreting and its applications to various fields, the reader is referred to Langdon and Cheng [2002].)

The process of interpreting during a speech-language pathologist/interpreter/client conference reported in this article is based on practices used in other professions that use the services of an interpreter (e.g., international conference interpreting, deaf interpreting, court interpreting). However, very few of these practices have been validated by research. “Interpreters and translators must meet some intellectual criteria. These mental aptitudes have been listed time and again intuitively by translation and interpreter trainers, but have not yet been determined scientifically, notwithstanding a small number or research endeavors” (Gile, 1995, p. 5). Therefore, there is a great need in all professions employing interpreters to research and document best practices. The term “interpreting” refers to oral communication and “translation” refers to written communication (Langdon & Cheng, 2002).

Interpreting can occur simultaneously or sequentially. Simultaneous interpreting is when the interpreter translates a given oral message into another language at the same time as it is transmitted. Consecutive interpreting is when the interpreter waits to hear the entire message in one language before conveying it into another language. Whispered interpreting is the same as simultaneous interpreting, but the message is conveyed to only one or two individuals at a time by whispering the information. Consecutive interpreting is the most common model used in allied health professions, which include speech-language pathology and audiology.

A conference where assessment results and recommendations are provided to clients and their family should follow a specific protocol. The speech-language pathologist and the interpreter should work as a united team, and the information should be conveyed clearly and accurately (Langdon & Cheng, 2002). The conference should include three steps: briefing, interaction, and debriefing (BID process). This process is outlined in Figure 1.

During the briefing step, the speech-language pathologist discusses the purpose and format of the conference with the interpreter prior to beginning the meeting. The assessment results are reviewed, and the speech-language pathologist must ascertain that the interpreter is familiar with the terminology used to convey the results. Some possible questions that may come up during the conference should be discussed ahead of time. For example, given the family’s concerns, their understanding of the special
education system and various disabilities, and their access to various agencies, what areas might need to be explained in greater depth? The team should decide on the type of interpreting to be used during the meeting, which might depend on the number of participants in the conference. For example, consecutive interpreting might be more appropriate for a small number of participants, but whispered interpreting would be preferable when more information needs to be presented. The speech-language pathologist and the interpreter should review procedures to follow to ensure successful outcomes: Messages should be conveyed accurately and clearly, everyone should understand the information presented, all discussions should remain confidential, and everyone should understand their roles and responsibilities. In addition, the client should understand his or her rights.

During the interaction step, certain aspects related to the physical environment and to the format of the conference must be considered. The client should be seated next to the interpreter, facing the speech-language pathologist to facilitate eye contact, keeping in mind cultural differences. For example, in some cultures, looking directly at a person who has the authority is not practiced (Cheng, 1991; Lustig & Koester, 1999). All participants should be introduced and their roles should be defined. The interpreter should translate everything that is said by all parties, including the speech-language pathologist, the client, or any person attending the conference. The preferred style of interpreting is one where the information is conveyed directly. All persons should address the client directly and avoid saying to the interpreter, “Tell Mr. X to contact the audiologist.” Instead, say, “I recommend you consult with the audiologist.”

The speech-language pathologist and the interpreter should pay close attention to nonverbal cues such as head movements, facial expressions, and intonation to determine if messages are clearly conveyed. In addition, all members should be informed that it is very appropriate to ask clarification questions. But ultimately, the speech-language pathologist should be the person in charge of conducting the conference because he or she is the one who is legally responsible for the information presented. In no instance should the interpreter be put in the position of being the advocate for the parent or the one providing advice without prior consultation and clarification from the speech-language pathologist.

The third step of the process is debriefing. The interpreter should not leave after the conclusion of the conference. There should be time allotted for the speech-language pathologist to review outcomes and determine if the session was productive. The team should discuss areas that went well and areas that should be emphasized in the future. General comments should be noted.

**Figure 1.** The briefing/interaction/debriefing (BID) process in conferences where assessment results are shared.

<table>
<thead>
<tr>
<th>Briefing</th>
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<tbody>
<tr>
<td>The format of the conference is explained.</td>
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<tr>
<td>Critical pieces of the assessment are reviewed.</td>
<td></td>
<td></td>
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<tr>
<td>Critical questions are reviewed (where applicable).</td>
<td></td>
<td></td>
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<tr>
<td>The interpreter is prepared to use specific vocabulary to explain results.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The type of interpreting (simultaneous, consecutive, whispered) is discussed.</td>
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<tr>
<td>General procedures are briefly reviewed (accuracy, clarity, confidentiality).</td>
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<tr>
<th>Interaction</th>
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<tbody>
<tr>
<td>The seating arrangeent is appropriate.</td>
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<td></td>
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<tr>
<td>Participants are introduced and their roles are defined.</td>
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<td></td>
</tr>
<tr>
<td>The purpose of the conference is stated.</td>
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</tr>
<tr>
<td>The team maintains eye contact with the parent (consider cultural issues).</td>
<td></td>
<td></td>
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<tr>
<td>The team’s language is understandable to the parent.</td>
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<td></td>
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<tr>
<td>The I/T interprets clearly and precisely everything that is said by all conference participants, including the parent/family or client when appropriate.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The I/T or any member of the conference asks for clarification when necessary.</td>
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<tr>
<td>The I/T interprets using “I say” instead of “Mr. X says.”</td>
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<tr>
<td>The speech-language pathologist appears to be ultimately responsible for the conference procedure, information sharing, and intent.</td>
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<tr>
<td>The I/T interprets all that the parent says.</td>
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<td></td>
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<tr>
<td>The team presents itself as a unit.</td>
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<tr>
<td>The environment is comfortable.</td>
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<td></td>
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<tr>
<td>Attention is paid to nonverbal cues.</td>
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<table>
<thead>
<tr>
<th>Debriefing</th>
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<tbody>
<tr>
<td>Was the session productive?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Areas that went well</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Areas to emphasize in the future</td>
<td></td>
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<tr>
<td>General comments:</td>
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</table>

*Note.* I/T = interpreter/translator.

pathologist and the interpreter to review information and to decide what went well, to discuss areas that need follow-up, and to plan strategies to improve the outcome of future conferences.

