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How Graduate Experience Changes Beliefs in Working with Culturally and Linguistically Diverse Populations: A Survey Study

By

Stephanie Cyrice Bové

A Thesis Submitted in Partial Fulfillment of the

Requirements for the Degree of

Master of Science

in

Communication Disorders

Minnesota State University, Mankato

Mankato, Minnesota

July 2018

June 28, 2018

How Graduate Experience Changes Beliefs in Working with Culturally and Linguistically Diverse Populations: A Survey Study

Stephanie Cyrice Bové

This thesis has been examined and approved by the following members of the student's committee.

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Abstract

Speech-language pathologists work in a variety of settings that require savvy transitions between patients from many cultures and backgrounds. Graduate students may get little practice working with culturally and linguistically diverse populations depending upon where they perform their practicum and internships. Researchers at a mid-western university developed a survey to collect student perspectives regarding cultural competence. A single cohort received the survey at three intervals to track a change in responses from the beginning of their first year of graduate school through their clinical fellowship. Students took a Multicultural Issues class between their first and second survey responses. Data collected surveys were analyzed to discern whether there was a significant difference in student perceptions of their competence, knowledge, and beliefs from pre- to post-course responses. This paper attempts address changes in students' perceptions of working with culturally and linguistically diverse populations after completing the Multicultural Issues course.

Acknowledgements

I would first like to express gratitude to my thesis advisor Dr. Bonnie Berg for her engagement and feedback throughout the years. Her door was always open to me for support and counseling in the process of developing this master's thesis. Her confidence in me continually fueled my progress in research and writing.

Furthermore, I would like to thank Dr. Sheen Chiou and Dr. Megan Mahowald for introducing me to the topic, offering their guidance, and sharing resources that informed every chapter of this work. Also, I would like to thank all the faculty in the Communication Sciences and Disorders department for demonstrating the importance of this topic in the provision of health services. I am incredibly grateful for the values and knowledge this process has instilled in me.

I would like to thank my amazing family and friends, who have supported and believed in me throughout this process. You've encouraged me in every step of my academic journey, reassured me in the most difficult times, and inspired me to reach for and attain my goals. I am truly indebted to you all.

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Chapter 1

Introduction

The field of Speech-Language Pathology provides professionals the opportunity to work with individuals from a wide variety of backgrounds in educational, medical, and clinical settings. Working with people who speak multiple languages and/or who have diverse cultural backgrounds, tasks speech-language pathologists (SLPs) with the responsibility of developing ways of providing services that meet their needs in potentially nontraditional ways. SLPs may need to use interpreters, learn bits of other languages, become familiar with cultural traditions and differences, alter assessment protocols, and redesign intervention methods to address therapy goals. Effective SLPs do all of this and build rapport with clients and their families, sometimes with minimal common language. Considering continuously changing demographics, both regionally and nationally, it is important for the field of speech-language pathology to address how graduate programs prepare clinicians for work with culturally and linguistically diverse (CLD) populations.

Students coming from all backgrounds will have biases that affect their clinical judgement, how they perceive information, how they communicate with clients and families, and their approach to treatment. It is not revelatory that the academic process offers students opportunities for expanding their worldview. College campuses typically expose students to diversity and require them to analyze information from different perspectives, as part of the educational mechanism, without requiring students to take courses directly addressing cultural or linguistic differences. However, beyond every day encounters on a diverse campus, students need experiences designed to connect their beliefs regarding diversity to their future careers in health services. Graduate experiences that target ethical service delivery and multilingual language development are meant to

force students to consider the perspectives of CLD populations seeking services.

Graduate programs should train clinicians to use evidence-based practice in their

assessment and treatment approaches. Graduate programs have an obligation to ensure

that students are prepared to work with diverse populations under a variety of

circumstances. This paper aims to address the influence of a Multicultural Issues in

Speech-Language Pathology course on students' beliefs in working with diverse

populations through the analysis of pre- and post-course survey data.

Learning objectives for the students aimed to meet ASHA Standards IV B, C, D,

E, F, and G, which were listed in the syllabus for referral (ASHA, 2016). Multiculturalism

was defined and interpreted in application with concepts and scenarios within the field

of communication disorders. The Multicultural Issues class covered three major areas of

practice with an emphasis on cultural competency. First, the instructor reviewed

foundational knowledge and skills necessary for work with CLD populations. She then

outlined and analyzed typical language learning and impairments in diverse populations

with application of assessment and intervention. Last, the instructor presented

information pertinent to neurological issues in bilingualism related to aging. Students

were asked to apply concepts from the course to research projects and presentations

throughout the four-month class.

Some important components of graduate studies and practice that begin to

address clinical competence with CLD populations include understanding the American

Speech-Language and Hearing Association (ASHA) Code of Ethics as a framework for

practice, cultural safety, and cultural competence. While SLPs' backgrounds inform their

practice and shapes their personal beliefs, ASHA's Code of Ethics provides a foundation

that guides SLPs through biases to service that does not discriminate against differences

(2016). Understanding how to create an environment that is culturally safe for clients

provides SLPs with the tools to build rapport and better serve the client and family. Understanding how to develop cultural competence provides graduate SLPs with skills that support service to larger communities with a more comprehensive approach to evaluation and treatment.

Demographics of Culturally and Linguistically Diverse (CLD) Populations

Before addressing current immigration statistics, there are several forms and definitions of culture to note. Culture is defined in a wide variety of ways and each definition is influenced by the field that definition comes from. Kohnert's widely recognized definition of *culture* is "… the shared, accumulated, and integrated set of learned beliefs, habits, attitudes and behaviors of a group or people or community … the context in which language is developed and used and the primary vehicle by which it is transmitted" (as cited by the International Expert Panel on Multilingual Children's Speech, 2012, p. 1). This definition focuses on "social heritage or tradition," "subjective culture (ideas and knowledge shared in a group)," and "social culture (shared rules of social behavior, institutions: Chiu & Hong, 2006)" as the primary influencing factors (Cohen, 2009, p. 195). Therefore, this paper will refer to cultural diversity as an indication of differences in beliefs regarding social behavior, habits, and knowledge as they pertain to health services.

Statistics regarding immigration at the national level include estimates of documented and undocumented immigration numbers. The Center for Immigration Studies (CIS) (2017) and Zong, Batalova, and Hallock (2018) reported that "13.5% of the population," or one in every eight U.S. residents, are immigrants. Adult immigrants were reported to have had nearly 16.6 million U.S.-born children in 2016 (CIS, 2017). The Current Population Survey (CPS) from 2017 showed that 27% of the population are immigrants and their US-born children (as cited by Zong et al., 2018). These numbers

indicate an increasing need for multilingual support across health services. Emphasis should be placed on ensuring that all, who present a need, are served competently.

Language can create a barrier in health service that many people find difficulty overcoming. Statistical data focuses on the language(s) spoken in the home. Data collected in 2016 indicated that 78% of the population speaks only English, while 22% of U.S. residents speak a wide variety of languages, including: Spanish, a Chinese language such as Mandarin or Cantonese, Tagalog, Vietnamese, Arabic, French, and Korean (Zong et al., 2018). This is in addition to many other languages that make up less than 2% of the population. The Navajo language is spoken by an estimated 170 thousand speakers in the U.S. (Burton, 2018).

The U.S. is widely recognized as a nation of immigrants, referring to the fact that the majority of its citizens are either recent immigrants or their following generations (Pearson, Newlson, Titsworth, & Hosek, 2017). It is important to acknowledge that the largest source of cultural diversity in the US population, continues to be immigration. Colonization was the initial source of Central America's largest shift in diversity. Native Americans had their own aspects of cultural and linguistic diversity before Europeans settled here. However, the arrival of Europeans introduced profound cultural differences to the Americas. With the influx of immigrants and the rise of technology over the past 400 years, a greater number of cultural differences have begun to seem less extreme in the overall population. Exposure to a variety of cultures became common with the advent of television, the internet, and social media. Now, if you have never met someone with a remarkably different culture from your own, it is still likely you have had some exposure to those cultures through media.

Clinical Importance of Beliefs Regarding CLD Populations

The beliefs SLPs hold about a population could potentially impact the evaluation process, and the amount and quality of services provided. Kritikos reported that 40% of participants in her study stated that their recommendations for intervention were different for multilingual versus monolingual students (2003). This potentially indicates a level of discomfort in ensuring accurate assessment for clients, especially children, who experience input with multiple languages. Kamhi's (1994, 1995) work showed that beliefs have a significant impact on clinical expertise. "Asking experienced SLPs to describe factors important to effective therapy Kami (1994) found that SLPs delineated four aspects: knowledge, technical skills, interpersonal skills, and 'clinical philosophies' (i.e., beliefs)" (as cited by Kritikos, 2003, p. 74). While more research needs to be done on how SLPs' beliefs may affect service delivery, research in the last 20 years demonstrates a potential impact on health service for CLD populations.

There is evidence supporting a fluid, tailored, dynamic assessment approach for multilingual clients. "Dr. Elizabeth Peña, Associate Professor at the University of Texas at Austin, has conducted extensive research in the area of dynamic assessment with culturally and linguistically diverse populations" (ASHA, 2018). Cultural competence involves using tools to identify language differences versus possible disorders. "Dynamic assessment (DA) is a method of conducting a language assessment which seeks to identify the skills that an individual child possesses as well as their learning potential" (ASHA, 2018). The DA process allows SLPs the opportunity to work with a multilingual client, teasing out their knowledge and adaptability. Dynamic assessment typically involves testing the client, teaching terms or concepts, then testing the client's ability to adapt to instruction and generalize the meaning of what they have learned.

