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GENERAL PROFESSIONAL CONSIDERATIONS FOR USE WITH BILINGUAL CHILDREN

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ABSTRACT

Growth trends indicate that Spanish-English families are on the rise, and this leads to an increase in the likelihood of a monolingual clinician treating an individual with a language difference (Pew Research Center, 2008; Instituto Cervantes, 2016). The increasing diversity in languages presents a new challenge for monolingual healthcare providers in their efforts to work with bilingual Spanish-English clients and their families. This commentary provides discussion of the following professional considerations to meet the needs of those clinicians: (1) Establishing Rapport through Verbal Communication, (2) Written Communication, and (3) Bilingual Assessment Methods. A clinical scenario is included with each professional consideration to aid in practical application for service delivery in speech-language pathology or audiology. This commentary also provides a brief overview of the Spanish language as well as discussion on the use of culturally related terminology when working with clients and their families from Spanish-speaking countries.

KEYWORDS*:* bilingualism, service-delivery, professionalism, multiculturalism

The United States (US) is home to countless bilingual individuals (Ryan, 2013). Hispanics make up the largest bilingual population within the US and account for 17% of the United States (US) population (United States Census Bureau, 2015). Growth trends suggest that the Hispanic population in the US will triple in size by 2050 making the US the largest Spanish-speaking country in the world after Mexico (Pew Research Center, 2008; Instituto Cervantes, 2016). Additionally, 59% of Hispanic children in the US are bilingual, which is leading to an increase of bilingual Spanish-English speaking children in educational settings across the nation (Instituto Cervantes, 2016). For this reason, healthcare providers can anticipate an increase of bilingual Spanish-English speaking children on their caseloads. This increase in bilingual patients and clients will also impact the field of speech-language pathology. The purpose of this scholarly commentary is to present and discuss three general professional considerations for service delivery to bilingual children and their families with particular emphasis on Spanish-English speaking children. Each consideration will be presented with a case scenario to assist the in maximizing clinical application regardless of the communication disorder. It is the authors' objective that the content of this commentary will be used by clinicians to enhance their professional clinical skills – regardless of the communicative area of concern – resulting in more effective and culturally sensitive service delivery.

Background

Based on growth trends of bilingual Spanish-English speaking families in the US, there is a significant chance that a clinician from a different cultural or language background will engage in a clinical experience with a bilingual Spanish-English speaking child or family. Furthermore, there is a chance that a monolingual English speaking clinician will service a bilingual speaking child with parents who are monolingual in a language different from the clinician (i.e., bilingual Spanish-English speaking child with a monolingual Spanish speaking parent). Thus, prior to the discussion on professional clinical factors, it is necessary to provide a brief background on cultural terminology and the language.

Hispanic versus Latino

While 'Hispanic' and 'Latino' are often used in a synonymous manner within the US, they are different in meaning. Historically, the term 'Latino' has been used to refer to individuals in the US whose ancestors originate from a Latin American country or Spain. The term 'Hispanic' was first used in the US Census in 1970 to describe a person of Mexican, Puerto Rican, Cuban, South, Central American, or other Spanish culture or origin (Clausing, 2017). This term is broad in nature and includes all who are from a Spanish-speaking country. For clinical purposes, Roseberry-McKibbin (2014) defines Hispanic as those individuals who originate from Spanish-speaking Latin American countries and/or Spain. Regardless of which term is preferred by a patient or family, it is important to note that the terms 'Hispanic' and 'Latino' are ethnicities and are not considered a race (e.g., White, African-American, Asian). Race has a biological basis and identifies and groups individuals together based on physical attributes. Ethnicity, on the other hand, is grounded on shared culture including language, traditions, and ancestry (Caballero, 2005; Roseberry-McKibben, 2014).

Which term is preferred by an individual – Hispanic or Latino – can vary. Results of a survey conducted by the Pew Research Center indicate that few (24%) Hispanic adults describe themselves using the terms 'Hispanic' or 'Latino and nearly half (51%) would prefer to be identified by their family's country of origin (e.g., Cuban, Venezuelan, Mexican). Results of the Pew Hispanic Center Survey further indicate that this preference varies by generation with immigrants preferring country of origin, while those who are generations removed from immigration prefer to use the term 'American' as a description. If made to choose between the two terms – Hispanic or Latino – 51% reported having no preference, while those that did have a preference favored Hispanic (33%) to Latino (14%) (Cohn, 2012).

Clinically, it is suggested that the clinician establish how the patient or family prefers to be ethnically and racially identified with the understanding that their choice may differ from the clinicians' perception. For example, a patient may physically appear to be of African descent (e.g., African-American), but identify as Hispanic or

choose to identify based on their country of origin (e.g., Colombian). The case history/intake form is an ideal opportunity to determine how the patient identifies. Clinicians are encouraged to include, as part of the demographic section of their case history/intake form, options for clients to select a race and/or ethnicity as well as write in a race or ethnicity that may not be listed.

