Speech-language therapy with multilingual people living with aphasia: from assessment to intervention

Companion booklet for speech-language therapists — version of 16 November 2026

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Objectives of this tool

The objective of this material is to allow us, speech-language therapists (SLTs), to feel better equipped for the care of multilingual people living with aphasia. By sharing data from the scientific literature, this tool aims to empower SLTs to provide culturally and linguistically adapted care.

Providing care to multilingual people can sometimes feel intimidating. We hope that consulting this booklet will help you feel ready to take the leap!

Some adaptations are sometimes necessary or desirable, but the way we provide care does not change entirely when a person speaks several languages. However, there are important considerations to keep in mind.

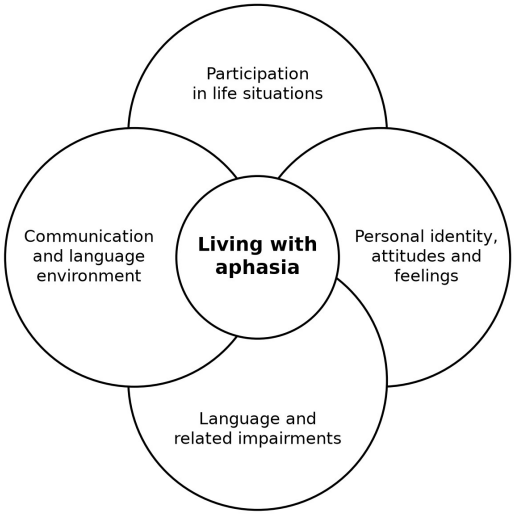
This tool aims to serve as a toolbox that can help us with a specific question, corresponding to a section of the tool, or with broader questions.

Structure of the tool

1. Introduction – the multilingual person living with aphasia
2. Elements to consider during a first meeting
3. Adapted assessment
4. Adapted speech-language therapy intervention
5. Collaboration with an interpreter or a translator
6. Points for reflection

Theoretical framework

The development of this tool is based on the A-FROM model and person-centred practice.



The A-FROM model, proposed by Kagan and colleagues (2008), allows us to consider the person as a whole and in all aspects of their daily life. The person is at the centre of the model and the SLT adapts the intervention according to their profile, abilities, and goals.

A-FROM. Adapted from Kagan et al. (2008).

This model invites us to adapt our interventions to the wishes of the person receiving care, their desires, their needs, and their individual characteristics, including multilingualism.



It is within their personal factors that we can find, for example, the importance that each language holds for the person, whether for communicating with family members, for professional life, for practising hobbies, or simply because a language is part of their identity.

Our own personal factors as SLTs will also influence the intervention, particularly depending on the languages we speak and our willingness to engage in care that may be outside the ordinary.

So why this tool?

As population movements become increasingly common, the need for linguistically and culturally adapted rehabilitation becomes ever more necessary. A growing number of people receiving speech-language therapy are indeed multilingual.

This tool brings together practical considerations for assessment and intervention, with attention to each person's languages, culture and participation priorities. Its development and evidence base are described in Birraud and Masson-Trottier (2026).

However, the lack of access to data in this recent field sometimes overshadows the crucial importance of taking into account this cultural and linguistic diversity to provide care adapted to each person's needs. This tool brings together various scientific sources of information in this field to facilitate your access to them.

1) Introduction – the multilingual person living with aphasia

Definitions

A multilingual person uses or understands several languages. Proficiency, literacy and everyday use vary across languages and contexts; multilingualism is a continuum rather than a requirement for equal fluency (Buschfeld et al., 2023).

Some people can read and write in all the languages they speak, others cannot (Buschfeld et al., 2023). It is quite common to see people who speak a language orally only, particularly for dialects that do not have written forms or for languages learned in a non-academic context. This will be an element to consider during the intervention.

We are referring to both people living in their country of origin who need several languages daily, and those who have immigrated and who may or may not speak the language of their country of residence.

Linguistic plurality also implies cultural plurality. Each language can correspond to social groups with different codes and vocabulary that exists or is used in one language only.

Characteristics of multilingual people

Multilingual people have phonological, lexical and syntactic representations in several languages. Languages can share conceptual representations and interact during a task. Proficiency, use and context shape these interactions (Buschfeld et al., 2023).

At the lexical level, some languages are richer than others when looking at a particular lexical domain. The possibilities for sentence structure and grammatical agreement rules also vary in complexity across languages. Speaking several languages does indeed influence the way one speaks in each of them.

Interactions between languages



Still in the context of multilingualism, two types of behaviour can be observed, which we will define as code switching and code mixing:

During the same conversation, an idea can be expressed in one language and another idea can be expressed in another language; this is code switching (Buschfeld, Ronan & Vida-Mannl, 2023). Similarly, within a sentence in one language, certain words may be said in another language, either because the word is more quickly accessible, or because the person does not know the word in the first language; this is code mixing (Buschfeld, Ronan & Vida-Mannl, 2023).

These two behaviours are common among multilingual people without neurological impairment and do not reduce conversational fluency when both communication partners share both languages (Ansaldo & Ghazi-Saidi, 2011; Buschfeld, Ronan & Vida-Mannl, 2023).

Characteristics of multilingual functioning

The fact that code switching or code mixing behaviours can be observed in multilingual people comes from the fact that when a concept is evoked, the number of words activated in the brain of a multilingual person is greater than for a monolingual person.



Language-control processes help select the intended language and manage interference from other languages.

Interactions between languages can increase task demands, including during naming. The effects vary with proficiency, use, the task and the situation; they should be assessed rather than presumed.

Managing more than one language is associated with differences in language-control and executive processes. These effects vary across individuals and tasks and should not be presented as a universal multilingual advantage (Bialystok et al., 2004; Dash & Joanette, 2016).

Some studies report associations between multilingual experience, aphasia severity, and treatment response, but findings are mixed and do not predict an individual person's profile or recovery (Paplikar et al., 2019; Masson-Trottier et al., 2022). Assessment must therefore focus on the person's own language history, current needs, and performance in each relevant language.

And when the multilingual person is living with aphasia?

Code switching, code mixing, and translanguaging may be ordinary, effective features of multilingual communication. They become clinically relevant when they are new, involuntary, difficult to control, or interfere with the person's goals and participation.

A response in another language may reflect interaction between language representations or a communication strategy. Compare it with the person's premorbid habits and the demands of the situation.

To interpret multilingual language behaviours accurately, SLTs need linguistic curiosity and information about the person's languages and communities. Features such as preposition choices, less specific words, or syntactic transfer may reflect multilingual use rather than impairment and should be interpreted against the person's premorbid profile.

Aphasia can restrict social participation. Choose communication goals with the person in the languages that matter for their relationships, activities and identity. The majority language alone may not meet all of these needs.

