The Assessment of Communication Disorders in Second Language Learners

Évaluation des troubles de communication chez les étudiants de langues secondes

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Abstract

Speech-language pathologists are challenged by the intricacy of assessing and diagnosing communication disorders in bilingual populations. This paper discusses some obstacles preventing clinicians from providing services to multiculturally diverse clients, and explores several key issues which should be considered when working with this population. The paper does not purport to be conclusive or exhaustive, but is rather a starting point for clinicians to examine their own procedures for assessment and remediation of communication disorders in multicultural populations. The need for further research in this area is acknowledged.

Résumé

Des orthophonistes se heurent à la difficulté de diagnostiquer et de traiter les problèmes de communication chez les personnes bilingues. L'article analyse certains obstacles qui empêchent des cliniciens d'offrir des services à des clients aux antécédents multiculturels divers, et aborde plusieurs questions importantes qui doivent être examinées lorsqu'on traite ce genre de client. L'article ne prétend pas être concluant ou exhaustif, mais constitue plutôt un point de départ pour permettre aux cliniciens d'examiner leurs propres méthodes d'évaluation et de traitement des troubles de communication chez les personnes bilingues. Il est évident qu'il faut des études plus approfondies dans ce domaine.

The Canadian population is becoming increasingly diverse. In order to increase Canada's population by just 1%, annual immigration alone must increase from 160,000 to 650,000 (Cummins & Danesi, 1990). The growth in speakers of languages other than English and French will be reflected in the caseloads of speech-language pathologists. It is anticipated that one-third of the clients serviced by Canadian and American speech-language pathologists and audiologists in schools will be children from Black, Hispanic, Asian, and Native North American cultures (Crago & Cole, 1991).

One of the challenges facing speech-language pathologists today is the assessment and diagnosis of speech and language disorders in learners of English as a second language (Mattes & Omark, 1984). The clinician must determine if a speaker presents with communicative differences typical of learners of a second language or with a communication disorder (Damico, 1991; Mattes & Omark, 1984; Ortiz, 1990a). For example, the clinician must determine if language revisions (e.g. "I want..., can I..., I need to..., I want to buy candy") is due to word retrieval difficulty, dysfluency, difficulty organizing text, or the lack of the English label for a target word (American Speech-Language Hearing Association [ASHA], 1984; Juarez, 1983). Identifying the most effective approach to remediation of the communication difficulty will depend on an accurate diagnosis of the problem. Reliable diagnosis therefore is vital in order to ensure that a client's needs are being met.

Canadian clinicians are faced with many barriers that have limited their effectiveness in providing services to multiculturally diverse populations. One of these barriers is the lack of guidance from professional organizations. The Canadian Association of Speech-Language Pathologists and Audiologists presently offers little guidance in this domain. Initiatives are underway, however, with the recent formation of an ad hoc committee to address multilingual/multicultural service issues (Ellis, 1991). Canada would do well to follow ASHA's example of demanding specific training on issues related to servicing multilingual clientele before applicants may qualify for certification in the Association (*Multicultural Resource Library and Services,* 1990). ASHA has also specified criteria for working with speakers of non-mainstream languages in their Code of Ethics (Mattes & Omark, 1984).

Another barrier for Canadian clinicians is the limited coverage given to servicing the multiculturally diverse population in university training programs. This situation may be changing slowly, possibly in response to the increasing political, educational, economical, social, and legal scrutiny of multicultural issues. Recognition of this training need has been more forthcoming in the United States, where resources are presently available from the *Multicultural Resource Library and Services* (1990) of the ASHA Office of Minority Concerns to help universities incorporate multicultural topics into their curriculum.