A lack in cultural competence may deprive clients of culturally accurate interpretations of behaviors, skills, and deficits. Initially, beliefs may impact the SLP's perceptions and interpretations of behavior such as arriving on time to appointments, lack of eye contact, volume of speech, acceptance of touch, and conversational turn-taking. Behavior and communication styles are heavily influenced by culture. Multilingual children may not initially understand the directions or process of assessment, but given appropriate time and instruction, their skills and accuracy can be identified and measured.

Ethical Obligations

One important reason to strive for cultural and linguistic competence is, of course, that it is our professional obligation to provide high quality service that reflects our code of ethics. ASHA published an article in 2017 titled, "Issues in Ethics: Cultural and Linguistic Competence." ASHA details the principles and rules within ASHA's Code of Ethics (2016) that directly pertain to services for CLD populations. For students, learning about the Code of Ethics is one of the first times future SLPs are introduced to the concept of cultural and linguistic competence. ASHA states, "Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations" (2017). Studying these documents provides students the opportunity, and obligation, to begin imagining how they need to proceed as team members and therapists with CLD individuals.

The principles and rules in the Code of Ethics (2016) provide professionals with the structure for developing a therapeutic practice in the field. The first principle of ASHA's Code of Ethics tells us that SLPs are responsible for ensuring that the client's well-being is at the center of practice. While culture and race can be sensitive topics, it is

important to address these issues in our communication with clients and families. We cannot provide competent services if we do not understand what the client's wants, needs, and goals for therapy are. The rules of Principle I that speak directly to service of a CLD population are:

A. Individuals shall provide all clinical services and scientific activities competently.

B. Individuals shall use every resource, including referral and/or interprofessional collaboration when appropriate, to ensure that quality service is provided.

C. Individuals shall not discriminate in the delivery of professional services or in the conduct of research and scholarly activities on the basis of race, ethnicity, sex, gender identity/gender expression, sexual orientation, age, religion, national origin, disability, culture, language, or dialect. (ASHA, 2016)

The second principle is vitally important in this discussion. It dictates our responsibility to realize the highest level of competence and a commitment to maintaining clinical competence through continued education. These standards emphasize that no matter the setting, SLPs are responsible for using evidence-based practice by staying up to date with research. Working with CLD populations requires that SLPs learn bits of foreign languages, work closely with interpreters, and gather information on the linguistic needs of a patient they may not be able to communicate easily with. This is a vital piece of practice with CLD populations in the field of speech-language pathology. If we neglect to reach out and work hard to educate ourselves adequately for assessment and intervention with a person whose primary/only language is not English, then we have failed to provide competent services. This reminds SLPs that

there are educational, environmental, and personal factors that affect a SLP's ability to prepare for work with a CLD client, which may include region of practice, technology available, access to an interpreter, and workplace resources. The rules of Principle II that contribute to this discussion are:

> A. Individuals who hold the Certificate of Clinical Competence shall engage in only those aspects of the professions that are within the scope of their professional practice and competence, considering their certification status, education, training, and experience.

> B. Individuals shall enhance and refine their professional competence and expertise through engagement in lifelong learning applicable to their professional activities and skills. (ASHA, 2016)

Since working with CLD clients requires professionals to work more closely with a diverse group of support personnel, Principle IV is an important piece of the framework puzzle. Principle IV illustrates the expectation of conducting business with respect to the collaborative nature of the profession, emphasizing the development of "harmonious" relationships within the profession and members of a team. Developing good working relationships with other professionals can mean working with colleagues who have a wide variety of differences. The rule of Principle IV that adds to this discussion is:

> L. Individuals shall not discriminate in their relationships with colleagues, assistants, students, support personnel, and members of other professions and disciplines on the basis of race, ethnicity, sex, gender identity/gender expression, sexual orientation, age, religion, national origin, disability, culture, language, dialect, or socioeconomic status. (ASHA, 2016)

Providing competent services to an individual requires SPLs to understand what their deficits are, which skills to build, and how to motivate and empower clients. The aim is to provide therapy that addresses functional goals for CLD clients and incorporate cultural and linguistic competence into practice. Betancourt, Green, Carillo, & Ananeh-Firempong described cultural competence as a process that requires SLPs to continually adapt their practice in response to growing understanding and accommodation of culturally appropriate service (2013). Their thorough explanation of cultural competence highlights the need to be open to cultural differences as professionals. Holding beliefs that inhibit the acceptance of cultural differences is a direct threat to the delivery of culturally competent services.

ASHA advocates embracing these concepts in many recently published articles (Issues in Ethics: Cultural and Linguistic Competence; Cultural Competence Checklist: Policies and Procedures; Cultural Competence: Overview; IDEA Part C Brief: Cultural and Linguistic Diversity; Research with Culturally and Linguistically Diverse Populations: Practice With Little Evidence… etc.). There are hundreds of resources extolling the importance of expanding evidence-based practice for work with CLD populations. "Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations" (ASHA 2017). It behooves SLP graduate students to fully absorb the impact of competency in working with CLD populations beyond clients to families, team members, and organizations.

Purpose

The purpose of this study was to examine data collected from cultural competency surveys given to a graduate cohort before and after taking a multicultural issues class to determine if graduate students' perceptions of working with CLD populations changed.

Three areas of the personal reflections section of the survey were analyzed to measure change. Areas of interest are knowledge of cultural differences, beliefs about working with different cultures, and clinical competence.

Hypothesis

It was generally hypothesized that graduate students' perceptions of working with CLD populations would change after having taken a multicultural class. When comparing class averages of survey responses, from before and after taking the class, there would be a positive increase in students' perceptions of their cultural competence. Analysis of questions specifically targeting areas of interest should also change. First, responses to questions (a, c, d, e, and i) about the students' knowledge regarding cultural differences would change after taking the class. Second, responses to questions (h and a) on the students' beliefs about working with different cultures would change after taking the class. Third, responses to questions (b, d, e, f, g, and i) regarding clinical/cultural competence would change after having taken the class.

Limitations

The known limitations of this study include the survey population size, rate of return, the scope of survey contents, and research reviewed. The survey was designed and distributed to measure perceptions of cultural competence, with a focus on multicultural issues. In the interest of identity protection, participants were not tracked from one survey to the next. Therefore, researchers cannot track an evolution in beliefs or responses for individuals over the course of their graduate program. In respect to this study, the broad questions within the survey make specific findings difficult to interpret or generalize.

Definitions

Culture is defined by Kohnert as "the shared, accumulated, and integrated set of learned beliefs, habits, attitudes and behaviors of a group or people or community … the context in which language is developed and used and the primary vehicle by which it is transmitted" (as cited by International Expert Panel on Multilingual Children's Speech, 2012, p. 1).

Culture has also been defined by O'Hagan as "the distinctive way of life of the group, race, class, community or nation to which an individual belongs. It is the first and most important frame of reference from which one's sense of identity evolves" (as cited by The Royal College of Speech and Language Therapists (RCSLT), 2007, p. 11).

Multilingual is identified as the ability to "comprehend and/or produce two or more languages in oral, manual, or written form with at least a basic level of functional proficiency or use, regardless of the age at which the languages were learned" (International Expert Panel on Multilingual Children's Speech, 2012, p. 1).

Cultural sensitivity refers to the act of recognizing characteristics of behavior that are related to cultural differences and using that knowledge to develop sensitivity in one's interpersonal skills that serve relationships with CLD professionals and clients (Maul, 2015).

Cultural Competence "acknowledges and incorporates—at all levels—the importance of culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs" (Betancourt et al., 2003, p. 294).

Cultural and Linguistic Competence was defined by ASHA as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations" (2017).

Cultural Safety was defined as "an environment which is safe for people; where there is no assault, challenge or denial of their identity, of who they are and what they need. It's about shared respect, shared meaning, shared knowledge and experience, of learning together with dignity, and truly listening" (Williams, 1999, p. 213).

Cultural reciprocity refers to a "posture" in communicative intent, outlined by Kalyanpur and Harry (1999) as involving: "(1) identifying cultural bases for a professional's interpretation of a student's difficulties; (2) discovering whether or not the family shares the bases for this interpretation; (3) acknowledging any cultural differences that may be revealed and explaining the cultural basis for the professional's interpretation; (4) determining ways of adapting professional interpretations to the value system of the family through discussion and collaboration (as cited by Maul, 2015, p. 752-753).

Cultural humility "incorporates a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and non-paternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations" (Tervalon and Murray-Garcia, 1998, p. 123).

Culturally diversity may "incorporate a variety of factors, including but not limited to age, disability, ethnicity, gender identity (encompasses gender expression), national origin (encompasses related aspects e.g., ancestry, culture, language, dialect, citizenship,

and immigration status), race, religion, sex, sexual orientation, and veteran status"
(ASHA, 2017).

Dynamic assessment "is a method of conducting a language assessment which seeks to
identify the skills that an individual child possesses as well as their learning potential"
(ASHA, 2018).

