8.4 Issues of Cultural Diversity

Sometimes, a child will arrive in preschool or kindergarten with very little English. Estimates in Texas, for example, are that more than one third of children under the age of 5 speak Spanish as their first language (University of Texas at Austin, 2010). For these children, assessments of their language and speech ability in English will likely place them in an at-risk category, not because they are more likely to *have* a speech or language disability but because their English is insufficiently developed to get an accurate indication, most assessment tools were developed for use with English-speaking monolinguals and thus do not accurately gauge the language of bilinguals, or both. "In the early stages of bilingualism, children's language skills are in flux, so there's a huge range of proficiency in their second-language performance, which makes it difficult to distinguish between typical second-language differences and genuine language impairment" (University of Texas at Austin, 2010). As a result, it is difficult to determine with certainty whether children from linguistically diverse backgrounds have a disorder or whether they are simply exhibiting developmental errors.

Fortunately, early-childhood educators need not worry about making a precise or accurate diagnosis of a speech disorder. It is important, however, to recognize the *possibility* that one exists in order to make a referral to a professional audiologist or speech-language pathologist. One of the factors that teachers and language pathologists have to consider is cultural, because certain speech behaviors that may sound aberrant in one culture may be considered normal in another. Moreover, the fact that a child is learning two languages may have an impact both on the child's speech and on our perception of whether or not it is developmentally age-appropriate. In the case of articulation disorders, as we saw in Chapter 6, most first language learners have acquired the individual sounds of the language by the time they are 5 or 6 years old, but some children will still be working out certain distinctions—producing /l, r, y, w/, for example, may take a little longer. In almost all cases, these persistent substitutions are evidence only of a slight delay and not of a deviance; they do not require remediation. If, however, there are patterns of deviation that are markedly different from other children of the same age, referral to a speech-language professional is appropriate. But what if the child is bilingual and exhibits aberrant pronunciation?

Bilingual children may experience interference between the sound systems of their two languages. As we saw in Chapter 2, although there are many similarities, different languages have different sounds, and those sounds are distributed (or ordered) differently. These differences may contribute to the articulation problems experienced by second language learners. In Mandarin, for example, the only consonants that occur at the end of a word are nasals, /m, n, ŋ/, so it is not uncommon for Chinese children to omit any word-final consonant that is not a nasal. Words such as *bead* and *Mike* might be rendered as bee and my. The Arabic language does not permit word-initial consonant clusters, so Arabic-speaking children might say "fie" for fly or "gain" for grain. These deviations from English pronunciation are developmental errors of the type we saw in Chapters 3 and 4, and remediation is unnecessary. In fact, speech language therapies can be counter-productive for second language learners who need, instead, further exposure and practice with their new language.



**Language differs from culture to culture. Care should be taken not to confuse culturally specific language traits with speech disorders. How would you evaluate a bilingual child's ability in both languages?**

*Randy Olson/National Geographic Stock*

The perception of fluency disorders is also culturally dependent, to a large degree. For example, one researcher has noted, "Asian Americans favour verbal hesitancy and ambiguity to avoid offence. . . . One should respect such a community's culture and thus the hesitancy should not be confused with a fluency disorder" (Kim, 1985; cited in Ndung'u & Kinyua, 2009). There is also a difference in what different cultures believe should be remediated. In North American Cowichan, for example, stuttering is seen by many as supernatural and remediation considered inappropriate. Similarly, there are some Native American communities in which the victim of a stroke is believed to have been "hit by the wind," because the person is out of harmony with nature (Westby & Begay, 2002; Ndung'u & Kinyua, 2009). Such beliefs would affect whether treatment was sought. Unfortunately, most treatments for speech and language disorders are most successful if they are begun early. The preschool years are well within the critical period for treatment since the brain retains its plasticity (Chapter 5), so children who arrive in preschool, kindergarten, or first grade with fluency problems can benefit from remediation.

With bilingual children, we must be extra careful to ensure that fluency orders actually exist since there is a possibility that what appears to be a dysfunction may be only a difference caused by limited proficiency in English. For example, a child who has not yet learned a vocabulary appropriate to her age level in English may hesitate or even stammer as she searches for the words to make herself understood. Similarly, a second language learner may make false starts and use frequent repetitions that impede the flow of speech. For these children, these impediments to fluency are developmental, and speech or language therapy is not recommended. On the other hand, teachers run the risk of not recognizing a speech disorder masked by an accent or a dialect that is markedly different from the teacher's own. The longer a disorder goes undetected, the more difficult it is to diagnose and treat (Guiberson, Barrett, Jancosek, & Yoshinaga-Itano, 2006). It is important, therefore, that someone who speaks their language or dialect assesses the children.

With regard to voice disorders, we know that ". . . voice quality is a language-specific property which may be different across different languages" (Yiu, Murdoch, Hird, Lau, & Ho, 2008) and that cultures vary in the amount of breathiness that is normal or acceptable in speech (Piper, 2007; Mattes & Omark, 1984). It is thus not surprising that the perception of voice disorders is largely culturally determined. For instance, in many African cultures masculinity and femininity are determined by paralinguistic features. A man who speaks in a low volume, a high pitch, or a smooth and slow voice, would be frowned upon and called upon to "speak like a man" (Ndung'u & Kinya, 2009).

Sometimes, the developmental errors that young bilingual learners make are a result of the normal process of learning English. Sometimes, they are indicative of a speech or language disorder. It is important to know which, because the intervention that works for one will not work for the other.

8.5 When to Refer

If a child seems to be significantly behind his or her peer group in language development, then parents or educators should consider the possibility of SLI. One diagnostic tool that professionals use for children between 24 and 36 months is to ask parents to complete a standardized questionnaire in which they identify the vocabulary the child knows and provide examples of two-word sentences that the child uses. "If the child's vocabulary contains fewer than 50 words and the child does not use any two-word sentences, that is an indication of SLI or another language disorder" (Davidson & De Villers, 2012).

