AMERICAN
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Clinical Management of Communicatively Handicapped Minority Language Populations

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Introduction

In 1984, the American Speech-Language-Hearing Association adopted the position paper "Clinical Management of Communicatively Handicapped Minority Language Populations." This followed what is believed to have been one of the most extensive development and review processes ever undertaken in the creation of an Association position statement. This position paper was drafted five times over a 3-year period and had as many peer reviews before professional consensus was achieved.

The initial draft was developed in 1982 as a concept paper, as part of the ASHA-sponsored Bilingual Language Learning System (BLLS) project, and was revised following review by the project's staff, advisory committee, and internal staff consultants.

The concept paper was reviewed by the ASHA Committee on the Status of Racial Minorities from which the second draft, a position paper, was derived. The draft position paper was submitted to approximately 750 ASHA members for a "limited" peer review. (Limited peer review typically involves dissemination to only 20–30 members.) These included members who are bilingual and or bicultural, members who serve minorities, the BLLS Advisory Committee, and the BLLS Trainers. This peer review resulted in approximately 500 pages of responses.

The revision process for the third draft followed the limited peer review and took 106 person hours to complete. The third draft was submitted to the Executive Board for approval for widespread peer review. However, the Executive Board required clarification of various areas of the draft.

In response to the Executive Board, a fourth draft was developed and published in the *Asha* journal for widespread peer review (*Asha*, June 1984). The paper was revised for the fifth time, incorporating comments received following review by the entire membership.

The fifth draft was approved by the Executive Board in August 1984 and submitted to the Legislative Council in November. The Legislative Council approved the position paper overwhelmingly.

Members of the Committee on the Status of Racial Minorities who endured long hours and intensive meetings in the preparation of this statement were Sandra L. Terrell (Chair), Maureen E. Aides, M. Parker Anderson, Hermozene Brown, Lorraine Cole (ex officio), Regina B. Grantham, Gail A. Harris, Barbara G. Loera, the 1983 monitoring Vice President for Planning, Patricia R. Cole and the 1984 monitoring Vice President for Planning, Carol P. Leslie.

Statement of Need

The special needs of minority language populations (native speakers of languages other than English) were the source of national controversy even before the Bilingual Education Act was enacted nearly two decades ago. Professionals in bilingual education, regular education, special education, linguistics, sociology, second language instruction, psychology, learning disabilities, as well as speech-language pathology and audiology, have debated innumerable issues, approaches,

theories, and philosophical positions regarding minority language populations. As a result of this widespread controversy, there has been considerable confusion among these various professionals concerning this population.

According to the 1980 Census, 34.6 million or 15% of the U.S. population is composed of native speakers of various minority languages. It is estimated by ASHA that approximately 3.5 million of these speakers have speech, language, or hearing disorders that are unrelated to the use of a minority language. Researchers and clinicians are only beginning to amass a knowledge base on the characteristics of normal language development in various minority languages, bilingual language learning, second language acquisition, dominance testing, bilingual assessment and remediation of communication disorders, and the applications of emerging computer technology for use with minority language groups. Therefore, it would be premature to propose in this paper optimum strategies for identification, assessment, and intervention of communication disorders among minority language populations.

However, it is firmly established that most ASHA members are aware of their limitations in language proficiency and in their knowledge of diverse cultures which restrict their competence to serve minority language populations. According to the 1982 ASHA Self Study Survey, 77% of the certified speech-language pathologists indicated a need for more knowledge and skill to serve bilingual-bicultural populations. Given that the minority language population is ever increasing, there is an immediate need for professionals to either upgrade their own levels of competence or to employ alternative strategies to address the needs of the communicatively handicapped among the various minority language populations. Thus, it is the purpose of this paper to recommend competencies for assessment and remediation of communication disorders of minority language speakers and to describe alternative strategies that can be utilized when those competencies are not met.