The term *Indigenous* refers to "the original inhabitants of a nation prior to colonization
or migration from other nations" (Speech Pathology Australia (SPA), 2009).

Sequential multilingualism "occurs in people who form solid foundations in the
acquisition of a first language ... before learning additional languages" (SPA, 2009).

Simultaneous multilingualism "occurs in people who are exposed to, and learn to speak,
two or more languages regularly from birth or soon after" (SPA, 2009).

Subtractive multilingualism is defined by Roberts (1995) as "the loss of language(s)
(usually the home language) as other language(s)(usually the dominant language of the
community) become more developed (as cited by SPA, 2009).

Language dominance is defined as "the language that a person is most fluent in.
Language dominance overlaps with, but is not necessarily equivalent to, language
proficiency. It considers the relative importance and use of each language in each of a
person's speaking contexts" *(*SPA, 2009).

Personal efficacy is defined by Dembo and Gibbson (1985) as "involv[ing] beliefs about
one's own ability to change individuals learning and behavior" (as cited by Kritikos,
2003, p 74).

General efficacy is defined by Allinder (1994) as "one's beliefs about the field's ability to
change individuals' learning and behavior (as cited by Kritikos, 2003, p 74).

Chapter 2

Review of Literature

Considering that the purpose of this paper is to analyze pre- and post-course responses to a survey on cultural competence, it is important to incorporate discussions and research on topics of or relating to competence, knowledge of cultural and linguistic differences, and beliefs regarding CLD populations. Research topics focused primarily on competence, cultural safety, issues in assessment, and global approaches to working with CLD populations. Each focus adds depth to the role of beliefs in a SLP's approach to the evaluation and treatment of CLD individuals. Since the subject of clinical competence includes cultural competence, please note that unless otherwise specified, references to "competence" will refer to cultural competence.

Competence

As it relates to this study, competence requires some degree of personal reflection and understanding that allows professionals to identify their strengths, weaknesses, and biases. Tervalon and Murray-Garcia (1998) summarized the work of Todd, Samaroo, & Hoffman, 1993; Todd, Lee, & Hoffman, 1994; Javitt, McBean, Nicholson, Babish, Warren, & Krakauer, 1991; and Friedman, 1994, explaining that "existing literature documenting a lack of cultural competence in clinical practice most reflects not a lack of knowledge but rather the need for a change in practitioners' self -awareness and changes in their attitudes toward diverse patients" (p. 119). Competence encompasses a SLP's ability to participate in professional teamwork with individuals from a client's family, health care team, and community. It requires clinicians to build relationships and work with team members to serve the interests of clients. It challenges SLPs to stand firmly in their role within the health services system, using all means available to serve clients to

the best of their ability. Competence insists that professionals work together to create a respectful environment. SLPs must continually measure their knowledge and understanding of their position within the wider field and their immediate community. This paper addresses competence with a lens attuned to cultural competence, clinical expertise, cultural humility, and efficacy.

In Kamhi's article "Defining, Developing, and Maintaining Clinical Expertise," he contributes to the conversation on competency by addressing gaps in clinical research regarding clinicians and the development of clinical practice. Kamhi conducted a study with 12 experienced clinicians, who were interviewed about what factors they thought were important in providing effective therapy. Kamhi then provided a model of clinical expertise that incorporates self-monitoring skills, knowledge base, procedural/problem solving skills, and interpersonal skills/attitudes. In the initial interview, all clinicians rated interpersonal/attitudinal factors to be more important than technical skills. Based upon interview findings, he concluded that the development of clinical expertise may be "characterized" by the clinician's level of "comfort" in the areas mentioned (1995).

Tervalon and Murray-Garcia expounded on the dynamics between patients and health providers in their article "Cultural Humility Versus Cultural Competence: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education" (1998). They offered evidence to demonstrate that the allocation of health services and resources can be dependent on a patient's race or ethnicity. The authors make a case for approaching clinical competence with the lens of cultural humility. "Cultural humility incorporates a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and nonpaternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations" (Tervalon & Murray-Garcia, 1998, p. 123).

While graduate students are exposed to the concept and importance of continued education, they may be less familiar with the concept of cultural competence. "The equating of cultural competence with simply having completed a past series of training sessions is an inadequate and potentially harmful model of professional development..." (Tervalon & Murray-Garcia, 1998, p. 119). The authors suggest that while the concept of cultural competence can be taught in graduate school, it is a professional's cultural humility that leads them into continued training and research for how to work best with diverse populations.

ASHA provides students and professionals in the field with thousands of resources on the development of competence in practice. In an "Issues in Ethics: Cultural and Linguistic Competence" statement they are noted linking the role of beliefs in cultural and linguistic competence; "The beliefs and values unique to clinical and research interactions must be understood, protected, and respected. Professionals must enter into the relationship with awareness, knowledge, and skills about their own culture and cultural biases, strengths, and limitations" (ASHA 2017). This statement is a powerful endorsement of the need for SLPs to acknowledge how their own backgrounds and beliefs affect service delivery with CLD populaitons.

In an increasingly divisive moment in national politics regarding immigration, refugees, and race relations, it is important that professionals engage fully with the communities they serve. To shy away from addressing our obligations to serve CLD populations effectively, is a discredit to the foundation of service provision. Looking to the foundational mission of the field, Goldstein presses that professionals address all of a client's languages; "[t]he overall purpose of intervention with bilingual children with learning impairment must be to effect positive change in children's ability to communicate in both Spanish and English..." (2012, p. 338). Growing multilingual

populations require professionals to be equipped with the knowledge and skills necessary to provide effective intervention.

There are discussions occurring across the U.S. that engage communities in conversations about language, culture, differences, rights for minority members of a community, and distribution of resources. ASHA has an opportunity to seize this moment and engage the public in ways to ensure better services in health services. It is time to reach out to CLD populations with invitations to be a part of research, contribute to the development of services for their communities, and recruit more multilingual and multicultural individuals into the field. This will generate much-needed data and aid in the development of innovative procedures that benefit SLPs and the diverse populations they serve.

Cultural Safety

The term *cultural safety* sprouted from work with indigenous populations in New Zealand and Australia. Applications of this term and its meaning appear to recognize and acknowledge the negative connotations and outcomes that health services have carried into indigenous populations all over the world. It recognizes the damage that colonization has done and acknowledges the stigma that those in health service positions are powerful and superior, posing a threat to indigenous people. SPA authors are quoted applying this concept in their position paper on working with CLD populations, "measures need to be taken to ensure services can provide culturally safe spaces to engage with all people to deliver culturally appropriate services in their home language that are based upon the best available evidence" (SPA, 2009, p. 8). Maul noted that participants in her study reported being seen as an example for how bilingual children should be treated in the school system. The significance of cultural safety is in the understanding that part of the work of SLPs is to create an environment that fully

embraces and respects individuals' culture and language(s) as a part of their humanity. Williams (1999), Zeidler (2011), and Maul (2015) demonstrate strong cases for the consideration of cultural safety in health services for diverse populations.

Williams (1999) reported that the term, cultural safety, was first developed by Maori nurses, citing work by Eckerman, Dowd, Martin, et al. (1994). She addressed why cultural safety is an important concept to incorporate into health services and how to begin the process. Williams defined cultural safety as an environment "which is safe for people; where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience, of learning together with dignity, and truly listening" (1999, p. 213). She encouraged professionals to face cultural issues head on and carry the conversation into practice.

Zeidler focuses on the idea of cultural safety with aboriginal and first nations peoples within the healthcare system. Her work provides readers with an in-depth account of what building positive relationships with indigenous people can look like. The author interviewed eight individuals, who have firsthand experience working with non-aboriginal professionals, from a First Nation community in British Columbia. She asked two questions of her participants and analyzed the interviews to identify themes. Interviewees were given a chance to respond to the themes and elaborate on them as desired. Zeidler identified nine themes in the analysis of interview transcripts. Themes include suggestions for professionals to connect with the people and place with which they work, cultivate an awareness of the impact of past experiences, and learn about and support the community and their traditions (Zeidler, 2011). Zeidler cites five principles presented by Ball (2007) to promote culturally safe environments: 1) Knowledge of protocols, 2) Personal knowledge, 3) Partnerships, 4) Process, 5) Positive purpose

(Zeidler, 2011. p. 137). Comparing Zeidler's findings to Ball's description of the five principles of cultural safety reveals essential commonalities. Both authors underscore the importance of understanding and respecting culture, finding value in the knowledge of colleagues and families, reciprocating the willingness to learn and collaborate. However, Zeidler pushed Ball's principles even further, encouraging SLPs to integrate into aboriginal communities and allow the community to get to know them personally. This suggests that part of building rapport within diverse communities means a level of mutual trust.

In 2015, Maul published a study of the perceptions and practices of SLPs in working with culturally and linguistically diverse populations. Nine SLPs were interviewed, recorded, and followed up with if needed. Analysis of answers to individual questions yielded four themes: "(1) language as a barrier and as a bridge, (2) working with interpreters, (3) respect for cultural differences, (4) positive interactions with CLD family members" (Maul, 2015, p. 754). While the author cited Williams (1999) and Zeidler (2011), it is the analysis of her interviews that offers insight into the importance of cultural safety in health services.