When we speak only one language or do not share the same languages as the person receiving care, strategies exist to work on the other languages they speak in order to support the return of their social participation in the different cultural and linguistic groups to which they belong.

Take-home points

• Describe multilingualism language by language: age and context of acquisition, proficiency and use.

• Code switching and code mixing are usual in multilingual speakers; in aphasia, distinguish habitual, functional mixing from involuntary switches.

• Each language can be affected and can change differently: do not infer the status of one language from another.

• Choose with the person the languages and communication situations that matter for their social participation.

2) Elements to consider during a first meeting

Case history



Let us start with the case history. In addition to the usual care questions, it is essential to inquire about the age and context of acquisition of each language, the degree of proficiency and daily use of each language, and the socio-cultural context in which these languages are used.

Choice of vocabulary



As in any type of care, we can use strategies to limit moments where the person might feel in a situation of communication disability, during the case history and throughout the care process. First, particular attention must be paid to the use of speech-language therapy jargon with all people living with aphasia, but even more so in the context of multilingual people. Indeed, a multilingual person may speak our working language as a second language and be comfortable in that language without necessarily understanding medical vocabulary and/or words related to speech-language therapy interventions.

In healthcare, health literacy concepts advise us to assume that the person and their relatives may not understand everything that health professionals explain (Koh & Rudd, 2015).

Relatives may not have sufficient proficiency in the clinician's language to understand medical vocabulary. They may therefore face the same communication barrier as the person receiving care.

Facilitating comprehension



Multimodal communication, also called total communication, can also be appreciated by the people we work with: it involves supplementing oral language with gestures, drawings, writing, and any other means of expression that can facilitate understanding.

Multimodal communication is relevant to use in speech-language therapy, beyond multilingualism and the world of aphasia.

Finally, summarising the key points of the assessment or session in writing can support understanding. Ideally, the summary is limited to three main messages, uses short sentences and avoids jargon (Hildenbrand et al., 2020). It should remain suited to the person's reading abilities.

It should nonetheless be kept in mind that writing is a more sensitive modality that may take time to recover, and therefore may not be suited to all people. However, even in cases where the person has difficulty reading paragraphs, for example, they may sometimes understand points written with short sentences or single words. Writing also has the advantage of being permanent and allowing the person to take the time they need to absorb the information.

This summary can be written during the session with the person, allowing us to personalise our interventions and slow down our speech. If needed, this written material can be supplemented with diagrams or images.

Using an interpreter



Overall, we need to ensure that information is well understood. In a multilingual context, using an interpreter may be necessary or desirable so that the person and their family can make informed decisions about rehabilitation goals, even when the person and we share a language or when communication strategies, such as those mentioned above, are used.

Communication difficulties can indeed be experienced during our intervention, regardless of the person's level of language proficiency. Even when the person speaks the language we use very well, some words may be unknown and require rephrasing.

The SLT's approach



Feeling that we are in an open posture and ready to constantly adjust can help the person feel more listened to. This stance supports the therapeutic alliance, which rests on agreement on goals, agreement on the tasks to reach them and a bond of trust; active listening and clear explanations, in a form suited to the person, help to build it. Its effects have mostly been studied in disciplines other than speech-language therapy (McGrath & Schultz, 2024).

Giving them the opportunity to tell us about aspects of their language related to their culture will once again show our desire to provide holistic care and will provide us with valuable information for the rest of the rehabilitation.

Clinical case: Sarah

Sarah is 66 years old and lives in Bordeaux with her French partner and their two cats, June and Mistigri.

Sarah was born in Juneau, Alaska, to a Mexican mother and an American father. She grew up speaking Spanish with her mother and English with her father; these are her first languages. She attended school in English and learned to read and write in Spanish through two hours of weekly classes during adolescence.

Sarah started learning French at 18, at university. It was during a semester in France that she met her current partner. They first lived in the United States for 30 years, then moved to France over 15 years ago. Sarah, now retired, used to be the sales manager of a Mexican company in the American market. She always worked remotely, in English with her clients and in Spanish with her colleagues and managers. Today, and for the past 46 years, Sarah speaks 50% English and 50% French with her partner. The couple's friends are predominantly English-speaking.

Sarah therefore speaks three languages and has the associated vocabulary and phonology in French, Spanish, and English.



Sarah's lexical fields are not the same in all languages: Sarah learned to cook with her dad in English, she knows little culinary vocabulary in the other two languages, she follows the news in Spanish only. She started taking painting classes in French six years ago. This specific vocabulary is developed in French only.

Sarah may have moments of code switching and code mixing: For example, in an English conversation, Sarah sometimes starts speaking French when she talks about her painting workshop. Code switching is not a problem for the couple since Sarah's partner understands both English and French.

It also frequently happens that Sarah code-mixes, saying certain words in English within a French sentence, either because the word is more quickly accessible or because she does not know the word in French.

Eight months ago, Sarah had a left-hemisphere stroke, causing non-fluent aphasia with moderate anomia and right hemiplegia. She spent four months in a post-acute rehabilitation unit. Since discharge she has not yet found a speech-language therapist. Residual weakness in her right upper limb persists.

Sarah's case will be our clinical case to illustrate this information tool for the care of multilingual people who, like Sarah, are living with aphasia.

Elements to consider when meeting Sarah

During the first meeting with Sarah and throughout the care process, we will be careful to use adapted vocabulary.



Sarah can participate in rehabilitation in French, but medical and speech-language therapy terminology may be difficult for her. Explain it clearly, check understanding and offer a qualified interpreter for explanations in English or Spanish according to her preference.



Furthermore, from the very first meeting with Sarah, it is essential to involve her in choosing rehabilitation goals and notably to ask her in which language(s) she wishes to progress. A person nearing retirement who wishes to return to their country of origin may not want to work on the language of the country where care is being provided; similarly, a person whose main communication partner speaks a specific language may wish to prioritise that language.

Sarah still uses her three languages daily, so she wishes to recover her abilities in all three languages.

What is important for Sarah?

When we begin caring for a person, we can complete this type of table to get an overview of their profile.

Context before the stroke 66 years old; retired from sales. English and Spanish from childhood. French acquired at 18.	**Family and social context** Married; no children. Painting group. Friends, cinema and theatre.	**Aetiology** Stroke in the left hemisphere.	**Previous coping strategies** Managed stress through painting and walks in nature.
	What matters to Sarah? **Regain a social life.**		
Communication Nonfluent aphasia. Word-finding difficulty. Difficulty with sentences and initiating communication.	**Cognition** Planning and working memory difficulties.	**Physical abilities** Residual weakness in the right upper limb.	**Mood and emotions** Feels isolated. Difficult emotional periods. Finds loss of independence hard.
Impact on daily functioning Communication difficulties reduce independence. Sarah finds it difficult to see her partner do tasks she can no longer do herself.			