It is obvious that assessment and remediation of some disorders of communication are not hampered by the client's use of a minority language. For example, assessment of pure tone hearing thresholds, auditory brainstem response, acoustic reflexes, and other similar services may not necessitate much communication exchange between the examiner and the client. Likewise, assessment of the physical support for speech, assessment of anomalies affecting speech such as cleft lip and palate, palatal insufficiency, oral malocclusion, etc., also may be conducted without proficiency in the minority language. These examples are by no means exhaustive, but are provided to emphasize that there are clinical services that can be provided appropriately by a monolingual English professional to a minority language speaker. However, because the effectiveness of the professional is dependent on interpersonal skill in addition to technical skill, the overall professional-client relationship is affected when communication is limited.

For many other aspects of speech, language, and hearing, assessment and remediation are much more complicated by the client's use of a minority language. For example, the phonemic, allophonic, syntactic, morphological, semantic, lexical, and pragmatic characteristics of a minority language cannot be adequately

assessed or remediated without knowledge of that language. Further, auditory discrimination and speech reception thresholds may be difficult to assess without the ability to test in the minority language.

Voice qualities, such as harshness, breathiness, loudness, pitch, and the production of clicks and glottal stops, vary across languages. These factors may make it difficult to rule out vocal pathology when the examiner is unfamiliar with the vocal characteristics common to a given language.

Hesitations, false starts, filled and silent pauses, and other dysfluent behavior may be exhibited by a bilingual speaker due to lack of familiarity with English. Thus, differential diagnosis of true stuttering from normal dysfluency may be difficult if the examiner is unfamiliar with the client's use of the minority language.

Identification of prosodic or suprasegmental problems is extremely difficult if the examiner is not familiar with the prosodic characteristics of the minority language. Even when the examiner is familiar with the given language, dialect differences *within* that language may be a confounding variable in assessment.

There are also cultural variables that may influence how speech-language pathology and audiology services are accepted by minority language populations. Differences between minority cultures and the general population in traditions, customs, values, beliefs, and practices may affect service delivery. Thus, speech-language pathologists and audiologists must provide services with consideration of such cultural variables, in addition to consideration of language differences.

Thus, it is apparent that the assessment and remediation of many aspects of speech, language, and hearing of minority language speakers require specific background and skills. This is not only logical and sound clinical practice, but it is the consensus set forth by federal mandates such as the Education for All Handicapped Children Act of 1975 (PL 94-142) and the Bilingual Education Act of 1976 (PL 95-561: Title VII of the Elementary and Secondary Education Act of 1965); legal decisions such as Dianna v. Board of Education (1973), Lau v. Nichols (1974), Larry P. v. Riles (1977) and the Martin Luther King Junior Elementary School Children v. Ann Arbor School District Board (1979); and the policies and practices of many professional agencies and organizations such as the National Association for Bilingual Education, the National Center for Bilingual Research, the Center for Applied Linguistics, and the National Hispanic Psychological Association.

Even state regulations are being developed to acknowledge the need for specific competencies to serve minority language populations. In California, for example, school districts are being encouraged by the State Education Agency to require resource specialists, speech-language pathologists and school psychologists to pass a state-administered oral and written examination on Hispanic culture, Spanish language, and assessment methodology before they conduct assessments for Spanish-speaking children with limited English proficiency. Other states and U.S. territories with education legislation which address the special needs of minority language populations include: Alaska, American Samoa, Arizona, Colorado, Connecticut, Illinois, Indiana, Iowa, Kansas, Maine, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, New York,

Oregon, Puerto Rico, South Dakota, Tennessee, Texas, Trust Territory of the Pacific Islands, Utah, Vermont, Washington, Wisconsin and Wyoming (American Speech-Language-Hearing Association, 1982).

Continuum of Language Proficiency

There are scores of different minority languages spoken in the United States. But within each group of minority language speakers there is also a continuum of proficiency in English. In the provision of services to minority language speakers with communication disorders, the continuum is particularly relevant. The continuum includes speakers who are:

- Bilingual English Proficient,
- Limited English Proficient,
- Limited in both English and the Minority language.

