Linguistically Diverse Populations: Considerations And Resources For Assessment And Intervention

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I. INTRODUCTION

Recognizing the vast cultural and ethnic diversity that exists in Texas, this document has been prepared by the Texas Speech-Language Hearing Association Task Force on Cultural and Linguistic Diversity (CLD) Issues in an effort to establish guidelines for assessment and intervention of speech and language disorders in culturally and linguistically diverse individuals. In the document entitled "Knowledge and Skills Needed by Speech-Language Pathologists and Audiologists to Provide Culturally and Linguistically Appropriate Services" written by the 2004 Multicultural Issues Board of the American Speech-Language-Hearing Association, ASHA recognizes the shortage of bilingual speech-language pathologists and audiologists *(ASHA Supplement 24).* Furthermore, they acknowledge the importance for all service providers to assume responsibility for effective services and to be prepared to competently respond to issues of diversity.

Diversity may include a variety of factors, such as race, ethnicity, culture, religious beliefs, sexual orientation, socioeconomic level, linguistic and educational background. However, the purpose of this document is to focus on issues related to linguistic diversity as it impacts the practice of speech and language pathology in the state of Texas.

Linguistically diverse populations include individuals who:

- learned two or more languages simultaneously (simultaneous bilingualism)
- learned an additional language(s) after development of the first language (sequential bilingualism)
- are fluent in one language but have significant exposure to other language(s)
- speak more than one dialect

As we are dealing with the population living within the United States, very often the "other" language in question is English. Frequently linguistically diverse individuals/public school students are classified or referred to as "Limited English Proficient"/English Language Learners (ELL). These are individuals who are learning or have learned to speak, understand, read, and/or write English as a second or other language, even though they may have spent a number of years in an English speaking environment.

The following guidelines are proposed as a means of enhancing the quality of speech and language services to linguistically diverse populations (1).

(1) This review focuses on the communication disorders that may be most affected by the presence of two or more languages, including articulation, language, and fluency.

II. ASSESSMENT

A. Information to consider in addition to traditional case history:

The examiner should obtain a case history from a variety of sources including interviews with family members and clients/students. (See case history samples in Kayser, 1995 and 1998 and Mattes, 1985 and 1991). In addition to questions regarding speech, language and other developmental history, information about the following should be obtained from records or through interview. The examiner should keep in mind that families may be sensitive to some questions:

- Family's country of origin
- Length of time the individual has been in the United States
- When and how the client/student learned the languages
- Pattern of language/dialect use in the home (e.g., use of code-switching)
- The extent and nature of his/her exposure to each language
- Academic and educational placement (e.g., language of instruction)
- Family's perception of the individual's communication abilities.

B. Language of Assessment

Assessment of the communication skills of bilingual or linguistically diverse individuals must be driven by the information obtained in the comprehensive case history. Proficiency levels in each language are important pieces of this case history. Determination of proficiency must take into account both the Basic Interpersonal Communication Skills (BICS) and the Cognitive Academic Language Proficiency (CALP) levels in both languages. BICS involves face-to-face, "context-embedded" communication (Cummins, 1992). Achieving proficiency in BICS typically requires a minimum of 1 to 2 years of exposure to the second language. CALP denotes the ability to understand and utilize the language skills required in academic settings (Cummins, 1992). Development of CALP equivalent to that of native speakers of a language can take from 5 to 7 years when there is native language support in the school setting (e.g., bilingual education programs) (Cummins, 1992). Without such support, CALP may require from 7 to 10 years to develop (Peregoy & Boyle, 1997).

Formal and/or informal data must be gathered to provide preliminary information about an individual's BICS and CALP levels. This knowledge will assist in determining to what extent skills in each language must be measured. If one language is stronger than the other, the stronger language is said to be the **dominant language.** It often happens that bilingual individuals show no clear language dominance. It is also important to note that dominance may shift over time; it is not permanent.

