RESPONSE TO A QUESTION FROM A SPEECH-LANGUAGE PATHOLOGIST:

How Do Monolingual Service Providers Best Address the Needs of Children Who Speak Languages Other Than English?

By: TSHA Cultural and Linguistic Diversity Committee members
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The TSHA Cultural and Linguistic Diversity (CLD) Committee was created in an effort to provide information and respond to questions on cultural and linguistic diversity from clinicians practicing in Texas. The CLD Committee is dedicated to providing current information to assist in the assessment and treatment of clients who speak languages other than English and who also may have different cultural backgrounds. Questions are answered by the committee. Please submit your questions by email to co-chairs **Lisa Carver** (lisa_slp@msn.com) or **Ivan Mejia** (ivan.mejia@bilingualspeech.org).

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"Dear TSHA CLD Committee: I am a school-based speech-language pathologist (SLP), and I only speak English. My caseload includes children from a variety of different backgrounds and languages. I serve a preschool program for children with disabilities (PPCD) classroom that is particularly diverse. We have several three- to five-year-old children in our PPCD classroom who were not exposed to English before coming to school. Among our PPCD students are children with Down Syndrome and one child with a hearing impairment. The children's home languages include English, Vietnamese, Spanish, and Mandarin Chinese. The PPCD teachers and assistants also only speak English. The campus administration and the Language Proficiency Assessment Committee (LPAC) are

encouraging the families to embrace English. Recently, I attended two separate Admission, Review, and Dismissal (ARD) meetings in which the school administrator recommended that the parents attend English classes in the community and speak only English with their child since that is the language used in the educational setting and the language that will help the child to make academic progress more rapidly. Here are my questions:

1. What is best practice for helping these children develop language and communication skills?

2. What are my legal and ethical responsibilities?'

3. What is the best way to serve the needs of these severely developmentally delayed children whose first languages are not English?

4. Do you have any advice on how to counsel the parents about learning English and communicating with their children?

5. Is there any research on serving bilingual children with severe developmental delays?"

Thank you for your question. This is a dilemma that has far-reaching social, educational, and long-term effects for speech-impaired children who are exposed to more than one language. Providing speech therapy services to increase communication skills is always the best option once a disorder has been identified, but addressing the linguistic and cultural needs of the child and family in each situation requires culturally competent clinicians to plan services that will lead to the best overall outcome for the client. This planning requires the service provider to first address basic questions such as the language of delivery, therapy approach, and ensuring that goals are both culturally and linguistically appropriate for the client and the family. An overview of best practices for demonstrating cultural competence, a description of the SLP's legal and ethical responsibilities, and service delivery options for severely handicapped CLD clients will be presented. Additionally, a discussion of evidence-based practice for counseling parents of CLD students and current research about bilingualism among children with multiple developmental delays will be provided. It is important to remember that there are many factors that influence a child's success in the educational setting, and there are social, linguistic, and educational expectations that require both the child and the family to participate as collaborators working toward a successful education for the child.

Showing for respect and valuing all the educational partners involved for a student is a first step toward this success. Fahey (2000) commented on the communication load placed on children new to the educational system, "When students enter school, they must learn three new and different discourses that exist simultaneously in the classroom: the language of curriculum, the language of control, and the language of personal identity." These discourses are often confusing and difficult for students with language differences or language learning disabilities, largely because school personnel seldom make them explicit to students. Instead, students arrive in schools, and teachers immerse them in the language of the classroom and expect them to figure out the rules. When served by a culturally competent SLP, the family and client can be assured that they have an advocate for the most successful communication and education of the student with special needs.

Best Practices and Recommendations for Language Use at School and Home

Best practices are highly dependent on many factors, including but not limited to the following: language exposure at home and at school, the child's language proficiency receptively and expressively, level of familial acculturation, and level of child's saturation in the home and mainstream cultures via real interaction or through media (e.g., television). Although federal mandates are in place to guide bilingual assessment practices (e.g., testing in both languages; Individuals with Disabilities Education Act, 2004), guidelines for therapy are less specific. Generally speaking, however, service delivery in the home language (L1) is highly recommended for younger children who are just beginning their academic careers and are coming from a monolingual, non-English-speaking environment. As children grow and are more exposed to English (L2), their needs may change. However, the service delivery is essentially on a continuum that should account for the dynamic nature of bilingualism

(Kohnert and Derr, 2004). For these younger children with speech and language disorders and with limited exposure to English, therapy should generally begin heavily in the L1 or exclusively in the L1 (when it is feasible to do so). As children from monolingual, non-English-speaking environments grow and are more exposed to English, a need for bilingual therapy or monolingual English therapy (for some older children) may arise. Kohnert, Yim, Nett, Kan, and Duran (2005) stated that the systematic support for the home languages of young children with language impairment is crucial to the long-term success of language intervention.

