

# Interpreting for the Student with a Cochlear Implant

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Advances in cochlear implant technology and an increase in the number of young cochlear implant users have created a need for educational interpreters to become more knowledgeable about effectively working with this population of students. This article details some of the issues inherent in working with students who use cochlear implants and offers recommendations for interpreters in this situation.

While the first cochlear implants were primarily seen in adults, today “about half” (Leigh & Christiansen, 2002) of implant recipients are children. Seal (2003) suggested that “by 2010, one in three deaf children under 5 years of age will be implanted” (p. 6). It is reasonable to expect a tremendous increase in the number of deaf children with cochlear implants in schools, especially in mainstream educational situations. Many experts recommend the continuation of the use of interpreters and other accommodations for students with cochlear implants. Interpreters face unique challenges in this situation.

First, students with cochlear implants do not present a common profile. Implanted students present wide variability in their ability to benefit from the cochlear implant (Seal, 2003; Nussbaum, 2003; Ertmer, et.al, 2002). It is, furthermore, clear that the cochlear implant does not overcome deafness (Miller & Wheeler-Scruggs, 2002; Harrington & Powers, 2004; Food and Drug Administration, n.d.; Nussbaum, 2003; National Association of the Deaf, 2000; Preisler, et.al., 2005). Seal (2003) stated that even those students who have “excellent results” with their device do not qualify as having “normal hearing,” but rather these students function in a similar manner to students with a “severe hearing loss” (p. 6).

The educational plan for the implanted student must change over time to adjust to the changing needs of the child and should ultimately be child-led (Sum-

mary Report, Discussion group G). Sign language should continue to be used after implantation to prevent developmental delays that “can be extremely difficult to reverse” (National Association of the Deaf, 2000, p. 3). The interpreter working with an implanted student must recognize the student’s changing needs and be flexible enough to meet them. Secondly, interpreters need to be aware of the parents’ and the educational team’s expectations for the cochlear implanted child. According to Nussbaum (2003), members of the educational team may not be familiar with implant technology, nor with reasonable expectations for children with implants. Parents may have unreasonable expectations for the implant. They may have chosen cochlear implants for their child in an effort to “fix” the deafness—to make the child be “normal” (Miller & Wheeler-Scruggs, 2002, p. 21; Preisler, et. al., 2005).

The interpreter, too, typically comes to this situation with a bias. By virtue of their connection with the Deaf community, interpreters are aware of the underlying issues of identity and acceptance that surround cochlear implants. The interpreter usually has a strong bias in favor of visual language as the only completely accessible language for the student (Geers, 2002). Interpreters also usually have great respect for sign language as a “necessary support for critical or abstract thinking, problem solving, and assimilating new information in an academic environment” (Nussbaum, 2002, p. 11). It is essential that interpreters recognize that parents act out of “a deep and abiding concern for the best interests of their children” (Miller & Wheeler-Scruggs, 2002, p. 21). In addition, it must be acknowledged that cochlear implants do provide some benefit in the accessibility of sound (Nussbaum, 2003), and thus possibly can aid in the learning of English grammar (Leigh and Christiansen, 2002).

Third, the student’s changing needs

and abilities create a need for constant assessment and re-evaluation of strategies and goals (Children’s Hospital Boston, 2002; Nussbaum, 2003). The educational interpreter is well-situated to play an important role in this assessment. As Seal (2004) asserted, “the interpreter is a language expert” (p. 100). The interpreter should be expected to provide information to the educational team about the “functional performance” of the student in both visual-only modes and visual plus aural/oral language (Children’s Hospital Boston, 2002, p. 1). The interpreter should also be able to analyze the student’s interpreting needs in various situations and respond to those needs appropriately (Seal, 2004).

Finally, the implanted student brings to the educational setting a need for environmental adjustments. Concerns about visual access and ambient noise are much the same for the student with a cochlear implant as they are for the hard-of-hearing student. Children’s Hospital Boston (2003) noted that “[a]ll children with cochlear implants have difficulty hearing clearly in group and noisy situations” (p. 1). Interpreters are often in a position to observe environmental barriers for individual students and to bring these to the attention of the educational team. The interpreter must anticipate situations in which the student may have trouble and give visible clues to help identify speakers and clarify information that was not made accessible to the student (Nealt, n.d.). Sometimes students with cochlear implants are positioned in the classroom in a manner designed to make best use of the implant, but this placement may not be optimum for interpreting, nor for the student’s visual access to speakers other than the teacher. This, too, is an issue that interpreters will have to address with flexibility and an understanding of the student’s goals.

