Knowledge and Skills Needed by Speech-Language Pathologists and Audiologists to Provide Culturally and Linguistically Appropriate Services

ASHA's Multicultural Issues Board

This knowledge and skills document is an official statement of the American Speech-Language-Hearing Association (ASHA). It describes the particular knowledge and skills needed to provide culturally and linguistically appropriate services in our professions. This document acknowledges the need to consider the impact of culture and linguistic exposure/acquisition on all our clients/patients, not simply for minority or diverse clients/patients. In doing so, this document augments and expands the ASHA Scope of Practice in Speech-Language Pathology (ASHA, 2001), the ASHA Scope of Practice in Audiology (ASHA, 1996 in references), and the ASHA Preferred Practice Patterns (ASHA, 1997a, 1997b).

This document was prepared by the members of ASHA's Multicultural Issues Board: Bopanna Ballachanda, Julie K. Bisbee, Catherine J. Crowley, Diana Diaz, Nancy Eng, Debra Garrett, Nikki Giorgis, Edgarita Long, Nidhi Mahendra, Joe A. Melcher, Wesley Nicholson, Constance Dean Qualls, Luis F. Riquelme, Marlene Salas-Provance, Toni Salisbury, Linda McCabe Smith, Carmen Vega-Barachowitz, Kenneth E. Wolf, and Vicki Deal-Williams (ex officio), and monitoring vice presidents for administration and planning Michael Kimbarow and Lyn Goldberg provided guidance. In addition, previous members of the Multicultural Issues Board—Ellen Fye, Charles Haynes, Celeste Roseberry-McKibbin, Emma Muñoz, Ravi Nigam, Jennifer Rayburn, Gari Smith, Kenneth Tom, and Janice Wright are gratefully acknowledged for their contributions to previous drafts and related policy that served as a basis for this document.

Introduction

The ethnic, cultural, and linguistic makeup of this country has been changing steadily over the past few decades. Cultural diversity can result from many factors and influences including ethnicity, religious beliefs, sexual orientation, socioeconomic levels, regionalisms, age-based peer groups, educational background, and mental/physical disability. With cultural diversity comes linguistic diversity, including an increase in the number of people who are English Language Learners, as well as those who speak non-mainstream dialects of English. In the United States, racial and ethnic projections for the years 2000-2015 indicate that the percentage of racial/ethnic minorities will increase to over 30% of the total population. The makeup of our school children will continue to diversify so that by 2010, children of immigrants will represent 22% of the school-age population (U.S. Bureau of the Census, 2000).

As professionals, we must be prepared to provide services that are responsive to this diversity to ensure our effectiveness. Every clinician has a culture, just as every client/patient has a culture. Similarly, every clinician speaks at least one dialect of English and perhaps dialects from other languages, as does every client/patient. Given the myriad factors that shape one's culture and linguistic background, it is not possible to match a clinician to clients/patients based upon their cultural and linguistic influences. Indeed, recent ASHA demographics indicate that only about 7% of the total membership are from a racial/ethnic minority background and less than 6% of ASHA members identify themselves as bilingual or multilingual (ASHA, 2002).

Only by providing culturally and linguistically appropriate services can we provide the quality of services our clients/patients deserve. Regardless of our personal culture, practice setting, or caseload demographics, we must strive for culturally and linguistically appropriate service delivery. For example, we must consider how communication disorders or differences might be manifested, identi-

fied, or described in our client's/patient's cultural and linguistic community. This will inform all aspects of our practice including our assessment procedures, diagnostic criteria, treatment plan, and treatment discharge decisions.

This document sets forth the knowledge and skills that we as professionals must strive to develop so that we can provide culturally and linguistically appropriate services to our clients/patients. The task may seem daunting at first. Given the knowledge and skills needed, we may shy away from working with clients/patients from certain cultural or linguistic groups. We may question whether it is ethical for us to work with these clients/patients. These guidelines provide a way to answer that question for each clinician.

