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The necessity for assessment and management of speech, language and communication needs to take account of cultural and multilingual diversity.

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Abstract. This paper argues for the need for a culturally responsive approach to the identification, assessment and intervention processes for multilingual children with speech, language and communication impairment. It highlights the potential for misdiagnosis and identifies the specific difficulties which may be evident and thus, potential indicators of language impairment as opposed to language difference. The paper critiques the standardised tests which are often used by therapists in the formal diagnosis process and argues that dynamic assessment offers the best potential for an accurate diagnosis.

Keywords: Inclusion, Speech, Language, Communication,

Introduction

This paper argues for the need for a culturally responsive approach to the identification, assessment and intervention processes for multilingual children with speech, language and communication impairment. It highlights the potential for misdiagnosis and identifies the specific difficulties which may be evident and thus, potential indicators of language impairment as opposed to language difference. The paper critiques the standardised tests which are often used by therapists in the formal diagnosis process and argues that dynamic assessment offers the best potential for an accurate diagnosis.

Defining Language Impairment and identifying key issues

Ten percent of children in the United Kingdom have speech, language and communication needs (O'Keefe & Farrugia, 2016). A communication-rich environment is one of the most effective ways of enhancing speech, language and communication (Glazzard, 2016). Children with speech, language and communication needs do not necessarily have cognitive delay (Glazzard 2016)

and a range of assessment tools should be used for early identification of need (NASEN, 2014).

Language impairment has been defined as 'the inability to learn language as manifested by deficits in expressive and or receptive language skills relative to age-matched peers who have comparable language exposure' (Bedore and Pena, 2008: 1). It is a neurodevelopmental disorder (Rice, 2004) which affects approximately 7% of the population.

Simultaneous bilinguals learn both languages before the age of 3 years (Paradis, 2010). In contrast, sequential bilinguals have their first language (L1) generally well developed prior to them learning a second language (L2) (Paradis, 2010). The dominant language is the one to which they have received most exposure. Development in the second language is not comparable to language development in age-matched monolingual peers (Bedore and Pena, 2008) and development in L1 may stall as L2 becomes more complex. Exposure to L2 and children's socio-cultural experiences influence language development (Nelson, 1990).

In many countries throughout the world speech and language therapy is a profession which is characterised by a largely homogenous workforce providing services to multilingual clients (Caesar and Kohler, 2007). In this context, therapists face significant challenges in relation to providing a culturally responsive service and there is limited research with practical significance to support therapists in overcoming these challenges (Verdon et al, 2015). These challenges are well-documented in the literature (Caesar and Kohler, 2007; Guiberson and Atkins, 2012; Williams and McLeod, 2012).

The multilingual population is heterogeneous in that individual circumstances vary in relation to age of second language acquisition and level of exposure to language (Paradis et al 2011). There are some differences in the ways in which monolingual and multilingual children acquire speech and language (Grech and McLeod, 2012) and these differences can lead to false assumptions that multilingual children have disordered language and/speech. It is important to emphasise that if a disorder occurs it will be evident in all languages and not just the target language (Paradis et al, 2011). If the difficulties exist in only one language then this is described as a speech/language difference rather than a disorder (Kohnert, 2010). The speech and language therapist is responsible for the accurate diagnosis of speech/ language disorder rather than diagnosing a speech/ language difference. Vocabulary deficits are evident in both languages when there is evidence of language impairment (Bedore and Pena, 2008), including expressive and receptive delays.

Delays in grammatical morphology, difficulties in relation to word meaning, word retrieval and word learning are comparable across languages (Bedore and Pena, 2008). Multilingual children with language impairment may also produce qualitatively different errors than the errors made by their monolingual peers (Bedore and Pena, 2008). This includes verb use (Jacobson and Schwartz, 2005) and patterns of grammatical production (Restrepo and Kruth, 2000). Identifying

these errors may enable the therapist to make a more accurate diagnosis of language impairment.

The problems with standardised tests: a critique

Speech and language therapists often use standardised tests to determine the presence of language impairment in combination with other methods (including observation and interviews). Thus, the validity of such tests is critical for accurate diagnosis. However, it has been argued that 'there are few psychologically sound measures of language development in languages other than English and few bilingual clinicians' (Pena et al, 2014: 2218). One of the pertinent issues documented in the literature is that speech and language therapists in English speaking countries tend to assess multilingual children's speech in English only (Caesar and Kohler, 2007; Williams and McLeod, 2012) and this can often lead to misdiagnosis (Toohill et al, 2012).

