

**SERVING THE 65+ CULTURALLY AND LINGUSTUCALLY DIVERSE  
POPULATION  
CSHA DIVERSITY COMMITTEE 2003-2004  
BACKGROUND**

There has been more information about the SLPs 's clinical management of the culturally and linguistically diverse (CLD) population of the preschool and school- age client. Much less has been published and written about the SLP's role in the diagnosis and treatment of acquired communication disorders and swallowing deficits with CLD clients. The following paper is by no means exhaustive but is written as a general guideline with the hope that the information will continue to be updated and revised.

**DEMOGRAPHICS**

- **The elderly 65 and up increased from 3 million in 1990 to 3.3 million in 1994. One in 8 were elderly in 1994, but 1 in 5 would be elderly by 2030.**  
     29.8 million White ==2.7 million Black  
     1.5 million Hispanic==134,000 American Indian, Eskimo and Aleut  
     615,000 Asian and Pacific Islander
- **Nine states have more than 1 million elderly:** California, Florida, New York, Pennsylvania, Texas, Illinois, Ohio. Michigan, New Jersey.
- **California has the largest population of elderly persons (3 million); its proportion of elderly (11%) is the 46<sup>th</sup> among the 50 states.**
- **Florida and Pennsylvania** have the highest percentage (19 % and 16% respectively).
- **More women than men 75 years of old or older needed assistance compared to men (33% vs. 25%).**
- **By 2050 the largest increase in the older population of 65+ will be among the Hispanic population** followed by the Asian group where the percentage will more than double. Note that the number of Black will be less than double including the White group

<b>GROUP</b>	<b>1990</b>	<b>2050</b>
<b>All races (+7.9%)</b>	<b>12.5%</b>	<b>20.4%</b>
<b>White (+9.4%)</b>	<b>13.4%</b>	<b>22.8%</b>
<b>Black(+5.4%)</b>	<b>8.2%</b>	<b>13.6%</b>
<b>Am. Ind-Eskimo Aleut(+7.0%)</b>	<b>5.6%</b>	<b>12.6%</b>
<b>Asian and Pacific Isl.(+9.3%)</b>	<b>6.0%</b>	<b>15.3%</b>
<b>Hispanic(+9.0%)</b>	<b>5.1%</b>	<b>14.1%</b>

**ENGLISH LANGUAGE PROFICIENCY AMONG 18+**

9 Million (from about 25 million) report speaking another language than English or 36.8% of the population.

- 45% report speaking English very well.
- 22% report speaking English well
- 21% report speaking English not well.
- 12% report not speaking English at all.

**BOTTOM LINE:**

**At least 33 % or 3 M do not have an adequate command of English.**

By virtue of addressing the adult population, it is clear that we are discussing language loss, language relearning, and the health and medical circumstances, which lead to the communication or swallowing issues. The following tables describe current issues of incidence.

**HEALTH TRENDS**

Source: U.S. Bureau of Census

<http://www.census.gov/hhes/www/disable/sipp/disab9495/ds9495/ds94t6.html>

Note: Trends were available for Black and Hispanic groups only

Area	Pop. 55-64	Pop. 65-79	Pop. 80+	Black 55-64	Black 65-79	Black 80+	HISP. 55-64	HISP. 65-79	HISP. 80+
Disability	36.3	47.3	71.5	46.0	61.8	81.4	42.9	55.3	76.8
Severe	21.9	27.8	53.5	35.0	44.3	63.2	27.7	33.1	62.1
M.Disab.	4.5	5.7	18.8	7.0	12.2	24.4	4.0	6.2	27.2
Diff.seeing	6.0	10.0	25.2	11.3	20.4	28.4	6.9	14.3	17.7
Diff.hear	6.5	12.5	28.2	5.6	12.9	26.7	6.2	10.3	31.4
Diff.eating	0.8	1.4	3.4	1.3	3.2	4.1	0.5	1.8	6.2
Diff.exp.lan	1.3	2.0	4.5	2.4	3.5	3.6	0.8	2.2	3.0
Diff. phone	1.3	3.6	13.3	2.1	5.0	14.6	1.4	3.8	12.4

Based on survey done in 1994-1995. More recent data could not be found at this time.

## LEADING CAUSES FOR DEATH AMONG DIFFERENT ETHNIC GROUPS

General Populations-All ages

ETHNICITY	HEART/STROKE	CANCER	ACCIDENT	OTHER CAUSES
White	39.7%	23.3%	-----	Variable causes including lower respiratory, accidents, diabetes, Alzheimer's
Black	35.5%	21.2%	4.3%%	Assaults, diabetes, HIV
Hispanic	31.2%	20%	8.6%	Diabetes, homicide
Asian/Pac.	35.9%	26.2%	5.2%	Pneumonia, diabetes
Am.Indian	26.3%	16.8%	12.6%	Liver, cirrhosis diabetes

P.S.