It is true that "Individuals shall engage in only those aspects of the profession that are within the scope of their competence, considering their level of education, training, and experience" (ASHA Principles of Ethics II, Rule B). So, without the appropriate knowledge and skills, we ethically cannot provide services. Yet, this does not discharge our responsibilities in this area. The ASHA Principles of Ethics further state, "Individuals shall not discriminate in the delivery of professional services" (ASHA Principles of Ethics I, Rule C). Thus, this ethical principle essentially mandates that clinicians continue in lifelong learning to develop those knowledge and skills required to provide culturally and linguistically appropriate services, rather than interpret Principles of Ethics II, Rule B as a reason not to provide the services. This document sets forth those knowledge and skills needed to provide culturally and linguistically appropriate services. It can be used to identify one's strengths and weaknesses, and to develop a plan to fill in any gaps in one's knowledge and skills in this area (ASHA, December 2001).

Cultural Competence

1.0 Role: Sensitivity to cultural and linguistic differences that affect the identification, assessment, treatment and management of communication disorders/differences in persons. This includes knowledge and skills related to:

1.1 Influence of one's own beliefs and biases in providing effective services.

1.2 Respect for an individual's race, ethnic background, lifestyle, physical/mental ability, religious beliefs/practices, and heritage.

1.3 Influence of the client's/patient's traditions, customs, values, and beliefs related to providing effective services.

1.4 Impact of assimilation and/or acculturation processes on the identification, assessment, treatment, and management of communication disorders/differences.

1.5 Recognition of the clinician's own limitations in education/training in providing services to a client/patient from a particular cultural and/or linguistic community.

1.6 Appropriate intervention and assessment strategies and materials, such as food, objects, and/or activities that do not violate the patient's/client's values and/or that may form a constructive bridge between the client's/patient's home culture and community or communication environment.

1.7 Appropriate communications with clients/patients, caregivers, and significant others, so that the values imparted in the counseling are consistent with those of the client/patient.

1.8 The need to refer to/consult with other service providers with appropriate cultural and linguistic proficiency, including a cultural informant/broker, as it pertains to a specific client/patient.

1.9 Ethical responsibilities of the clinician concerning the provision of culturally and linguistically appropriate services.

2.0 Role: Advocate for and empower consumers, families, and communities at risk for or with communication/swallowing/balance disorders. This includes knowledge and skills related to:

2.1 Community resources available for the dissemination of educational, health, and medical information pertinent to particular communities.

2.2 High risk factors for communication/swallowing/balance disorders in particular communities.

2.3 Prevention strategies for communication/cognition/swallowing/balance disorders in particular communities.

2.4 The impact of regulatory processes on service delivery to communities.

2.5 Incidence and prevalence of culturally-based risk factors (e.g., hypertension, heart disease, diabetes, fetal alcohol syndrome) resulting in greater likelihood for communication/cognition/swallowing/balance disorders.

2.6 Appropriate consumer information and marketing materials/tools for outreach, service provision, and education.

Language Competencies of the Clinician

3.0 Role: Ability to identify the appropriate service provider for clients/patients.

3.1 *Bilingual/Multilingual clinician.* Native or near-native proficiency in the language(s) spoken or signed by the client/patient. Knowledge and skills related to the impact of the differences between the dialect spoken by the clinician and by the client/patient on the quality of services provided.

3.2 Clinician without native or near-native proficiency in the language(s)/dialect(s) spoken or signed by the client/patient. Knowledge and skills related to:

A. Obtaining information on the features and developmental characteristics of the language(s)/dialect(s) spoken or signed by the client/patient (see Language section).

B. Obtaining information on the sociolinguistic features of the client's/patient's significant cultural and linguistic influences.

C. Developing appropriate collaborative relationships with translators/interpreters (professional or from the community):

1) Maintain appropriate relationships among the clinician, the client/patient, and interpreter/translator.

2) Ensure that the interpreter/translator has knowledge and skills in the following areas:

a) Native proficiency in client's/patient's language(s)/dialect(s) and the ability to provide accurate interpretation/translations.

b) Familiarity with and positive regard for the client's/patient's particular culture, and speech community or communicative environment.

c) Interview techniques, including ethnographic interviewing.

d) Professional ethics and client/patient confidentiality.

e) Professional terminology.

f) Basic principles of assessment and/or intervention principles to provide context to understand objectives..