An additional barrier to effective service is the unavailability of assessment materials in languages other than English. To compensate, some clinicians have translated English tests for use with their clients who speak other languages (Langdon, 1983). While this may yield valuable information regarding the language skills of their clients, caution is required when this option is pursued. First, it is important to recognize that English norms cannot be used when a test has been translated (Erickson, 1981; Evard & Sabers, 1979; Shulman, 1988). Second, translation of a test does not take into account the appropriateness of particular items for speakers from a differing cultural background. Third, translation can alter the difficulty of the items being presented (Miller, 1984b). Paradis (1984) lists various components of test construction that must be controlled in order to maintain the linguistic equivalence in test translation. These include maintaining word length and frequency, maintaining phrase length, ensuring that common consonant clusters in the second language are replaced by equally common clusters in the first language, and maintaining syntactic complexity. Movement away from the use of standardized tests appears inevitable. Other options worthy of exploration include the use of informal measures (Langdon, 1983), curriculum based assessments (Tucker, 1990), and the use of auxiliary personnel (Crago, Annahatak, Doehring, & Allen, 1991). Crago et. al. (1991) suggest that "nonstandardized procedures ought to become the standard procedures, particularly for minority language populations" (p.44).

Ideally, a speech and language assessment should be conducted in the speaker's native language (Health & Welfare Canada, 1982; Langdon, 1983; Ortiz, 1990a; Williams, 1984). Legislation in the United States (i.e., PL 94-142) subscribes to this ideal and mandates that language assessments be conducted in the client's primary language (ASHA, 1981). Consequently, some monolingual clinicians in that country are not servicing bilingual populations at all, for fear of resulting legal action (Juarez, 1983). In Canada, a noticeable barrier to servicing multilingual populations is the overall limited number of clinicians. Of this limited pool, fewer still are speakers of languages other than English or French. This number is further reduced when language proficiency of the clinicians is taken into account (ASHA, 1984). Guidelines outlined by Health and Welfare Canada (1982) strongly recommend that the evaluator of non-native English speakers be a native speaker of that language or have "near native competence."

Proficiency in a second language is not the only criteria required to meet the demands of the multilingual/multicultural population. Knowledge of relevant issues, such as second language learning and language loss, is necessary if the clinician is to service this clientele effectively. For example, a bilingual clinician might assess a client's competency in the native language, but have little awareness of the factors that may have contributed to the loss of skills in that language. A client whose native language skills have deteriorated over time may present with a profile similar to a client with a developmental language disorder. Failure to consider factors contributing to loss of skills in the native language can result in an inaccurate diagnosis. Furthermore, even bilingual speech-language pathologists are likely to be required to provide services to clients who speak languages with which they are not familiar (ASHA, 1990).

The validity of assessments conducted in a client's second language has received considerable attention in the literature. The educational system has been criticized for overidentifying minority groups as handicapped (Cummins, 1984; Fuchs & Fuchs, 1989; Hamayan & Damico, 1991a; Mattes & Omark, 1984; Mercer, 1983; Shulman, 1988; Taylor & Payne, 1983; Williams, 1984). Accordingly, speech-language pathologists must strive to improve the reliability of their assessment methods, by becoming familiar with aspects of biculturalism, bilingualism, and second language acquisition (ASHA, 1984; Cheng, 1990; Cummins, 1984, 1990; Evard & Sabers, 1979; Juarez, 1983; Mattes & Omark, 1984; Taylor & Payne, 1983; Wiener & Heller, 1985).

It is the author's viewpoint that the assessment of communication disorders in children learning English as a second language by speech-language pathologists who do not necessarily speak the client's native language, would be more reliable if relevant linguistic and experiential issues were considered in the evaluation. Some of these issues are presented in Table 1. This list is not conclusive or exhaustive. Rather, it is simply a starting point for speech-language pathologists who wish to examine their procedures for the

Table 1

I. LINGUISTIC FACTORS

1. Reported language skills in the first language (L1).
2. Language Development of the L1.
3. Attrition of the L1.
4. Time exposed to the second language (L2).
5. Expected errors.
6. Motivation/attitude towards learning the L2.
7. Progress in learning the L2 and in acquiring academic skills.

II. EXPERIENTIAL FACTORS

1. Familial.
2. Medical.
3. Social/historical.
4. Previous school experience.

assessment, diagnosis, and remediation of communication disorders in the multilingual/multicultural population.