Maul shared stories from two different SLPs and analyzed the language they used to reveal interesting contrasts between the SLPs approaches to communicating with CLD populations. One SLP used "neutral language" in her story, related attempts to understand the mother's position in an IEP meeting and had a satisfactory resolution to a problem. The other SLP used judgmental and generalizing language, did not attempt to understand, and had no resolution. Maul illustrates how the work of many authors is demonstrated in her study. She noted that the first SLP naturally applied the model of cultural reciprocity outlined by Kalyanpur and Harry (1999) in her communication with the family of her student. The author related this approach to a stance of cultural

humility, in which the SLP leveled the communicative field by attempting to better understand the mother's background without presuming she knew why the mother behaved a certain way. Maul identified that this approach "created a culturally safe environment," as described by Zeidler (2011) (as cited by Maul, 2015, p. 759). These concepts, conveniently fit together here, make evident how beneficial implementing their use into practice can be.

Issues in Assessment

One of the more increasingly common issues we must navigate in service provision for CLD populations includes assessment. In the simplest terms, while there are a variety of monolingual and multilingual assessment tools available, there are caveats to access and use of these tools. SLPs working in schools typically have access to popular tools that are applicable to a high number of students, which may not include CLD students on their caseload. Standardized assessment tools that are culturally and linguistically appropriate for a wide variety of individuals are not widely accessible. Extra time and resources for assessment and intervention are often required as a result of limited access to appropriate assessment tools and bilingual support staff (Kritikos, 2003). As mentioned in Chapter 1, DA requires SLPs to test a student's language skills and learning ability by teaching language and retesting to identify the individual's language learning abilities.

When CLD individuals are referred to a SLP for evaluation, they must be aware of language differences that coincide with cultural differences versus disorders that require our services. In the development of a position paper, McLeod, Verdon, and Bowen identified three main challenges in assessment, "… lack of culturally appropriate tools for assessment, lack of norms for multilingual speech acquisition, and a lack of confidence in differential diagnosis between speech sound disorder and speech difference" (2013, p.

377). As it relates to this study, a lack of confidence in assessment can outweigh the

availability of a tool. Guiberson, Miron & Brickl (1998) reported that, "as many as 42% of

SLPs reported being uncomfortable with the reliability of their assessments of culturally

and linguistically diverse children" (as cited by McLeod et al., 2013, p. 377).

Studies examining SLPs beliefs and issues in assessment regarding bilingual

populations are limited. Kritikos authored a study focused on SLPs' beliefs regarding

language assessment of CLD individuals. She analyzed data generated from a

questionnaire that covered three domains of assessment: personal efficacy (individual

skills in assessment administration), general efficacy (beliefs about field professionals'

skills in assessment administration), and "beliefs about the role of bilingual input"

(Kritikos, 2003, p. 75). SLPs who participated in the study fell into three groups:

monolingual (M), acquired a second language through academic study (AS), or acquired

a second language through cultural experiences (CE). Kritikos anticipated that those

having experienced the process of language acquisition may have more insight into

difference versus disorder among CLD populations. However, more than 70% of

respondents, from all three groups, indicated that they "were 'not competent' or only

'somewhat competent,' with the help of an interpreter, to assess an individual's language

development in a language that the SLPs did not understand or speak" (Kritikos, 2003,

p. 85). This potentially indicates that regardless of a professional's personal language

experience, more comprehensive training is needed to ensure that SLPs feel confident in

their assessment and intervention recommendations and methods.

A lack of available bilingual support staff (such as interpreters) may have an

effect on a SLP's confidence and ability to provide assessment and intervention for CLD

clients (Kritikos, 2003). Bogatz, Hisama, Manni, and Wurtz noted that "[b]eliefs about

the role of bilingual input on language acquisition may in turn lead to overidentification

or underidentification of language disorders" (as cited in Kritikos, 2003, p. 74). Kritikos'
findings contribute to the larger conversation on how beliefs influence decision making
in evaluation and treatment of diverse populations. As previously mentioned, she found
that the majority of participants report beliefs of low personal efficacy and low general
efficacy, and approximately 40% of participants reported that they would not be equally
likely to refer an individual with bilingual input for intervention as a child who hears
only one language (Kritikos, 2003).

  The use of an interpreter should provide clinicians with clarity in the assessment
process. Given proper training and communication between interpreters and clinicians,
assessments can yield vital information that affect the analysis of the assessment and
recommendations for services. Langdon and Cheng (2002) and Langdon and Quintinar-
Sarellana (2003) advise SLPs to consider applying the BID process to their work with
bilingual support staff. The BID process contains three phases: "(1) the briefing, (2) the
interaction, and (3) the debriefing" (as cited by Maul, 2015, p. 752). This process allows
the SLP and interpreter to analyze the interaction/assessment together to effectively
differentiate differences from disorder.

  While interpreters are valuable team members in working with CLD populations,
poor communication and rapport can lead to dissatisfying assessments and results. In
Maul's study, SLPs noted more drawbacks than benefits to the use of interpreters in
working with CLD families. Problems that SLPs identified were related to either the
behavior of the interpreter or other professionals involved, such as: professionals talking
for too long before pausing for interpretation, holding sidebar conversations in English,
and using professional jargon that is difficult to translate and understand; as well as
interpreters adding their own comments, answering questions without translating them,
and giving incorrect translations (Maul, 2015, p. 756-757). Demonstrating respect for the
families' culture, language, and circumstances helps build rapport that allows the family

to open up to professionals more than they might otherwise. Ensuring that all professionals and support staff have communicated and agree on guidelines for proceedings is an important aspect to effective communication and building rapport with CLD families.

Global Approaches

When we consider the assessment and intervention of CLD populations, it is important to look at how speech and hearing associations (as well as individuals) from around the world address clinician training and support. Speech and language associations from the UK and Australia have published statements on accepted and promoted practices in working with CLD populations. While Ziedler (2011), Maul (2015), and Williams (1999) have also contributed to the discussion on global approaches in work with diverse populations, this section will focus on the statements released from associations, the position paper from International Expert Panel on Multilingual Children's Speech (2012), and the McLeod et al. (2013) discussion of the development of the panels position paper. Analysis of their recommendations demonstrates consistency observed throughout available literature on the importance of the competence, knowledge, and beliefs of SLPs in their work with CLD populations.

The Royal College of Speech and Language Therapists (RCSLT) endorsed an article on "Good Practice for Speech and Language Therapists Working with Clients of Linguistic Minority Communities" in 2007. The author notes, similarly to SPA (2009), that bilingualism "is an advantage and rarely the cause, or exacerbating feature, of any language difficulty" (RCSLT, 2007, p. 4). They promote the incorporation of all languages a client uses or has regular exposure to and offer support for the client's use of their home language to maintain family bonds and open communication.

The author outlines work that a SLP must do to deliver services competently. They advise therapists to create a knowledge base about languages their caseload population uses to inform their choices for assessment and intervention. SLPs can do this by taking part in professional courses, collaboration with a manager or specialist, networking with the RCSLT, looking into local and national specials interest groups (SIGs), and engaging in research on the languages through written and technological professional publications (RCSLT, 2007).

At the end of the document, the organization provides recommendations for potential contributions to this area of study. Recommendations include an increase in studies into bilingualism and comparative linguistics/phonetics in training programs, recruiting more multilingual SLPs, development of the role of multilingual co-workers with better representation and guidelines, cultivate "programmes of action research to monitor and increase the evidence base for our work with bilingual clients," and engage users in the development of culturally and linguistically competence services (RCSLT, 2007, p. 20). These recommendations reflect similar calls for an increase in the research and development of CLD health services from reviewed authors (Tervalon & Murray-Garcia, 1998; Kritikos, 2003; Kahmi, 1995; and the International Expert Panel on Multilingual Children's Speech, 2012).

Speech Pathology Australia (SPA) published a position statement on "Working in a Culturally and Linguistically Diverse Society" in 2016. This position paper was written under the guidance of 19 SLPs to incorporate perspectives representative of the scope of practice in Australia. Their population contains a mix of colonial influences, indigenous peoples (Aboriginal and Torres Strait Islanders), and immigrants from Europe and Asia, which provides SLPs with an uncommon perspective on working with CLD populations. They have a positive stance on multilingualism. Summarizing the work of Adesope,

Lavin, Thompson, and Ungerleider (2010); Bialystok, Craik, and Freedman (2007); Park and Sarkar (2007) they state benefits such as "enhanced metalinguistic skills and executive functioning, the ability to form relationships with speakers of their home language, ability to participate in community activities…" and a potential for "protection against the onset of dementia" (SPA, 2009, p. 4). This standpoint supports an environment of respect and understanding toward multilingual populations.

In addition to cited benefits, De Houwer (1998) points out the value of maintaining a connection to one's mother tongue, family, and community; "a child develops their first relationships in the language of the home and an adult will have many memories of their homeland and earlier times attached to the home language" (as cited by SPA, 2009, p. 4). This statement from SPA illustrates that language is the link that connects children to their social network, and the utmost care should be taken to ensure those bonds remain intact through health service intervention. The authors emphasize that "support for all languages spoken by an individual should be provided when delivering speech pathology services" (SPA, 2009, p. 4). This implies a need for SLPs to be acutely aware of their client's language exposure, as well as the need to be well versed in providing adequate support for those languages.