Case-profile format: ICAP training, Farrington-Douglas & Rutter (2023).

Case-profile format adapted by Michèle Masson-Trottier from ICAP training by Farrington-Douglas and Rutter (2023).

Sarah is 66 years old, she is retired, she previously worked in sales. Sarah has two first languages: English and Spanish, which she still practises daily; and she started learning French at 18 and has always continued to practise it since, with her French partner.

Sarah is married and has no children. She goes to a painting club once a week. She sees her friends regularly and enjoys going to the cinema and the theatre.

Her aphasia follows a stroke in the left hemisphere.

Before the stroke, Sarah used to manage her stress by painting or walking in nature.

Communication difficulties manifest mainly as word-finding difficulties, difficulty producing structured sentences, and difficulty initiating communication.

Since her stroke, Sarah fatigues easily and has difficulties with planning and working memory.

Sarah has recovered well from her right hemiplegia; residual weakness in the upper limb persists.

Sarah has felt very isolated since her stroke; she describes very difficult periods emotionally and struggles with being assisted for everything

Impact on functioning: Sarah's difficulties make her not very independent in daily life; it is very difficult for her to see her partner doing everything she can no longer do.

The most important thing for Sarah is to regain a social life.

Following the meeting with a multilingual person living with aphasia

Following the first meeting(s), it will be useful to summarise the person's strengths and the difficulties to be addressed. It is indeed important to adapt the objectives according to the language profile, the needs, and the context of each person.

As SLTs, our goal will be to reduce the gap between what the person can do and what they want to do.

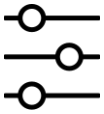
Clinical case: Sarah

For Sarah to regain a social life, such as attending her painting class, a goal could be focused on participating in a short, simple discussion to catch up.

Take-home points

- For each language, gather the history of acquisition, proficiency and use before and after the stroke, as well as the person's goals.
- Avoid jargon; support understanding with multimodal communication and a short written summary (three messages at most).
- Use a qualified interpreter when we are not sufficiently proficient in the language; relatives can support intervention but do not replace one.
- Keep an open stance: the person and their relatives are the experts on their languages and culture.

3) Assessment



Assess each language relevant to the person's communication, using suitable tools and linguistic support whenever feasible. If a language cannot be assessed, document the gap and its consequences for interpretation rather than treating the majority language as a complete picture of the person's abilities.

How to assess?

Assess noun and verb retrieval directly in each relevant language, using single-word tasks and connected speech where appropriate. Their relative difficulty can vary with the task, language and features of the words, including imageability. Do not infer an individual's pattern from the number or order of languages acquired (Li & Kiran, 2024).



Describe language switching, delayed naming, anomia and groping while recognising correct concepts expressed in another language (Ansaldo, Saidi & Ruiz, 2010). Compare current behaviour with premorbid habits and the person's goals rather than treating every switch as an error.

When appropriate, supplement language-specific assessment with a conceptual description or score that recognises accurate concepts expressed across languages, including through translanguaging. Keep this supplementary information distinct from standardised scores, follow each test's administration rules and document adaptations. Describe language switches in relation to premorbid habits and communication goals (Goral & Galletta, 2024; Arslan & Peñaloza, 2026).



Familiarity with the person's languages may help the SLT recognise responses that would otherwise be missed. It does not replace the language proficiency, task preparation or qualified interpreting needed for a valid assessment.

What tools to use for assessment?



Language-background questionnaires such as the LEAP-Q, BLP, or LUQ can document acquisition, proficiency, use, and sociolinguistic context for each language. For aphasia assessment, the BAT and adapted versions of the CAT support structured comparison across languages. The assessor should have high proficiency in the language or work with a qualified interpreter prepared for the task; being a native speaker alone does not guarantee valid administration (Paradis, 2011; Siyambalapitiya & Davidson, 2015; Alani et al., 2024).

Check the norms and validation of the specific language version: norms established with another population speaking the same language are not automatically appropriate; their relevance must be examined for the task and the person.

Clinical case: Sarah

For Sarah, consider whether an assessment reflects Mexican Spanish, her education and her cultural context: norms established with another Spanish-speaking population do not automatically apply to her.

When a suitable standardised assessment is unavailable, translating a test is a starting point, but direct translation alone does not establish equivalent difficulty or validity: the results must be interpreted cautiously and are not equivalent to those of a standardised test (Paradis, 2011). Adapt the tasks linguistically and culturally, document the changes and interpret unvalidated versions descriptively (Lorenzen & Murray, 2008).

Testing people in certain languages or dialects may seem very difficult; however, this is what we should strive for in order to avoid the normalisation of rehabilitation in the majority language only. The ITC Guidelines (Nguyen et al., 2024) provide a framework for systematic adaptation of assessment tools.

In the case of assessments adapted by ourselves, with or without the help of a family member or interpreter, these will not be standardised and must be interpreted with caution.

A scoping review of 135 studies on language assessment in bilingual and multilingual aphasia shows why such assessments are often hard to interpret and compare: only 31 studies defined bi/multilingualism, language profiles relied mostly on self-report, the assessor's language competence or the involvement of an interpreter was inconsistently reported, and only five studies reported certified interpreters (Favis et al., 2026). The practical implication: record in every report each language's profile (history, proficiency and use before and after the stroke), the language in which each task was given, who administered it and what language support was used. The studies routinely supplemented standardised batteries with non-standardised tasks; this is therefore common practice, provided it is described and the results are interpreted descriptively. The review maps current practice; it does not validate tools or norms.

Overall assessment of the person

Beyond the assessment of language, executive functions, memory, and attention must also be assessed. These domains highlight the relevance of multidisciplinary care and collaboration.

Neuropsychological expertise can help clarify cognition. Interpret results in relation to education, culture, testing language and the person's language history; monolingual norms are not automatically applicable. Document language-related responses and departures from standardised administration, and interpret adapted tasks descriptively unless their validity has been established (Goral & Lerman, 2020; Nguyen et al., 2024).