**Ensuring a successful process.** Abiding to the code of ethics proposed by Langdon and Cheng (2002) will benefit the client and everyone involved in the conference. The speech-language pathologist should be knowledgeable about bilingual assessment and issues and should work with interpreters who have been trained appropriately. The speech-language pathologist should adequately prepare the interpreter for each conference and assessment regardless of how many times the two of them have worked together. If possible, the process can be improved by working with the same interpreter over time and by documenting successful strategies followed by the same speech-language pathologist/interpreter team.

The interpreter should interpret and translate all messages accurately. All information that is shared during conferences and assessments should remain confidential. The interpreter should seek clarification in case of uncertainty about the meaning of a message or comment made by any member of the conference, including the client, a parent, or a family member. The interpreter should not accept a job where there might be a conflict of interest. The interpreter should remain neutral, without taking any sides. The speech-language pathologist and the interpreter should continue to improve their skills through continuing education offerings. Ultimately, an interpreter should be formally trained and only accept assignments that are within his or her scope and experience.

The roles played by the speech-language pathologist and the interpreter in this process are difficult for many reasons. A speech-language pathologist who cannot convey information directly to clients or their families and who must depend on an interpreter may feel “somewhat disconnected” because a genuine interaction with the client is impossible. The speech-language pathologist must make an extra effort to provide information that is presented clearly, and must ensure that the client is understanding what is being said and shared. Thus, the speech-language pathologist must be watching and making “internal interpretations” of the verbal and nonverbal messages conveyed by all participants. In sum, a conference involving an interpreter is quite complex and demands additional time and effort on the part of the speech-language pathologist.

Even though the role of an interpreter is to remain neutral, he or she is also the center of the turn-taking process (Englund Dimitrova, 1997). The interpreter is the only one who knows the two languages, who is familiar with two different cultures, and who can best read the nonverbal communication conveyed by all persons involved in the conference. He or she is the manager of two languages that depend on two different verbal and nonverbal components. Approximately 65% of meaning is conveyed through nonverbal communication; only 35% is conveyed verbally (Knapp, 1972). Additionally, cultural rules that vary among speakers of different languages must be considered. “There are no formal sets of rules to provide a systematic list of the meanings of a culture’s nonverbal code systems. But, we cannot ignore that nonverbal messages can be used to accent, complement, contradict, regulate, or substitute for the verbal message” (Gile, 1995, p. 226). All in all, the process is very complex because it takes place in an educational/therapeutic situation where the roles of the speakers are very different: One of the speakers is a professional, and the other one is the “recipient” (often from a less prestigious language) (Roy, 2000). There is no social equality between the participants, and training of interpreters and professionals is limited.

The success of an interpreted message depends on the correct choice of words to convey a given meaning rather than on transmitting a word-by-word translation. The interpreter must be aware of the educational level and experiences of the client. Terms in one language can be translated using different words that are more accessible and intelligible to a given audience. It is also the role of the interpreter to alert the speech-language pathologist or the parent/client when a given term might be difficult to convey in the other language. For example, the word *knowledge* may be translated as *conocimiento* or *lo que sabe* (one is more formal than the other) or the word *place/put* may be translated as *colocado* or *puesto*. Thus, the interpreter needs to “manipulate a large spectrum of speech styles from the most formal and articulate to the least coherent non-standard variety in two languages” (Benmaman, 1997, p. 184). Effective interpreters can successfully handle the task of switching and interpreting between two different verbal/nonverbal modes. They play an important role in the process, but the decision making is the speech-language pathologist’s responsibility.

**Assessing the success of the process.** The previous discussion described the roles and responsibilities of the speech-language pathologist and interpreter with limited focus on the role of the client as assessor of services rendered. Checklists to assess the effectiveness of the interpreter have been proposed by Fradd (1993) and by Langdon and Cheng (2002). Collecting feedback from a service provider who uses interpreters is different and somewhat less complex than seeking this information directly from the client (Garber & Mauffette-Leenders, 1997). The researchers offer some guidelines, but the outcome of their research merits further study. Initially, the researchers were interested in determining if medical, legal, casework, and educational services rendered to a growing Vietnamese population were satisfactory. Due to issues of confidentiality, the researchers opted for a questionnaire instead of a phone conversation. However, because their clients had limited schooling in their own language, they had to devise a simpler and clearer questionnaire.

The interpreters who had worked with those clients were asked to ensure that the questionnaires were returned. Some of the interpreters refused to participate in the project because they felt that their clients would not be objective. The initial pool of questionnaires had a low rate of return because of a lack of cooperation on the part of some of the interpreters in asking the clients to complete them. The researchers modified their questionnaire and adapted it in two other languages, Portuguese and Polish. This time, more questionnaires were returned because the new
questions were easier to fill out and because the client had the option of participating in a follow-up call. Overall, the clients seemed satisfied with the services rendered. Therefore, devising a questionnaire to assess clients’ level of satisfaction with services that were rendered is important to evaluate the effectiveness of the process. However, it is problematic because some of the clients may not want to be negative in case they need services from an interpreter in the future, and others may not be able to fill out the questionnaires because they do not have sufficient command of writing skills even in their own language. In addition, clients may believe that requesting assistance from the interpreter may compromise their relationship.

DESIGN OF THE INITIAL STUDY

The objective of the initial study was to document practices used by teams of speech-language pathologists, interpreters, and clients who participated in a conference. The focus was on describing how speech-language pathologists and interpreters worked together to maintain their respective roles and on documenting the level of client satisfaction of the process and outcomes of an interpreted conference. Three sets of questionnaires (Appendices A, B, and C) were developed, one for each of the three members involved in the meeting.

Appendix A was designed for the speech-language pathologist and included a total of 20 questions. The first five questions pertained to contact with the interpreter and training (Questions 1–5). The sixth question (Question 6) was related to whether the speech-language pathologist had time to brief and debrief with the interpreter. The following four questions (Questions 7–10) pertained to the process. Questions 11–15 related to various possible scenarios and global evaluation of the conference, and the final set of questions (Questions 16–19) asked for suggestions for areas to consider in improving the process. Additional comments were requested as well (Question 20).

The questionnaire designed for the interpreter (Appendix B) included the same areas except that questions were directed to the interpreter instead of to the speech-language pathologist. Some of the questions were worded differently to indicate that they were addressed to the interpreter. These included questions on what to do if the client does not agree with the advice provided by the speech-language pathologist (15a) and what to do if the interpreter does not agree with the advice provided by the clinician (15b).