Assessment should address primary (L1) and secondary languages.
Practice in the public schools is directed by federal mandates PL94-142 and Title VII of PL 95. These mandates indicate that assessment of speech and language disorders of limited English proficient speakers should be conducted in the native

language or language(s) the child speaks. IDEA, 2004 states that assessments should be "provided and administered in the child's native language or other mode of communication and in the form most likely to yield accurate information on what the child knows and can do academically, developmentally, and functionally, unless it is clearly not feasible to so provide or administer; [300.304(c)(1)(ii)]. At the same time, it is very important to note that the individual's native language may not be the dominant language at the time of the assessment. In any case, each language should be addressed to the extent appropriate. This assessment may involve only informal language sampling or it may include norm referenced testing. This recommended practice (Anderson, 2002; Roseberry-McKibben 2002; Goldstein, 2000) is appropriate for all clinical settings (e.g., hospital, clinic, public schools) and will fulfill legal requirements.

Evaluation of CLD individuals requires specific competencies which ASHA has defined in the 2004 Knowledge and Skills document. In general, the following hierarchy should be followed in selecting personnel to conduct the evaluation.

Level 1: Trained (in CLD issues) bilingual speech-language pathologist fluent in the individual's native language and English.

If this option clearly is not feasible, the following options should be considered:

Level 2: Trained (in CLD issues) monolingual speech-language pathologist assisted by trained bilingual ancillary examiner. The ancillary examiner is one who has received in depth training in the measure(s) to be used and administers testing in the native language in the presence of the SLP. The SLP is responsible for analyzing all testing data.

Level 3: Trained (in CLD issues) monolingual speech-language pathologist assisted by trained interpreter.

Use of trained interpreters is acceptable when services of a bilingual SLP cannot be obtained. Information regarding interpreter training can be found from several sources including Langdon (2002).

C. Assessment Procedures

A variety of assessment techniques should be utilized in order to thoroughly describe the individual's speech and language skills.

- Standardized testing may be conducted in the native language, if appropriate measures are available. However, before testing in the native language, obtain information regarding language exposure, use, and proficiency in each language. Many speakers lose native language skills due to lack of use (i.e., language loss); therefore, formal measures may be of limited use. Test scores should be utilized with caution, as the

standardization sample may not be representative of the individual tested. When the match between the student/client and the standardization sample is questionable, norms should not be used; however, the strengths and weaknesses demonstrated on test tasks can be analyzed (without scoring the test) and used as criterion-referenced assessment.

- If the individual has been exposed to English, then level of functioning in English must be addressed, to whatever extent appropriate. Again, information regarding language exposure, use, and proficiency should be obtained prior to evaluation. Often, it will not be appropriate to report standard scores, as the standardization sample will not reflect the linguistic background of the individual. Results can be reported as criterion-referenced assessments.

- Informal testing such as speech and language sampling, dynamic assessment, structured observation, and narrative assessment must be conducted. The results of these measures should be considered equally as significant (if not more so) as the results of any standardized measures in making a determination about the communication skills of CLD individuals. For more information on these techniques, refer to the works of Hamayan and Damico (1991), Kayser (1998), Peña (1996), Peña and Gillam (2001), and Roseberry-McKibbin, 1995.

1. Language

Below are descriptions of available language assessment tools and strategies for the evaluation of linguistically diverse populations. Since English is usually the "other" language of concern, assessment in English will be specifically addressed.

- Standardized measures of language skills are available in Spanish to assess receptive and expressive vocabulary, morphology, and syntax for individuals age 0 to 21. Depending on the student's cultural/linguistic background and family's country of origin, these measures may or may not be appropriate for administration.

- The Bilingual Verbal Ability Test, which measures vocabulary and verbal reasoning skills, is available in at least eighteen different languages.