Researchers from around the world have also contributed to the conversation on working in an increasingly diverse community. McLeod et al. (2013) published the "International Aspirations for Speech-Language Pathologists' Practice with Multilingual Children with Speech Sound Disorders: Development of a Position Paper," which provides professionals with additional discussion on the position paper published by the International Expert Panel on Multilingual Children's Speech (2012). Authors combined the experience and expertise of 57 professionals in and around the field of speech-language pathology, having worked in 33 different countries, to provide clinicians with

best practice guidelines for working with CLD children with speech sound disorders. They started the process by conducting a 1-day face-to-face workshop with 14 of the participants. Authors then created online versions of the position paper for all members of the panel to edit and comment on. The separate versions were merged into one document where all input was consolidated and edited. This process enabled these professionals to work together in determining ways of improving international practices and guidelines for SLPs.

McLeod et al. noted research that reinforces guidelines for appropriate intervention practices. Gutierrez-Clellen & Simon Cereijido reported that research shows "the effectiveness of intervention with multilingual children can be maximized when the home language is used" (as cited by McLeod et al., 2013, p. 377). While we know that evidence-based practice incorporates the home language into intervention, support staff, proper training, and material resources do not always match the need in a community. Reviews of research by Jordaan (2008), Kritikos (2003), Stow and Dodd (2003), and Williams and McLeod (2012) reveals "that SLPs conduct intervention in their own language rather than in the multilingual children's languages" (as cited by McLeod et al., 2013, p. 377). While the setting may not readily offer language resources for assessment and intervention, SLPs must advocate for their multilingual clients based on the research available. Roseberry-McKibbin et al. (2005) suggested that "SLPs who have received theoretical and practical training for working with culturally and linguistically diverse populations are more likely to report higher levels of confidence in working with multilingual children and families" (as cited by McLeod et al., 2013, p. 378). This research supports the need for training in multilingual and multicultural issues before SLPs enter the field.

The International Expert Panel on Multilingual Children's Speech (2012) addresses issues regarding the ethical evaluation and treatment of children with speech sound disorders and offer recommendations for culturally competent services. It is a guide to developing culturally safe and competent service to a wide range of people within a community. The panel provides SLPs and other professionals with definitions, their purpose, the framework, challenges to provision of services, position statements, and detailed best practice recommendations. Acknowledgment of areas that present challenges include: referral, assessment, intervention, service delivery, cultural competence, knowledge of other languages, training, and collaboration with interpreters. These challenges are intrinsic to the work SLPs do and must be addressed in individual practices and at the national level.

The position statement includes 6 recommendations for providing services to CLD individuals and families. The panel highlights the need to provide culturally respectful and appropriate services in all languages the child uses. They advise SLPs to strive for culturally competent approaches to therapy that promote collaborative intervention for children and families. They urge professionals to "generate and share knowledge, resources, and evidence nationally and internationally to facilitate the understanding of cultural and linguistic diversity that will support multilingual children's speech and acquisition and communicative competence" (International Expert Panel on Multilingual Children's Speech, 2012, p. 2). Lastly, the panel recommends that organizations and institutions recognize the need for resources that support culturally competent and safe health service provision.

Chapter 3

Methodology

This study intends to address whether student perspectives toward work with diverse populations changed after taking a course on Multicultural Issues in Speech-Language Pathology. Students in a communication disorders graduate program were given the "Cultural Competence Survey" (See Appendix A.) at three intervals throughout the course of the program. The present study focused the analysis on the data collected from the first two surveys, given before and after students took the Multicultural Issues course.

Participants

All participants involved in this study were working toward a master's degree in speech-language pathology at a midwestern university. Information about participants was collected from the "Cultural Competency Survey." Both pre- and post-course surveys were distributed at the end of a class period. Students were encouraged to look over the permissions and survey and consider participating. No names or other specific identifying information were attached to the surveys upon completion. Three rounds of surveys were given or mailed to students from the 2014 graduate cohort, consisting of 22 graduate students. It should be noted that there were non-degree seeking students included in the survey who were pursuing graduate programs. The first set contained 24 respondents; the second set contained 20 respondents; the third set contained 9 respondents. This study focuses on the first and second sets of surveys, which will be referred to as pre- and post-course data sets.

Pre-course data shows that 24 first year graduate students participated in the survey, one male and 23 females. Twenty students were 20-29, two were 30-39, and one

was 50-59 years of age. One participant was non-degree seeking. Twenty-two participants identified themselves as white, one identified as Asian. Twenty-two students listed their religion as Christian, and one as "other." Twenty-two students spoke English as their first language. One student spoke English and Korean fluently, and one student spoke English and Spanish fluently. There were 10 students who identified their family as professional class, and 12 identified as working class. Two students were from a metropolitan area, 11 from a suburban area, and 10 from a rural area. Fourteen students reported having attended a multicultural event on campus, and twelve students gave examples of specific events, such as Nepal Night, Cultural Fair, Spoken Words with Black History Month, Drag Show, and Deaf Culture Night. Sixteen students reported having a close friend or family member who was culturally or linguistically different from them.

Post course data contains 20 first year graduate students who attended the Multicultural Issues course. All participants were females between the ages of 20 and 29 years of age, white, English only speakers. There were 14 students who identified their family as working class, 5 were professional class, and 1 was wealthy. Four students reported attending multicultural events on campus. Eleven students reported having a friend was culturally or linguistically different from them.

Materials and Design

The material used for this study was a survey developed within a communication disorders program. The Cultural Competence Survey was developed with six sections, which include: Background Information; Professional Setting; Professional Perspectives: Personal Reflection; Professional Perspectives: Service Delivery; Professional Perspectives: Educational Training; and Continuing Education.

The Background Information section includes standard data to create the general picture of participants. General background information requested was age, gender, race/ethnicity, religion, languages a participant is fluent in, socioeconomic status, level of parents' education, and ASHA/NSSLHA membership status. In this section, participants are asked for more specific background on participants' graduate program status to define who may be an undergrad, non-degree seeking, or master's student. There are questions asking students to report attendance of an outreach program in Belize and multicultural events on campus. Several questions target relationships of cultural and linguistic diversity. Participants are asked about close relationships with CLD people and having had any specialized training in service provision for CLD populations and where it was provided. For question 19, students are asked, "What classes offered in our department contain information regarding services to individuals with diverse cultural or linguistic backgrounds?" There is space after the question for students to list their selections.

In the second section, students are asked to indicate the practicum and internship experiences they have completed, which include standard practicum in the University clinic and internships in school and medical settings. Students were asked to provide information on their caseloads' cultural and linguistic diversity. Students were asked about their desired employment setting and population. Students were asked about their current work location, number of hours working in a clinical setting, frequency of interpreter use, and number of clients. For the remaining questions, students are asked to estimate their caseload diversity, given the student is participating in clinic, internship, or clinical fellowship. For question 29, students are asked to indicate percentages of individuals on the caseload belonging to 8 racial categories: White, Hispanic, African American, Black African (i.e., Somali) American Indian/Native

Alaskan, Asian, Hispanic/Latino, and 'other.' For question 30, students are asked to

indicate percentages of individuals on the caseload speaking one of the 13 languages

listed as their first language, including 'other.'

In the next three sections of the survey, the author asks students to respond to

statements regarding professional perspectives in cultural competence. Questions in the

first subsection, number 31 - personal reflection – of the survey, are designed for

students to report a measure of their cultural competence, knowledge, and beliefs

regarding work with CLD populations. This subsection contains nine statements that

students respond to on an ordinal scale from strongly disagree (1) to strongly agree (5).

Statements (b., f., and g.) specifically relate to views of clinical competence. Responses to

statement (f.), for instance, would indicate the students' preparedness for addressing

difference versus disorder. Statement (c.) pointedly relates to knowledge about the effect

of cultural differences (c. I understand the impact of culture on life activities and child-

rearing practices.). Statements (a. and h.) are representative of beliefs. The first, (a.),

asks students to rate their agreement with the statement that skills vary across cultures

(a. Communication skills may vary across cultures.), while responses to (h.) explicitly

reflect students' beliefs about languages other than English (h. I believe that it is

acceptable to use a language other than English in the U.S.).

In the second subsection, number 32, – service delivery – students are asked to

give responses to beliefs and preferences related to service delivery. There are 21

statements (a-u) in this section that participants responded to with an ordinal scale,

indicating strongly disagree (1) through strongly agree (5). Many of the statements

require at least practicum experience with clients to provide a response. Examples of

statements in relation to preferences in service delivery include: (c.) "I prefer to assess

clients from my own culture", and (l.) "I prefer to treat monolingual English Speakers."

Statements of a student's belief in their competence were phrased similarly to statement

(a.): "I am competent assessing an individual from a cultural or racial background other

than my own." There are six statements regarding practices the student may have used in

service delivery with CLD populations. Examples of those statements include: (h.) "I ask

client's family members and friends about the client's exposure to English and native

language(s)", and (o.) "I provide written information for clients to take home in their

native language(s)." In statement (g.) students are asked whether they believe they have

been taught nonbiased assessment strategies. Toward the end of this section, two

statements assert that it is acceptable for SLPs, that do not share the native language of

the client, to provide services. It's clear upon review that answering one of these

questions differently than the other identifies a bias.