The questionnaire for the client (Appendix C) included only 10 questions and was based on the studies by Garber and Mauffette-Leenders (1997). The client was asked to rate the questions from 1 (very good) to 5 (poor), with 0 as not applicable. Questions were related to the definition of roles of the team members, quality and clarity of the information provided, issues of confidentiality, understanding of clients’ rights, opportunities to voice concerns, and general impressions of the conference. The questionnaire was translated into Spanish by this researcher because it had been the main language requested when potential speech-language/interpreter teams had been surveyed for the project.

RESULTS AND DISCUSSION OF THE INITIAL STUDY

For the original project, 13 students enrolled in a graduate-level bilingual assessment class were scheduled to collect and analyze 13 sets of questionnaires from speech-language pathologist/interpreter/client teams. However, many circumstances, including exceeding delays in securing permission from the Human Subject Committee, lack of time (the questionnaires were to be collected by students during a 3-week period), accessibility to teams of speech-language pathologists and interpreters that worked regularly together, and a very small number of returned questionnaires, limited the scope of the study. In addition, the initial criteria that the speech-language pathologist must have 2 or more years of experience in the field, that he or she should have worked at least twice with the same interpreter, and that the interpreter would contact the client and request his or her participation in the project, made it very difficult to complete the initial study. Only three complete teams of speech-language pathologist/interpreter/client, or 23% of the sets, were fully completed. In two additional cases, only the speech-language pathologists and one of the interpreters returned their questionnaires. In sum, only questionnaires from three clients, four interpreters, and five speech-language pathologists could be analyzed. However, despite the limited data, it was possible to gain a general overview of the responses.

A follow-up study was undertaken to validate responses provided by speech-language pathologists to the process, and this information is described in the next section.

Clients’ Feedback

The three clients who returned their questionnaires rated all answers with a (1) or (2), indicating that all phases of the conference had been handled at a very good or good level of satisfaction to the client. All three questionnaires came from parents who had children enrolled in school. One of the parents stated in Spanish, “Estoy totalmente agradecida y satisfecha respecto al programa y conferencias-Gracias” (I am very grateful and satisfied about the program and the conferences. Thank you). The two questionnaires that were not returned were from a client who had received services in a hospital setting and from a client in a school setting. Although the sample was small, all three clients who responded were appreciative of the process. However, it is difficult to determine if their responses accurately depicted their feelings. As one of the data collectors indicated, it is likely that the parent was giving positive feedback because her child was receiving help in speech and language therapy and she did not want to antagonize the system.

Speech-Language Pathologists’ and Interpreters’ Feedback

The most typical responses provided by the speech-language pathologist/interpreter teams to the various questions are reported in Figure 2.
Figure 2. Responses provided by the speech-language pathologist (SLP)/interpreter (I/T) teams.

SLPs: Total 5 I/Ts: Total 4

How many times the teams had worked together:
(1) 2 times
(2) 5 times
(3) 6 times
(4) more than 5 times
(5) 20 times (hospital)

Have you received any training to work with an I/T or SLP?
SLP: Yes 3 No 2
I/T: Yes 2 No 2

Do you have any continuing education opportunities in this area?
SLP: Yes 3 No 2
I/T: Yes 2 No 2

When do you work as a team? (Please circle all that apply):
SLP: Conferences 2 All sorts 3 (including treatment)
I/T: Conferences 1 All sorts 3

What type of interpreting does the I/T use? (Please circle all that apply):
SLP: Consecutive 3 Simultaneous 3 Whispered 1
I/T: Consecutive 3 Simultaneous 2 Whispered

Do you have time to brief and debrief with the I/T prior to and after an interview, an assessment, or a conference where you share results or progress in therapy?
SLP: Yes 2 No 3 Time constraints, follow-up possible though
I/T: Yes 1 No 2 Usually not necessary

If yes, how often: Almost Always—Often—Sometimes—Rarely (Please circle)
(This question was omitted by most respondents who said YES except for one case)

How do you know that what is being interpreted is clear to the client?
SLP:
• I am able to understand some Spanish.
• Client asks for clarifications.
• When the client does not understand, I ask the client to describe task/expectation.
• Verbal/nonverbal cues. Sometimes stop and ask if they understand or they have questions.
• Monterey County Office of Education (MCOE) I/Ts are well-trained and are able to clarify information if a client appears confused (facial expression, body language or requests from clients).
I/T:
• I ask clarifying questions from the SLP.
• I feel comfortable about the time I am given, even if I take more time when expected to make the client more comfortable.
• Nothing as long as the message is transmitted accurately and understood by the client, that’s what counts!

How do you ensure that the shared information is confidential?
SLP:
• Confidence in the I/T.
• I/T is a resource aid and has been trained on confidentiality.
• Discuss ahead of time with the I/T.
• Through I/T programs and knowledge of applicable laws.
I/T:
• I am a confidential employee.
• I don’t share information with others, outside the SLP team.
• I don’t talk about the patients to anyone.
• I only translate what is given to me and I cannot control the rest.

How do you know that the information you conveyed is interpreted accurately?
SLP:
• Past experience with the I/T.
• I understand Spanish.
• Periodically ask client questions to check for understanding.
• I don’t always know. However, the I/T I usually work with is very reliable. We have a good working relationship.
• Trust. The I/Ts I work with are very well-trained. They are knowledgeable about the laws and cultural differences of our clients.
I/T:
• I will ask clarifying questions.
• I will ask the SLP before I would interpret.
• When I am interpreting exactly what is being said.

What do you do when the client seeks advice directly from the I/T during the interaction?
SLP:
• I listen to the gist and interrupt.
• The I/T turns the questions back to me.
• Ask the translator to translate all information so that I may respond.
• I ask the I/T to interpret what the client has said.
I/T:
• In my situation, it’s a little different since I am also a psychologist.
• I ask the SLP and then ask the client to make sure it is acceptable.
• I explain that I’m just an interpreter—and the SLP however can answer their questions and concerns.
• I ask the questions in the exact manner as the SLP. I do not add or omit any words.