Another critical component that needs to be mentioned is bilingual education, which can help to solidify the advances made in therapy. The rationale for this approach is that the process of developing academic proficiency for L2 is on a continuum. It is well-known, for example, that the process of developing L2 can generally take several years (Kohnert and Bates, 2002). Utilizing this bilingual model embraces the home language and culture while encouraging language development and capitalizing on the benefits of all positive bilingual phenomena (e.g., language transfer), while at the same time minimizing the likelihood of negative bilingual phenomena (e.g., language loss). At the very least, abandoning the home language covertly or overtly devalues the child's native language and home culture, which makes the home language particularly vulnerable to loss (i.e., language attrition, incomplete acquisition) in bilingual children. This is of great concern because the family is the primary context for social, emotional, and cognitive development for two- to five-year-olds. As a result, home language enrichment must be a priority in early intervention programs (Kohnert et al, 2005). Parents and caregivers should be encouraged to speak to their children in their native language and be assured that using the home language with their child will benefit him or her. Moreover, speech-language pathologists should encourage parents of children on their caseloads to interact with their children in linguistic exchanges at home (e.g., language play activities, reading, singing, rhyming, narrating, alphabet songs). It is additionally important to recommend that these activities be in the parents' native language to encourage meaningful language learning. Parents should play an active role in their child's success, regardless of language used, as providing a language-rich environment at home will improve overall language skills.

According to Fahey (2000), "Many of the difficulties that minority-language students experience in mainstream classrooms can be attributed to the devaluing of their culture by their teachers and other educationists. Forced to choose between family and school, between familiar and the unknown, too often language-minority students or those from poor families, families of color, or of non-mainstream ethnicities perceive themselves as outsiders and are at risk of feeling as if they do not belong anywhere. Honoring culture and linguistic difference goes a long way toward stemming students' feeling of alienation. Consequently, effective teachers and SLPs communicate a clear assumption that the language and culture each non-mainstream learner brings into the classroom is both appropriate and deserving of respect."

As monolingual service providers or providers who may not speak the child's primary language (L1), best practice involves understanding the basic language tenets of the students' native language and the home culture. We should not demand language structures that do not exist in the students' native language. At a recent ARD attended by one of the authors of this article, for example, there were speech and language goals written for a fourth grade student who was exposed to Vietnamese from ages zero to five years. Articulation goals included use of clusters and multisyllabic words, while the proposed language goals involved plurality. In Vietnamese, however, words are monosyllabic; consonant blends would never occur, and plurals do not exist. Essentially, a number is placed prior to a noun to indicate plurality. For example, in English, we would say, "I see three dogs." In Vietnamese, one would say, "Tôi thấy ba con chó. I see three dog." An "s" or other morphological marker is not added to the end of the noun to indicate plurality. Therefore, goals selected for this particular child were not appropriate since these forms do not exist in Vietnamese, the native language. Instead, goals should focus on basic language tenets that exist in both languages (e.g., use of appropriate mean length of utterance, answering basic WH-questions).

Legal and Ethical Responsibilities

What does the American Speech-Language-Hearing Association (ASHA) say? As professionals, we have the benefit of strong leadership from our national organization in regard to our professional responsibilities to serve all potential clients using the best research we have access to and in the least biased way possible. A review of links to ASHA's resources and stance regarding the ethical and legal responsibilities of clinicians working with culturally diverse clients is provided:

- http://www.asha.org/practice/ethics/cultural-and-linguistic-competence/
- http://www.asha.org/policy/PI2011-00326/

ASHA policy on providing culturally and linguistically appropriate services (2004) states that intervention and assessment must focus on a child's abilities in both languages and also must be aligned with a family's expectations, values, and goals as well as those of the larger cultural and linguistic community. ASHA policy also states, "These practices are predicated on the belief that families provide a lifelong context for a child's development and growth." (ASHA, 2008, p. 2) The clinician, educator, supervisor, and researcher must be mindful of the impact of cultural and linguistic diversity in interactions with clients, families, students, and colleagues. Regardless of personal culture, practice setting, or caseload demographics, professionals must strive for culturally and linguistically appropri-

ate service delivery. This will impact all aspects of professional practice, including assessment procedures, diagnostic criteria, treatment plans, treatment discharge decisions, and research.