Linguistic Factors

Reported Language Skills in the First Language

Language disorders affect common processes underlying different surface structures. Therefore, a client with a language disorder will present with the disability in the first language (L1) (Juarez, 1983; Mattes & Omark, 1984; Ortiz, 1990a). In an attempt to determine if a speaker presents with a communication difference associated with second language learning or a communication disorder, the monolingual speech-language pathologist must try to ascertain whether or not the speaker has a language disorder in the native language. Typically then, the speech and language assessment of a non-native English speaker includes some measure of that speaker's abilities in the native language.

The monolingual speech-language pathologist cannot assess a client's skills in the native language directly and therefore must rely on indirect, informal measures. Informants who speak the client's L1 may be asked to report on the speaker's language skills, after having engaged that speaker in a conversation. The informant may be a parent or relative, or someone unknown to the client. The speech-language pathologist also may collaborate with an interpreter or other auxiliary personnel to assess the client's language skills (Crago, Annahatak, Doehing, & Allen, 1991). There are various factors that need to be considered in either approach.

Parent as Informant

A parent interview typically is part of a speech and language assessment. Parents may be asked to comment on how well their child seems to understand and speak the L1. While it is critical for the speech-language pathologist to obtain this information, the following examples from clinical experience suggest that details of parental reports are not always reliable.

Parents who have limited experience with the Canadian culture, and with educational and health care professionals, may find interviews with speech-language pathologists particularly intimidating. In such instances, parents may respond with the answers they believe the examiner is seeking. Additionally, the parents may have views about the role of the educational system that are different from its actual function (Mattes & Omark, 1984). In the Chinese culture, for example, parents often feel ashamed when their children are identified for special academic attention (Cheng, 1991).

The limited proficiency of parents in the language of the interview is another factor that can yield unreliable information. It is often difficult to explain the nature of the communication disorder when the speech-language pathologist and the parents speak two different languages. If available, trained interpreters can be helpful.

Parents new to Canada may have many pressing concerns including immigration, financial, and housing worries. As such, education and remediation of communication difficulties may currently be low on their list of priorities. Immigration matters for example, can be quite complex. As the school system is often seen as an institution of power, parents may be reluctant to share information with school personnel that they believe might negatively affect their immigration status.

Native Speaker as Informant

The judgement of a native speaker other than the client's parents or relatives can be useful in a speech and language evaluation. However, such judgments may need some interpretation. Native speakers who make judgments of language competency usually are not qualified to diagnose a language disability (Mattes & Omark, 1984). This lack of training has been noticed in clinical experience, for example, when native speakers confuse the concepts of "speech" and "language." It is not uncommon to hear obscure comments such as, "His language is okay, he can say all the words clearly", in such an evaluation.

Judgments made by native speaking informants are subjective. In my clinical experience, such informants sometime take the role of an active listener and unknowingly fill in the gaps in the child's linguistic expressions. When this occurs, the child will be judged to have better expressive language skills than he/she really does. While evaluations by native speakers can be extremely informative, the speech-language pathologist needs to be prudent and not base their diagnosis only on one such judgment. Additional measures are necessary.

Collaboration with a Native Speaker

The involvement of native speakers in collaboration with the speech-language pathologist may be a very effective way to establish a client's linguistic skills (Cummins, 1984; Crago & Annahatak, 1985; Crago et. al., 1991; Taylor & Payne, 1983). There are at least two forms of collaboration. In the first, the speech-language pathologist assesses the client and discusses the findings with the native speaker in order to obtain validation regarding the client's language skills. The second is to involve the native speaker directly in an assessment.

Native speakers working with speech-language pathologists must receive sufficient training if they are to collaborate effectively (Ortiz, 1990b). The speaker also must be aware of metalinguistic factors associated with the language being assessed, testing and clinical procedures (ASHA,

1984), and must avoid giving the client clues inadvertently (Shulman, 1988). Speech-language pathologists also need training to be able to instruct paraprofessionals appropriately (Cheng, 1991). They should learn how to access the services of interpreters efficiently (Ortiz, 1990a; Yates, 1973). Langdon (1983) suggests that the clinician requires the following: (1) knowledge of the dynamics of the interpretation procedure; (2) the ability to plan and execute pre- and post-test conferences with the interpreter; and (3) the ability to help interpreters follow ethical practices.