Depending on the client's English language proficiency on the continuum, recommended competencies for the professional vary.

Competencies

Bilingual English Proficient

There are bilingual individuals who are fluent in English or who have greater control of English than the minority language. Such individuals can be regarded as bilingual English proficient.

For individuals who are bilingual English proficient and exhibit a communication disorder in English, it is *not* essential that the speech-language pathologist or audiologist be proficient in the minority language to provide assessment and remediation services *in English*. However, the speech-language pathologist must have certain competencies to distinguish between dialectal differences (due to interaction from the minority language) and communication disorders. These competencies include understanding the minority language as a rule-governed system, knowledge of the contrastive phonological, grammatical, semantic, and pragmatic features of the minority language, and knowledge of nondiscriminatory testing procedures (refer to "Social Dialects: A Position Paper," *Asha*, September 1983).

It is recognized that some bilingual English proficient speakers who do not present a true communication disorder may seek the services of a speech-language pathologist. If the bilingual individual has a foreign dialect and seeks to acquire a more standard production of English, the speech-language pathologist may provide elective clinical services. (Refer to "Social Dialects: A Position Paper," *Asha*, September 1983.)

Limited English Proficient

Some bilingual individuals and monolingual individuals are proficient in their native language but not in English. Assessment and intervention of speech and language disorders of limited English proficient speakers should be conducted in the client's primary language. This is consistent with federal mandates (PL 94-142 and Title VII of PL 95-561), legal decisions (such as Dianna v. Board of Education, Lau v. Nichols and Larry P. v. Riles), and the education regulations of many states.

To provide assessment and remediation services *in the minority language*, it is recommended that the speech-language pathologist or audiologist possess the following competencies:

Language Proficiency: Native or near native fluency in both the minority language and the English language.

Normative Processes: Ability to describe the process of normal speech and language acquisition for both bilingual and monolingual individuals; and how those processes are manifested in oral and written language.

Assessment: Ability to administer and interpret formal and informal assessment procedures to distinguish between communication difference and communication disorders.

Intervention: Ability to apply intervention strategies for treatment of communication disorders in the minority language.

Cultural Sensitivity: Ability to recognize cultural factors which affect the delivery of speech-language pathology and audiology services to minority language-speaking community.

Limited in Both Languages

There are bilingual individuals who are truly communicatively handicapped, possessing limited communication competence in both languages. For such individuals, speech and language should be assessed in both languages to determine language dominance. Thus, the same competencies listed for limited English proficient speakers are recommended for assessment for this group of speakers. The most appropriate language for intervention would be determined from the assessment.

If the most appropriate language for intervention is the minority language, then the competencies recommended for serving limited English proficient speakers should be met to provide therapy. If the most appropriate language for intervention is English, proficiency in the minority language may not be necessary to provide therapy.

It is important to note that the determination of bilingual dominance in communicatively handicapped individuals may be particularly difficult. It is stressed that both objective and subjective measures should be utilized to determine if the client's dominant language is either English or the minority language.

Alternative Strategies for Use of Professional Personnel

It is recognized that not all speech-language pathologists and audiologists possess the recommended competencies to serve limited English proficient speakers. Following are some strategies for procuring speech-language pathologists who do meet the afore-mentioned competencies when there are none on staff.

1. Establish Contacts

   Bilingual speech-language pathologists or audiologists can be hired by school districts and other clinical programs as consultants to evaluate and remediate minority language speakers on an as needed basis.
2. Establish Cooperative

A clinical cooperative can be developed to allow a group of school districts or clinical programs to hire an itinerant bilingual speech-language pathologist or audiologist whose primary responsibility is to serve a specific minority language population.

3. Establish Networks

   Strong ties could be established between professional work settings and university programs that have bilingual speech-language pathology or audiology programs so that there can be an interchange of existing resources. Once such a liaison is established, it can facilitate recruitment of speech-language pathologists or audiologists who are competent to serve minority language populations after they graduate.