The third subsection of professional perspectives – educational training – is split

into two questions (33 and 34). In question 33, participants are asked to react to nine

statements that address training and skills needed for competent service delivery.

Statements in this section range from (a.) "I have sufficient training in serving culturally

and linguistically diverse clients" to (e.) "Improving services to the

culturally/linguistically diverse populations is an appropriate initiative for ASHA."

Responses in this section may help to identify varying beliefs on how important or

necessary education in areas of multilingual/cultural issues in speech-language

pathology is or will be to their future career.

The last portion of the survey contains questions 34 and 35. Question 34 –

educational training – presents issues an SLP may experience in their work with CLD

populations. Participants are instructed to indicate the frequency in which they

encounter 17 challenges (lack of a common language, knowledge about culture or

bilingualism, etc. See Appendix A.). Responses to these questions offer insight into

students' perceptions of their knowledge and confidence in working with CLD populations. Question (q.) provides a space to write any additional issues that come to mind. Question 35—continuing education – asks if students are interested in more training on multicultural issues. Space is then provided for students to provide ideas about which continuing education topics interest them.

Procedure

The cultural competency survey was given to graduate students of one cohort at three intervals during their graduate education and clinical fellowship. The first survey was given to graduate students, on campus, at the beginning of the first semester of their graduate program. The second survey was given to the students, on campus, after completing the Multicultural Issues course at the end of their first year. The third survey was mailed to students during their clinical fellowship with an envelope and consent form included for return.

The first analysis of the data focused on the first two survey sets, representing before and after taking the multicultural class, to measure group changes regarding the personal reflection section of the survey. The following three analyses focused on determining a change in students' perceptions of knowledge, beliefs, and competency. Perceptions of knowledge of cultural differences were examined using questions a, c, d, e, and i. Beliefs about working with different cultures were examined using questions a and h. Understanding of cultural competence was examined using questions b, d, e, f, g, and i.

Chapter 4

Results

A cohort of graduate students at a midwestern University received a survey on cultural competence three times from their first year of graduate school through their clinical fellowship. This study attempts to determine if perceptions of working with diverse populations changed after taking a multicultural issues course. The first survey was completed at the beginning, the second at the end, of the first year of graduate school. A data analysis was completed on pre- and post-course responses to nine statements (a.-i. detailed below) in question 31 - Personal Reflection - of the Cultural Competency Survey. Results of the analysis show a significant difference in five of the nine statements analyzed.

Group Comparison

The survey and subsequent data were reviewed to establish the boundaries for this study. It was determined that a group comparison of pre- and post-course data would be completed to identify changes in students' perceptions of working with CLD populations after having taken a Multicultural Issues class in their graduate program. The nine questions of the first subsection – number 31, personal reflection – were organized into three categories that a panel of researchers defined and agreed upon: competence, knowledge, and beliefs. It should be noted that several questions fell into more than one category, and their overlap was taken into consideration during analysis. The organization of each question can be seen in Table 1. Responses to statements on competence, knowledge, and beliefs were measured using the participant ratings on statements (from 1= strongly disagree to 5=strongly agree) in the survey. An independent samples t-test was completed to determine if there was a statistically

significant difference in the ratings of statements relating to competence in pre- and post-course surveys. Each statement was tested within its category.

Perceptions of Competence

Perceptions of competence were determined by the statements: b., d., e., f., g., and i. Perceptions of competence were defined to include the identification of strengths and weaknesses, willingness to build relationships, knowledge of cultural differences, interpersonal skills and attitudes, and cultural humility. Students were asked to respond to statement b., "I treat all of my clients with respect for their culture and do not impose my beliefs and value systems on my clients, their family members, or their friends." Results for b. pre- (M=4.56; SD= .662) and post-course (M=4.9; SD= .307) were statistically different (t(31.99)=-2.170, p= .038). Post-course data showed that 90% of participants "strongly agreed" with this statement. Students were asked to respond to statement d., "I am aware of the changing demographics of my communities." Results for d. pre- (M=3.66; SD= .916) and post-course (M=4.35; SD= .58) were also statistically different (t(39.59)=-2.989, p= .005). However, only 55% of students "agreed" with this statement in post-course results. Students then responded to statement e., "Clinical competence is related to knowledge of different cultures." Results for e. pre- (M=4.25; SD= .737) and post-course (M=4.6; SD= .598) were not statistically different (t(41.98)=-1.738, p= .089). Post-course responses showed 65% of participants "strongly agreed" with the primary statement addressing clinical competence. The author prompted students to respond to statement f., "I am well-prepared to identify communication differences versus communication disabilities." Results for f. pre- (M=2.916; SD= .829) and post-course (M=3.8; SD= .951) were statistically different (t(38.07)=-3.248, p= .002). Pre-course data showed 41% of participants had a "neutral" response to the statement; post-course data showed 50% "agreed" that they were prepared to identify

differences and disorders. Analysis showed similar responses to statement g., "I am well-prepared to deal with the verbal and nonverbal communication differences found in individuals from culturally/linguistically diverse backgrounds." Results for g. pre- (M=2.54; SD= .779) and post-course (M=3.7; SD= .978) were statistically different (t(36.06)=-4.282, p= .000). Post course data showed only 50% of participants "agreed" with this statement. Students were asked to respond to statement i., "I understand that the use of a foreign accent or limited English skills is not a reflection of the ability to communicate clearly and effectively in a native language." Results for i. pre- (M=4.42; SD= .662) and post-course (M=4.7; SD= .571) were not statistically different (t(40.87)=-1.622, p= .112). Although not significant, data analysis showed that 50% of pre-course responses "agreed" with the statement while 75% strongly agreed in the post-course responses (see Figure 1).

Perceptions of Knowledge

Perceptions of knowledge were determined by the statements: a., c., d., and e. Perceptions of knowledge were defined to include cultural impacts on communication and life activities, community demographics, and parameters of competence. Students were asked to respond to statement a., "Communication skills may vary across cultures." Results for a. pre- (M=4.458; SD= .883) and post-course (M=4.631; SD= .683) ratings were not statistically different (t(40.98)=-.725, p= .473). Data showed an 18% increase in the number of participants that "strongly agreed" with this statement. Students then responded to statement c., "I understand the impact of culture on life activities and child-rearing practices." Results for c. pre- (M=4.41; SD= .775) and post-course (M=4.70; SD= .470) ratings were not statistically different (t(38.65)=-1.491, p= .144). Data showed that 90% of pre-course responses "strongly agreed" with the statement, increasing to 95% in post-course responses. As previously shown in the competence

category, participants responses to statement d. on awareness of changing demographics, pre- and post-course, were statistically different ($t(39.59)=-2.989$, p= .005). Also shown in competence, participant responses on statement e. – competence is related to knowledge of different cultures – and statement i. – foreign accents or limited English skills do not reflect communicative skill in a person's native language – in pre- and post-course surveys were not significantly different (see Figure 2).

Beliefs

Beliefs were determined by statements a. and h. Beliefs were defined as including opinions regarding language and cultural differences. As shown in the knowledge category, results for statement a. were not statistically different ($t(40.98)=-.725$, p= .473). Students responded to statement h., "I believe that it is acceptable to use a language other than English in the U.S." Results for h. pre- (M=4.375; SD= .710) and post-course (M=4.8; SD= .410) ratings were statistically different ($t(37.762)=-2.475$, p= .018). Data showed a 25% increase from the pre-course to post-course surveys in the number of students who "strongly agreed" with this statement (see Figure 3).

Chapter 5

Discussion

The incorporation of a multicultural issues course into a program of study is the first step in supporting students' ability to cultivate a sense of cultural competence. Analysis of the survey data found connections between topics covered in the Multicultural Issues course and changes in student perceptions from pre- to post-course survey responses. Over-all, a significant difference was demonstrated in five of the nine analyzed statements. Group comparisons revealed an increase in confidence (neutral to strongly agree) among responses for the majority of students. This study attempts to reflect on theses initial responses to pre-professional consideration of multicultural issues within the field of speech-language pathology.

Connecting the Literature to the Study

Participant responses to statements in the category of competence indicated mixed levels of confidence in personal efficacy as outlined and demonstrated by Kritikos (2003). Research reviewed on the development of competency is echoed in the findings of the present study. Four of the six statements relating to competence showed a significant difference in analysis. The nature of responding to statements in which the participants must question if and to what degree they agree lends itself to Kamhi's (1995) model of clinical expertise. In Kamhi's model students are required to practice the introspection necessary for building their clinical and cultural competence. Participant post-course responses to statements f. and g. indicate that 50% believed they were well-prepared to identify and "deal with" communication differences versus disorders in work with CLD populations. Both statement responses changed significantly from pre- to post-course surveys with ratings from "strongly disagree" to "strongly agree." This may

indicate that 50% of the participants had low confidence or that they have acquired a sense of cultural humility as defined by Tervalon & Murray-Garcia (1998). If participants concluded that they do not feel comfortable with dynamic assessment and intervention, they may be demonstrating the self-evaluation needed for clinical competence. This would illustrate effective self-monitoring and evaluating skills and abilities against what they understand about treatment processes they may not have used at that time. This is an appropriate response for graduate students with limited experience in working with CLD clients. This relates to Kamhi's (1995) findings that connected clinical expertise to clinician's level of comfort. As students gain experience working with CLD populations and performing dynamic assessment, their level of confidence should rise.