Language Development of the Native Language

Children who present with language disorders often have a history of delayed language development. Therefore it is important to question parents about the child's language development. Parents may or may not be able to answer specific questions. Depending on circumstances, parents may have been preoccupied with providing for the child's basic needs, rather than charting language development. Sometimes the parent has not been the primary caregiver and may not know the information requested. In some instances, a case history may suggest the reason why language developed slowly (e.g. frequent ear infections, complications at birth, etc.) and may allow for a more reliable diagnosis of the communication problem. For many children however, few explanations are available.

Attrition of the Native Language

An assessment of a child's speech and language abilities in the L1, whether obtained directly or indirectly, must be interpreted with caution. It is not uncommon for children to experience a loss in the L1, especially if there is little opportunity to use the L1 (Hamayan & Damico, 1991b; Mattes & Omark, 1984). The L1 may be replaced gradually by the dominant L2, a phenomenon known as subtractive bilingualisn (Cummins, 1984). Cummins (1984) notes that in some respects these children exhibit less well developed language skills than speakers of either language. Interpretation of L1 skills must consider the possibility that reduced abilities may reflect language loss and not a communication disorder. Issues regarding the maintenance and loss of L1 skills need to be considered; these include attitudinal, linguistic, and experiential factors that affect the learner directly or via the family, community, and government (Westernoff, 1990).

Time Exposure to the Second Language

It is generally accepted that minority language children acquire proficient conversational skills in the L2 within two years of arrival in the host country and that the language skills required for educational purposes develop between five and seven years (Cummins, 1984). While this information is valuable and should be considered when assessing language skills, it is a general guideline and does not take into account individual differences in the actual hours that a client is exposed to the L2. The exposure to the L2 may be more limited than expected, due in part to the fact that in large cities people from the same culture tend to live together in the same area. In these situations, a child may be exposed exclusively to the L1 at home (Shulman, 1988), in the community, and with friends. It is conceivable, that the child's only exposure to the L2 is during school hours. Moreover, the student may attend a community school with the other children of the same cultural and linguistic background and, so, may be using the L1 even at school, for example, at recess, lunchtime, and when talking to peers in class. Although these children may have lived in Canada for two years, their exposure to the mainstream language may have been extremely limited. It is important for the speech-language pathologist to consider the amount of time that the student is actually exposed to the second language. Redlinger (1977) presents a questionnaire that includes a measurement of time to outline L1 and L2 exposure in the home. Further research on the application of this procedure in the home and at school should be explored.

Expected Errors

Learners of a second language are expected to make errors (Damico, Oller, & Storey, 1983; Frith, 1983; Hamayan & Damico, 1991b; Miller, 1984a). This is how they test and refine various linguistic hypotheses about the target language (Frith, 1983). Speech-language pathologists must try to differentiate between the errors expected of a second language learner and those that reflect a communication disorder (Juarez, 1983). Cheng (1991) and Ruhlen (1976) describe the phonological and structural elements of various languages that may be used to assist clinicians in understanding why certain errors might be made (Shulman, 1988). The clinician must also be aware of differences in the sociocultural aspects of language use (e.g., eye contact and turn-taking) in order to be able to interpret communication behaviours more accurately (Crago & Cole, 1991; Garcia, 1990; Mattes & Omark, 1984).

Motivation/Attitude Towards Learning the Second Language

Success in acquiring a second language is dependent, at least in part, on the learner's attitude towards speakers of the L2 and his/her willingness to associate with that group

(Gardner & Lambert, 1972; Hamayan & Damico, 1991b; Mercer, 1983). To help the speech-language pathologist differentiate between a language difference and a language disorder, it is important to estimate the child's motivation to learn the second language. Langdon (1983) recommends obtaining parental opinion regarding how motivated their child is to know and learn in another language.