- English receptive and expressive skills may be addressed via formal and/or informal measures. The examiner must carefully consider what measures are most appropriate for the client, how to utilize the measure, and the most valid method of interpreting the outcomes of the measure. These considerations will be guided by knowledge about the individual's exposure to and level of proficiency in English.

At times, due to lack of available instruments in low incidence languages, examiners may consider the option of translating items from English language measures in order to assess specific native language skills. Although such testing may provide insights regarding the individual's abilities, it is never appropriate to report any score as the result of such testing. Further, if this strategy is utilized, the following precautions should be observed.

- Translation of English-language measures into the native language should be completed with caution. There will be some test items that cannot be directly translated into another language and still measure the targeted skill. (e.g., translation of sentence repetition tasks)

- These translations should be completed, administered, and results analyzed only by a clinician working with a trained interpreter. The clinician must be competent and knowledgeable about assessment of CLD individuals.

- Such translations may be used as informal probes or criterion-referenced measures; original test norms do not apply to the translation so scores must not be reported.

2. Articulation/Phonology

Articulation/phonological assessment also will be guided by knowledge of the individual's linguistic background:

- Assessment of articulation skills may be conducted only in the individual's first language when the exposure to the other language(s) is determined to be negligible. (See Goldstein, 2000 for normative information on a variety of languages.)
- When two languages are spoken by the client/student, articulation skills should be assessed in both languages.
- Interpretation of results must consider the influence of each phonological system on the other(s).

Determination of an articulation impairment cannot be based only on the phonology of English/L2. If the individual's articulation skills are within normal limits in the primary language (L1) then an impairment does not exist. Dialectical variations cannot be considered as articulation errors.

3. Fluency

When suspecting a stuttering problem in a bilingual speaker, a number of issues merit consideration during the assessment process.

- Family and cultural attitudes toward speech, fluency, and stuttering.

There is quite a bit of variability in the health beliefs and practices across cultural groups. Through discussion and exploration, it is important that the clinician strive to understand how speech disorders and stuttering, specifically, is viewed by the client and family members. Some groups view stuttering as an emotional disturbance or a punishment by a spiritual figure (Bebout & Arthur, 1992). Such beliefs may impact the clinician's ability to diagnosis stuttering and will affect the nature of intervention.

- Bilingualism as a risk factor for stuttering.

  There is little empirical evidence to support the belief that bilingualism per se puts an individual more at risk for stuttering or impedes his/her ability to recover from stuttering (Van Borsel, Maes, and Foulson, 2001). More important to the differential diagnosis of chronic stuttering is a family history of stuttering and delays and/or disorders in the acquisition of first and/or second languages.

- Nature of disfluencies in both languages.

  Since disfluency patterns may differ in the languages spoken and these differences may provide insights as to the nature of the fluency problem (i.e., linguistically based or chronic stuttering), it is important to assess fluency in both languages. In connected speech samples of both languages, frequencies, disfluency type and nature, and stuttering loci should be examined.
    - *Frequencies:* Disfluency rates may be higher in the less proficient language (Van Borsel et al., 2001). If the client reports and/or the clinician observes significant differences in the disfluency frequencies in the two languages, the influence of language learning and /or loss merits consideration.

    - *Types and nature:* Stuttering types seem to be similar across languages (Bernstein-Ratner, 2004). These types generally consist of within word disfluencies, such as sound and syllable repetitions, blocks, and prolongations. These behaviors can be observed even when the listener does not speak the language of the speaker. If disfluency types predominantly are between words (e.g., revisions, interjections), the fluency problem may be linguistically based rather than chronic stuttering. The clinician also should note the presence of struggle, tension, and/or extra movements during disfluencies. These behaviors are often associated with chronic stuttering.

    - *Loci of stuttering:* The phonemic and linguistic loci of stuttering may differ in the two languages spoken. More stuttering may occur at higher levels of linguistic complexity, including during code-switching moments (Bernstein-Ratner, 2004). Understanding the influence of language complexity on the client's fluency will

provide insights about his language proficiency as well as potential linguistic fluency stressors. These insights are important considerations when planning and providing intervention.