How do you ensure that the client understands his/her rights?
SLP:
• No absolute, need to proceed as with my English-speaking clients.
• Parents’ rights are explained, assessments are explained, and examples are given.
• Client is given written information that corresponds with IEP meeting. During the IEP, the client is asked several times if rights are understood.

I/T:
• Ask clarifying questions from the SLP.
• I feel comfortable about the time I am given, even if I take more time when expected to make the client more comfortable.
• Nothing as long as the message is transmitted accurately and understood by the client, that’s what counts!

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• Discuss ahead of time with the I/T.
• Through I/T programs and knowledge of applicable laws.
I/T:
• I am a confidential employee.
• I don’t share information with others, outside the SLP team.
• I don’t talk about the patients to anyone.
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• Through I/T programs and knowledge of applicable laws.
I/T:
• I am a confidential employee.
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• I don’t talk about the patients to anyone.
• I only translate what is given to me and I cannot control the rest.

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SLP:
• Past experience with the I/T.
• I understand Spanish.
• Periodically ask client questions to check for understanding.
• I don’t always know. However, the I/T I usually work with is very reliable. We have a good working relationship.
• Trust. The I/Ts I work with are very well-trained. They are knowledgeable about the laws and cultural differences of our clients.
I/T:
• I will ask clarifying questions.
• I will ask the SLP before I would interpret.
• When I am interpreting exactly what is being said.
I/T:
- Rights are given in the primary language; if help is needed, parents ask.
- I explain if she understood the rights regarding assessment. I just can say exactly what the staff members are saying to the client. If the client does not understand, he/she will ask for clarification. They always ask.

How do you know that the client is satisfied with what you said?

SLP:
- I can tell, we have to repeat or rely on the I/T.
- Verbal responses, body language, facial expression.
- Ask if there is anything they would like to add or issues they would like me to address.

What do you do if the client brings a bilingual advocate to the meeting?

SLP:
- This has not been the case. This has never happened.
- Enlist the aid of the IEP administrator to resolve the problem.

I/T:
- We would try to come to an agreement.
- This has never happened. If it were to happen, we should discuss it.
- I say: “I am not going to argue with you. I am just doing my job. If you think that you can do a better job than I, you are welcome to take over if the parties involved in this meeting agree.”

What do you do when the I/T appears to be counseling the client without involving you?

SLP:
- I trust the I/T.
- I/T will be strongly reminded to just translate.
- Reemphasize importance of translating only information given by therapist.
- I will stop the interaction and ask the I/T to just translate.
- This has never happened.

What should you do if the client does not agree with the advice given by the SLP?

I/T:
- I would interrupt and involve the SLP. You should interpret what is said to you.
- I do my best to explain what the SLP’s concern is about and also the client’s.
- I tell the SLP.
- I interpret what the client has to say in the disagreement.

What do you do when you do not agree with the SLP’s advice?:

I/T:
- I am an interpreter. I am asked to interpret only, unless asked my opinion.
- As an interpreter, you only interpret what you are asked to do.
- This has not happened yet.
- It is not my place to agree or disagree with what the parties have to say.

What suggestions do you have to improve service delivery when an I/T is involved?

SLP:
- Emphasize parents’ needs; need more time for meetings.
- Districts should have staff available during school hours to interpret.
- Provide written and verbal information regarding expectations.
- Allow more time before and after the interpreting.
- None at this time. MCOE I/Ts are great!

I/T:
- Have more time to make sure that information from SLP is conveyed.
- Make sure the I/T knows exactly what he or she is supposed to interpret.
- The I/T needs to repeat and say exactly what the SLP says.
- The I/T should sit next to the Spanish speaker (client). Use language as close as possible to the level of literacy of the client. Speak directly to the client, especially when the interpretation is simultaneous and without headphones.

What are some of your personal reactions to the I/T-SLP process?

SLP:
- I do not feel my observations are as fully reported because of time constraints.
- Lots of work when it’s a language other than Spanish. Difficult to find reliable I/Ts.
- It is often difficult to determine that the information is being translated correctly.
- It works well, depending on the quality of the interpreter.
- It has been a positive experience and very professional.

I/Ts:
- It can be difficult explaining the details to some parents as it is foreign to them. A summary of testing results is not as overwhelming an answer for the lay person to understand.
- I think the process is done correctly.
- I believe it’s effective and beneficial.
- None in particular. I just do my job.

What characteristics do you observe in a “good” I/T? A “good” SLP?

SLP:
- Listening to parents and professionals and, when familiar, interjecting own judgment.
- Good listener, good eye contact with client, will ask for clarification if needed.
- An I/T with a good command of both languages and the ability to translate quickly without “searching for the correct word.”
- Being familiar with the “special ed lingo” (vocabulary), being familiar with tests used, not using their agenda but strictly acting as an interpreter.
- Knowledge and I/T’s ability to interact in a positive manner with client.

I/T:
- Give clear and concise explanations
- Interpret exactly what the SLP would like for client to know.
- Empathy, patience, and knowledge are characteristics of “good” SLPs.
- Present clear-summurized information about his/her report. Show interest in the student report of language skill. Show expertise and competence.

What characteristics have you observed in a “poor” I/T? A “poor” SLP?

SLP:
- Not had bad experience.
- Gives own interpretations of test results.
- An I/T who talks with clients/family while waiting for therapist.
- Taking on a role other than interpreter.

I/T:
- Not being able to give clear explanations.
- I have had an opportunity to observe a poor SLP.
- The opposite of what I said for “good” SLP.

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The teams had worked together from two to twenty times. Approximately 50% of both the speech-language pathologists and the interpreters had received formal training and/or had continuing education opportunities in working with interpreters. Both group members reported that they worked together in conferences as well as in conducting assessments. Various types of interpreting were used. In some cases, it was consecutive; in others, it was simultaneous or whispered. Although the number of respondents was low, consecutive interpreting seemed to be used slightly more frequently than the others.

There were more instances where the team had no opportunity to meet with each other, before or after the conference. Both types of respondents (speech-language pathologists and interpreters) stated that lack of time was the main reason, but one of the interpreters stated that it was not necessary to meet. It is possible that the briefing and debriefing steps were skipped once teams of speech-language pathologists and interpreters had worked together for some time. However, best practices suggest that both steps should be considered to enable the team to review the information before and after a conference, regardless of how many times the teams have collaborated.