The Spanish Language

Similar to other languages, Spanish is a language with dialectal differences prevalent across all areas where Spanish is spoken. Establishing an individual's country of origin or where they have resided can give some insight into potential variations that may be present in one's use of Spanish. In comparing English and Spanish, there are noticeable differences between the two languages (e.g., syntax, phonetic complexity; Roseberry – McKibben, 2014). Bilingual individuals, particularly children, who are in the process of learning both languages, may inadvertently confuse linguistic rules of one language for the other. Thus, it is imperative that clinicians become familiar with linguistic differences in order to effectively identify language errors due to language learning versus those that may be the result of a communication disorder. The clinician should seek information/resources regarding the linguistic differences and the typical and atypical speech and language development for the Spanish language. The clinician could consult with a bilingual speech-language pathologist and receive professional guidance (Rhea, 2014).

Additionally, given the dialectal differences that exist within the Spanish language, clinicians are again encouraged utilize the case history/intake form to provide the patient a chance to identify their country or countries of origin. This allows the clinician to research dialectal differences that may be associated with particular countries or regions. Clinicians are cautioned, however, to not assume that all patients will present with all dialectal variations typically associated with a region or country.

General Professional Considerations

As established by ASHA Code of Ethics, professionals are to provide quality services to individuals who are culturally and linguistically different (American Speech-Language-Hearing Association, 2016). This includes individuals who are bilingual. The following Professional Clinical Considerations are presented and discussed with the intent to impact the overall assessment and treatment of bilingual Spanish-English speaking children and their families: 1. Establishing Rapport through Verbal Communication, 2. Written Communication Considerations, 3. Bilingual Assessment Methods.

Consideration 1: Establishing Rapport through Verbal Communication

Verbal communication is often the foundation to establishing a strong and trusted relationship between a parent and clinician. For parents of bilingual children, verbal communication may pose a barrier for some. It can often be the case that parents of a bilingual Spanish-English speaking child may be monolingual Spanish speakers with limited or no proficiency in English. Regardless, clinicians must consider establishing verbal communication at the outset with the family in order to establish rapport and ensure that parents receive comprehensive information relating to their child's service delivery.

In most cases, this means making arrangements in advance for an interpreter to be present during interactions with the parent and/or family. It most cases, clinical settings often have established mechanisms in place to request an interpreter as needed. Ideally, clinicians who practice in communities with large bilingual populations – regardless of the language – will familiarize themselves with local interpreting resources immediately as to reduce the difficulty of securing an interpreter when one is actually needed.

It is important to note that it is less than ideal to utilize a family member as an interpreter. Bilingual family members, while proficient in the language, are not necessarily trained on how to interpret for diagnostic or intervention purposes. Particularly in an assessment setting, family members may not understand or agree with administration guidelines to ensure the standardization often required for some assessment tools.

For children, the decision for intervention is not up to the child, but to the parents. Thus, it is imperative that clinicians are clear that the parent fully understands the clinician's plan and recommendations. Securing a trained interpreter makes this possible. A professionally trained

interpreter can play an integral role in developing a strong client-clinician relationship resulting in a greater likelihood of a successful intervention outcome. Clinicians should remember that – even when using an interpreter – they must remain an active listener and display an appropriate sense of empathy towards the family through use of effective nonverbal communication. In some cases, parents are informed that their child has communication disorder or impairment through an interpreter. This can be difficult even for parents who share the same language as the clinician and even more difficult for those who do not share the same language and are, instead, receiving the diagnosis or treatment plan through the voice of an interpreter.

An additional point for this consideration addresses the way in which clinical information regarding the child is delivered to the parents. With a difference in language as a barrier, use of jargon with parents of bilingual children may create a breakdown in communication. Some parents may have a limited educational background or level and may not fully understand particular concepts related to speech and language. Verbal explanation of the concepts in a simple manner allows parents to understand and process the information provided as seen the following clinical scenario:

Clinical Scenario: *A clinician receives a referral to assess a child for a concern of articulation. During the scheduling of the assessment, the clinic secretary mentions that the parent began their phone conversation in Spanish and switched to English once it was apparent that the clinic secretary did not speak Spanish. The clinic secretary added that the parent did appear to exhibit some difficulty understanding the content of the conversation in English and also used some Spanish words interchangeably with English during the conversation.*

Clinical Response: *The clinician should anticipate that a professional interpreter may be needed to aid in verbal communication with the parent and family during this visit. Prior to the assessment the clinician should arrange interpreting services and schedule a meeting with the interpreter prior to the assessment. During this meeting, the clinician has an opportunity to summarize the assessment plan and discuss any assessment methods or tools that may be important for the interpreter to understand prior to the assessment. This also provides the clinician with a moment to review any related terminology that they may encounter during the assessment.*

