THE CHALLENGE OF LANGUAGES TO SPEECH THERAPISTS IN INDIA*

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This paper is nofiUtsearch report; it only intends to underline a problem faced by Speech and Hearing therapists in India, and to indicate some tentative solutions to this problem unique to us. The stimulus for this paper came from the enquiries received by us for Speech and Hearing therapists. Many of them insisted that the person should be a native speaker of the language spoken in the area. It seems to be a tacit assumption that it is essential for a Speech Pathologist and Audiologist to be a native speaker of the language his cases speak. Corder (1966) assumes that the therapist is himself 'of course normally a native speaker of the language of his patients'. Corder was writing in the British Journal of Disorders of Communication and his assumption might be very valid in the U.K. Can we automatically transport that assumption to India? No. This assumption is not valid in India, not at least at present and as I see it, it will not be in the foreseeable future. The reasons for this are many and we will look at them later. Can we at least assert that though the therapist is not a native speaker he should at least be well versed in the language? Should we insist on this at the time of employment as is being done in several places? The answer again is no, not reasonable. Am I saying that knowledge of the language of the cases is not useful to a therapist? No, not at all. It is extremely useful and hence desirable; but it is not always possible to achieve and it is not essential.

The conditions that make this difficult to achieve are many. India is known for the diversity of its languages. What is often ignored is the fact that most of the Indian cities are cosmopolitan and a multitude of languages coexist in all cities. There is a great mobility of people across state boundaries and a mixing of languages is a necessary outcome. Speech and hearing problems are not the monopoly of any one language. That means that any therapist working in a city can realistically expect to have to work with cases from any language spoken in the city which actually means any Indian language. Would it then be realistic to expect any therapist to know all those languages! And nobody is a native speaker of all those languages! Even in a comparativaly small conservative city, Mysore, we have had to work with twelve different languages spoken by people residing in the city. If we include cases from out of the city the number goes higher. I have had most of my education and spent most of my life in the city of Mysore. And I do not know all those languages! The situation in larger cities must indeed pose a greater problem.

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If we insist that a therapist be a native speaker of the languages his cases use we in Mysore would have to appoint at least twelve different therapists. While this high number of therapists could be made available in an All India training institution such as ours, how many centers can be expected to do so? We need not feel despondent because as I said earlier we need not insist on a native speaker as a therapist. It is not realistic to so insist.

There is another difficulty and that *is in* terms of therapists not being available in all parts of the country so that cases w ih various languages can approach therapists near them. This, if possible, would make therapy in the cases language more feasible. The present situation is far from this. There are very few speech and hearing therapists in the country today and still fewer speech and hearing centers. There are whole states which have .no speech and hearing therapy facilities and even in those states where these facilities are available they are very scarce and can be called only nominal. Even many teaching hospitals and some with post-graduate teaching in E. N. T. do not yet have the services for Speech Pathology and Audiology.

It is at present difficult to imagine that one day all cases needing these services will have these facilities available. Letus try this task for size. There have been many surveys conducted to guage the prevalance of speech and hearing problems. Among the most conservative estimates i*s* six per cent. If we accept that six per cent of our population have speech and hearing problems needing professional attention, that gives us an astronomical figure *o*f 33 million out of a population of 550 million. How many therapists will be need to help these 33 " o n people? A speech and hearing therapist can at best work with ten cases per day and even if he on alternate days he can work with twenty cases at a time. Even if we assume that on sees his cases the average the cases need o month for effective therapy a therapist can help 240 cases in a year. Even if we boost this figure to 300 cases 13 ten years a therapist can help only 3000 people with the. kinds of therapy given now. Even if we suggest that only half of our cases need therapy this would mean that 5000 therapists will be needed to work for ten years to treat them. This also assumes that there will be no addition to these cases in ten years. At present it does not seem possible that we will be able to produce that many therapists nor that we can appoint them in the next ten years. The present output of therapists in the country is 17 (Mysore)+15 (Bombay)+3 (Ahmedabad). 35 per year. Employment absorption of these is at present not even that fast.

Nor can we honestly expect cases to travel back to places where therapy in their own languages is provided. India is a land of distances and these distances become greater here because of the inability of people to afford to traverse them.

This just means that for a long time to come each therapist will have to accept the responsibility for a large population speaking a variet of languages. Each therapist has to face the fact that he has to give therapy to cases with whom he does not share a language. This is something that all of us must accept as a reality.

If we reject the alternative of ignoring those cases who do not share a language with the therapist available to them we have but one alternative left. We have to do therapy in languages that we do not know and it is for us to develop techniques of therapy for such an endeavour. We must in our training programmes equip our students to handle therapy in languages not known to them.

Now we have the crucial question: Can this be done? One of our students surprised his interviewers by suggesting that therapy can be given without a common language between the therapist and the case. Surprise us it might; but his assertion is correct. And therapy has to be given willy nilly.

When we consider the functions of a speech and hearing therapist from this point of view we soon recognise that audiometry, hearing aid selection and fitting, ear mould making and diagnosis of voice problems, and functions not dealing with cases, are functions that do not apparently make essential a common language. However the functions of diagnosis of other speech and language problems, counselling and therapy apparently demand direct involvement of language and would apparently make it very difficult to progress without it. It is for these functions that we have to find alternate means.