The speech-language pathologists offered several reasons to ascertain that the information was clearly conveyed. Some of them indicated that they could understand some of the language (mostly Spanish), that the client was asked to state if something was unclear, that both verbal and nonverbal cues were observed, or that they relied on a well-trained interpreter. The interpreters answered the same question by stating that they were the ones asking if clarification was needed, they watched if responses matched statements previously made, and, like the speech-language pathologists, they watched facial expressions to determine if the meaning was clear. According to the speech-language pathologists, the information was conveyed accurately because they could rely on their interpreters based on past experience in working with them, they could understand some of the language, or they periodically asked the clients if they had any questions. The interpreters stated that they were the ones who asked the clients if they had any questions, that they asked the speech-language pathologist to make sure that the information was clear, or that they were interpreting only what was said. Best practices suggest that clarity and accuracy should be checked by the speech-language pathologist and not the interpreter. It is the clinician who should ask the client if all that is said is clear to the client. The interpreter’s role is to filter the information presented and alert the speech-language pathologist if something is unclear or inaccurate. However, because interpreters are the ones who have command of two languages and two sets of communication skills (Englund Dimitrova, 1997), they may provide suggestions to the speech-language pathologists to ascertain that the information is clear. Nevertheless, the speech-language pathologists must convey the message that they are the leaders of the process.

Concerning the appearance that the interpreter was taking more time to interpret what had been said, the speech-language pathologists stated either that it had not happened to them or that they reminded the interpreter to translate what was said, including the client’s statements. The interpreters asked for clarification from the speech-language pathologist but, in general, they did not feel that this was an issue as long as the message had been clearly conveyed to the client. Best practices suggest that speech-language pathologists monitor the length and reactions to what is translated so they need to listen carefully to and watch how messages are conveyed from one language to the other.

The speech-language pathologists stated that confidentiality was not an issue if the interpreter could be trusted and had been trained on this aspect or if confidentiality was discussed prior and during the conference. The interpreters reported that they did not share information with others, they did not talk about the client or patient to anyone else, or their function was to translate. Best practices suggest that issues of confidentiality need to be conveyed to all parties involved in a conference, including the client.

The speech-language pathologists reported that they interrupted the conversation if they felt that the interpreter was giving advice to the client. In those situations, they requested that all information provided by all parties be retranslated so that they could respond. The interpreters indicated that they involved the speech-language pathologist in the process. They explained that they were just interpreters, and they deferred to the speech-language pathologist or any team member if the client was asking for advice. In one case, the interpreter stated that she may have answered the question by herself because she spoke two languages and therefore had a double role as psychologist and interpreter. If the client did not agree with the advice given by the speech-language pathologist, the interpreters reported that their job was to interpret and not to give advice, or that their place was not one where they need to agree or disagree with what was said. It appears that the teams surveyed followed best practices for the most part. It is important to remember that it is the speech-language pathologist who has the legal responsibility of conveying the information and who is the one in charge of providing advice and recommendations.

The speech-language pathologists indicated that the parents’ and clients’ rights are explained with examples, and that written information in the clients’ primary language is available. Clients are repeatedly asked during the meetings if they have any questions. The interpreters indicated that parents asked for clarification concerning their rights, that they explained the client’s rights, or that they interpreted what the staff said regarding this issue. One interpreter reported that “clients always ask.” It is important that all members of the team understand that providing rights in written form in the client’s primary language is not sufficient to ensure that the rights are understood.

Several of the team members indicated that they asked the clients if they needed any clarification regarding their rights. One effective way is to ask clients to restate what they have understood using their own words and request the interpreter to translate what was said.

To assess the client’s satisfaction with the conference, the speech-language pathologists reported that they could tell,
but they needed to rely on the interpreter; they watched the client’s verbal responses, body language, and facial expressions; or they asked clients to add or say something that may not have been stated previously. Watching the client’s responses and asking questions is important to determine if the client is satisfied. The speech-language pathologists noted that they had never had to be concerned about the presence of a bilingual advocate at a meeting. In case a bilingual advocate would accompany a client, they would rely on the administrator presence at the meeting to resolve a possible conflict. The interpreters stated that they would attempt to come to an agreement, or they would discuss the issues with the advocate and the conference members. One of the interpreters stated that she would step out of the meeting if the presence of an advocate would create a problematic situation. Defining roles and responsibilities may resolve any lack of agreement between a bilingual advocate and the team.

According to the speech-language pathologists, emphasizing clients’ needs, allowing more time for meetings, providing written and verbal information regarding expectations, and allowing more time before and after the interpreting meeting were needed to improve service delivery in collaborating with interpreters. The interpreters’ feedback was similar. Ensuring that the interpreter knows exactly what needs to be interpreted, conveying clear messages, and adapting the translated language to the level of literacy of the client are important features to ensure the success of an interpreted conference. Working with an interpreter demands more time and effort from all parties involved. Therefore, administrators must be educated about the process and the importance of providing additional time and money to ensure that the process is carried out legally and professionally.

The speech-language pathologists commented that observations are not always fully reported because of time constraints; the process demands “lots of work,” especially when it was another language than Spanish; it is difficult to translate information correctly; and the process works well if the interpreter is well-trained. The interpreters stated that some of the content may be difficult to convey to parents because “the topics are foreign to them.” Other responses were that the process can be effective and beneficial if sufficient time is allotted for planning.

A “good” interpreter was defined as someone who listens to parents and professionals and, when familiar, interprets his or her own judgment. Making good eye contact with the client and asking clarification questions were other characteristics stated. Command of two languages and ability to translate quickly as well being familiar with the “special education lingo” were cited as important assets of a good interpreter. The comments made by the speech-language pathologists mirror qualifications that are necessary for interpreters to conduct their job successfully. The interpreters’ definitions of a “good” speech-language pathologist included providing clear and concise explanations; interpreting exactly what the speech-language pathologist would like the client to know; demonstrating empathy, patience, and knowledge; and presenting clear information. In addition, according to one interpreter, the speech-language pathologist should show interest in reporting the student’s language skills and project expertise as well as competence. Thus, the success of an interpreted conference depends on the quality of the speech-language pathologist’s presentation of the assessment results and suggested recommendations. Therefore, skills recommended for speech-language pathologists working with bilingual clients need to be emphasized in university training and continuing education trainings.