In summary, Boscolo, Bernstein-Ratner, and Rescorla (2002) suggest that the following conditions may indicate a fluency problem associated with limited English proficiency rather than chronic stuttering:

- No secondary features during disfluent moments.
- Lack of a self-concept as a person who stutters.
- Locus of disfluency at positions of increased encoding difficulty in the less proficient language.
- Lack of stuttering in the stronger language.

For additional information see Watson and Kayser, 1994.

D. Interpretation of Assessment Results

When interpreting assessment results, the distinction must be made between a communication impairment and a dialectical, cultural, or language difference. As defined in IDEA, 2004, a determination of an impairment cannot be due to limited English proficiency [300.306(b)(1)(iii)]. Further, IDEA states that determination of a communication impairment cannot be made on the basis of a single measure but rather requires data from "a variety of assessment tools and strategies." Therefore, sufficient evidence must be gathered in the assessment to allow the clinician to clearly document the presence or absence of a communication impairment. In order to distinguish between a communication impairment and a dialectical, cultural, or language difference, the clinician must consider:

- Information from case history
- Language development (e.g., the process by which s/he became bilingual)
- Educational history (e.g., bilingual/ESL instruction)
- Bilingual issues (e.g., current BICS and CALP levels)
- Analysis of formal and informal assessment results, in both languages

The knowledge and experience of the speech-language pathologist in second language issues is important when interpreting assessment results. The complexity of the issues requires the ability to integrate and comprehend the data collected before determining the need for speech therapy services.

III. Intervention

A. Determining language(s) of intervention.

The decision as to which language to use during intervention is mediated by the client's needs and proficiencies, legislation, and case law (IDEA, 2004; TEA 1991, 2001, 2003). In the public schools, speech-language services should be developed to enable the CLD student to receive an educational benefit. Current law states that "in the case of a student with limited English proficiency, consider the language needs of the student as those needs relate to the student's IEP" (IDEA, 2004) [300.324(a)(2)(ii)]. Although it will be the Admission, Review, and Dismissal (ARD) committee's decision as to which language should be used in therapy, the SLP is responsible for making an informed recommendation based on the information obtained during the assessment.

Decisions regarding language of intervention depend on:

- Client's dominant language
- Family language use
- Language environments

In most cases, services initially should be provided in the dominant language if **clear** dominance can be determined (Langdon & Saenz, 1996). In cases where no clear dominance can be determined, services should be provided in the home language (L1). This approach will promote the development of first language skills (skills that may be transferred to the second language) and facilitate family involvement (Kiernan & Swisher, 1990; Perozzi, 1985; Perozzi & Sanchez, 1992). Another option is based on the bilingual model where content is addressed in both languages. This model stresses the transfer of knowledge and skills between languages and emphasizes that both languages are valued and valuable (Kohnert & Derr, 2004). The decision to provide services in the client's first language or in both languages is based on current understanding of intervention environments and outcomes. Recommendations intended to promote maximum therapeutic benefit (e.g., L1 intervention, bilingual intervention) may or may not align with the current language of instruction and/or parental preference, but *should be based on the client's current language profile.*

Since client needs and skills are dynamic and evolving depending on his/her exposure to each language, the language of intervention requires careful and regular evaluation and may change over time. (For additional information, refer to *Communicologist* Aug. 2004; Beaumont, 1992; Goldstein, 2000; Goldstein, 2004; Ortiz, 1984; and Roseberry-McKibben, 1995.)

B. Intervention Models

When a language other than English is recommended for intervention, consider one of the following models as described by Kayser (1998) and outlined below to determine how services will be provided.

1. Bilingual support model: Monolingual speech-language pathologist uses a speech-language pathology assistant or technician (e.g., communication helper) who is bilingual to assist the speech-language pathologist in providing service in the minority language.