Clinical case: Sarah

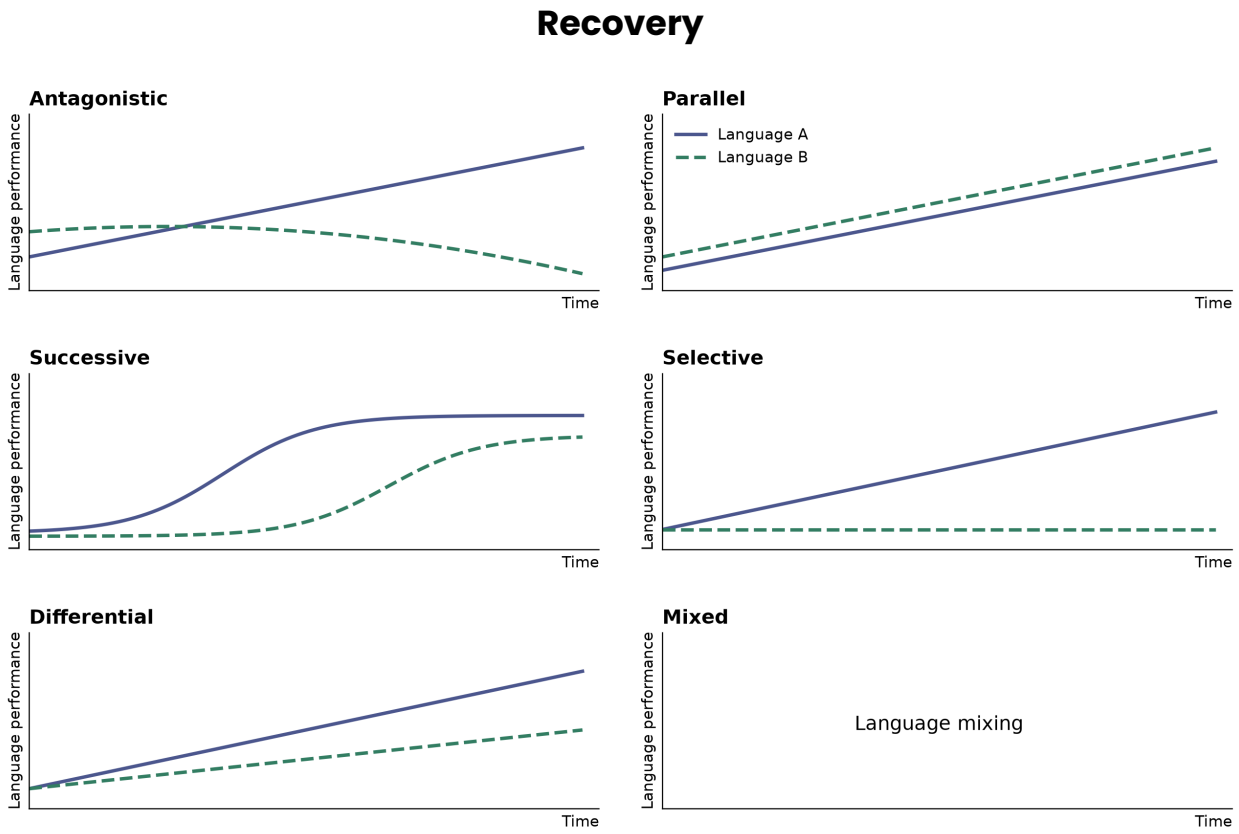
Review Sarah's existing neuropsychological assessment when planning care. It describes planning and working-memory difficulties and relatively preserved inhibition. Reassessment depends on the current clinical question and any change in her presentation, rather than being automatically required or ruled out.

Note that calculation disorders and social cognition difficulties are not investigated here.

Take-home points

- Assess each language that is relevant to the person, including the exploration of nouns and verbs as well as connected speech.
- Check the validation and norms of the version used; a direct translation is a starting point, not an equivalent test; a translated or adapted version is interpreted cautiously and descriptively.
- Keep the conceptual score separate from standardised scores; record adaptations, the language of administration and the language support used.
- Interpret cognitive results with caution: monolingual norms do not automatically apply.

4) Intervention



Illustrative recovery patterns based on Köpke (2013) and Lorenzen and Murray (2008); individual outcomes vary.

Following aphasia, the recovery trajectory of the different languages spoken by the person will vary greatly from one individual to another (Kiran & Roberts, 2012). Whether these languages were spoken at the same level before the stroke or not, this situation may be quite different after aphasia. The best-spoken language before the stroke may not be the same afterward.

Different recovery patterns are possible (Köpke, 2013; Lorenzen & Murray, 2008):

• parallel recovery, where the different languages are recovered simultaneously

• selective recovery, where recovery is observed in one language but not another during the period assessed.

• successive recovery, where one language improves before the other.

• antagonistic recovery, where one language begins to recover, then the progress fades in favour of another language.

• differential recovery, where the different languages begin to progress at the same time but not at the same rate.

• mixed or blended recovery, in which languages may become intermingled. Distinguish involuntary mixing that disrupts intended communication from habitual, effective multilingual practices.

Most descriptions of recovery patterns come from bilingual cases, although reports involving more than two languages also exist and can show more complex patterns (Filiputti et al., 2002).

Use recovery profiles to describe observed changes rather than predict individual outcomes. Monitor every relevant language and adjust the intervention to the person's participation goals and measured response.

The primary caregiver can provide us with valuable information about the progress observed in the different languages, especially those we do not speak.

Clinical case: Sarah

For Sarah, monitor English, Spanish and French directly. Intervention may produce different changes in each language, and gains in untreated languages cannot be assumed.

Cross-language generalisation

Cross-language generalisation is possible when working in a single language, although it is neither systematic nor predictable for a given person.



Lexical and orthographic similarity between languages can influence recovery and transfer, without guaranteeing them (Edmonds & Kiran, 2006; Goral & Lerman, 2020).

Clinical case: Sarah

If we work in French with Sarah, progress in English or Spanish may follow, but it is not guaranteed: measure the effects in all three languages directly rather than inferring them from their similarity.

Cross-language generalisation has been reported, but its size and direction vary across people, tasks and treatments. Proficiency and use, language similarity, control processes, trained items and treatment characteristics may interact. Measure transfer directly rather than assuming it (Goral et al., 2023; Lee & Faroqi-Shah, 2024; Russell-Meill et al., 2025).

Treatment in L1 or in an early-acquired language often produces good gains in that language. Some studies report broader generalisation after treatment in L2, whereas others find better outcomes in the stronger language: the direction of generalisation is mixed across studies. There is therefore no universal rule that treating L1 or L2 will produce better recovery or more transfer. Choose the treatment language from the person's goals, premorbid and current proficiency, daily use, linguistic distance, access to partners and materials, cognitive profile and response to treatment, then monitor every relevant language (Goral et al., 2023; Lee & Faroqi-Shah, 2024; Marte et al., 2025).

Generalisation can be asymmetric: it may appear in one direction but not the other, and the direction cannot be inferred from order of acquisition alone. Monitor treated and untreated languages regularly, then adjust the intervention plan to the changes observed.

Relative proficiency and everyday exposure may influence recovery and transfer, but multilingual profiles are rarely perfectly balanced and change over time (Ansaldo & Saidi, 2014; Goral & Lerman, 2020). Gains and cross-language generalisation have been observed after semantic treatment delivered in either language in Mandarin–English bilingual adults (Li & Kiran, 2023). When intervention in a preferred language is unavailable, a language used regularly in daily life is therefore a practical choice; outcomes in all priority languages still need to be measured.