It is clear that interpreting in an educational setting for a child with a cochlear implant is neither simple nor

straightforward. It seems that there are three areas in which the interpreter can be effective: 1. S/he can provide important information to the educational team about the child's ability to access and understand information in different contexts; 2. S/he can ensure access to language within the school environment; and 3. S/he can aid the attainment of listening and speaking skill goals for the student.

First, interpreters should work collaboratively with classroom teachers and other professionals who are part of the educational team. It is imperative that interpreters have advance access to lesson plans and that they understand the goals of each lesson so that they may most effectively do their work in a manner that promotes those goals while providing access to classroom communication. The interpreter may need to cue the teacher when the student needs more time to comprehend the message in dual modes (both of which may require visual attention). The interpreter must also help the teacher be aware of those times when the student is excluded from language and/or information. Regardless of the method of communication used with the student, "full access to language and concept development" is essential (Summary Report, Discussion Group 2-A). Interpreters may be ideally situated to observe whether this is accomplished for the student.

The interpreter must function as a member of the individualized education plan (IEP) team. Interpreters are in a position to observe the student's ability to function in both visual and aural/oral modes, and their expertise should certainly be included as the team develops and adjusts the IEP. As part of their role on the IEP team, interpreters must have the opportunity to "advocate for the children and themselves" (Summary Report, Discussion Group G).

Secondly, it is also the interpreter's responsibility to provide access to communication in the school environment. The interpreter will generally rely on the student's stronger language for content (Summary Report, Discussion Group B-1). New subject matter or difficult concepts may be more dif-

ficult for students with cochlear implants to comprehend (Food and Drug Administration, n.d.). Communication should be built around the student's preferred style. "Code switching" (change of modalities) should be used when it can enhance communication. Where code switching occurs, it can be helpful to alert the student to the modality used. The interpreter may wish to cue the student by indicating whether it is a time to look or to listen. It is important to recognize that implanted students don't have the ability to distinguish where a voice is coming from, and they will need cues to aid them in following spoken discussion (Summary Report, Discussion Group B-1).

Seal (2003) warned interpreters to expect that students may become more distractible as their awareness of sound in the environment increases. As the student becomes more able to access information auditorially, s/he may depend on the interpreted message less. The interpreter should plan for the frustration of not having the student's full attention. Because of the wide variability of students and implant outcomes, placing one interpreter with multiple students should be resisted. The interpreter who is valued as a member of the educational team will be able to clarify the need for individualized interpretation.



Lastly, if the interpreter has the opportunity to collaborate with the educational team and understand the auditory and oral goals for the implanted child, s/he will be in a position to aid in the attainment of those goals. Exposure to oral language is important for the student with a cochlear implant, and the educational team must devise ways to create an auditory learning environment. Leigh and Christiansen stated that the challenge for the educational team working with an implanted child is to balance exposure to both signed and spoken language, without sacrificing content.

It may be helpful to separate spoken and visual language, both physically and at various times. Setting apart certain areas of the room as "sign only" or "speech only" areas can help students make the transition from one mode to another. Designating particular times during the day for each mode can also aid clarity. Planning ahead in this way can help the interpreter and teacher coordinate lessons so that important academic information is presented to the student in the most accessible mode. Interpreters should be alert to how different situations lend themselves to either oral or visual emphasis. Leigh and Christiansen (2002) advised that the "obvious" be presented "in an auditory-only manner" (p. 24).

Nussbaum (2003) has recommended that when using spoken language, new vocabulary be introduced in high-context situations where the meaning will be more obvious, and that the introduction of new vocabulary be accomplished with plenty of repetition. When working with implanted, signing children where some level of proficiency in oral language is a goal, it is important to value both spoken and visual language. Input from both sources can be valuable for the child, and proficiency in both can certainly be an asset. Preisler, et. al. (2005) wrote, "[a]n important goal. . . must be to enable deaf children with cochlear implants to have. . . a bicultural identity. This means that sign language must play the same important role as spoken language in their lives" (p. 266).

Clearly, interpreters will increasingly find themselves being asked to work with students with cochlear

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implants. Interpreting for these children is not the same as interpreting for a child who has not been implanted but can be challenging in new and different ways. The interpreter in this situation has an important role and perspective to offer as an essential member of the educational team. ■



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