Knowledge and beliefs are impactful components to perceptions of competence. Findings in the category of statements indicating perceptions of knowledge showed less change from pre- to post-course surveys. Pre-course responses to statement c. included "disagree" and "neutral" ratings, while post-course responses showed 65% "strongly agree." Participant responses showing that students do not understand "the impact of culture on life activities and child-rearing practices" could indicate an understanding that professionals must work to learn about the community they serve in order to cultivate an environment of cultural safety as was demonstrated in Maul's (2015) study. Knowing that, as professionals, we do not know everything about the impact of cultures in our community is as important as developing clinical confidence. Foundational knowledge and understanding the need for continuing education are just the beginning components of developing a culturally safe environment. Post-course responses to statement e. showed just 65% of students "strongly agreed" that knowledge of other cultures is related to clinical competence. The minimal change from pre- to post-course

results for e. indicates a possible disconnect in participants' understanding of the scope

of clinical competence.

Responses to statements in the belief category are important for assessing

emergent personal efficacy of participants. Results from the responses to statement a.

did not demonstrate a significant difference in pre- post- responses, showing 10% of

participants responded that they "disagree" that "communication skills may vary across

cultures" in post-course analysis. Initially, participant responses to statement h. ranged

from "neutral" to "strongly agree." Post-course data shows a 100% of participants "agree"

or "strongly agree" that "it is acceptable to use a language other than English in the U.S."

These results are important indicators into how the participants will relate to their future

clients. Research from Kamhi (1995) and Kritikos (2003) highlight the importance of

beliefs in clinical practice. Kamhi's study found that expert clinicians "rated

interpersonal/attitudinal factors as significantly more important than technical aspects

of therapy" (1995, p. 353). Responses to both statements a. and h. have potential to

reveal biases regarding cultural and linguistic differences. However, even minor changes

in responses toward the understanding and acceptance of cultural and linguistic

diversity demonstrate a positive outcome.

Research Support for Study Results

Considering that participants were surveyed during their graduate program of

study, responses should be viewed with the understanding that a significant portion of

students have limited to no experience working with CLD populations in a professional

capacity. The Roseberry-McKibbin et al. (2005) findings that training and application of

theory to work with diverse populations coincides with an increase in confidence are

reflected in the changes seen from pre- to post-course analysis of statements regarding

preparedness (f. and g.) in the present study. After receiving instruction regarding

research into multilingual language development and approaches to assessment and intervention, participants demonstrated elevated confidence in their ability to navigate work with diverse populations. Mcleod et al.'s (2013) assertion that the lack of confidence in differential diagnosis is a significant challenge to work with CLD populations indicates that this study, and others like it, are important steps toward better preparing emergent professionals.

The present study's findings indicate that while students may be developing a sense of clinical competence, their knowledge and confidence in work with CLD populations grows more slowly and requires real life experience to connect concepts with practice. This is demonstrated in participant responses to statements a., c., e., and i. These statements showed little change from pre- to post-course surveys, and they all require a more sophisticated understanding of competence. Findings from Maul (2015) and Roseberry-McKibbin et al. (2005) correspond with Kamhi's finding that, in the development of clinical expertise, "[t]he novice clinician typically treats the communication problem in the person rather than the person who happens to have a communication problem" (1995, p. 355). Students first grapple with understanding how to address communication problems and then learn how to work with clients. This is reflected in Maul's observation that eight of nine participating SLPs "felt that they had learned about cultural differences mostly through day-to-day interactions and memorable experiences with CLD family members" (2015, p. 758).

Limitations of The Study

The author considered limitations of the survey, population, and research reviewed in the analysis of the data and interpretation of results. The Cultural Competency survey was not written by the author of the present study. Interpretations of the survey questions and participant responses were conducted with the lens of research

reviewed on culture, competence, cultural safety, beliefs and perceptions of SLPs, international approaches to work with CLD populations, and U.S. cultural and linguistic demographics. The population size and rate of return present limitations to generalizing results of the study. Surveys were not linked to identifying information and participants were not tracked from the first to the third surveys. Therefore, the author was not able to observe an individual's responses evolve from the first to the third surveys. Student responses to broad survey questions were found to be difficult to interpret considering the possibility that students simply had not understood the implications of a question or statement.

Implications for Future Research

Available literature on the impact of multicultural education in students entering speech language pathology is minimal. The increasing overlap in cultural and linguistic diversity and health services will need to be continually addressed. There is room for additional research into the development of cultural competence in students in health service professions. This study found that students responses to beliefs regarding language use had changed after taking a multicultural class. Further research into undergraduate and graduate coursework is warranted. Furthermore, longitudinal studies addressing the impact of cultural experiences on student beliefs could benefit the discussion of cross cultural relationships in health services.

Conclusion

The purpose of this study was to determine if student perceptions of working with CLD populations changed after taking a multicultural issues course. Analysis of survey data showed positive change in participant responses to statements regarding the ethical treatment of clients, awareness of community demographics, level of

preparedness to identify difference versus disorder, and beliefs about multilingualism. Research reviewed supports both the increase in confidence after having received training and responses indicating some confusion over competence. This study can serve as evidence to support a requirement for multicultural issue training in all ASHA accredited programs. Given the rising need for multilingual support staff, SLPs should receive specialized education regarding culturally competent service delivery.

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Tables and Graphs

Statements	Competence	Knowledge	Beliefs
a. Communication skills may vary across cultures.		5=73%	
b. I treat all of my clients with respect for their culture and do not impose my beliefs and value systems on my clients, their family members, or their friends.	SIGD* 5=90%		
c. I understand the impact of culture on life activities and child-rearing practices.		5=65%	
d. I am aware of the changing demographics of my communities.	SIGD* 4=55%		
e. Clinical competence is related to knowledge of different cultures.	5=65%		
f. I am well-prepared to identify communication differences versus communication disabilities.	SIGD* 4=50%		
g. I am well-prepared to deal with the verbal and nonverbal communication differences found in individuals from culturally/linguistically diverse backgrounds.	SIGD* 4=50%		
h. I believe that it is acceptable to use a language other than English in the U.S.			SIGD* 5=75%

i. I understand that the use of a foreign accent or limited English skills is not a reflection of the ability to communicate clearly and effectively in a native language.	5-75%		

Table 1**:** Statement Categories of Question 31 -Personal Reflections-

Note: SIGD represents the statement responses that demonstrated a significant difference in analysis. Percentages represent majority responses of the highest post course ratings.

Figure 1: Average ratings in perceptions of competence

Figure 2: Average ratings in perceptions of knowledge

STUDENT PERCEPTIONS IN WORKING WITH CLD POPULAITONS
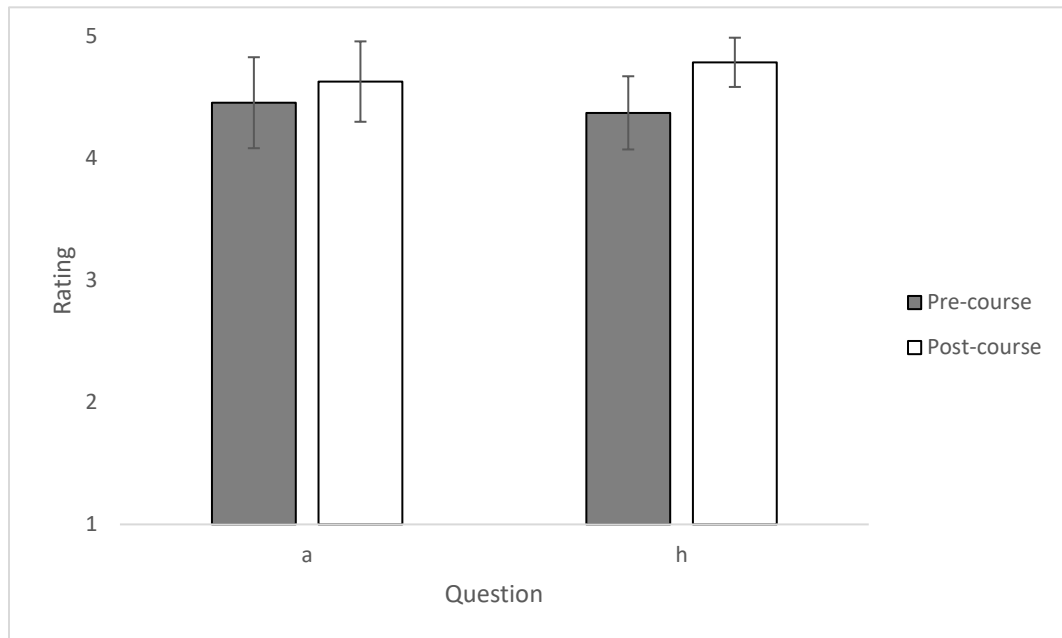
Figure 3: Average ratings of beliefs

Appendix A

Cultural Competency Survey

Background Information

1. My age is

   o < 20

   o 20 – 29

   o 30 – 39

   o 40 – 49

   o 50 – 59

   o 60 +

2. I am

   o female

   o male

3. I am

   o a student

   o CFY

   o Licensed speech-language pathologist

4. I attended Belize Initiative.

   o Yes

   o No

5. My academic program

   o Undergraduate

   o Non-degree seeking

   o Master's

6. My racial/ethnic background is

   o White

   o African American

   o Black African (i.e., Somali)

   o American Indian/Native Alaskan

   o Asian

   o Hispanic

   o Other (please indicate): _____

7. I am

   o US citizen

   o international student

8. My religious background is

   o Christian

   o Jewish

   o Muslim

   o Other (please indicate): _____

9. English is my first language.

   o Yes

   o No. What is your first language?

