Challenges of Treating Bilingual and Multilingual Stuttering

Upasana Bagchi, PhD and K. Jayasankara Reddy, PhD

Keywords
access to care, challenges, clinician–patient relationship, stuttering, bilingual, culture/diversity, patient expectations, patient satisfaction

Stuttering or stammering is a communication disorder in which the fluency of speech is disrupted (1). With over 50% of the World population speaking 2 or more languages, bilingual stuttering and multilingual stuttering poses challenges to the traditional frameworks used to understand and conceptualize stuttering. This, in turn, impacts research, measurement, and treatment of stuttering (2). The misdiagnosis of stuttering due to bilingualistic or multilingualistic challenges shatters the client’s self-esteem and the clinician’s confidence with the patient. It also invites wrong and ineffective treatment. Since stuttering is not covered fully or in part by insurance, the medical expenses increase manifold without any productive results. This article discusses the challenges faced by clinicians in treating stuttering in a bilingual and multilingual context and explores ways to resolve them.

Outdated Frameworks

The first major challenge faced by clinicians is that the available frameworks which are considered standard are based on monolingual assumptions which are largely based on English. Each language has a unique set of rules and patterns that it follows. Although languages of the same language family may share some similarities, there are major differences amongst them on multiple parameters. English is the most commonly used language used by clinicians to study, measure, and treat stuttering but it has different structures, rules, and exceptions compared to other languages. So clinicians dealing with clients who speak another language apart from English find it very challenging to conceptualize the client’s stuttering in the same framework as there are obvious differences in the nature and severity of stuttering. Only if the listener is linguistically well-versed in juggling multiple languages can they account for the pragmatic, syntactical, semantic, morphological, and phonetic differences, which is not usually the case (3). As a solution, further research on inclusive data is suggested to update the existing English-based paradigms and account for the changing linguistic population.

Misinterpreting the Role of Bilingualism

Clinicians are often misinformed about bilingualism or multilingualism of the client as a factor in stuttering. They acknowledge its importance and relevance in understanding stuttering but are found to misinterpret the relationship between stuttering and bilingualism or multilingualism. It is mistakenly believed that bilingualism or multilingualism is a causative factor in the development of stuttering. As a result, some clinicians have been found to prescribe the use of only language during treatment because they believe that juggling multiple languages puts a cognitive load on their brain’s processing. However, researchers have established that bilingualism or multilingualism is better explained as a contributory factor in the equation rather than as a causative factor for developing stuttering. This means that speaking multiple languages need not necessarily cause stuttering, but may be a factor that can increase the chances of stuttering (3). To counter this challenge, updating the existing training curriculum and practicum of clinicians is the need of the hour. Clinicians need to adapt the prescribed methods to suit linguistically and culturally diverse populations with sensitivity and humility.

Source of Stuttering Identification

The source of identification of stuttering can also greatly vary the measure of severity of stuttering. For example, self-report

1 Department of Psychology, Christ University, Bangalore, Karnataka, India

Corresponding Author:
Upasana Bagchi, Department of Psychology, Christ University, Hosur Road, Bangalore 560029, Karnataka, India.
Email: upasana.bagchi@res.christuniversity.in
is more likely to be a more accurate measure of severity. Reports from other sources are subject to the language match between the speaker and the reporter. A parent or a teacher report coming from a person who speaks the languages spoken by the client is likely more accurate than a nonspeaker of that language. Standard diagnostic criteria are largely in English and often fail to account for bilingual or multilingual differences.

The standardized tools to assess the stuttering are mostly dependent on one language so the statistical values of stuttering severity measures would differ for monolingual and bilingual or multilingual populations. The selection of assessment tasks and speech samples is language-dependent and is subject to the clinician’s and client’s familiarity of the languages being spoken. Earlier diagnosis reports or clinician’s individual judgment is often a less reliable method to assess stuttering severity (4). We suggest that standardized measures with data using diverse population groups need to be the focus among clinicians so that proper diagnosis and treatment can be offered to the clients. The client data can then be compared to the standards of the relevant language groups that they belong to.

**Familiarity of Language**

The familiarity of the clinician with the language of the client plays an important role in understanding and treating stuttering. Sounds, word lengths, vocabulary, word position, syllabic lengths, grammatical class of words, dialect, accent patterns, stress, tone, rhythm patterns, and so on, are very specific and unique to a specific language (5). Studies show that clinicians who did not speak the client’s language were more likely to identify more disfluencies and categorize those disfluencies as stuttering-like disfluencies (SLDs). As a result, clinicians find it difficult to identify the frequency, location, and nature of SLDs in the client’s speech.