Characteristics of a “poor” interpreter included not having sufficient experience, giving one’s own “interpretation” of test results, talking with the family while waiting for the speech-language pathologist, and taking a role other than the interpreter’s. According to interpreters, a “poor” speech-language pathologist was one who could not give clear explanations or provide clear information about her reports, could not show interest in the student, and could not show expertise or competence. Therefore, speech-language pathologists should not be relying on the interpreter to “reinterpret” what they said. Instead, they should express themselves very clearly to facilitate the interpreter’s job.

FOLLOW-UP STUDY: RESULTS AND DISCUSSION

Responses from a larger number of clinicians were obtained to validate the findings of the initial study and to document current practices followed by speech-language pathologists during conferences where the collaboration of an interpreter is needed. The participants were attendees at a presentation on services for bilingual populations during the annual meeting of the California Speech-Language Conference in the Spring of 2001. The same questionnaire (Appendix A) was used except for adding in number of years of experience in the field. A total of 73 questionnaires were collected.

Of those, only 63 could be analyzed because the other 10 were completed by speech-language pathologists who were in the process of fulfilling their certificate of clinical competence, or more than 50% of the questions were not answered, or because the clinician had never worked with an interpreter.

The analysis of the data was conducted based on the speech-language pathologists’ number of years of experience in the field, resulting in six different groups: Group 1 (1–4 years); Group 2 (5–10 years); Group 3 (11–14 years); Group 4 (15–19 years); Group 5 (20–24 years), and Group 6 (25–35 years). Table 1 includes a summary of the clinicians’ years of experience in the field, number of times that they had worked with an interpreter, formal training, opportunities for continuing education in issues of working with interpreters and translators, type of interpreting used in conferences, opportunities to abide to the BID process, and frequency of adhering to the process.

In addition, responses to all other questions pertaining to clarity, accuracy, interpreting process, counseling issues, confidentiality, and other areas pertaining to the process that were discussed in the previous sections were collected and analyzed. Results indicated that speech-language pathologists who had been in the field from 1 to 4 years had fewer
opportunities to work with interpreters more than 20 times as compared to all other speech-language pathologists (20% contrasted with 50%–60% for each of the other groups). More than 60% of speech-language pathologists surveyed who had been in the field from 1 to 14 years had received some formal training in working with interpreters. The largest percentage (85%) who had received some form of training was among the most recent graduates. Those who had been in the field for a longer time had less formal training as a group (55% or less). In general, clinicians who had been in the field for 1 to 19 years had had more opportunities to pursue continuing education opportunities as compared to those who had been in the field longer (40%–54.5% compared to only 10% for those who had been in the field for 20 or more years). The discrepancy between the different age groups in opportunities to receive training and continuing education in working with interpreters reflects the increasing immigration of various linguistic groups to California in the last 20 years.

The respondents to this survey indicated that a combination of simultaneous and consecutive interpreting was used in their conferences. Regardless of the number of years in the field, the speech-language pathologists indicated that they abided to the BID process at least 66% of the time (Group 5) to as frequently as 80% to 87% of the time for those speech-language pathologists who had been in the field for 1 to 10 years. The process was used by most groups, 40% of the time or more, with the highest number for those who had been in the field for more than 25 years (83%). Therefore, regardless of the clinicians’ type of training or continuing education opportunities, they were following the BID process almost always during at least 40% or more of the time. Interestingly, those who had been in the field for more than 25 years followed the process almost always during at least 40% or more of the time despite fewer opportunities for formal or continuing education opportunities. There may be many reasons for this high percentage: more time allocated to working with interpreters and/or more experience in following recommended practices. The initial survey had indicated that only 2 out of 5 speech-language pathologists, or 40%, followed the process.

A qualitative analysis of responses to the various questions revealed many similarities with the initial project regardless of speech-language pathologists’ number of years in the field. The only difference was that younger clinicians (1–4 years) relied on or trusted their interpreters to secure clarity and accuracy of information more frequently instead of adopting other strategies such as questioning the client or the interpreter directly. Therefore, more training and experience is necessary for speech-language pathologists to rely on their own observations. Responses to other questions related to strategies to follow in case the interpreters appeared to provide direct advice to the client. Determining if clients understood their rights, if they were satisfied with what was said, and all other questions related to the dynamics of the conference were answered very similarly to examples provided by the 5 speech-language pathologists who participated in the initial study. Some speech-language pathologists felt that the process worked well, whereas others felt disconnected from their clients. Comments included, “I lament that it was not me discussing my findings” or “I felt left out of the conversation.” Descriptions of “good” and “bad” interpreters included comments similar to those provided by speech-language pathologists in the initial project.

**Summary and Future Research Ideas**

The intent of the study was to collect and analyze comments made by teams of speech-language pathologists,
interpreters, and clients regarding their judgment of an effective conference where the results of an assessment and recommendations are discussed. Only three complete sets from 13 could be collected because of time constraints or lack of cooperation from the participants. Two other sets, although incomplete, were returned and analyzed because they included comments from speech-pathologists and interpreters. The initial analysis of the data indicated that approximately 50% of the speech-language pathologists and interpreters had received formal training or had opportunities for continuing education in strategies on working with interpreters and translators. The respondents indicated that they used a variety of interpreting methods (simultaneous, consecutive, whispered). Often they did not have an opportunity to brief or debrief their conferences. Many of the questions related to accuracy, clarity of information presented, confidentiality, sharing of client’s rights, and the team members’ roles in ensuring that the speech-language pathologist is the one providing advice and suggestions following best practices suggested in the literature. Both parties offered their views on the process and suggestions for training and defined the characteristics of a “good” interpreter or speech-language pathologist and a “bad” interpreter or speech-language pathologist.

Validation of the speech-language pathologists’ responses was conducted with a follow-up survey given to attendees at a state conference. A total of 63 surveys were analyzed. Respondents had 1 to more than 30 years of experience. Data indicated that the younger clinicians (1–4 years of experience) had had more opportunities for formal training in working with interpreters as compared to clinicians who had been in the field longer. Those clinicians who had 1–19 years of experience had had more continuing education opportunities in this area. The group as a whole followed the BID process more often than the participants in the initial survey. It is difficult to make a definite conclusion because the number of respondents in the initial project was very limited. However, one possible explanation is that the initial group of speech-language pathologists worked more frequently with the same interpreter and felt that the briefing and debriefing steps were not as necessary because the team members had collaborated more frequently.