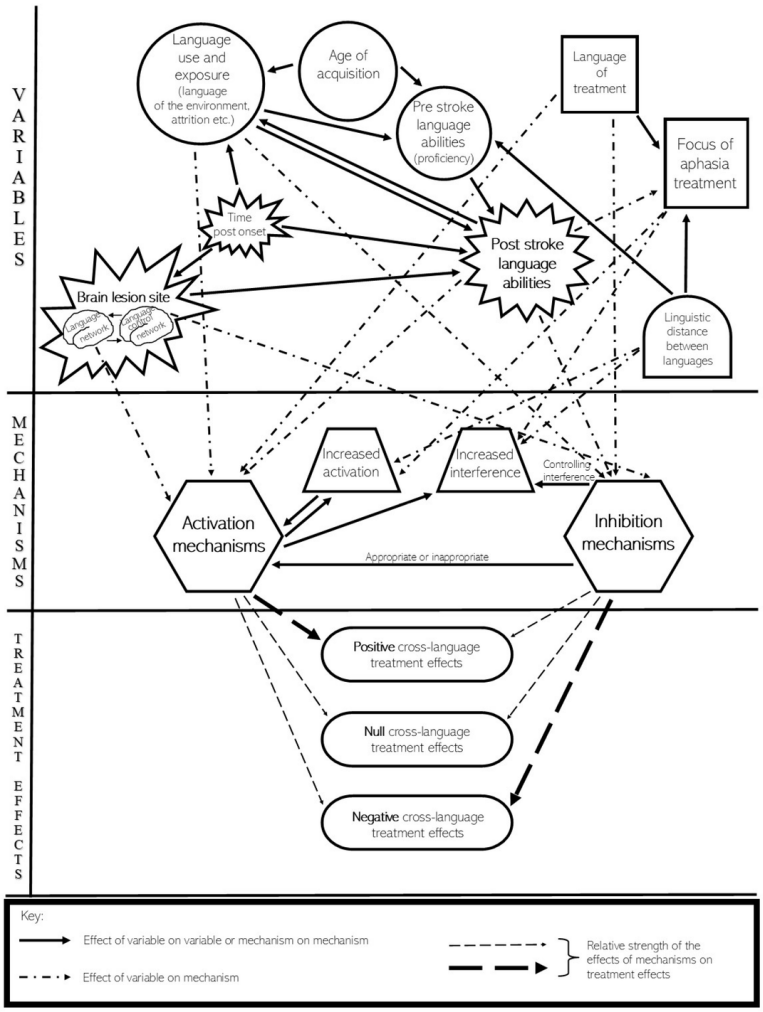
Can the best treatment language be predicted? A double-blind randomised trial tested this with 48 Spanish–English bilingual adults with chronic aphasia (Kiran et al., 2026). For each person, the BiLex computational model simulated the response to treatment in each language from three parameters: age of acquisition of the second language, exposure to and use of each language, and severity of impairment. Participants then received 40 hours of semantic treatment, either in the language the model recommended or in the other language. Naming gains in the treated language were similar in both groups; generalisation to the untreated language was actually greater, but more variable, in the group treated in the non-recommended language (47 people in the randomised analysis; exploratory subgroup analyses qualify this result). For the clinician: these parameters remain worth documenting, but no tool yet identifies the "right" language. Treating the language that the person's goals, partners and resources make feasible is a defensible choice, provided progress is measured in both languages.

Intervention approach

If the person wishes to recover a language that we do not speak, a “classical” approach can be offered while incorporating considerations for stimulating the desired language, using a translator or technological tools, for example. We will develop this further in the tool.

Similarly, when the different languages are worked on at the same time, there are several ways to proceed.

Multilingual people living with aphasia may have language deficits influenced by abnormalities in the processes of activation and/or inhibition of languages (Goral & Lerman, 2020). The Treatment Effects in Aphasia in Multilingual people (TEAM) model proposed by Goral & Lerman (2020) helps explain the interactions between the different domains to consider during intervention with a multilingual person living with aphasia. The TEAM model allows all these factors to be taken into consideration and better understand the influence of the type of intervention according to the person’s recovery profile.



TEAM model reproduced from Goral and Lerman (2020), Behavioral Sciences, 10(9), 144, under CC BY 4.0. https://doi.org/10.3390/bs10090144

Impact of executive functions on intervention choices

Consider executive and language-control processes alongside goals, language history, everyday communication and service resources when deciding how to organise intervention (Goral & Lerman, 2020).



When a person has difficulty controlling their languages (involuntary switches, frequent interference), do not conclude straight away that only one language should be treated. Two arrangements are possible: structured work in one language at a time, or work that lets the person move between languages. Try the one that best fits their goals and communication habits, observe the response, then adjust. Neither language-control difficulties nor broader executive weaknesses are enough, on their own, to decide how many languages to treat (Gray & Sandberg, 2026).

A decline in one language while another improves calls for reassessment of language performance and the intervention plan; it does not by itself establish executive dysfunction. Cognates may facilitate retrieval or cause interference, so test their effects individually.

When language control is preserved, separate or integrated multilingual practice may be feasible. Match the approach to the person's habits and communication goals, monitor outcomes and adjust. Respect habitual, functional language mixing; no single executive score determines which languages to treat.

Clinical case: Sarah

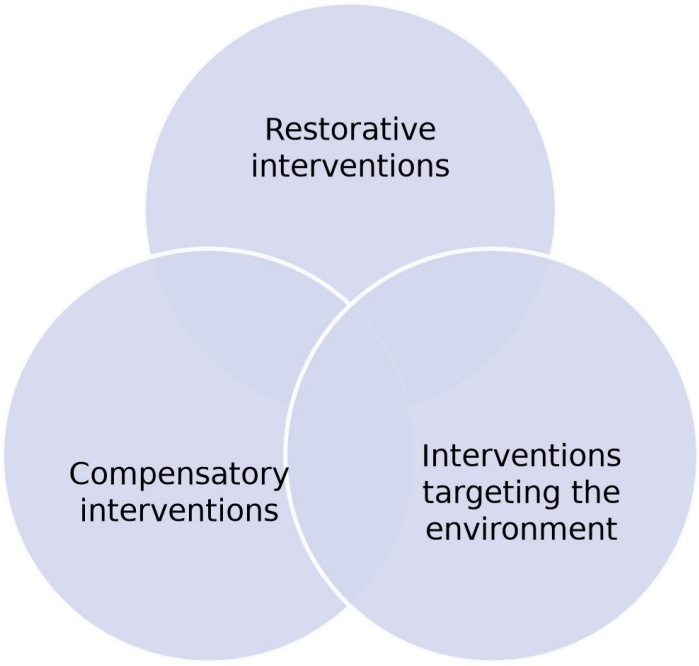
Sarah's planning and working-memory difficulties do not by themselves establish a language-control impairment. Her habitual mixing of English and French, relatively preserved inhibition and participation goals support considering more than one language, with direct monitoring. Check the effects of cognates individually because they can facilitate retrieval or create interference (Kurland & Falcon, 2011; Lerman & Malcolm, 2025).