Diagnosis can be viewed in two mutually dependent parts—the etiologic and the descriptive. The etiologic diagnosis is made with the help of medical personnel, the case history and direct examination and by an observation of the detailed descriptive diagnosis. The case history can be easily taken by using an interpreter who may be the parent or hospital assistant and by using limited language which can be memorized or written down in the therapist's language. If there is a language shared between the therapist and the case moderately efficiently this can be used at this stage even if therapy has to be given in a different language, the mother tongue of the case.

The descriptive diagnosis which is most useful in defining initial behaviour and hence in planning the course of therapy poses a different kind of a problem. The therapist in this case can utilise his knowledge of linguistics and he can compare the speech of the case with that of the case's parents or escorts. This is in fact more valid than absolute evaluations resorted to hy some therapists and more valid than even a comparison of the case's speech with that of the therapist when he speaks the same language. Considering the existence of dialects and inter-group variations the parents, siblings or escorts of the case are the most valid norms for descriptive diagnosis. Responses from the case can be elicited through modelling and through miming. That we can achieve all this with cases with severe hearing loss, proves this can be done. The therapist can use his trained ear and knowledge of linguistics to mark the deviations and then to discern the patterns in the deviations exhibited by the case.

Counselling involves giving the cases and parents an explanation of what is deviant in the case, an indication of the available approaches to rehabilitation and their comparative merits, mapping out the plan of action in terms of therapy

and motivating the parents to follow our advice regarding the rehabilitation. The same modes of communication as are used in diagnosis can be used to counsel the cases. In addition to this, prepared counselling sheets or instructions can be handed over to the parents detailing the possible approaches to rehabilitation and their own responsibilities in following them.

Therapy poses a greater challenge and techniques of therapy need to be developed. Our greatest resources in terms of therapy lie in the parents, in the home of the case. It is becoming more and more evident to us that the best therapy, particularly in India, is that which we do not have to give. The situation in India already briefly described makes it incumbent on us to provide techniques which eliminate or reduce the dependence of the cases on direct intervention by the therapist. If the therapist can pass on the responsibility of actual therapeutic activity to the parents and takes up the responsibility mainly for special assistance and continued guidance then he will be able to handle more cases at a time than estimated earlier. This will also help the cases who cannot attend therapy away from home for long periods. Speech therapy is a slow process and takes time and this often keeps a case from seeking expert assistance. When this assistance is kept minimal and is finished in a short time it will be more economical in terms of time, effort and money both for the case and the therapist. In addition to all this, therapy at home from parents under the guidance of the therapist will reduce the need for the therapist to know the language in which therapy is given. The therapist can diagnose the case, plan out a strategy for therapy and pass this information on to the parents. He may even demonstrate therapy to them so that they can follow up with the therapy at home.

In many cases the therapist may have to provide the initial therapy and demonstrate the techniques of therapy. The initial modifications can be made by the therapist and the later systematic programme can be laid out in simple terms for the laymen to follow. In voice cases the therapist may obtain the optimum voice and leave continued therapy and stabilization to the cases or their family and friends. The parents can then contact the therapist continually for guidance and assistance with specific difficulties.

The therapist can acquire a limited language by asking others and use it in this initial therapy stage. He can, during or before therapy, obtain samples of the desired speech patterns or words, and in therapy, use them. He can use previously prepared flash cards. Even as therapy proceeds he can acquire a basic vocabulary which will help him gain more and more command over the language gradually.

The therapist can use interpreters to communicate with the case, and if necessary with the family of the cases. He can indicate to the parents what is desired and they can elicit the responses under his guidance.

He can provide therapy through mime.

He can elicit responses and indicate modifications through analogues. He can use pictures and illustrations.

He may demonstrate the desired changes and have the case follow him.

Reinforcements can be given tangibly or with easily understandable gestures and words.

Some kinds of instructions can be taped in advance and played to the cases and their parents.

There is nothing new in these techniques. These are being used with the deaf who have no language. Tapes have been extensively used with the laryngectomees. New languages are taught through recordings. What is now needed is enough imagination to use these or modifications of these to meet this challenge of therapy to cases with whom we do not share a language.

This can be done; but we must be aware that it can be, and we must be prepared for this challenge.

In actual practice what may happen is that within a short time through exposure to the local languages and through faltering attempts in the therapy situation most therapists will quickly learn enough of the languages they deal with and the need for such techniques may diminish. The challenge of languages would grow weak.

The training programme at the All India Institute of Speech and Hearing provides some attempts at meeting this challenge of languages. We have so arranged our syllabus that all our students will know English, Hindi, Kannada and at least one other Indian language. We are encouraging the students to be exposed to as many languages as possible. We expect this array of languages should stand our students in good stead in most parts of the country.

We are also exposing our students to practical therapy with cases with whom they do not share a language. They are trying out the techniques.

In addition to this we are giving our students a fairly strong background in linguistics so that they can use this in linguistic analyses of other languages and of the deviations in the cases. This linguistic knowledge and their experience should also help our students in charting out the programme of therapy for each case.

We are also trying out a variety of therapy techniques. Our hopes are to evolve simple techniques which can easily be followed by laymen at home. The use of sophisticated equipment in complicated techniques may provide great face validity; but their real utility at best can be only in the initial stages of therapy. What we need are efficient but easily followed techniques. We are also trying out new techniques of therapy to be used with cases who do not share a language with the therapist. These have to be developed in the near future.

We are now convinced that it is necessary and possible and that new techniques have to be and can be developed to suit the special needs of the country. This needs the concerted effort of all people concerned.