The responses to the various questions related to the process, dynamics of the conference, and role played by the members were similar to those in the initial survey. They conformed to best practices for the most part. However, the younger group of clinicians stated that they relied more on their interpreter to ensure that the information was clear and accurate. All other answers mirrored those provided by speech-language pathologists in the initial survey. The few clients surveyed indicated that they were satisfied with the process and outcomes of the interpreted conferences they had attended. However, definite conclusions cannot be made due to the limited number of surveys returned.

Several conclusions can be made based on the results of this survey:

- Speech-language pathologists who have more recent training in the field have had more opportunities to receive more formalized training in working with interpreters. However, continuing education opportunities are lacking for all groups.
- Although best practices seem to be followed in ensuring that information is conveyed in an accurate and clear manner, they are not implemented evenly. Many clinicians rely too much on the expertise of the interpreter instead of being directly involved in ensuring that what is said is accurate and clear. This process appears to be more frequent in younger clinicians who are still in the process of learning about their profession. Consistent training of speech-language pathologists and interpreters is needed.
- Issues of clarity, confidentiality, definitions of specific roles and responsibilities of speech-language pathologists and interpreters, importance in following the BID process, and brainstorming of specific situations such as disagreements or potential disagreements between participants need to be discussed.

Langdon and Cheng (2002) and Roy (2000) discussed specific strategies and challenges that should be considered in working with I/Ts.

- Clients’ rights should be conveyed both orally and in writing. It is the speech-language pathologist’s role and not the interpreter’s role to ensure that clients understand their rights.

- Clinicians must continue to emphasize their role as leaders of a conference. This is a difficult role to maintain because the speech-language pathologist does not have direct contact with the client: All information must be filtered through the interpreter.

- To ensure the success of a conference, the speech-language pathologist must convey information that is comprehensible. As one of the interpreters stated, a “good speech pathologist should present clear-summarized information. He or she should show interest in the student in reporting his or her language skills. He or she should show expertise and competence.” Competence means adequate training in assessing bilingual populations, taking into account the variables reviewed in the literature portion of this article.

Most speech-language pathologists indicated that the success of the process is dependent on districts and agencies having interpreters who are available and are well-trained, and that more time should be allotted to the process. Interpreters reported that more time is needed, and that they, as interpreters, must interpret only what the speech-language pathologist says. In addition, the interpreter should convey the information accurately, taking into account the level of literacy of the client.

Qualities in a “good” interpreter were echoed in the responses provided in the initial and follow-up studies. Interpreters should be good listeners, maintain eye contact with the client, be positive, have a good command of the two languages, translate quickly, be familiar with the “special education lingo,” be familiar with tests, and adhere to the original agenda to be “an interpreter”—and nothing else.
There should be an effort to evaluate the client’s satisfaction with an interpreted conference to outline better practices that enable the client to be a more active participant of the process.

The research project has several limitations because it was conducted on a very finite number of participants in only one part of California. Future research efforts should (a) attempt to obtain feedback from a larger number of clients, involving the interpreters in the process and ensuring both parties that the information is necessary to benefit all persons included; (b) survey a larger number of interpreters and speech-language pathologists working in various settings; (c) and survey more clinicians within the state and across the nation. The results reported in this article represent only the beginnings of research needed to document best practices to follow when speech-language pathologists and interpreters work as a team. Documenting and validating best practices is greatly needed because our nation and world is becoming increasingly linguistically and culturally diverse.

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Contact author: Henriette W. Langdon, San Jose State University, Communication Disorders and Sciences, One Washington Square, San Jose, CA, 95192. E-mail: hlangdon@email.sjsu.edu
APPENDIX A. QUESTIONNAIRE FOR THE SPEECH-LANGUAGE PATHOLOGIST

Setting (Please circle): School  Clinic  Hospital  Private Practice

Conference when the interpreting took place: (Please circle all that apply):
  To share assessment results  To share progress
1. How many times have you worked with this I/T? (Please circle): 1  2  3  4  5
2. Have you received any training for working with an I/T? Yes _____  No _____
   If yes, when, where, and how long was the training?
   ___________________________________________________
3. Do you have any continuing education opportunities in this area? Yes _____  No _____
   If yes, please describe: ________________________________________________
4. When do you work with an I/T? (Please circle all that apply):
   Interviews  Assessments  Conferences to report results  Conferences to report progress
   Which one(s) is/are more frequent? _________________________________________
5. What type of interpreting does the I/T use? (Please circle all that apply):
   Consecutive  Simultaneous  Whispered
6. Do you have time to brief and debrief with the I/T prior to and after an interview, an assessment, or
   a conference where you share results or progress in therapy?
   Yes____  No______  If no, please state reason(s)_____________________________
   If yes, how often: Almost Always—Often—Sometimes—Rarely (Please circle)
7. How do you know that what is being interpreted is clear to the client?
   _______________________________________________________________________
8. What do you do when you feel that the I/T has interpreted what you said, taking more time to
   convey the information in the other language?
   _______________________________________________________________________
9. How do you ensure that the shared information is confidential?
   _______________________________________________________________________
10. How do you know that the information you conveyed is interpreted accurately?
    _______________________________________________________________________
11. What do you do when the client seeks advice directly from the I/T during the interaction?
    _______________________________________________________________________
12. How do you ensure that the client understands his/her rights regarding assessment, receiving a given
    procedure, or understanding the therapy or intervention suggested?
    _______________________________________________________________________
13. How do you know that the client is satisfied with what you said?
    _______________________________________________________________________
14. What do you do if the client brings a bilingual advocate to the meeting and the I/T and the advocate
    do not agree on the meaning of a given word or statement?
    _______________________________________________________________________
15. What do you do when the I/T appears to be counseling the client without involving you?
    _______________________________________________________________________
16. What suggestions do you have to improve service delivery when an I/T is involved?
    _______________________________________________________________________
17. What are some of your personal reactions to the I/T–SLP process?
    _______________________________________________________________________
18. What characteristics have you observed in a “good” I/T?
    _______________________________________________________________________
19. What characteristics have you observed in a “poor” I/T?
    _______________________________________________________________________
20. Any other comments?
    _______________________________________________________________________

_____________________________________________________________________________
APPENDIX B. QUESTIONNAIRE FOR THE INTERPRETER/TRANSLATOR

Setting (Please circle): School               Clinic               Hospital

Conference when the interpreting took place: (Please circle all that apply):
   To share assessment results   To share progress

1. How many times have you worked with this SLP? _____________________

2. Have you received any training to be an I/T? _____________________
   If so, when, where, and how long was the training?