Types of intervention

There are several types of care for multilingual people; the important thing is to adopt a person-centred intervention and adapt to the person receiving the intervention: the person before us is not monolingual, so the care cannot be the same as for a monolingual person, even if we choose to work in a single language.

Furthermore, as always, the care offered will vary from one multilingual person to another. Each person is different, as are their abilities and needs.

The diagram below groups the usual interventions that can be offered in the field of aphasia, in a single language, in different languages simultaneously, or in one language after another.



Restorative, compensatory and environmental approaches can be combined.

We find restorative interventions, which, depending on the case, can target anomia, comprehension, morphosyntax, etc.; compensatory interventions which involve implementing communication and/or clarification strategies, including the use of AAC; and interventions targeting the environment through partnership with communication partners.

Let us now move on to some examples of methods and strategies that can be used with multilingual people living with aphasia. This non-exhaustive overview does not negate the effectiveness of other therapies. Most restorative interventions were developed for monolingual people and were subsequently studied in multilingual populations. We will develop different sections on interventions targeting naming, syntax, discourse, and executive functions.

Intervention targeting naming

Semantic Feature Analysis (SFA) therapy (Boyle, 2004) was first developed for monolingual people living with aphasia to work on naming and was later studied with multilingual people (Kiran & Roberts, 2010).



SFA can improve trained items and, for some profiles, transfer to semantically related items or another language; this transfer is variable (Kiran & Roberts, 2010; Lee & Faroqi-Shah, 2024). Prioritise functional items because directly trained words are generally those that improve most. Frequency, imageability, language similarity, and cognate status may influence cross-language generalisation without guaranteeing it (Goral & Lerman, 2020; Lerman, Edmonds & Goral, 2019).

Abstract Semantic Associative Network Training (AbSANT) targets abstract words and related semantic networks (Sandberg & Gray, 2020). Verb Network Strengthening Treatment (VNeST) targets verbs and associated agents and patients (Edmonds & Babb, 2011). These approaches require individual adaptation; the cited studies do not establish universal multilingual transfer.

TAbSANT (Translanguaging Abstract Semantic Associative Network Treatment) is an adaptation of AbSANT. In AbSANT, the person works on abstract words linked to a theme (for example, university): sorting words by theme, selecting then checking semantic features of each target word, giving a synonym, then naming as many words from the theme as possible, all in one language (Sandberg & Gray, 2020). In TAbSANT, the same steps are carried out in a translanguaging context: the person and the clinician use both languages freely during the session, which places fewer demands on language control. In two Spanish–English bilingual people, TAbSANT was at least as effective as single-language training; one participant, whose language control was impaired, improved only in the mixed-language context (Gray & Sandberg, 2026). For the clinician: difficulty with language control is not a reason to impose a single language; mixed-language practice can be tried and its effects measured. Two cases do not allow conclusions for all profiles.

Semantic treatment can improve trained words and may benefit related items or other languages. Transfer varies and should be measured directly (Kiran & Roberts, 2010). A shared conceptual system does not guarantee recovery in every language.

Focus on Switch Back Through Translation therapy

SBTT may be considered when involuntary language switching obstructs the person's communication goals. It has been described in a single bilingual case study, so its usefulness should be evaluated individually (Ansaldo, Saidi & Ruiz, 2010).

SBTT uses translation as a compensatory route back to the intended language. If a response comes in the other language, a cue such as "which means…" invites the person to translate it. The cue is given in the intended language and can gradually become a gesture (Ansaldo, Saidi & Ruiz, 2010; Ansaldo & Ghazi-Saidi, 2011).

This approach presupposes relatively preserved translation ability, which should be checked first. The aim is an increasingly self-managed communication strategy, rather than eliminating all language mixing.

Strategies to facilitate naming work in a language we do not speak



Technological tools may support naming work in a language the SLT does not speak, for example by helping prepare candidate words or pronunciation models. Automated output must be checked by a proficient speaker, qualified interpreter, or another reliable language resource before it is used clinically.

Offering family members the opportunity to participate in interventions, notably to verify the person's response or to give them the correct answer for an item in a language we do not speak, is also a valuable strategy. Explain clearly that the aim is to take part in the intervention, not to take on the therapist's role: their help must not change the dynamics of their relationship with the person, and it does not replace an interpreting service.

Intervention targeting syntax

At the syntactic level, cross-language generalisation may be more likely when the targeted structures are shared across languages, but evidence is limited and highly dependent on the person and language pair. No syntax treatment has yet been validated specifically across all multilingual people with aphasia (Goral & Lerman, 2020).

When working on sentence production or comprehension, it is interesting to check whether the languages spoken by the person share the same syntactic structure. For example, in a simple sentence, Spanish, French, and English share the same structure (Subject + Verb + Object).

We will then need to proceed by trial and error to propose sentence types as suitable as possible for the person's profile. Knowing this, different options are available for working on syntax.

Strategies to facilitate syntax work in a language we do not speak



Verified recordings in the target language can provide models of sentences and intonation. Choose functional phrases with the person and have a proficient speaker or qualified interpreter check linguistic accuracy before clinical use.

These voice recordings can be made by an interpreter or a family member of the person, with sentences recommended by the family member and/or previously chosen by the person and us. This support can also allow the person to practise at home, alone or with their family members.

Intervention targeting discourse



Discourse intervention can support functional communication. Improvement in an untreated language has been reported, but its direction and extent vary across people and tasks (Lerman, Edmonds & Goral, 2019).

Video Implemented Script Training for Aphasia (VISTA) uses a video model to practise personally relevant scripts (Grasso et al., 2019). Adjust speed and linguistic complexity, and involve the person and relevant partners in writing the script. Gains are clearest for trained scripts; transfer to new content or another language is variable and should be measured.

Discourse work can notably be done through script training prepared with the help of a family member or interpreter. The SBTT mentioned earlier can complement the intervention, depending on the person's needs.

ECoLoGiC-Tx (Expanding Communication and Language Opportunities Generated in Conversation Treatment) is a conversation-based intervention: sessions are built around conversations on topics chosen by the person and meaningful to them, rather than around prepared items. In its bilingual version, both languages are welcome: code-switching, translanguaging and translation are treated as natural communicative choices, and the intervention takes account of the person's linguistic and sociocultural history, language preferences and real-life contexts. Two people (Hebrew–English and Yiddish–English) improved on formal tests, in functional communication and on patient- and family-reported measures, and the gains were largely maintained six weeks later (Neumann et al., 2026). For the clinician: conversation in the person's own languages can be a treatment target in itself, without requiring a single language. This is a two-person case series with no control group, and effects on conversation itself were not measured directly.