- Data are averaged between males and females. Website provides data on females and males separately.
- Note the much higher incidence among Whites for cause of death due to cardiovascular disease and cancer compared to the other groups.
- ----Different causes were mentioned. Noteworthy Hispanic females tend to have a higher rate of disease of the heart compared to males (34.3% vs. 27.9%)-same for cancer (21.2% vs.18.7%). Contrary for accidents with greater male prevalence (11.2% vs., 4.7% in females)
- Risk for stroke is 1.3 higher at ages 35-64 and slightly lower at ages 65-74.
- Among Hispanic 18 and older, almost 50% of men and 57% of women are sedentary.
- Note the larger proportion of percentages of death caused by vascular disease among Asian and Black groups.
- **A view on the American Heart Association Website provides detailed information on various statistics in various populations.**

### SUMMARY

- 1-A greater percentage of minority groups has more disabilities at any given age compared to the general population.
- 2-Same goes for severe disabilities.
- 3-More Blacks reported having more mental disabilities compared to general population including Hispanics
- 4-Older Hispanics 80+ have less difficulty with vision compared to other groups, but have more hearing problems and eating problems compared to the other two groups at the same ages.
- 5-Problems with expressive language varies. More for Blacks compared to other groups in the ranges of 55-80years of age. This also includes being

able to use the phone.

## **LANGUAGE AND AGING-TRENDS IN BILINGUALS**

### **General Comments:**

- Changes in healthy adults are subtle.
- Greatest challenge: word retrieval.
- Lots of variability-mostly in locating the phonological shape of words.
- Early vs. late second language acquisition delays difficulty in naming in that language.
- Comprehension of auditorally presented sentence-length material declines with age.
- Metalinguistic abilities, syntax, self-monitoring for speech errors do not decline with age.
- Language changes caused by aphasia present different patterns according to when the injury occurs.
- Stroke related onset of Broca's aphasia sets in about a decade earlier than Wernicke's
- In bilinguals or polyglots, the most frequently used language around the time that the stroke occurred recovers first; it is more variable for bilingual individuals who are 65 and older.

## **COMMUNICATION DISORDERS IN ADULTS**

### **Clinical Management Considerations:**

The SLP's evaluation of the adult populations involves many of the same issues faced by clinicians who primarily work with children. Both groups of SLPs are faced with limited choices of assessment instruments in the CLD's primary language, and the need to adequately collaborate with an interpreter/translator. For adults, we must also take into account social language usage, vocational language, and functional language. The emotional, social and economic factors which face the individual and family are as numerous as the types of communication deficits encountered. The types and degree of communication disorders in adult CLD populations are not significantly different from the general English-speaking populations (neurogenics vs. structural, namely the head and neck cancer population).

The clinical management of adult neurogenic and structure communication disorders, necessitates consideration of cultural issues of dealing with sick family members, loss of head of household, loss of income and the needs of the caregiver takes prominence. Certain cultures will expect healing and progress while others accept fate. Trying to encourage individuals and family members to think positively and respond proactively is ethnocentric at best, despite the good intentions of the clinician. Trying to determine the belief systems and coping strategies of all of the participants produces far richer benefits.

### **Assessment Considerations:**

Assessment of the CLD adult population necessitates the need to address the testing

environment and experience. If patients have had a formal education, they are equipped with the pattern of responding to naming tasks, receptive language tasks, and cognitive scenarios. If the adult has no formal education, the testing experience is foreign and the patient may undergo stress and confusion. Explaining the purpose of assessment is very important. Assignments must be carefully planned. If a patient has had limited experience with writing it may not be helpful to suggest the maintenance of a daily log to assist in enhancing memory skills.

### **Laryngectomees:**

Specific conditions such as of the CLD laryngectomee must be considered. Treatment of an Asian language speaker or any speaker of a tonal language needs to be carefully planned. The loss of the vocal cords affects pitch changes necessary to discriminate semantic changes which are related to tones. Esophageal speakers and electrolarynx users are unable to produce the minor tone changes that signal a change in word meaning. The syllable [ma] can have 5 different meaning depending on the tone. Therefore, the speaker must use circumlocutions to get the point across to the listener.

### **Swallowing disorders:**

Swallowing disorders may affect the CLD's individual ability to actively participate in eating preferred regional foods, and participate in cultural events that celebrate with meals. Enrolling the family's support using creativity and offering the elements of probable improvement assist in the recovery of functional eating.

### **Language Recovery.**

When assessing speech, language and communication abilities of CLD patients who have suffered brain injury resulting from stroke or trauma. Consider the following areas: (Special thanks for Lupe Ramirez-Steele, SJSU student for her initial search on this topic).

- Assess all languages known to the patient.
- Use Bilingual Aphasia Test, which has been adapted to 65 languages.
- Each language should be assessed on different days. (if at all possible)
- Patient may not demonstrate same pattern with each language.
- There are three different periods to consider the acute phase, lesion phase which lasts up to 4-5 months, and the late phase.
- Best time is to assess during the lesion phase.
- Reexamine language patterns at the late phase.
- Paradis (2001) states that 40% of polyglot aphasics exhibit parallel recovery.
- Most common is that problems are seen in one language, but not in the other.
- Patient recovers the language that was most familiar to them.
- It all depends and would work if there were no lesion to the language centers, but rather an "inhibitory" phenomenon. (Pitres' rule)
- Grammatical errors in bilingual aphasics are the same as those of monolingual in a given language.
- Language of intervention is still in debate. It all depends on the patient, family, and preference.

- Agrammatic patients tend to use simpler sentences and those forms that are most common in the various languages.
- Many patients may use other forms to avoid complexity.
- High frequency forms in a language are more resistant to errors.
- However, one type of grammatical error in one language is not manifested in another due to the structure of the language.

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### HELPFUL WEBSITES TO GET INFORMATION ON CLD AGING POPULATIONS

- EthnoMed Site: <http://ethnomed.org>
- Diversity RX: <http://www.diversityrx.org>
- MEDLINE- Spanish –Reduplication of virtually the MEDLINE in English