Language

4.0 Role: Obtain knowledge base needed to distinguish typical and disordered language of clients/patients. This includes knowledge and skills related to:

4.1 Sociolinguistic and cultural influences including:

A. Client's/patient's speech community or communication environment, including its discourse norms, and the impact of topic, participant, setting, and function on language use.

B. Effective interviewing techniques so caregiver/parent and/or client/patient feels comfortable providing accurate and complete information.

C. Impact of social and political power and prestige on language choice and use.

D. Impact of sociolinguistics on code-switching and code-mixing.

E. Language socialization patterns that affect language use in the clients/patient's speech community. Types of language socialization patterns include narrative structure; importance of labeling; attitudes toward appropriateness of child-adult and child-child communications, ways of gathering information, and ways of giving commands such as known questions and veiled commands/indirect speech acts.

F. Cultural differences and similarities held by both client/patient and clinician, with resultant impact on language use in all communicative environments.

G. Impact of client's/patient's attitudes, values, and beliefs toward non-oral approaches to communication such as augmentative/alternative communication, sign language, and assistive listening devices.

4.2 Language and linguistics including:

A. Typical language development in simultaneous and sequential bilinguals.

B. Normal processes of second-language acquisition, including language transfer, language attrition, interlanguage, and affective variables.

C. Difference between an accent and a dialect, and a language and a dialect.

D. Patterns of language recovery following neurological insult.

E. Grammatical constraints on code-switching and code mixing.

F. Typical development in the client's/patient's language(s)/dialect(s) in all areas (see 4.3).

4.3 Identifying, obtaining and integrating available resources to determine what is typical speech/language development in the client's/patient's speech community and communication environment, including:

A. Research on the client's/patient's culture(s), speech community, or communication environment.

B. Interview with a parent or other caregiver on how the client's/patient's speech/language development compares to peers in his/her speech community or communication environment.

C. Interview with a family member, or other person who knew the client/patient previously, to describe and compare the client's/patient's language skills before the insult or injury that may have led to an acquired language disorder.

D. Family history of speech/language problems or academic difficulties.

E. Cultural informant/broker to gain insight into the impact of culture on the client's/patient's communication skills.

F. Linguistic/sociolinguistic informant/broker from the client's/patient's speech community or communication environment, such as for grammaticality judgments and for judgments based upon sociolinguistic considerations related to the client's/patient's speech community or communication environment.

G. Use of speech/language data provided by translator/interpreter.

H. Clinician's personal knowledge base.

I. Application of the clinician's clinical judgment to synthesize, evaluate, analyze, and make determinations based upon all the data/information gathered.

5.0 Role: Identification/Assessment of typical and disordered language. This includes knowledge and skills related to:

5.1 *Foundational content:*

A. Current research and preferred practice patterns in the identification/assessment of language disorders/delays.

B. Legal, regulatory, ethical, and professional guidelines relating to language assessment.

C. Appropriate criteria for distinguishing a disorder from a difference by using the norms of the client's/patient's speech community as the standard.

D. Appropriate ethnographic interviewing techniques, such as knowing effective ways to ask for crucial but sensitive information so the caregiver/parent and/or client/patient, is comfortable enough to provide that information.

E. Impact on language use by the client/patient with regard to topic, participants, setting, and function on the linguistic interaction, based upon knowledge of the standards of communicative competence in the client's/patient's speech community or communication environment (see 4.3).

5.2 *Assessment materials/tests/tools:*

A. Appropriate use of published test materials in language assessment including standardized norm-referenced tests and criterion-referenced tests, including analyzing normative sampling limitations, general psychometric issues especially related to validity and reliability, and inherent cultural and linguistic biases in these test materials.

B. Application of appropriate criteria so that assessment materials/tests/tools that fail to meet standards be used as informal probes, with no accompanying scores.