Consideration 2: Written Communication

In addition to verbal communication, considerations should also be made for methods of written communication with parents of bilingual children. Again, parents of bilingual children may have limited proficiency in English. Proficiency can vary depending on whether the user is speaking the language, writing the language or reading the language. Thus, it is important that clinicians are ready with written communication in both Spanish and English. The availability of forms in both languages give the parent the opportunity to provide comprehensive information regarding their child's developmental, medical history as well as information regarding their child's speech and language concerns. The information usually gathered through written form from an assessment is crucial for the clinician and provides invaluable insight about the child. When gathering written information, clinicians should include questions regarding the family's demographics as well as the child's exposure to language input and output. Professionals who do not acknowledge linguistic and cultural differences would be violating the Code of Ethics, and may misinterpret the diagnosis of the child from a language difference to a language disorder (Rhea, 2014). Additional information that was asked of the parents was their occupation, education level, languages spoken at home, the child's academic information, and the family's medical information. Since most of the parents who we interacted with were of Hispanic descent, our forms were translated to Spanish as seen in the following clinical scenario:

Clinical Scenario: *A researcher is conducting a study examining speech disfluencies in bilingual Spanish-English speaking young children. A child arrives with her parents for their scheduled research visit. Upon arrival, both parents converse with the researcher fluently in English. The researcher begins the visit by providing the parents with the informed consent research form as well as a case history/intake form. Nonverbal communication from the parents suggest to the researcher that the parents are having some difficulty completing the form.*

Clinical Response: *Although the parents are proficient in their verbal use of English, it could be the case that they are less proficient in their ability to read and/or write in*

English. Based on the nature of the study, the clinician has already anticipated this scenario and has already prepared an informed consent research form and case/history problem solve that has been translated into Spanish. The clinician can then offer the family assistance in completing the form and include the option of completing a Spanish version of both forms. In the future the clinician can minimize this occurrence by offering both versions of the forms (i.e., English version or Spanish version) at the beginning of the visit.

Consideration 3: Bilingual Assessment Methods

Moreover, an important factor in assessing Spanish-English speaking children is the process of evaluation and the materials used. An assessment must be non-biased for culturally and linguistically diverse individuals. Clinicians may use a variety of methodologies and approaches for treatment. A traditional approach to assessment refers to determining the child's skill level and comparing it to that of peers (Gutierrez-Clellen & Peña, 2001). This comparison will not accurately depict the child's capabilities and could lead to inaccurate diagnoses in culturally and linguistically diverse children. Research has provided an alternative approach to evaluating and treating culturally and linguistically different children, this approach is known as a dynamic assessment (DA). In this approach, the clinician will observe how the client learns and what is needed for the client to learn (Rhea, 2014). This approach takes into consideration the child's zone of proximal development (ZPD) (Gutierrez-Clellen & Peña, 2001).

Additional considerations should be choosing an appropriate standardized test based on the normative samples that reflect the language characteristics of the child who is being screened. Bilingual children, who perform in standardized tests which are based on the norms of monolingual children, tend to perform below average (Peña, Gillam, Bedore, & Bohman, 2011). An alternative to biased standardized testing may be the use of criterion-referenced tests (Rhea, 2014). These types of tests, focus on the assessment of specific behaviors that are established by the clinician and client. A professional should take a holistic approach when evaluating a bilingual child and should not only base the assessment on the use of norm-referenced tests only. English tests should not be the only type of tests administered to bilingual children, they should be provided with tests that reflect their native language. Language samples can be gathered in the child's languages in addition to other assessments (Rhea, 2014) as seen in the following clinical scenario:

Clinical Scenario: *A clinician is preparing to conduct an assessment on a bilingual Spanish-English speaking child who has been referred by her kindergarten teacher for concern with expressive language. The child currently attends a monolingual English only school. The child currently does not qualify for English language learning support due to her proficiency in English.*

Clinical Response: *Given that the child is bilingual in Spanish and English, the clinician prepares an assessment protocol that includes establishing the percentage of input and output the child has in both languages. This is usually done through parent-report and may involve formal assessment tools that have already established methods to determined percentage of input and output. The clinician has selected assessment tools that are normed on bilingual Spanish-English speakers and takes into account the language difficulty due to language learning versus a language disorder. The clinician understands that this will mean using assessment tools that are not commonly used for monolingual English speaking children, but would yield the best examination of language skills for this bilingual child.*

Conclusion

Language barriers should not impact the quality of service delivery to bilingual children and their families. If anything, language barriers should motivate clinicians to anticipate areas of their service delivery where adjustments may be needed. While a bilingual child may be able to communicate with a clinician, the clinician must consider the child as a whole which includes their parents and, in some cases, extended family. It is up to the clinician to plan ahead, make any additional arrangements that may involve translating, interpreting or selecting different assessment materials. This will also require the clinician to educate themselves on a culture other than our own in order to guarantee the best relationship between the clinician, the child and their family.

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