

# How do Speech Pathologists work in a Multilingual and Culturally Diverse Society?



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## Is Australia a multilingual and culturally diverse society ?

Yes. The 1996 Australian Census noted 353,000 people who identify themselves as Aboriginal & Torres Strait Islander origin. This is roughly 2% of Australia's population. (Australian Bureau of Statistics, 1996).

Australia's resident population as estimated at 30 June 1997 was 18.53 million persons, of whom 23.3% (or 4.32 million persons) were born overseas. Migrants born in the main English speaking countries represented 9.1% of the Australian population and migrants born in non-English speaking countries 14.2% (Australian Bureau of Statistics, 1999).

Multilingual and culturally diverse clients are those who use languages and dialects other than Australian English or do not share the same cultural background as the speech pathologist. Clients could be from overseas, from overseas-born families, Aboriginal and Torres Strait Islander people, or members of the deaf community. Clients may belong to a different culture and communicate in a language different from the speech pathologist, or may share the speech pathologist's language to some degree while belonging to a different culture.

All Australian residents should have equitable access to speech pathology services irrespective of cultural or linguistic background.

## How does a speech pathology service reflect the society it is part of ?

The development of cross-cultural competence is essential. Good, effective practice with clients of different cultural and linguistic backgrounds may take considerably more time and resources than with clients whose culture and language the speech pathologist shares (Lynch, 1998).

While the principles of assessment and management of communication and swallowing problems remain the same, their application may need to be adapted according to the needs of individual clients.

Speech pathologists are trained to be innovative and flexible. Service delivery models are developed and reviewed in collaboration with the client's community and other informants.

Ideas for alternative service delivery include:

- intervention service in a naturalistic situation – for instance, preparing a meal, participating in a playgroup;
- health promotion
- community development;
- skilling and learning from co-workers ('two-way training');
- transdisciplinary work.

## Is working with an interpreter or translator necessary ?

When communicating with the individual who has a different linguistic background, translations of written material and face-to-face interpreting are usually viewed as the minimal conditions to ensure informed choice, particularly when significant medical, educational or vocational situations occur.

Professional, accredited interpreters and translators must be engaged when possible. The speech pathologist may need to advocate strongly on behalf of clients to ensure appropriate access to services. However, it is recognised that professional interpreting services are not available in all places for all languages, and alternative arrangements will then need to be made.

## Assessment

Multiple sources of information are used by speech pathologists in an ethnographic, diagnostic process. The speech pathologist tries to obtain appropriate assessment materials for assessing both/all of the client's languages across the various language parameters, that is, phonology, vocabulary, semantics, syntax, pragmatics, prosody and fluency. Feedback regarding assessment results are provided verbally and may be supported by visual information, such as photos or video, to enhance communication and client/family decision-making.



## Which language should be used for speech pathology intervention ?

The speech pathologist aims to arrange intervention in the languages used by the client in his/her daily repertoire, particularly the client's home language.

Bilingualism is viewed positively. Learning to communicate in more than one language is an advantage and not the cause or exacerbating feature of any disability (de Houwer 1998; Watson 1999). Further, authors such as Duncan (1989), suggest that intervention for children in the home language has positive effects on the development of the second language.

De Houwer (1998) points out the emotional dimension involved in the use of any language. A child develops their first relationships in the language of the home. An adult will have many memories of earlier times attached to their first language(s). Giving up the first language(s) in favour of using only Australian English has an emotional cost.

The effects of acquired communication disorders on all languages in the client's repertoire are examined to facilitate a functional outcome.

If the bilingual adult client requests intervention in Australian English, and if Australian English is the most affected, then it is reasonable to provide therapy in Australian English.

It may be necessary to provide intervention in more than one language (for example, Australian English and a community language) as current research does not clearly indicate the transfer of intervention across languages.

Where an aged or confused client requires predominantly a community language in social situations, the client may need this language in therapy to facilitate rehabilitation. Baker (1995) in her study of elderly bilingual migrant Australians pointed out just how context-specific language use is. Dementia clients may respond only to the first language as the condition progresses.

Whenever possible, the speech pathologist arranges intervention in the language/s preferred by the client.

## Do speech pathologists work on "accent reduction" ?

Intelligibility enhancement may be an appropriate therapeutic goal where the accent, or effect of the first language's phonology, make the client's Australian English productions difficult for the listener to understand. The client may report significant difficulties in day-to-day communication, or may be concerned about the effect on vocational opportunities (Huntley Bahr, 1998). In order to make appropriate diagnostic judgments, the speech pathologist finds out about the phonological system of the client's first language and the usual interference patterns that can be expected when someone from that language background learns English as a Second Language. Testing includes the phonology of both languages (Swan & Smith, 1987).

## Should augmentative and alternative communication systems use Australian English only?

No. Communication systems need to be both culturally and linguistically appropriate. Some examples include:

- developing a pictograph system, such as one using Compic, which includes both languages – preferably with the home language above the pictograph and Australian English below it (this draws attention to the home language and emphasises acceptance of the home language);
- developing an appropriate signing system for use with the home language;
- obtaining an appropriate synthetic voice or an appropriate Braille script;
- for the hearing impaired, oral advocates need to organise oral work in the home language(s).

## What about swallowing and eating disorders ?

The life-threatening nature of swallowing and eating disorders makes it very important that clients have access to information and instruction in their own language. This may be achieved by working with interpreters and translators to:

- explain the reasons and implications of investigations
- educate family members on the techniques to improve the client's ability to swallow safely and how to prepare meals of appropriate consistency;
- instruct the family about alternatives to oral feeding, for example, nasogastric feeding.

Speech pathologists assess the sociocultural factors associated with eating and aim to provide examples of culturally appropriate foods and fluids that clients can manage safely. Modified diet preparation may also be required.

**References:** Please contact Speech Pathology Australia's National Office for the references used to create this Fact Sheet.

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