The beliefs and values unique to that individual service provider-client encounter must be understood, protected, and respected. Providers must enter into the relationship with awareness, knowledge, and skills about their own culture and cultural biases, strengths, and limitations. Care must be taken to avoid making assumptions about individuals that may lead to misdiagnosis (Goldstein, 2004) or improper treatment of the individual. To best address the unique individual characteristics and cultural background of individuals and their families, providers should be prepared to be open and flexible in the selection, administration, and interpretation of diagnostic and/or treatment regimens.

Certain materials and activities may be inappropriate and even offensive to individuals who are not from the U.S. mainstream culture. Families may choose complementary and alternative medicine, traditional healing practices, and different communication styles as opposed to mainstream diagnostic and therapeutic approaches. This applies to the treatment of communication disorders as well as swallowing and balance disorders. Clinicians are encouraged to prepare themselves by researching and learning about the cultures that they serve.

When a professional is not proficient in the language used by the client and family, a suitable interpreter should be used. The use of interpreters and others who are proficient in the language of the persons served does not negate the ultimate responsibility of the professional in diagnosing and/or treating the individual. Speech-language pathologists and audiologists who present themselves as bilingual for the purposes of providing clinical services must be able to speak their primary language and to speak (or sign) at least one other language with native or near-native proficiency in lexicon (vocabulary), semantics (meaning), phonology (pronunciation), morphology/syntax (grammar), and pragmatics (uses) during clinical management or conducting of research. In addition, bilingual clinicians must understand issues related to cultural and linguistic diversity, such as second-language acquisition, dialectal differences, and bilingualism.

Kohnert et al (2005) reported several evidence-based service delivery options for clinicians who do not speak the home language of the client, including:

- Training parents to implement the therapy directly to their children in their first language using specific language facilitation techniques (modeling, expansion, recasts, imitation, responsive feedback) by clinician demonstration, coaching, role-play, videotaped examples, and written materials. Consequently, a study presented by Law, Garrett, and Nye (2004) found that intervention administered by trained parents was as effective as intervention with SLPs.
- Peer-mediated intervention strategies using typically developing older siblings or bilingual students combined with direct shaping or mediation of the language used in play provided by the SLP
- Training a bilingual paraprofessional to interpret and mediate intervention strategies concurrently during the therapy session

Research on Developmental Delay and Bilingualism

The discussion of the language in which a child will be educated often depends on school resources and the availability of bilingual staff. It is often the case that academic concepts in PPCD will be presented in the language of the classroom (English), but that does not mean that the communication professional only supports language intervention in English. Instead, the family is encouraged to maintain communication in the home language and facilitate improved language with their child using techniques modeled by the SLP. Research by Kay-Raining Bird, Cleave, Trudeau, Thordardottir,

Sutton, and Thorpe (2005) regarding the ability of bilingual children with Down Syndrome to maintain and develop functional language skills in both languages concluded that, as a group, bilingual children with Down Syndrome can be successful in acquiring two languages and that bilingual children perform in their dominant language as well as monolingual peers with Down Syndrome who were matched for developmental level. In a recent article by Bunta and Douglas (2013), the authors investigated dual-language education for bilingual students with hearing impairments who wore listening devices and found that the language skills of these students were commensurate with hearing-impaired monolingual peers; additionally, they found that there was not evidence of further language delay with bilingual education. The argument that presenting educational concepts and communicating in English only will enable a child with a disability to learn more easily and make progress more rapidly—while it sounds logical—is not supported by research and may have negative consequences. Some of these may include isolation from important life contexts shared with family members and decreasing natural interactions between parent and child if parents have to attempt to communicate in a language in which they are not proficient or as comfortable (Kay-Raining Bird et al, 2005). Recommending that families speak only English when it is their second language and it is not spoken proficiently by the family is contrary to research and may be considered an unethical practice (Restrepo, 2005).

Summary

Although additional data is still needed to improve our understanding of bilingual children and effective service delivery models, resources and best practices do exist to help guide professionals who work with multilingual and multicultural populations. These resources were outlined in this document, and best practices have been discussed as they relate to the clinician's questions about how to best serve the children in the educational setting. Although it is impossible for every clinician to speak all the languages of the clients who may be encountered professionally, it is both feasible and possible that clinicians can support, facilitate, and cultivate communicative success for their clients through a variety of different service delivery models. ★

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