4. Establish CFY and Graduate Practicum Sites

   Graduate students or recent graduates from bilingual communication disorders programs, under the direct supervision of a bilingual speech-language pathologist or audiologist, could be used to assist personnel in schools and other clinical facilities in assessment and intervention of limited English-proficient individuals.

5. Establish Interdisciplinary Teams

   A team approach can be implemented which includes the monolingual speech-language pathologist or audiologist and a bilingual professional equal (e.g., psychologist, special education teacher, etc.) who is knowledgeable of nonbiased assessment procedures and language development of the particular minority language.

An agency contracting the services of a speech-language pathologist or audiologist to serve limited English-proficient speakers may not be in a position to evaluate the professional's competencies. Therefore, when employing the preceding alternative strategies, efforts should be made to assure that the speech-language pathologist does, indeed, possess all of the recommended competencies. This may require consulting resources outside the agency during the interview process. Furthermore, it should never be presumed on the basis of race, ethnicity, or surname, that a speech-language pathologist or audiologist is competent to serve a given minority language population.

Use of Interpreters or Translators

Interpreters or translators could be used with minority language speakers when the following circumstances exist: (a) when the certified speech-language pathologist or audiologist on the staff does not meet the recommended competencies to provide services to limited-English proficient speakers; (b) when an individual who needs services speaks a language which is uncommon for that local area; and (c) when there are no trained professionals readily available with proficiency in that language that would permit the use of one of the previously described alternative strategies. Individuals who could serve as interpreters or translators can include (1) professional interpreters from language banks or professional interpreting services, (2) bilingual professional staff from a health or education discipline other than communication disorders, or (3) a family member or friend of the client.

If the use of interpreters or translators is the only alternative, the speech-language pathologist or audiologist should:

1. Provide extensive training to the assistant on the purposes, procedures and goals of the tests and therapy methods. The assistant also should be taught to avoid the use of gestures, vocal intonation, and other cues that could inadvertently alert the individual to the correct response during test administration.
2. Pre-plan for an individual's services to insure the assistant's understanding of specific clinical procedures to be used.
3. Use the same assistant(s) with a given minority language client rather than using assistants on a random basis.
4. Use patient observation or other nonlinguistic measures as supplements to the translated measures, such as (1) child's interaction with parents, (2) child's interaction with peers, (3) pragmatic analysis.

It is recommended that the speech-language pathologist and audiologist state in their written evaluations that a translator was used and the validity of the results may be affected.

Future Directions

It is stressed that the competencies and alternative strategies delineated herein are interim in an effort to address the crisis that presently exists in the delivery of services to minority language populations. Therefore, these competencies and alternative strategies may be subject to revision or expansion as our professional knowledge base continues to increase. In addition to promoting the continued advancement of knowledge, it should be the ultimate goal of the profession to increase the percentage of speech-language pathologists and audiologists who are competent to serve minority language populations. This can be accomplished by (1) stimulating bilingual student recruitment efforts, (2) promoting relevant continuing education activities, and (3) promoting the topic of minority language populations within professional education.

The establishment of competencies in the area of service delivery to minority language populations is not intended to impose prohibitions or a “hands off” philosophy for those who do not meet those competencies. But it is the professional responsibility of the speech-language pathologist and audiologist to judge their own minority language proficiency, clinical knowledge base, and cultural sensitivity in terms of the competencies delineated in this paper. Where there are deficiencies that can be reversed, it is incumbent on professionals to upgrade their level of competence through professional and continuing education programs, independent study of the growing literature on minority language populations, and ongoing involvement within the community of minority language speakers. Otherwise alternative strategies should be implemented to serve minority language speakers.

Because the competencies and alternative strategies discussed in this paper are interim, multicultural research and continued development of techniques and materials for assessment and intervention need to be priorities of professionals who provide services to these populations. Professionals also should stimulate further

development and implementation of creative alternatives in order to provide appropriate and effective speech-language pathology and audiology services to minority language speakers.

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