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Limitations to Practicing as a Bilingual Speech-Language-Pathologist in the United States

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Editorial

There have been many calls to train speech-language-pathologists (SLPs) who have the linguistic and cultural competence to service the increasingly diverse multicultural and multilingual population in the United States [1,2]. Intervention in each of the multilingual speaker's languages is important in order to improve the quality of life since multilingual speakers use each of their languages in different domains and contexts with different people when communicating. The inability to provide services or withholding services in any of the languages that the multilingual speaker uses can be equated to withholding services to a monolingual speaker and also discriminatory [1,3]. A few training programs have taken the initiative and are already providing dual bilingual training tracks to their SLPs. There is still need to understand some of the challenges involved in training SLPs that are equipped to cater for the multilingual population in the United States.

One of the greatest challenges in training bilingual SLPs is that there are very few bilingual individuals in the United States who are currently practicing or are being trained as SLPs [4]. Although there has been a sharp increase in multilingual speakers [1,2,5], there has not been a proportional increase in the number of programs which place an emphasis on training SLPs equipped with providing assessment and intervention to this population. A survey carried out in 2015 revealed that only about 6% of the American Speech-Language-Hearing Association's (ASHA) over 150,000 members identified themselves as bilingual [6,7,8]. This is a true reflection of the training efforts of most SLP programs. Most programs are not taking the initiative in seeking out and training bilingual SLPs, rather they wait for already proficient SLPs to apply to their programs. This therefore means that there is a huge mismatch between the languages that most SLPs speak, predominantly English native speakers, and the multilingual clientele they are supposed to service [4,8]. It is necessary to mention that one of the major obstacles to practicing as a bilingual SLP is one of matching the languages that the clinician speaks to the clients and or patient. Even in those cases that the SLP is proficient in another language, in some cities and states, for instance, New York City, there will still remain a huge mismatch between the languages that the clinicians speak and that the general population speak due to the general demographics of the population. The other challenge is one of insufficient skills to provide assessment and intervention that are appropriate for the multilingual population [9,10]. Although most of the student clinicians take a few courses in a foreign language, most of them have limited functional proficiency in most of these languages to be considered bilingual. According to ASHA, "clinicians need to possess a native or near native proficiency in those languages spoken or signed by the client" [2,7]. The limited proficiency in another language therefore presents problems when considering providing intervention to the multilingual clientele. In addition to acquiring native like proficiency, clinicians also need to acquire the knowledge base that will enable them to differentiate and distinguish what is typical development and what is disordered language of their clients [2]. Another obstacle may come from not knowing the typical language development in simultaneous and sequential bilinguals and also what can be considered as normal in terms of second language acquisition. This means that there is a huge need for professional organizations and training programs to support the acquisition of additional languages and professional terminology. Emphasis should be shifted from student clinicians having had some experiences with another language to being functionally competent in another language. This is key if multilingual clients are to be supported in their acquisition and use of all their languages to improve their quality of life [10].

In order for SLPs to effectively deliver service to the multilingual and multicultural clientele they need to have the necessary cultural competence to assess and treat this group [2,11,12]. Although some programs are offering some version of cultural competence infusion in their programs, there is still need for focused training if both underdiagnosing and over diagnosing are to be reduced [10]. Limited cultural competence is demonstrated in those cases whereby the SLPs fail to adapt to cultural differences and in the inability to adapt their services to meet the non-traditional client who may generally have unique needs to what the SLPs are likely to encounter on a day to day basis [10,13]. Cultural competence can be improved by attending workshops and events that help in learning about the culture, engaging the community members and also getting immersed in the communities that the SLPs serve [10]. On the other hand, a failure by the SLPs to identify their own cultural variables and being aware of their own culture and how it can impact their service delivery can be a key factor in identifying factors that may influence how service delivery will go in the clinical setting [2]. Clinicians need to be aware of their own beliefs, biases, respect individual's race, lifestyle, physical/mental ability, one's own limitations and also be able to use appropriate intervention and assessment tools and materials.

In those instances where the proficiency of the SLP does not meet the required standard by ASHA, it has been suggested that interpreters and other cultural support workers should be used [2,14]. However, it is important to note that it is not always possible to find interpreters who understand the exact language you require a service for. It is not always easy to find interpreters who has native proficiency so that they can provide accurate interpretations [2]. Even with proficient interpreters and translators, they do not always possess the vocabulary and terminology pertinent to the field, and hence they may require further training before they can be effective in providing the required service. However, collaboration with interpreters, cultural support

workers, educators and families should be explored in order to obtain an accurate picture of what the multilingual individual knows and their deficiencies [2,12]. Some of these collaborators will be critical in establishing, for instance, the appropriate conduct and also in learning what may be taboo or appropriate in terms of social interactions with this population [2,10,14].

Even in those instances where the aforementioned challenges are eradicated, another possible challenge to practicing as an SLP can emerge from the unavailability of valid and culturally appropriate assessment tools and intervention practices. According to ASHA, children should be assessed and treated in each of their languages by respecting the already existing competencies, cultural histories and heritages [2,10]. In some instances, there are assessment tools that have been normed and standardized for monolingual populations, for example, English and Spanish. However, using the tests normed on monolingual speakers for multilingual speakers is equivalent to treating a multilingual speaker as two monolinguals [1,3]. Although there may be some published materials both for standardized norm-reference tests and criterion-referenced tests, the SLP will be faced with the task of analyzing some of the limitations of these normative samples, and issues related to their validity and reliability [2]. So this means that there is need for concerted efforts in creating and providing valid and culturally appropriate tests that are normed on the populations that they intend to assess and help treat.

To summarize, some of the factors that have to be addressed as limitations to practicing as bilingual speech-language-pathologists include training in cultural competence, adequate bilingual SLP training, collaboration with interpreters, unavailability of valid and culturally appropriate assessment tools and intervention based on the best evidence based practices on multilingual populations. If proper training and opportunities for growth in the deficient areas in the training of culturally competent and proficient bilingual speakers are not provided, this will only result in most SLPs not practicing as bilingual SLPs. According to the ASHA's Ethics II, Rule A, SLPs can only practice in areas permitted by their scope of competence that is in line with their training, level of education and skills [14]. It is not possible for SLPs to practice in areas they have not been trained, however on the other hand, according to ASHA Principles of Ethics I, Rule C, professionals should strive to provide services to all the different groups in their purview of their practice [14]. This means that in view of the increasingly diverse population, mechanisms should be put in place to equip the SLPs to have the competencies that are necessary for them not to be discriminatory in their practice [14].

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