Progress in Learning the Second Language and in Acquiring Academic Skills

The student's progress in learning the second language might be a useful indicator of a language disorder. The amount of support that the student has received should be taken into account in evaluating progress. For example, one would not suspect a communication disorder in a student who is making satisfactory progress after a year of ESL support. However, one might suspect a problem if a student is not making satisfactory progress after three years of support. Academic progress is another measure that is useful in assessment (Ortiz, 1990a). Cummins (1984) maintains that students should show evidence of continuous academic progress towards grade norms over approximately a seven year period. Students with language disorders generally will have difficulty with written language skills (Mattes & Omark, 1984). Consequently, academic progress may be slower for language disordered children learning a second language.

To help establish if the L2 learner's communication skills are within normal limits, language performance can be compared to that of other L2 learners with similar cultural and linguistic backgrounds and experiences (Cummins, 1984; Juarez, 1983; Mattes & Omark, 1984; Ortiz, 1990a; Shulman, 1988). Such comparisons might include an examination of the client's present L1 skills as well as the acquisition of the L2.

Experiential Factors

Familial Factors

Family background needs to be considered in the assessment of a child's language skills. There may be a familial history of communication problems. Changes in the family structure also may affect the child. For example, the family may be in the process of being reunified after a lengthy separation, and there may be new family members for the child to become acquainted with in the new country. Under these circumstances, the child's priority may not be the learning of a new language, or for that matter, a new dialect. In addition, it is important to ascertain not only which languages are spoken in the home, but also with whom (Crago & Cole, 1991).

Medical Factors

Medical factors (e.g., hearing impairments) should be closely examined. The speech-language pathologist should become knowledgeable about childhood illnesses (and their effects) that occur frequently in the child's native country. Thalassaemia and sickle cell anaemia, for example, are common among children from the Mediterranean, Caribbean, African, and Asian countries and are associated with pain and lethargy (Miller, 1984c).

Social/Historical Factors

The social and historical background of a client new to Canada is also important (Cheng, 1990). Some children have spent much of their childhood in refugee camps, while some have witnessed the atrocities of war and political strife. In addition to learning a new way of life and a new language, these children may be trying to cope with complex emotional and experiential trauma.

Previous School Experience

The child's prior learning experience needs to be considered. Schooling varies from country to country and from rural to urban settings. To evaluate the child's previous school experience effectively, the clinician needs to be familiar with the school system of the home country. It may be useful to obtain the child's opinion of the previous school. During one assessment, a student from Africa informed me that the school was next to a graveyard from which offensive odours would emanate, particularly on hot days. This may have had some impact on school attendance and the learning that took place there.

Attendance at school should be verified. It is not uncommon for some children to miss many days of school because of the harvest season, weather, or travelling distance. Finally, the student's progress at the previous school should be considered; it may provide some insight into the child's present progress (Cummins, 1984).

Summary and Conclusion

The identification of communication disorders in minority-language speakers learning a mainstream language is a fascinating and rewarding challenge for the monolingual and bilingual speech-language pathologist. Some obstacles restricting clinical services have been identified and suggestions for establishing a more empowering approach have been presented. In addition, some linguistic and experiential

factors for consideration in a speech and language assessment have been described.

Initiatives that remove or reduce the obstacles discussed need to be explored and encouraged. To this end, two suggestions are offered: First, our professional organizations should mandate that professional training include issues related to the multicultural population. This would require that university training programs revise their curriculum to include pertinent areas of study. Second, university training programs should actively promote awareness of the fields of speech-language pathology and audiology to students of minority-language populations and encourage them to apply for admission into the programs. With more clinicians well-trained in multicultural/multilinguistic issues there will be more opportunities for clinical research in these areas that will expand our knowledge base and also improve our services to the multiculturally diverse population.

The linguistic and experiential factors that affect the speech and language assessment of L2 language learners require further research, particularly the effectiveness of use of interpreter services in assessment procedures, the effects of examiner familiarity on assessment results, and the attrition of the L1 as it pertains to a diagnosis of a communication disorder. Provision of services to the multiculturally diverse population is an area with great potential for professional growth. By embracing the clinical and research challenges of working with this population, speech-language pathologists will be better able to meet the needs of second-language learners who have speech and language disorders.

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