Strategies to support discourse in a language we do not speak

Among the strategies for facilitating discourse work in a language we do not speak, it is for example possible to use the many videos available in all languages on the internet to work on comprehension, production, and conversation.

Interventions for severe aphasia

For severe aphasia or co-occurring apraxia, choose approaches according to the person's profile, goals and abilities. MIT and PACE are options to consider, rather than automatic prescriptions. For MIT, use suitable, verified models of functional phrases (Marchina et al., 2023). Also consider multilingual AAC with relevant languages, vocabulary, images and partner support; check access and usability with the person. (Dietz et al., 2020; Hung et al., 2023; Mitchell & Baker, 2024).

Furthermore, Promoting Aphasia Communication Effectiveness (PACE) therapy (Davis, 2005) is a method that uses multimodal communication to convey information without constraints on how it is done. This therapy can be used in collaboration with the person's family members, who can reuse this technique in daily life. Additionally, the family member can help us distinguish between jargon and a word said in a language we do not speak.

Intervention targeting executive functions



When language-control difficulties co-occur with executive-function impairment, cognitive intervention may be considered alongside language treatment. Evidence is preliminary and does not establish improvement across all languages (Culicetto et al., 2025).

If the most relevant language is not accessible to the clinician, treatment in another language combined with support for control processes may be a pragmatic option. Language choice and tasks should remain functional and individualised, and effects in untreated languages must be measured directly rather than predicted.

Strategies to facilitate executive function work in a language we do not speak

Multimodal instructions, demonstrations and accessible response formats can support executive-function tasks in a language the clinician does not speak. Check that language comprehension does not obscure the cognitive skill being assessed or practised.

When we wish to limit the stimulation of language functions during executive function work, non-verbal exercises can include more motor dimensions, such as card sorting tasks (for attentional flexibility), action sequences (for planning), or non-verbal go/no-go tasks (for inhibition).

Note: Alexia - Agraphia

This tool focuses on the oral dimension of aphasia. This choice does not negate the fact that a large proportion of people living with aphasia have an associated alexia and/or agraphia.

Written language also occupies an important space in our daily lives: each of us is exposed to numerous messages, emails, and written elements on social media.

When the person is multilingual, it frequently happens that their family lives in different countries or different continents. Distance can make written language all the more important.

When exploring the person's written abilities, it can be useful to compare the different languages, particularly to take into account questions of transparency at the grapheme-phoneme correspondence level (e.g., Spanish is more transparent than French or English).

Intervention with family members



Communication partners can have an important role in care, according to the person's wishes. Ask whom they want involved, what support is helpful and when private discussion or independent interpreting is preferred. The therapeutic alliance can thus include relatives, depending on the person's preference, cultural appropriateness and context (McGrath & Schultz, 2024).

Partners can help describe the person's communication habits, preferences and understanding of aphasia. Ask about the individual's experiences and beliefs rather than inferring them from cultural-group membership. Use this information to adapt explanations and support participation.

Collaboration with family members can take the form of Communication Partner Training (CPT), which involves sharing the SLT's communication strategies with the family member (Simmons-Mackie et al., 2010). Modelling the use of communication strategies can facilitate smoother exchanges. Especially in a context where the person living with aphasia does not find their L1 in their living environment, the family member becomes an even more privileged communication partner. This method is particularly relevant in the context of multilingualism; giving the dyad effective communication strategies is essential.

Involving the family member also has the advantage of giving the SLT the opportunity to demonstrate the competencies of the person living with aphasia in front of their primary communication partner.

Intervention with Sarah

For Sarah, the choice of items to work on in naming and word–picture matching was made with her partner. She chose useful everyday items and was able to inform us about their habits: the couple always calls a baguette "baguette," even in an English sentence. It would therefore not be ecological to expect a different response than "baguette" during naming work in English. As Sarah progresses, these expectations can change and the English word can be worked on so that Sarah can communicate appropriately with English-only speakers.

For naming work in Spanish, choose pronunciation models checked by a proficient speaker or qualified interpreter. Automated pronunciation can support preparation, but must be verified before use.



Sentence practice with Sarah can focus on useful everyday phrases. Her partner can record verified English models; Spanish models should be prepared or checked with a proficient speaker or qualified interpreter. Choose techniques from Sarah's assessed abilities and goals, and monitor phrase production and functional use.

Later in the care process, discourse in Spanish was worked on with an interpreter.

Home practice



Home practice can increase opportunities to use languages the clinician does not speak (Nichol et al., 2022). Choose accessible, functional activities and verified materials with the person and their partners. Check the burden, engagement and outcomes, then adjust. Adapt the amount and type of support to the individual. Checking in at each session on what worked well, on any barriers and on the goals, to make sure they still match the person's priorities, supports collaboration and engagement between sessions (McGrath & Schultz, 2024). Free tools can help, such as Aphasia Therapy Online (12 languages, no sign-up).

Home practice for Sarah

Sarah appreciated being able to work at home; she likes feeling like an active participant in her own care.

To work on her comprehension in Spanish, we can advise Sarah to watch videos intended for people learning Spanish. The dialogues are simplified and non-verbal cues are more numerous. Adding subtitles could help stimulate her reading abilities.

Furthermore, with her partner who attended the sessions, Sarah can revise the items worked on in naming using the images she takes home. For Spanish, she can also practise on her own with Aphasia Therapy Online.

Take-home points

• No universal rule identifies the language to treat: decide from goals, proficiency, use and resources.

• Generalisation to an untreated language is possible but not guaranteed: measure progress in each relevant language.

• Difficulty with language control does not on its own mean treating a single language; respect habitual, functional mixing.

• When we do not speak the language: draw on verified technological tools, relatives, an interpreter and home practice.

5) Collaboration with an interpreter or a translator

Working with an interpreter

Speech-language therapy requires understanding what the person says and analysing how they say it, including linguistic productions in their cultural context. Access to a qualified interpreter who is prepared for the specific demands of speech-language assessment and intervention is a service responsibility and an equity and safety requirement when the clinician does not have sufficient proficiency in the relevant language (Langdon & Saenz, 2016; Larkman et al., 2023; Alani et al., 2024).

For effective intervention, it is useful to organise a meeting before and after in order to make the most of the interpreter's presence. It will also be important to inform them about speech-language therapy practices and our expectations regarding the interpretation.

The frequency of collaboration with the interpreter will depend on the person's needs.

Do people who need an interpreter receive the same care? An integrated synthesis of two Australian research programmes shows that they do not: assessment or intervention not offered in all languages, inconsistent use of interpreters, mood less often assessed, less access to some evidence-based therapies, longer stays and less independence at discharge (Mellahn et al., 2026). These gaps stem largely from organisational constraints, especially limited time for clinicians and interpreters. For the clinician, there are two implications. In practice: request an interpreter systematically, plan time to brief and debrief, adapt materials, and offer these people the same assessments and interventions as others. In the service: report unmet needs, because these barriers cannot be removed by individual clinicians alone. A collaboration tool for speech-language therapists and interpreters was perceived as useful by those who used it; its efficacy has not been shown in a controlled trial.