Studies have found evidence of cultural bias in tests (Sattler, 2001). Thus, cultural content and culturally specific knowledge is often embedded into test items (Warren, 2006) and this can detrimentally impact on the performance of children from multilingual backgrounds (Schon et al, 2008). This can result in the disproportionate representation of students from minority ethnic backgrounds in special education which has been a concern for over 30 years (Strand and Lindsay, 2009).

Many standardised tests available for speech and language therapists are monolingual (Goral and Conner, 2013). The standardised norms are based on monolingual native speakers of English, whilst some tests are normed with monolingual speakers of another language (Goral and Conner, 2013). According to Bedore and Pena (2008) 'the result is that bilingual children are often inappropriately compared to a monolingual norm' (p.19). There are relatively few standardised tests which provide normative data from multilingual individuals (Goral and Conner, 2013) and given the heterogeneous nature of the multilingual population it would be extremely challenging to be able to find a test which is based on normative data which matches the multilingual individual being tested. Most tests are normed on monolingual individuals (McLeod and Verdon, 2014), which calls into question the validity of the results when the test is used on someone who is multilingual. There are also specific debates about the language proficiency of those administering the tests and the acceptability of code-switching during the assessment (Goral and Conner, 2013). There are few bilingual clinicians (Pena et al, 2014) which automatically places this group at a disadvantage.

To address some of these issues the use of translation in test adaption and the development of local norms are common solutions (Bedore and Pena, 2008; Stow and Dodd, 2003; Taylor and Payne, 1983). However, these solutions are not unproblematic. Direct translation of tests into other languages assumes that language development is consistent across languages, which cannot be assumed (Bedore and Pena, 2008). Although there are similarities in language acquisition

across languages there are differences which can affect test performance (Bedore and Pena, 2008). For example, research has found that prepositions are more difficult in Spanish than in English (Zimmerman et al, 2002).

Additionally, although translated tests may target linguistic forms of language impairment in the source language, they may omit aspects of the target language that might potentially differentiate between children with and without language impairment (for example, vocabulary use and narrative components) (Bedore and Pena, 2008). This is likely to be the case if item selection on tests is guided by the difficulties that children typically experience in the source language. When tests are adapted from English to other languages the markers of language impairment in the target language are often not addressed (Bedore and Pena, 2008).

Most tests of language ability in English fail to meet the criteria for accurate diagnosis of language impairment (Spaulding et al, 2006). Tests which do accurately meet the criteria for accurate diagnosis select the items that children with language impairment find the most difficult (Perona et al, 2005). Most vocabulary tasks are not sufficiently challenging (Bedore and Pena, 2008)

Dynamic Assessment

Dynamic Assessment (DA) has been recommended as a strategy for assessing speech, language and communication needs in children from linguistically and culturally diverse populations (Hasson and Joffe, 2007). This approach is considered to minimise assessment bias due to lack of exposure to language (Laing and Kamhi, 2003) because the approach does not measure static knowledge which is subject to linguistic and cultural bias (Pena et al, 2014). Instead, DA focuses on the learning process rather than norm comparisons (Pena et al, 2014). It is the most commonly applied assessment approach for assessing children from culturally and linguistically diverse backgrounds (Laing and Kamhi, 2003) and research has suggested the value of this approach in assessing word learning (Pena et al, 2001), narrative production (Kramar et al, 2009) and categorisation (Ukrainetz et al, 2000).

According to Goral and Conner (2013: 132) 'Dynamic assessment is a promising tool for differentiating multilingual children with PLI (Primary Language Impairment) from [those with] TLD (Typical Language Development) . Static assessment may not be accurate because multilingual children may demonstrate a wide range of performance in their current linguistic skills (Goral and Conner, 2013). Multilingual children may demonstrate a wide range of achievement in reaching typical developmental milestones (Goral and Conner, 2013) and achievement can be influenced by variables including age, language status, language input, pattern of exposure (sequential or simultaneous) and frequency of exposure (Goral and Conner, 2013). Therefore separating multilingual children with typical and atypical language development is inherently complex (Goral and Conner, 2013) and tenuous (Anderson and Marquez, 2009) because there may be overlap in errors between the two groups, for example in article use.