3. Do you have any continuing education opportunities in this area?       Yes _____       No _____
   If yes, please describe:______________________________________________

4. When do you work with an SLP? (Please circle all that apply):
   Interviews     Assessments     Conferences to report results     Conferences to report progress
   Which one(s) is/are more frequent? _________________________________

5. What type of interpreting do you typically use when working with an SLP? (Please circle all that apply):
   Consecutive          Simultaneous          Whispered

6. Do you have time to brief and debrief with the SLP prior to and after an interview, an assessment, or a conference where you share results or progress in therapy?
   Yes _____       No _____
   If no, please state reason(s) ________________________________________
   If yes, how often: Almost Always—Often—Sometimes—Rarely (Please circle)

7. How do you know that what is being interpreted is clear to the client?

8. What do you do when you feel that what you interpreted may have taken more time than would be expected given the information provided by the SLP?

9. How do you ensure that the shared information is confidential?

10. How do you know that the information you conveyed is interpreted accurately?

11. What do you do when the client seeks advice directly from you during the interaction?

12. How do you ensure that the client understands his/her rights regarding assessment, receiving a given procedure, or understanding the therapy or intervention suggested?

13. How do you know that the client is satisfied with what you said?

14. What do you do if the client brings a bilingual advocate to the meeting and you and the advocate do not agree on the meaning of a given word or statement?

15. a. What do you do when you think the client does not agree with the advice provided by the SLP?

16. What suggestions do you have to improve service delivery when an I/T is involved?

17. What are some of your personal reactions to the I/T–SLP process?

18. What characteristics have you observed in a “good” SLP?

19. What characteristics have you observed in a “poor” SLP?

20. Any other comments?
APPENDIX C. QUESTIONNAIRE FOR THE CLIENT

Language: ___________________ Date: ___________________

Conference when the interpreting took place: (Please circle all that apply):
- To share assessment results
- To share progress

How many times have you worked with this I/T? (interpreter) 1 2 3 4 5
How many times have you worked with this SLP? (speech-language pathologist) 1 2 3 4 5

On a scale from 1 to 5, please rate the follow questions: 0–Not applicable 1–Very good 2–Good 3–Average 4–Below average 5–Poor

1. Did the speech-language pathologist and the interpreter explain their roles clearly to you? 0 1 2 3 4 5
2. How well did you understand this interpreter? 0 1 2 3 4 5
3. The interpreting was done accurately? 0 1 2 3 4 5
4. The information will be kept confidential? 0 1 2 3 4 5
5. Your understanding of your rights regarding assessment, receiving a given procedure, or the therapy or intervention suggested is? 0 1 2 3 4 5
6. If you brought a bilingual advocate to the meeting, do you think that the team included this person’s input? 0 1 2 3 4 5
7. Do you feel that your concerns or questions were answered? 0 1 2 3 4 5
8. Do you think that the interpreter communicated accurately what the SLP said? 0 1 2 3 4 5
9. Did the interpreter make you feel at ease? 0 1 2 3 4 5
10. On a scale of 1 to 5, please rate your satisfaction in having worked with an interpreter. 0 1 2 3 4 5

Please provide any further comments: ____________________________________________________________

THANK YOU VERY MUCH FOR YOUR TIME.
Please enclose this questionnaire in the envelope provided and mail it as soon as possible.


CUESTIONARIO PARA EL PADRE DE FAMILIA O TUTOR (Spanish translation)

Idioma: ___________________ Fecha: ___________________

Tipo de conferencia que se llevó a cabo con el/la interpreter: (Favor de poner un círculo alrededor del tipo de conferencia):
- Para reportar resultados de una evaluación
- Para compartir progreso

¿Cuántas veces ha tratado con Ud con esta / este interpreter? 1 2 3 4 5
¿Cuántas veces ha trabajado con esta especialista del habla y lenguaje? 1 2 3 4 5

Usando una escala de 1 a 5 favor de contestar las siguientes preguntas:
0–No se aplica 1–Muy bien 2–Bien 3–Regular 4–Promedio bajo 5–Mal

1. ¿El/la especialista del habla y lenguaje y el/la interpreter explicaron su respectivo papel en este tipo de conferencia? 0 1 2 3 4 5
2. ¿Qué le pareció la interpretación de lo que se dijo? 0 1 2 3 4 5
3. ¿Le pareció que la interpretación fue clara? 0 1 2 3 4 5
4. ¿Piensa que la información impartida permanecerá confidencial? 0 1 2 3 4 5
5. ¿Se siente con confianza entendiendo sus derechos tocante a la evaluación, tocante al proceso sugerido, a la terapia o a la intervención discutidas? 0 1 2 3 4 5
6. ¿Si una amistad o persona de confianza bilingue lo/la acompañó a la junta, cómo siente que fueron recibidas sus opiniones o sus comentarios por las demás personas en la junta? 0 1 2 3 4 5
7. ¿Cómo siente que le contestaron sus preguntas o preocupaciones? 0 1 2 3 4 5
8. ¿Qué tan bien le comunicó el/la interpreter lo que le estaba explicando la especialista del habla y lenguaje? 0 1 2 3 4 5
9. ¿El/la interpreter lo/la hizo sentirse a gusto? 0 1 2 3 4 5
10. ¿Usando una escala del 1 (lo mejor) a 5 (lo peor) por favor díganos que tan satisfecho/a quedó con los servicios del/de la interpreter? 0 1 2 3 4 5

Por favor añada comentarios adicionales si así lo desea: ____________________________________________________________

MUCHISIMAS GRACIAS POR SU TIEMPO. Favor de mandar el cuestionario en el sobre adjunto.