Although the first person to suspect that a child might have a language or speech disorder is usually a parent or preschool teacher, it sometimes takes a number of speech-language professionals to confirm the diagnosis. Using assessment tools, often involving the use of puppets or toys to elicit specific language samples such as past tense or plural, they will test the child's speech and language skills. They will evaluate how well the child constructs sentences and whether or not she keeps words in the proper order. They will also estimate the number of words in the child's vocabulary and the quality of his or her speech. Tests are available for use with children between 3 and 8 years old and are best administered and interpreted by speech-language professionals.

Generally speaking, children might have a language disorder and should be referred if they exhibit the following conditions:

* They produce speech in combinations or patterns that are inconsistent with the language they are trying to speak and inappropriate for their age. For example, a 2- or 3-year-old child who says "gangershef" for handkerchief is no reason for concern, but a 6 year old might well be, unless it is an isolated instance and all other aspects of her pronunciation are normal.
* They appear not to understand certain words or categories of words that other children their age understand.
* They appear unable to follow directions or appear to be unaware of the "rules" of conversation by talking out of turn or failing to respond when it is their turn.
* They are significantly delayed in acquiring a number of speech sounds. For example, a child who cannot produce the entire spectrum of English consonants by school age might have a language disorder. Saying "do" for *shoe* or "delly" for *jelly* are perfectly normal substitutions in an 18-month old but not in a 4-year-old.
* They consistently produce shorter sentences than their peers.
* Parents or caregivers of bilingual children report irregularities in the child's first language.

**Entering the Field of Speech Pathology**

**Why Labels Matter**



**By a child's 6th birthday, any potential speech or language disorders should have been diagnosed and treatment begun. Labels, despite their drawbacks, can help ensure success in school and life.**

*Hemera/Thinkstock*

Labels matter. Think about it. You are in a supermarket, and you read the label of a product—say a breakfast cereal. In addition to processed wheat and corn, you see a list of 17 ingredients, none of which has fewer than three syllables, most of which you have never heard of and one of which has received some negative press. What do you do? You probably put the box back on the shelf. What you do not do, usually, is to take the box home and have a closer look or even taste it. But suppose the label says *calciferol*. Never heard of that so it can't be good for you, right? In fact, *calciferol* is just another name for Vitamin D, which won't hurt you and might actually be good for you. What does this have to do with children?

While it is important to identify children with communication disorders and to identify them correctly, that is not the end-point but the beginning. In other words, labeling should not be confused with treatment. Although professionals use labels as a shorthand for talking about conditions and their treatments, there are dangers in labeling. The biggest one may be that it is the *child* who often gets labeled, rather than the *condition*. When it comes to dealing with children with communication disorders—or, indeed, any learning or cognitive disorder—educators need to focus not on changing the child but on helping the child overcome or cope with the condition. With children, we have to look beyond the label.

Although it is important to identify communication disorders early, it is also important what happens next. Labeling a child as having a particular disorder does not make the disorder disappear, nor does it mark the child as deficient in some way—the child may have a condition that sets his learning on a different path. But the purpose of diagnosis and intervention is to help the child either work his way back to the more commonly traveled path or, if that is not possible, to smooth the way along his own path. In no way should the child with a communication disorder be viewed as deficient. Labeling a child in a particular way, while useful for professionals in understanding and discussing treatment, has inherent dangers (see *Advantages and Disadvantages to Labeling*).

**Advantages and Disadvantages to Labeling**

Labels are sometimes useful and almost always unavoidable. Educators need to ensure, however, that any labeling is done only to the child's benefit and, above all, that labeling is not harmful.

**Advantages**

* Labels enable professionals to communicate with one another because the diagnostic labels convey general information about the nature of the disorder. When we hear that a child has a fluency disorder, for example, we know that her stream of speech is affected in some way but that her comprehension is unaffected.
* The human mind seems to require some kind of categorical shorthand—a mental "hook" to think about and solve problems. It is easier for educators to think and talk about the causes and treatments for SLI than to use many sentences to describe the disorder. If the label did not exist, one would quickly be created to take its place.
* Labeling a disorder can raise social awareness and assist in advocacy efforts.

**Disadvantages**

* Labels may shape teacher expectations. If a child is labeled as language delayed, it may be tempting to assess all the child's behavior in that context when, in fact, all children have some troubling behaviors.
* Labels imply that the problem is with the child and may lead us to forget that the job of a teacher is to teach the child as is. Teaching and learning are interactive processes.
* Labels refer to categories of disorders and are abstract. Children are real and they are individual— no two children are the same even though they may have the same condition. No two stutterers are alike, and no two children with SLI will exhibit exactly the same behaviors.
* Diagnostic labels may be unreliable, but once they are in place they are hard to remove.
* Ch. 8 Conclusion
* While the course of language learning is normally a seamless and seemingly effortless task, there are children who experience delays or deficits in the process. Communication disorders are among the most commonly reported conditions requiring intervention reported in the U.S. public school system, collectively affecting up to 20% of the population at some time during childhood. Speech disorders are those affecting the oral language a child produces, consistently and over time. Language disorders affect a child's ability to process language and may be either productive or receptive. The causes for communication are as varied as the disorders themselves—some have physical causes, some are associated with other cognitive disorders, and some have no known cause. For the early-childhood educator, it is important to recognize when children might have a communication disorder, not to put a label on them but to ensure that they get appropriate intervention that will help them improve or to overcome the disability. Fortunately, the prognosis for many children with communication disorders is excellent if the disorder is recognized and the appropriate intervention is begun early enough.