C. Inherent problems in using translated tests so that translated tests are used only as informal probes, with no accompanying scores.

D. Appropriate use of alternative approaches to assessment including dynamic assessment, portfolio assessment, structured observation, narrative assessment, academic and social language sampling, interview assessment tools, and curriculum-based procedures, including analysis of validity, reliability, and inherent cultural and linguistic biases.

E. How cultural and linguistic biases in assessment tools impact on an appropriate differential diagnosis between a language disorder and a language difference.

1. Cultural biases include question types, content, specific response tasks, and test formats that are not commonly used in the client's/patient's speech community or communication environment.

2. Linguistic biases include differences in when certain features of language are acquired and/or in certain linguistic forms that may not be common, or present at all, in the language(s) and/or dialect(s) spoken or used by the client/patient.

5.3 *Differential diagnosis:*

A. How linguistic features and learning characteristics of language differences and second-language acquisition are different from those associated with a true learning disability, emotional disturbance, central auditory processing deficit, elective mutism, or attention deficit disorder. (Diagnoses that might be confused with a linguistic or cultural difference or second language learning.)

B. Preparation of written reports that incorporate information about the client's/patient's cultural and linguistic influences.

C. Determination of whether a language disorder is present based upon one's clinical judgment after reviewing and analyzing all the critical information (See 4.3).

D. Determination of the severity level of any identified language disorder.

E. Ethical issues raised if scores are provided for tests that are psychometrically flawed, translated and not adapted, culturally biased, and/or linguistically biased.

6.0 Role: Treatment/Management of disordered language. This includes knowledge and skills related to:

A. Current research and best practices in the treatment/management of language disorders/delays, including various delivery models and options for intervention.

B. Appropriate language(s)/dialect(s) to use in treatment and management.

C. Impact of the client's/patient's current and historical language/dialect exposure and experience.

D. Standards of the client's/patient's speech community or communication environment in determining discharge/dismissal criteria, rather than base that decision on the client/patient mastering the clinician's or interpreter's/translator's language(s)/dialect(s) and language socialization practices.

E. Integration of the client's/patient's attitudes, values, and beliefs toward non-oral approaches to communication such as augmentative/alternative communication, sign language, and assistive listening devices when those approaches are incorporated into treatment.

F. Consideration of client's/patient's and/or parent's/caregiver's desire and need for fluency in the native language and/or English when considering the language for intervention.

G. Legislative and regulatory mandates and limitations to resources that may impact the language used for intervention.

Articulation and Phonology

7.0 Role: Identification/Assessment of individuals at risk for articulation/phonological disorders. This includes knowledge and skills related to:

A. Current research and best practices in the identification/assessment of articulation/phonological disorders in the languages(s) and/or dialect(s) spoken by the client/patient.

B. Phonemic and allophonic variations of the language(s) and/or dialect(s) spoken in the client's/patient's speech community and how those variations affect a determination of disorder or difference.

C. Difference between an articulation disorder, phonological disorder, an accent, a dialect, transfer patterns and typical developmental patterns.

D. Standards of the client's/patient's speech community or communication environment to determine whether he or she has an articulation or phonological disorder/delay. Identifying and using available resources to determine what is typical speech development in the client's/patient's speech community or communication environment (See 4.3).

8.0 Role: Treatment/Management of individuals with articulation or phonological disorders. This includes knowledge and skills related to:

A. Current research and best practices in the treatment/management of articulation and phonological disorders/delays in the languages(s) and/or dialect(s) spoken by the client/patient.

B. Community standards of typical articulation and phonology patterns, so that in treatment/management dialect, and accent features are not treated as articulation or phonological disorders.

C. Standards of the client's/patient's speech community in determining discharge/dismissal criteria so that discharge/dismissal is based upon whether the client/patient is speaking his/her dialect appropriately.

Resonance/Voice/Fluency

9.0 Role: Identification/Assessment and Treatment/Management of individuals at risk for resonance, voice, and/or fluency disorders. This includes knowledge and skills related to:

A. Current research on preferred practice patterns in the identification/assessment and treatment/management of resonance, voice and/or fluency disorders.