2. Coordinated service model: Monolingual and bilingual speech-language pathologists work as a team to provide services.

3. Integrated bilingual model: The bilingual speech-language pathologist provides all services.

4. Combination of bilingual support and coordinated model: The monolingual speech-language pathologist and bilingual assistant provide services with the support of the bilingual speech-language pathologist.

Instructional approaches, materials, and activities must be appropriate to the culture and language of the student.

IV. FINAL OBSERVATIONS AND CONSIDERATIONS

The guidelines and practices described in this document are intended as a resource for consideration when conducting assessments and providing intervention for linguistically diverse populations. The document is not a prescriptive formula to address all disorders that may occur in the CLD population. Cultural and linguistic issues are multifaceted, dynamic, and require an ongoing commitment to learning. The CLD Task Force developed these guidelines in the hopes of providing a better understanding of the requirements, procedures, and knowledge needed when providing services to those of diverse linguistic backgrounds.

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Texas Education Agency (2001), *Fernando P. b/n/f Alicia P. v. Pasadena ISD,* TEA Docket No. 374-SE-600.

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RESOURCES (2)

(2) Although many relevant resources are included, this list is not exhaustive and other books, journals, websites, tests, and materials are also useful. Readers are encouraged, as with all resources, to critically review these resources when applying them to clinical, empirical, or other activities.

Tests:

Articulation Tests:

Hodson, B. (1986). *Assessment of phonological processes-Spanish.* San Diego: Los Amigos. Research Associates.

Mason, M. (1974). *Medida espanola de articulacion.* San Ysidro, CA: San Ysidro School District.

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Zimmerman, I., Steiner, V., Pond, R. (2002). *Preschool language scale-4, Spanish edition (articulation screener).* San Antonio, TX: Harcourt Assessment.

Language Tests:

Boehm, A. (2000). *Boehm test of basic concepts, third edition.* San Antonio, TX: Harcourt Assessment.

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Werner, E., & Krescheck, J. (1983). *Spanish structured photographic expressive language test-II.* DeKalb, IL: Janelle Publications, Inc.

Werner, E., & Krescheck, J. (1989) *Spanish structured photographic expressive language test-P.* DeKalb, IL: Janelle Publications, Inc.

Zimmerman, I., Steiner, V., Pond, R. (2002). *Preschool language scale-4, Spanish edition.* San Antonio, TX: Harcourt Assessment.

Therapy Materials

Articulation

Ninos y Sonidos, Bilingual Speech Resource
Spanish Articulation Picture Cards, Academic Communication Associates
Teaching Spanish Sounds, Academic Communication Associates
¡Oscar! Spanish Flashcards, TrabaLenguas

Language

Spanish Vocabulary Development, Leap Frog
Fiesta in the House-Party en la Casa, Leap Frog
Ver y leer de Richard Scarry, Leap Frog
Bilingual Language Picture Resource, Academic Communication Associates
The Incredible City, Academic Communication Associates
Basic Concepts for Language Learners, Academic Communication Associates
Talk About Stories in English and Spanish, Academic Communication Associates
Language Booster Cards Decks, Spanish/English (Spatial Concepts and Actions)

Websites for therapy ideas:

- www.bogglesworld.com – Language Activities
- www.enchantedlearning.com – Crafts and language activities
- www.csusm.edu/csb/espanol/ - Recommends a variety of Spanish books
- www.innovative-educators.com – Bilingual, feely, and board books
- www.tsl.state.us/ld/projects/ninos/songsrhymes.html - Traditional songs, rhymes, finger plays, and games in Spanish and English
- www.spanishtoys.com – Spanish language toys, videos, software, and books
- www.PsychoCorp.com
- www.asha.org- Go to the Multicultural Affairs site addressing CLD issues, latest research, and materials for intervention.
- www.clas.uiuc.edu - promotes intervention practices that are culturally appropriate