Dynamic assessment essentially measures the rate of change in performance (Goral and Conner, 2013) and information about the learning strategies employed by the child. Children with primary language impairment for example may attend to different features of words (Goral and Conner, 2013) compared to typically developing children and this may lead to more accurate identification of multilingual children with primary language impairment (Alt and Suddarth, 2012). Research has found that multilingual children with primary language impairment switched between languages more frequently than typically developing bilingual children (Iluz-Cohen and Walters, 2012). Additionally, this research found that multilingual children with primary language impairment code-switched twice as frequently from L2 to L1 than from L1 to L2 in contrast with typically developing bilinguals who code-switched equally in either direction (Iluz-Cohen and Walters, 2012). Dynamic assessment makes it possible to identify these errors as well as providing an indication of the rate of change in performance over time.

Children with primary language impairment are often partly due to inefficiencies in memory and attention (Gillam et al, 2009; Pena et al, 2014). Dynamic assessment which incorporates clinical observation of strategy use as children are actively engaged in language learning can help to differentiate between multilingual children with language impairment and those who are typically developing. Attention and memory processes can then be systematically observed over time when children being to retell longer and more complex narratives (Pena et al, 2014). Dynamic assessment enables the clinician to gain insights into the learning behaviours of multilingual children with language impairment, thus making it possible to identify the underlying nature of children's language difficulties and hence, their intervention needs (Pena et al, 2014).

Working in partnership with families: developing cultural responsiveness

The Code of Practice for Special Educational Needs and Disabilities (DFE, 2014) emphasises the importance of establishing effective partnerships with parents and carers at all stages of the process. These stages form part of a graduated response (DFE, 2014) which includes the following processes: identification and assessment of need; target setting; supporting the child to meet these targets; reviewing and evaluating progress. It is perhaps pertinent to note that parental referral to speech and language services is greater for monolingual children than it is for multilingual children (Stow & Dodds, 2005) so it is critical to ensure that parents are informed about the availability of services in their communities.

It is critical that speech and language therapists are able to demonstrate cultural understanding to enable them to work effectively with different cultural groups (Bellon-Harn and Garrett, 2008). The starting point for this is for therapists to develop an awareness of their own cultural assumptions and to increase their knowledge of the values held by different cultural groups (Garrett & Pichette, 2000). This will enable therapists to understand more accurately the specific barriers to developing effective parent partnerships. However, it cannot be assumed that values are shared across a cultural group. Therapists should

therefore be willing to engage in cultural conversations with families in order to help them understand the cultural values that clients hold.

The professional values of a therapist may not align with traditional family values. Whilst the therapist may view speech, language and communication difficulties as requiring specific intervention, family members may view these needs as an essential part of the child's identity (Bellon-Harn & Garrett, 2008). Some cultural groups do not believe that they have a right to interfere with the child's biological characteristics and may seek spiritual intervention rather than clinical intervention (Bellon-Harn & Garrett, 2008) to help the child. Other cultures may believe that clinical intervention may be counter-productive to the development of a positive and productive life (Bellon-Harn & Garrett, 2008). Clearly, where cultural and professional values clash, the speech and language therapist plays a critical mediating role to help family members understand the necessity for clinical intervention. Some cultural groups may be reluctant for therapists to refer to child onto additional services due to fears that this might make the problem worse and they may believe that the problem will resolve itself (Bellon-Harn & Garrett, 2008). In cases like this it is critical that the therapist establishes positive relationships with families in order to gain their permission for referral (Bellon-Harn & Garrett, 2008).

It is critical that the therapist develops a level of cultural understanding when working with clients from different cultures to enable them to manage the process of clinical intervention with cultural sensitivity and empathy. In this respect therapists need to understand traditional cultural values which will inevitably determine which family members are included in the process. Some cultures retain strong gender roles and this often determines who makes key decisions within the family. In Latino families the father is usually responsible for making decisions without any consultation with other family members (Brice, 2002). In African American cultures decision making processes are usually collaborative and involve all family members (Terrell & Hale, 1992). Native Americans place more emphasis on the role of women and elders as decision-makers (Portman & Garrett, 2005). For the therapist, understanding these cultural values will help them to decide who should be involved in the consultation process (Bellon-Harn & Garrett, 2008). This process can take time and might involve an element of family counselling and therapists may therefore need to exercise a degree of patience whilst families come to terms with this.

