CLD CORNER: Linguistic and Multicultural Considerations in Patients with Dysphagia: 2020 at a Glance

By: Guest Author Jennifer Maya, MS, CCC-SLP

The CLD Corner was created in an effort to provide information and respond to questions on cultural and linguistic diversity. Questions are answered by members of the TSHA Committee on Cultural and Linguistic Diversity (CLD). Members for the 2015-2016 year include ***Raúl Prezas****, PhD, CCC-SLP (co-chair);* ***Brittney Goodman Pettis****, MS, CCC-SLP (co-chair);* ***Amanda Ahmed****, MA, CCC-SLP;* ***Mary Bauman****, MS, CCC-SLP;* ***Phuong Lien Palafox****, MS, CCC-SLP;* ***Alisa Baron****, MA, CCC-SLP****; Judy Martinez Villarreal****, MS, CCC-SLP; and* ***Ryann Akolkar****, BA, student Representative. Submit your questions to TSHACLD@gmail.com and look for responses from the CLD Committee on TSHA's website and in the* Communicologist*.*

As a regional director of rehabilitation and a bilingual speech-language pathologist (SLP) who practices primarily in the skilled nursing environment, I've often been asked to interpret or translate for the interdisciplinary team. Provided that I work in the world of rehabilitation, the majority of requests come from the physical therapy (PT), occupational therapy (OT), and speech-language pathology staff. As a bilingual therapist, it is not uncommon to co-treat with the PT and OT staff to enable the patient/therapist to communicate effectively throughout their session or to assist with educating family/caregivers. As a result, the conversations with my peers often resulted in personal reflections that they themselves should have been more attentive in their Spanish, Chinese, or one of the wide varieties of language classes they received credit for in college. Perhaps it would have enabled us all to better evaluate and treat one of the many culturally and linguistically diverse (CLD) populations we see in our practice today, regardless of whether we work with the pediatric or adult population.

Dysphagia, in particular, may be especially difficult to assess and treat in multiple languages given the severity and complexity of the disorder, not to mention the added challenge when a language difference exists. The Dysphagia Fact Sheet estimates that approximately one million patients annually are receiving a new diagnosis of dysphagia (Encore Medical, L.P., 2005). Other statistics, according to The National Foundation of Swallowing website, indicate that there may be between 300,000 and 600,000 individuals in the U.S. who are affected by neurogenic dysphagia each year. Moreover, 10 million Americans are evaluated each year for swallowing difficulties, per a description of Swallowing Disorder Basics, which may be found on the same website.

Some practitioners may say they do not have *any* barriers, particularly with the non-communicative patient; however, part of our role as therapists is to educate and train primary caregivers (e.g., family members) whose language may be different than our own. This may be especially critical with the pediatric and/or the cognitively impaired patient whose treatment will be dictated primarily by the carryover of the caregiver and their understanding of the treatment procedures. The proactive and thorough clinician will concur that dysphagia treatment does not end with diet recommendations. Patients and family members frequently require additional education to carry over diet modifications into daily meal planning (*Communicologist*, 2014). Interestingly, in my experience, I've even had bilingual SLPs request translation assistance in order to communicate the correct medical terminology to the caregiver/patient regarding their particular dysphagia. After all, we do not normally learn the skilled dysphagia vocabulary in our everyday language. Therefore, some SLP programs now incorporate an emphasis on the CLD population. With the increasing number of CLD individuals being diagnosed with dysphagia annually, will there be a sufficient number of bilingual SLPs to meet the demands of this population with dysphagia in 2020?

A review of the demographic profile of American Speech-Language-Hearing Association (ASHA) members providing bilingual services from August 2012 reveals that, of the 150,241 individuals represented by ASHA, 7,039 (5%) indicated they met the ASHA definition of bilingual service

provider. While ASHA does not offer bilingual certification, the organization did request on its 2012 dues notice that ASHA members self-identify as being bilingual based on ASHA's policy. ASHA's policy document, which is titled "Bilingual Speech-Language Pathologists and Audiologists Definition," requires native or near-native proficiency in a second language. According to the Texas Speech-Language-Hearing Association (TSHA) CLD Committee, a trained bilingual SLP is someone who speaks a second language fluently, has received additional training on the unique development of speech and language skills in the second language, knows appropriate therapy targets, and is able to acknowledge how cultural influences affect the therapeutic process ("The Difference Between Spanish-Speaking SLPs and Bilingual SLPs," 2014).

Per the U.S. Census Bureau website, "Language Projections: 2010 to 2020" reported that, in 2009, 57.1 million people (20% of the population 5 years and older) spoke a language other than English (LOTE) at home. In 1980, there were 23.1 million (11% of the population 5 years and older) LOTE speakers, making for an overall increase of 148 percent. By 2000, more than 70 percent of the population speaking another language spoke Spanish, Chinese, Japanese, Korean, Vietnamese, or Tagalog (Shin and Bruno, 2003). The largest numeric increase in the population speaking a language other than English at home was for Spanish speakers (numbers increased by 24.4 million speakers), whereas the largest percentage increase was for Vietnamese speakers (a 533% increase).

Additionally, the article states that the number of Spanish speakers is projected to reach between 39 and 42 million in 2020. Spanish is projected to remain the most commonly spoken language over the next 10 years. Spanish speakers are projected to represent about 13% of the total population ages 5 and older and to account for more than 60% of the population who speak a language other than English in 2020. Reportedly, Chinese remains the second most commonly spoken language other than English in the United States , followed by French, Tagalog, and Vietnamese.

A CNN report via CNN.com released in 2015 states that the U.S. is now the second largest Spanish-speaking country, second only to Mexico and surpassing major Spanish-speaking nations including Spain and Colombia. The U.S. is home to 41 million native Spanish speakers, with an additional 11.6 million who are bilingual, according to data from the U.S. Census and other government sources. By 2050, the U.S. will have the largest Spanish-speaking population in the world at 132.8 million, according to the report. In addition, they also found that Spanish is the third most-used language on the internet, following Chinese and English, and second after English on social media platforms such as Facebook and Twitter (Melendez, 2015).

The above research and literature review suggests that, in addition to the increase in the diagnosis of dysphagia on an annual basis, the U.S. will continue to be a culturally and linguistically diverse nation in the years to come. With increased awareness in the field, I am hopeful bilingual individuals are inspired to learn more about the professions of speech-language pathology and audiology. While the demand for bilingual SLPs continues to grow, so does our need for more clinically trained bilingual clinicians. As proactive SLPs, we must meet the needs of our patients, and, in accordance with ASHA's Principle of Ethics II, rules B and C, clinicians should continue in life-long learning to develop the knowledge and skills required to provide culturally and linguistically appropriate services (ASHA, 2013). Although not all providers are proficient in a second language, I encourage all SLPs to find the necessary resources to provide appropriate intervention for their culturally and linguistically diverse patients. Given ASHA's stance on the responsibility of the SLP to care for the CLD population, are you prepared to meet the needs of these patients? More importantly, will you be prepared in the years to come?

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