The familiarity and closeness of language families and roots increase the accuracy of diagnosis and assessment of stuttering. Furthermore, making out the difference between a typical disfluency and atypical disfluency requires a certain degree of familiarity and exposure to the language of the client. So clinicians dealing with stuttering need to be trained to understand linguistic diversity and sensitize themselves to cater to the needs of multilingual populations. This would avoid false-positive identification cases and misdiagnosis of stuttering cases (4).

**Language Dominance Versus Language Preference**

The language processing differs in monolingual brains from bilingual or multilingual brains. The language processing pathway that is followed in monolinguals gets multiplied with the increasing number of languages learnt by the speaker. In addition, there is evidence of shared pathways of language processing in bilinguals and multilinguals which complicate the cognitive understanding of language processing in such cases of stuttering (2). Thus, the English sample of a monolingual English speaker with stuttering is likely to be very different from the English sample of bilingual or multilingual speakers. The interaction of language dominance and stuttering severity can vary largely based on if English is the language learnt first or a secondary language learnt later.

Apart from the rules of language dominance, language preferences play a pivotal role in language processing. Factors like the familiarity, proficiency, exposure, comfort, confidence, complexity, age of language learning, educational background, lifestyle, and so on, impact the personal choices and language preferences of the clients (4,6). The personal language preference of the client need not necessarily be in line with the rules of language dominance. It is suggested that clinicians need to be trained to understand the differences in language dominance and language preferences of clients in taking speech samples. This will help practitioners to cater to their therapy needs adequately.

**Language and Culture**

Each language brings with it a set of beliefs, traditions, and cultural values. Clients who speak a certain language also imbibe sociocultural values. It is noticeable that all cultures have a word for stuttering. However, there are differences in the cultural attitudes toward eye contact, communicativeness, emotional expressions, gender rules, age appropriate behaviors, communication styles, and so on. Cultural biases and stereotyping can make initial rapport building a barrier from both the clinician’s end and the client’s side which will hamper the client satisfaction and the treatment outcome (7).

Also, the culture-specific beliefs about stuttering, health, abnormality, and accepted modality of treatment play crucial roles in understanding stuttering from the client’s perspective. These differences in understanding the cultural mores can be interpreted as secondary characteristics of stuttering and lead to the wrong diagnosis. Thus, cultural competency training for clinicians is the need of the hour to improve the rapport with clients and planning treatment according to cultural standards (7). The focus of clinicians should be on therapeutic relationship building with the client using communication effectiveness and managing their personal biases in their professional environment.

**Conclusion**

With the changing World, paradigms need to change. Understanding stuttering through flexible, adaptable, and inclusive frameworks will help clinicians and clients to comprehend, to assess, research, plan, and treat stuttering more effectively. Clinicians handling bilingual and multilingual clients with stuttering should focus on achieving
speech fluency and speech naturalness in their therapy by qualitatively approaching stuttering rather than quantitatively. Since conversational speech serves as the best way to understand the client’s stuttering, speech samples can be collected in multiple languages to make the understanding of stuttering more comprehensive and inclusive. Clinicians can also observe how the clients use language as dysfunctional escape and avoidance behaviors and explore language as a coping mechanism in treating stuttering. Cultural awareness and sensitivity in practice go a long way in building effective rapport between clients and clinicians in therapy. Most importantly, client satisfaction and treatment outcome depend on the therapeutic relationship and working alliance. So cultural competency training for clinicians needs to be included in practicum and continuously updated with dynamic research findings.

Declaration of Conflicting Interests
The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding
The author(s) received no financial support for the research, authorship, and/or publication of this article.

ORCID iD
Upasana Bagchi https://orcid.org/0000-0002-0643-5561

References
1. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 5th ed. American Psychiatric Publishing; 2013.
2. Krawczyk A. Crosslinguistic Analysis of Stuttering and Typical Disfluencies in Polish-English Bilingual Adults Who Stutter. Electronic Theses and Dissertations. 2018;5955.
3. Shenker RC, Lim V. Assessment and treatment of bilingual persons who stutter: what clinicians want and need to know. Procedia Soc Behav Sci. 2015;193:328-9.
4. Byrd C, Werle D, Coalson GA, Eggers K. Use of monolingual English guidelines to assess stuttering in bilingual speakers: a systematic review. J Monolingual Bilingual Speech. 2020;2:1-23.
5. Hubbard CP. Word familiarity, syllabic stress pattern and stuttering. J Speech Hear Res. 1994;37:564-71.
6. Cosyns M, Einarsdottir J, Borsel JV. Factors involved in the identification of stuttering severity in a foreign language. Clin Linguist Phon. 2015;29:1-13.
7. Ferguson WJ, Candib LM. Culture, language, and the doctor-patient relationship. Fam Med Community Health Publ. 2002;34:353-61.