B. Community standards of typical resonance, voice, and/or fluency patterns.

C. Application of the standards of the client's/patient's speech/communication community for dismissal/discharge criteria.

Swallowing

10.0 Role: Identification/Assessment and Treatment/Management of individuals at risk for swallowing/feeding disorders. This includes knowledge and skills related to:

A. Current research and preferred practice patterns in the identification/assessment of swallowing/feeding disorders.

B. Community standards of typical swallowing/feeding patterns and preferences.

C. Incorporation of the client's/patient's dietary preferences, related to the identification/assessment of swallowing/feeding disorders.

D. Application of the standards of the client's/patient's community for dismissal/discharge criteria.

Hearing/Balance

11.0 Role: Identification/Assessment of clients/patients with or at risk for hearing/balance disorders. This includes knowledge and skills related to:

A. Current research and preferred practice patterns in the identification/assessment of hearing/balance disorders.

B. Application of the community standards and beliefs regarding hearing/balance impairment.

C. Culturally and linguistically appropriate assessment materials, tools, and methods.

D. Inherent problems in using speech testing materials (e.g., word lists, speech discrimination lists) that have been translated, not adapted, and/or not fully researched and not reflective of the phonological patterns of the client's/patient's language/dialect.

E. Influences of language and speech differences including issues related to bilingualism and dialectal differences between the client/patient and the clinician on hearing evaluation decisions, such as in speech recognition tests in quiet and noise. (See sections 7.0 and 8.0).

F. How other factors, (e.g., the color and consistency of cerumen), may influence findings on otoscopic examination and external canal management.

12.0 Role: Treatment/Management of individuals at risk for hearing/balance disorders. This includes knowledge and skills related to:

A. Current research and preferred practice patterns in the treatment/management of those hearing/balance disorders that are more prevalent in certain racial/ethnic communities and which are more prevalent due to cultural variables.

B. Application of the community standards and beliefs regarding hearing/balance disorders.

C. Attitudes and beliefs related to the treatment/management of hearing/balance disorders, such as attitudes towards using a manually coded system of communication; and assistive listening devices such as hearing aids, FM units, and cochlear implants.

D. Application of the standards of the client/patient speech community for dismissal/discharge criteria.

E. Components of a culturally appropriate audiological rehabilitation program.

F. Availability of personal assistive devices such as earmolds and hearing aids with greater cosmetic appeal for varying skin tones.

Terminology

Accent: (1) A set of shared variables, related to pronunciation, common to a particular speech community. It is standard practice to distinguish *accent* from *dialect*. *Accent* refers only to distinctive features of pronunciation, whereas *dialect* refers to distinctive lexical, morphological, and syntactical features. (2) A set of phonetic traits of one language that is carried over into the use of another language a person is learning (foreign accent).

Bidialectalism: The use of two different dialects of a given language. In terms of linguistic structure, one dialect of any language is not "superior" to another; however, from a social point of view, several dialects are considered to be prestigious and others are considered to be non-prestigious.

Bilingualism: The use of at least two languages by an individual. The degree of proficiency in the languages can range from a person in the initial stages of acquisition of two languages to a person who speaks, understands, reads, and writes two languages at native or near-native proficiency.

Code mixing: (1) Code-switching. (2) Term used to describe the mixed-language utterances used by a bilingual individual. It involves the utilization of features of both languages (usually at the lexical level) within a sentence (intra-sentential level).

Code switching: The juxtaposition within the same speech exchange of passages belonging to two different grammatical systems. The switch can be intrasentential, (within a sentence) (Spanish-English switch: *Dame a glass of water. "Give me a glass of water").* It can be intersentential, across sentence boundaries *(*Spanish-English switch: *Give me a glass of water. Tengo sed.* "*Give me a glass of water. I'm thirsty").* The switches are not random; they are governed by constraints such as the Free Morpheme Constraint and the Equivalency Constraint. Many who are bilingual and/or bidialectal are self-conscious about their code switching and try to avoid it with certain interlocutors and in particular situations. However, in informal speech it is a natural and powerful feature of a bilingual's/bidialectal's interactions.

