Therapy Weekly April 11 2002: FEATURE AND HARD EVIDENCE 7

Of dialects and syntax

Sean Pert and Carol Stow have devised a set of assessment tools that are tailor-made to meet the complex speech and language needs of Rochdale's large Pakistani community

It's official - bilingualism is an advantage. It says so in the Royal College of Speech and Language Therapists' professional standards[1], and when packing to go on holiday this summer many people will be thinking "I wish I could speak Spanish/Italian/Greek".

We work with a large Pakistani heritage community. The reality of day-to-day life means that their language skills are often ignored and denigrated; their bilingualism viewed as a problem rather than as an advantage.

Not only does this mean a bleak future for Urdu phrase books but also a real threat to the culture of this population, and a lack of support for families that experience a communication disorder.

Rochdale is an old mill town in Lancashire, not the first place you think of as the centre of a thriving bilingual community.

Yet, in fact, 17 per cent of Rochdale schoolchildren are bilingual, speaking 35 languages in addition to English.

Currently 12 of those languages are represented on our caseload. The majority of our clients and their families reflect the distribution of languages in Rochdale, speaking Mirpuri (a distinct dialect of Punjabi), Punjabi, Urdu or a combination of these. Crucially, most pre-school children from this community are monolingual in their mother tongue.

It is, therefore, essential to be able to identify and subsequently remediate communication disorders in the mother tongue.

In contrast, the assessment of English skills is at best peripheral and at worst irrelevant to this large, potentially bilingual group of pre-school children.

Despite this the catalogues, although full of assessments aimed at assessing in English, are bereft of bilingual assessments designed for our local community, Clearly, the identification of language disorder must precede the remediation process.

Rochdale is unusual in that all bilingual children referred to the speech and language therapy department are directed to two specialist clinics staffed by two therapists and three co-workers.

We are two white monolingual English-speaking clinicians. Our professional activities would prove impossible without the skills of our bilingual co-workers, who provide translations at a standard often much more detailed and complex than that required in other health settings.

Additionally, they also provide a cultural link, which enables us as clinicians to appreciate the belief systems and reality of daily life for our clients' families.

We thrive on shared ideas and debate. Discussion between the coworkers (who share languages but not mother tongues) reveals both similarities and differences between the languages. This has, for example, allowed us to make a claim for the poorly understood Mirpuri variant of Punjabi as a separate language.

Close links with other support services offering input to this community enable us to build up a database of information, including details of linguistic profiles and religious affiliation.

Armed with this information we decided to devise a set of assessment tools - something that is taken for granted in most community clinics.

The essential difference was that these assessments would be tailor-made to meet the needs of the community, not merely translated from the English assessments already available.

The first outcome is an assessment of early language, "je zindegi", which employs culturally appropriate colour photographs; although still in a trial version, the assessment is producing encouraging results[2].
It is envisaged that the assessment scoring system will be based on the language structures employed by local bilingual children; it will reflect the developmental pattern of the main languages spok. en - the exact language we wish to and, where appropriate, remediate.

This could not be said of assessments translated from English, which do not address grammatical
Appear in Mirpuri, Punjabi and Urdu.

We have carefully compared and contrasted the languages and dialects, identifying differences and similarities, As a result, syntactic and morphological components, including elements not found in English, such as word order and gender be carefully analysed.

We can therefore differentiate "different" from "disordered" and identify those children who truly need our assistance from those who merely have a different language and culture experience.

Remediation in mother tongue is full of challenges. We do not claim as individual clinicians to speak nor fully understand the languages we attempt to remediate.

However, working as a team we are clearly able to pool our skills. We see the co-workers as mother tongue models. As clinicians, we define our role through planning, guiding and evaluating the therapy delivered by our co-workers.

This model removes the clinician as specialist at the focus of the therapy process, and places him or her as guide and consultant. Through this model we hope to provide a quality service in mother tongue and take advantage of the insights of experienced clinicians.

As part of this process we are actively comparing and contrasting English with Mirpuri, Punjabi and Urdu, which allows us to develop therapy targets specific to the language in focus rather than just English targets translated into mother tongue.

For example, all these languages have a set of adjectives which agree with the gender of the noun (and others which do not). This is clearly not a feature of English, and would be missed if a purely English developmental were translated.

The development of language-specific therapy targets has also highlighted syntactic features for our co-workers, who are trained not only to translate, but also to develop their meta-linguistic analysis skills.

The language-disordered child is at the heart of the therapy process.
Therapists who have observed the language remediation soups we suit mother tongue have commented on the children's enthusiasm.

Children engage with the co-workers because the therapy environment matches the child's experience at home; together we have the opportunity to prove that bilingualism is an advantage.

Sean Pert is senior speech and language therapist and Carol Stow is specialist speech and language therapist (bilingualism) at Baillie Street Health Centre, Rochdale.

"We compare and contrast English with Mirpuri, Punjabi and Urdu, which allows us to develop therapy targets specific to the language in focus...

Seventeen per cent of Rochdale schoolchildren are bilingual.

References

[1]Communicating Quality 2- professional standards for speech and language therapists (1996); Royal College of Speech and Language Therapists, London, RCSLT, p150.
[2]Pert S, and Stow C (2001): je zindegi: a speech and language resource for the assessment and remediation of language skills in bilingual children (research edition)