Once decision-makers have been established, the therapist needs to develop cultural understanding about the level of involvement that families might wish to have. In some Latino and Asian cultures the family may prefer to leave formal decision-making up to the therapist (Chan, 1998; Roseberry-McKibbin, 1995). Some Asian parents are less assertive and may prefer the therapist to work as an advocate in the best interests of the family (Huang, et al, 2004). In contrast research has indicated that first generation Chinese families may expect to be advocates for their child and play a full role in any decision-making processes (Parette, Chuang & Huer, 2004).

In addition to the dilemmas outlined is also the issue of how clinicians communicate with family members from different cultural groups (Barerra & Corso, 2002). Attitudes to non-verbal forms of communication (for example, eye-contact, hand-shaking, and proxemics) can vary across cultures (Adler, Rosenfeld and Towne, 1989), as can attitudes to verbal communication. In some cultures laughter and humour are critical to communication (Garrett et al, 2005) whilst silence may be valued in other cultures. Some cultural groups may prefer the clinician to communicate with them in writing (Bellon-Harn & Garrett, 2008), although literacy levels need to be taken into account. Conversely, other cultures may prefer oral communication rather than written communication (Sileo & Prater, 1998).

Essentially, families need to trust the therapist. They need to be able to trust that the therapist is working in their child's best interests (Bellon-Harn & Garrett, 2008). Therapists can establish this trust by explaining to families why specific interventions are needed. In the absence of this understanding, cultural mistrust can develop (Bellon-Harn & Garrett, 2008) and families may choose not to participate in interventions which should be carried out in the home (Kaylanpur et al, 2000). Although families may not openly challenge the therapist for fear of being viewed as disrespectful (Hwa-Froelich & Wesby, 2003), cultural mistrust can manifest itself in families not complying with the recommendations made by the therapist. There is also potential for families to misinterpret the recommendations, resulting in families implementing interventions in the home in ways which do not address the identified need.

Families from some cultural groups are likely to find the experience of working with a speech and language therapist stressful (Bellon-Harn & Garrett, 2008). Some of this stress may be caused by families not understanding what the therapist is attempting to achieve. Additionally, families may not understand how the clinical intervention will support the child in achieving long-term aspirations which families have for their child. The therapist therefore has a critical role to play in establishing positive relationships based on trust, sensitivity and empathy. The therapist should always seek to minimise stress for families by explaining clearly how the intervention will benefit the child. The importance of therapists listening actively and attentively to multilingual parents has been emphasised in the literature (Verdon et al, 2015), including the need for the therapist to gain specific knowledge of dialectal variations (Verdon et al, 2015). Ultimately, the family, their culture and associated values, will determine what they want for their child (Bellon-Harn & Garrett, 2008). Involving families in open discussions which provide them with opportunities to share their own views and experiences of their child is one way of ensuring that therapists deliver a culturally responsive service (Sue & Sue, 2003).

Intervention

The impact of interventions can be maximised if the home language is used as the language of instruction (Kohnert et al, 2005). Additionally, intervention in all languages spoken has been found to have the greatest impact (Paradis et al, 2011). The choice of intervention and approach to delivering it will be influenced by the

therapist's ability to deliver an intervention in the home language (Kritikos, 2003) and the availability of bilingual staff to support the therapist in administering the intervention (Verdon et al, 2015). A community-based approach to intervention, where assessment and intervention take place in the community, outside the clinical setting, may help parents to feel safe and valued (Verdon et al, 2015) and may also address issues such as low-referral rates (Stow & Dodd, 2003; 2005) and non-participation in intervention.

Conclusion

This paper has argued that difficulties in relation to speech, language and communication impairment are evident in both the home language (L1) and the target language (L2) and therefore assessments of children's performance in both languages is necessary for an accurate assessment. The paper has also argued that proficiency in L2 is affected by variables such as type and length of exposure to the second language as well as the age of the child and dynamic rather than static assessment enables therapists to ascertain the rate of progress over time as well as making it possible to assess language use within social and cultural contexts. This paper argues that therapists need to develop cultural knowledge, sensitivity and empathy when working with clients from multilingual populations. Values in relation to intervention may not be shared across cultures and the therapist will need to convince the family that intervention is necessary to support the child. This process is not unproblematic, given that families may be suspicious about the therapist's motivations. However, a complete assessment cannot take place without including the perspectives of the parents. This paper has argued that therapists may wish to consider adopting a community approach to assessment and identification in order to support parents through the graduated response.

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