Communication environment: The communicative environment of users of assistive or augmentative communication systems, and some forms of manual communication.

Communicative competence: The ability to use language(s) and/or dialect(s) and to know when and where to use which and with whom. This ability requires grammatical, sociolinguistic, discourse, and strategic competence. It is evidenced in a speaker's unconscious knowledge (awareness) of the rules/factors which govern acceptable speech in social situations.

Cultural informant/broker: A person who is knowledgeable about the client's/patient's culture and/or speech community and who provides this information to the clinician for optimizing services.

Culturally diverse: When an individual or group is exposed to, and/or immersed in more than one set of cultural

beliefs, values, and attitudes. These beliefs, values, and attitudes may be influenced by race/ethnicity, sexual orientation, religious or political beliefs, or gender identification.

Dialect: A neutral term used to describe a language variation. Dialects are seen as applicable to all languages and all speakers. All languages are analyzed into a range of dialects, which reflect the regional and social background of their speakers.

Linguistic/sociolinguistic informant/broker: A trained and knowledgeable person from the client's/patient's speech community or communication environment who under the clinician's guidance can provide valuable information about language and sociolinguistic norms in the client's/patient's speech community and communication environment. A properly trained informant/broker can provide information such as grammaticality judgments as to whether the client's/patient's language and phonetic production is consistent with the norms of that speech community or communication environment; information on the language socialization patterns of that speech community or communication environment; and information on other areas of language including semantics and pragmatics.

Interlanguage: An intermediate-state language system created by someone in the process of learning a foreign language. The interlanguage contains properties of L1 transfer, overgeneralization of L2 rules and semantic features, as well as strategies of second language learning.

Interpreter: A person specially trained to translate oral communications or manual communication systems from one language to another.

Language loss (also known as language attrition): A potential consequence of second-language acquisition whereby a person may lose his/her ability to speak, write, read, and/or understand a particular language or dialect due to lack of use or exposure.

Linguistically diverse: Where an individual or group has had significant exposure to more than one language or dialect.

Sequential bilingualism (also known as successive bilingualism)**:** Occurs when an individual has had significant exposure to a second language after the first language is well established.

Simultaneous bilingualism: Occurs when a young child has had significant exposure to two languages simultaneously, before one language is well established.

Speech community: A group of people who share at least one speech variety in common. Members of bilingual/bidialectal communities often have access to more than one speech variety. The selection of the specific variety depends on such variables as the participants, the topic, the function, and the location of the speech event.

Translator: A person specially trained to translate written text from one language to another.

References

American Speech-Language-Hearing Association. (1996, spring). Scope of practice in audiology. *Asha* 38 (Suppl. 16), 12–15.

American Speech-Language-Hearing Association. (2001). *Scope of practice in speech-language pathology.* Rockville, MD: Author.

American Speech-Language-Hearing Association. (1997a). *Preferred practice patterns for the profession of audiology.* Rockville, MD: Author.

American Speech-Language-Hearing Association. (1997b). *Preferred practice patterns for the profession of speech-language pathology.* Rockville, MD: Author.

American Speech-Language-Hearing Association. (1997a, 1997b). *Preferred practice patterns.* Rockville, MD: Author.

American Speech-Language-Hearing Association. (2001, December 26). Code of ethics (revised). *The ASHA Leader*, 6(23), p. 2.

American Speech-Language-Hearing Association. (2002). *Communication development and disorders in multicultural populations: Readings and related materials.* Available online at http://www.asha.org/about/leadership-projects/multicultural/readings/OMA_fact_sheets.htm

National Standards for Culturally and Linguistically Appropriate Services in Health Care. (2001, March). Washington, DC: U.S. Department of Health and Human Services, OPHS Office of Minority Health.

U.S. Bureau of the Census. (2000). *Statistical abstract of the United States* 119th ed. Washington, DC: U.S. Department of Commerce.