Why meet the interpreter before the meeting with the person?



It is important to meet the interpreter beforehand to provide them with information about the person, about aphasia, and to inform them about the session's proceedings. This will also be an opportunity to discuss the specific instructions for the person. It will also be necessary to remind them of the importance of reporting all the person's errors to us and not giving them any additional cues, whether verbal or non-verbal.

It will also be necessary to agree on how we wish the interpreter to translate. "Consecutive interpretation" seems more suited to being attentive to the person's non-verbal cues.

Why meet the interpreter after the meeting with the person?

After the session with the person and the interpreter, taking stock will help improve future collaborations. Adjustments can be discussed so that the people, the interpreter, and we can benefit even more effectively from this collaboration in the future.

A short briefing and debriefing can clarify roles, tasks and observations. Hold these discussions at dedicated times to keep the person included. During the encounter, address the person directly and maintain eye contact while the interpreter conveys their responses. Check understanding throughout.

How to find an interpreter?

Depending on the country and place of practice, interpreting services are available in different formats: the exchange can, for example, be done only by telephone or by making an appointment a week in advance. In some countries, it is also possible to be put in contact with an interpreter through embassies or through peer-support associations or organisations working with immigrants.

In France, for example, there is the association Inter Service Migrants (ISM) Interprétariat in Paris and the Réseau Louis Guilloux in Rennes, which both offer a medical-social interpreting service. In other countries, similar services may be available through local healthcare networks or community organisations.

When a qualified interpreter is temporarily unavailable, verified translation or text-to-speech may provide limited support and can bypass written language. These tools and interpretation by relatives do not replace the service's responsibility to provide a trained interpreter when the clinical situation requires one. Document each occasion when interpreting was not available and report it: this record supports advocacy for more resources at the institutional level.

Working with Sarah and an interpreter

If the clinician has insufficient proficiency in both English and Spanish, arrange qualified interpreting in each language when clinically required. Sarah's partner can contribute history and support practice, but does not automatically replace an interpreter. Ask Sarah about her preferred language and who she wants present, including for sensitive discussions.

The interpreter came once a week to work on Spanish. The entire session was then translated: greeting phrases, instructions, and interactions during the exercises were all communicated through the interpreter.

In this teaching example, about one session a month focuses on Sarah's feelings and priorities in daily life. She prefers discussing sensitive difficulties in Spanish with an interpreter so that she can speak independently of her partner, who also supports her at home. Ask about this preference rather than assuming that a relative should interpret.

Translations and adaptations



Translation is also an area to explore; when we have materials mainly in one language, these materials can be translated and adapted to be used with a person who does not speak that language.

Adaptation can be prepared with a translator or a person who is proficient in the relevant language and culture. The aim is not word-for-word translation, but conceptual, linguistic, cultural, and difficulty equivalence across versions. Automated tools can help prepare a draft, but clinical content must be checked before use (Paradis, 2011; Fyndanis et al., 2017).

Adapting exercises takes time and a sound understanding of the target language. Linguistic objectives, cues, distractors, and difficulty do not remain equivalent automatically after translation. Describe any locally adapted version as non-standardised, check it with someone proficient in the language and culture, and refine it from the person's responses.

What is translation versus adaptation?

Translation transfers meaning between languages. Adaptation also considers linguistic structure, culture, use and task difficulty to support appropriate care; a translated activity is not automatically equivalent to its source. Consider the following features:

- Syntactic differences: Languages can have very varied grammatical structures (Example: Word order (SVO in French vs SOV in other languages))
- Phonological complexity: Some languages have longer words or more complex phonological structures.
- Reading and writing: Linguistic opacity: Some languages have regular grapheme-phoneme correspondence (e.g., Spanish), while others are more opaque (e.g., French or English).
- Cultural pragmatics: Language behaviours (gestures, politeness, ways of telling a story) can vary widely between cultures.

Key principles for adapting materials

Learn about the target language, including its phonology, writing system, syntax and relevant cultural conventions. Work with proficient speakers or qualified interpreters to check linguistic and cultural suitability. Consider the person's literacy, language history, use and goals. Test, document and adjust the adaptation; local checking does not establish standardisation.

Take-home points

• Working with a qualified interpreter is a service responsibility and a matter of equitable care; document and report each occasion when one is not available.

• Plan time before the session (goals, roles, vocabulary, materials) and after it (debrief).

• Address the person directly; ask for complete rendition, errors included, with no added cues.

• Adapt materials rather than translating word for word: aim for linguistic, cultural and difficulty equivalence.

6) Points for reflection

Unconscious bias and structural barriers can affect access to care. In interviews with eight Black people with aphasia in the United States, participants described concerns about respect, inclusion and whether healthcare providers heard their voices (Brown & Azios, 2025). Ask each person about their own experiences; do not infer them from cultural-group membership. Language, migration, socioeconomic circumstances and citizenship can create interacting barriers to participation (Canadian Council for Refugees, n.d.).

These accounts support attending to respect, inclusion and communication access in practice. They do not establish that cultural sensitivity alone improves clinical performance. Explore the person's preferences and address barriers to equitable participation (Brown & Azios, 2025).

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Resource links

Select the appropriate language version and check its validation, norms and reuse conditions before clinical use. Some sites require browser verification or may change; this list does not certify that every link was accessible on the same date.

The multilingual aphasia resource / La ressource sur l'aphasie multilingue

https://michelemassontrottier.ca/aphasie-multilingue/

Language Experience and Proficiency Questionnaire (LEAP-Q)

https://bilingualism.northwestern.edu/leapq/

Bilingual Language Profile (BLP)

https://blp.coerll.utexas.edu/

Language Use Questionnaire (LUQ)

https://www.bu.edu/aphasiaresearch/files/2019/09/Kiran_LanguageUseQuestionnaire.pdf

Bilingual Aphasia Test (BAT)

https://www.mcgill.ca/linguistics/research/bat

Comprehensive Aphasia Test (CAT)

https://www.routledge.com/Comprehensive-Aphasia-Test/Swinburn-Porter-Howard/p/book/9780367761615

Tradaphasia

https://tradaphasia.hypotheses.org/

Aphasia Therapy Online

https://www.aphasiatherapyonline.com/

ISM Interprétariat

https://ism-interpretariat.fr/interpretariat-en-sante/

Réseau Louis Guilloux

https://rlg35.org/

HAS interpreting guidance / Référentiel HAS sur l'interprétariat

https://www.has-sante.fr/jcms/c_2746031/fr/interpretariat-linguistique-dans-le-domaine-de-la-sante