     _____

10. I speak a language other than English fluently

    o Yes. What language(s) do you speak

      _____

    o No

11. As a child/youth, my family was considered

    o Poor

- o Working class

- o Professional class

- o Wealthy

12. At least one of my parents completed college.

- o Yes

- o No

13. As a child/youth the primary setting I lived was

- o Rural

- o Suburban

- o Metropolitan

14. I have participated in multicultural events on campus.

- o Yes (please indicate):

  _____

- o No

15. My family member or close friend is cultural and linguistically different from me.

- o None

- o A few (1-5)

- o Some (6 – 10)

- o A lot (more than 10)

16. I have been employed as a SLP or paraprofessional/educational assistant/SLPA within speech-language pathology.

- o 0 year

- o 1 – 3 years

- o 4 – 6 years

- o 7 – 10 years

- o 11 – 15 years

  o More than 15 years

17. I have had specialized training in providing services to individuals with diverse

 cultural or linguistic backgrounds.

  o Yes (please answer the next question)

  o No (skip the next question)

18. This training was provided by (check all that apply)

  o Graduate school

  o Professional workshops

  o Mentorship from other SLPs

  o Employer (i.e., school district)

  o Other (please describe):

   _____

19. What classes offered in our department contain information regarding services to

 individuals with diverse cultural or linguistic backgrounds? Please list them:

 _____

20. I am a member of ASHA or NSSLHA

  o Yes

  o No

Professional Setting

21. I have completed (select all that apply)

  o Clinical practicum in Speech-language and Audiology Clinic

  o School internship

  o Medical internship

  o None of the above

22. My desired employment setting is

- o School

- o Hospital (inpatient)

- o Rehab centers or clinic

- o Private practice

- o University

- o Other (please indicate) _____

23. My desired clinical population

- o Children

- o Adults

24. The area in which I current work is best described as

- o Rural

- o Suburban

- o Metropolitan

25. As an SLP/paraprofessional in speech-language pathology, I currently work in a clinical setting

- o None

- o 1- 10 hours/week

- o 11-20 hours/week

- o 20-30 hours/week

- o more than 30 hours/week

26. The number of times I have used translators/interpreters in the past two years

- o 0

- o $1-5$

- o $6-10$

- o More than 10

27. These translators/interpreters were most often (check all that apply)

    o Family members/friends of client

    o Colleagues

    o Professional translator/interpreters

    o Paraprofessional

    o Community representative

28. The average number of different clients on my monthly caseload is

    o Less than 15

    o 16 – 30

    o 31 – 45

    o 46 – 60

    o More than 60

29. Please indicate the percentage of individuals on your caseload who are

    o **White**

      Less than 10%   10 – 25%   26 – 50%   51 – 75%   More than 75%

    o **Hispanic**

      Less than 10%   10 – 25%   26 – 50%   51 – 75%   More than 75%

    o **African American**

      Less than 10%   10 – 25%   26 – 50%   51 – 75%   More than 75%

    o **Black African (i.e., Somali)**

      Less than 10%   10 – 25%   26 – 50%   51 – 75%   More than 75%

    o **American Indian/Native Alaskan**

      Less than 10%   10 – 25%   26 – 50%   51 – 75%   More than 75%

    o **Asian**

      Less than 10%   10 – 25%   26 – 50%   51 – 75%   More than 75%

    o **Hispanic/Latino**

Less than 10%   10 – 25%   26 – 50%   51 – 75%   More than 75%

o **Other (please indicate):** _____

Less than 10%   10 – 25%   26 – 50%   51 – 75%   More than 75%

30. Please indicate the percentage of individuals on your caseload who speak the

following as their first language

o **English**

Less than 10%   10 – 25%   26 – 50%   51 – 75%   More than 75%

o **African American English**

Less than 10%   10 – 25%   26 – 50%   51 – 75%   More than 75%

o **Spanish**

Less than 10%   10 – 25%   26 – 50%   51 – 75%   More than 75%

o **Hmong**

Less than 10%   10 – 25%   26 – 50%   51 – 75%   More than 75%

o **Somali**

Less than 10%   10 – 25%   26 – 50%   51 – 75%   More than 75%

o **Vietnamese**

Less than 10%   10 – 25%   26 – 50%   51 – 75%   More than 75%

o **Russian**

Less than 10%   10 – 25%   26 – 50%   51 – 75%   More than 75%

o **Lao**

Less than 10%   10 – 25%   26 – 50%   51 – 75%   More than 75%

o **Cambodian**

Less than 10%   10 – 25%   26 – 50%   51 – 75%   More than 75%

o **Arabic**

Less than 10%   10 – 25%   26 – 50%   51 – 75%   More than 75%

- o **Oromo**

  Less than 10%   10 – 25%   26 – 50%   51 – 75%   More than 75%

- o **Serbo-Croatian**

  Less than 10%   10 – 25%   26 – 50%   51 – 75%   More than 75%

- o **Others (please indicate)**

  _____

  Less than 10%   10 – 25%   26 – 50%   51 – 75%   More than 75%

Professional Perspectives: Personal Reflection

31. Please use the following scale to react to statements a. – i.

   a. **Communication skills may vary across cultures.**

     1= strongly disagree 2=disagree 3= Neutral 4= agree 5=strongly agree

   b. **I treat all of my clients with respect for their culture and do not impose my beliefs and value systems on my clients, their family members, or their friends.**

     1= strongly disagree 2=disagree 3= Neutral 4= agree 5=strongly agree

   c. **I understand the impact of culture on life activities and child-rearing practices.**

     1= strongly disagree 2=disagree 3= Neutral 4= agree 5=strongly agree

   d. **I am aware of the changing demographics of my communities.**

     1= strongly disagree 2=disagree 3= Neutral 4= agree 5=strongly agree

   e. **Clinical competence is related to knowledge of different cultures.**

     1= strongly disagree 2=disagree 3= Neutral 4= agree 5=strongly agree

   f. **I am well-prepared to identify communication differences versus communication disabilities.**

1= strongly disagree   2=disagree   3= Neutral   4= agree   5=strongly agree

g. I am well-prepared to deal with the verbal and nonverbal communication differences found in individuals from culturally/linguistically diverse backgrounds.

1= strongly disagree   2=disagree   3= Neutral   4= agree   5=strongly agree

h. I believe that it is acceptable to use a language other than English in the U.S.

1= strongly disagree   2=disagree   3= Neutral   4= agree   5=strongly agree

i. I understand that the use of a foreign accent or limited English skills is not a reflection of the ability to communicate clearly and effectively in a native language.

1= strongly disagree   2=disagree   3= Neutral   4= agree   5=strongly agree

Professional Perspectives: Service Delivery

32. Please use the following scale to react to statements a. – u.

a. I am competent assessing an individual from a cultural or racial background other than my own.

1= strongly disagree   2=disagree   3= Neutral   4= agree   5=strongly agree

b. I am competent assessing bilingual/multilingual clients.

1= strongly disagree   2=disagree   3= Neutral   4= agree   5=strongly agree

c. I prefer to assess clients from my own culture.

1= strongly disagree   2=disagree   3= Neutral   4= agree   5=strongly agree

d. I prefer to assess monolingual English speakers.

1= strongly disagree   2=disagree   3= Neutral   4= agree   5=strongly agree

e. **In assessment with mainstream populations, I would rely on the results of standardized tests.**

1= strongly disagree   2=disagree   3= Neutral   4= agree   5=strongly agree

f. **In assessment with culturally & linguistically diverse clients, I would rely on the results of standardized tests.**

1= strongly disagree   2=disagree   3= Neutral   4= agree   5=strongly agree

g. **I have been taught nonbiased assessment strategies.**

1= strongly disagree   2=disagree   3= Neutral   4= agree   5=strongly agree

h. **I ask client's family members and friends about the client's exposure to English and native language(s).**

1= strongly disagree   2=disagree   3= Neutral   4= agree   5=strongly agree

i. **I am competent treating an individual from a cultural or racial background other than my own.**

1= strongly disagree   2=disagree   3= Neutral   4= agree   5=strongly agree

j. **I am competent treating bilingual/multilingual clients.**

1= strongly disagree   2=disagree   3= Neutral   4= agree   5=strongly agree

k. **I prefer to treat clients from my own culture.**

1= strongly disagree   2=disagree   3= Neutral   4= agree   5=strongly agree

l. **I prefer to treat monolingual English speakers.**

1= strongly disagree   2=disagree   3= Neutral   4= agree   5=strongly agree

m. **I consider my client's beliefs in both traditional and alternative medicines or treatment when I create my treatment plan.**

1= strongly disagree   2=disagree   3= Neutral   4= agree   5=strongly agree

n. **I seek assistance from trained interpreters, bilingual coworkers and those related professions who can help interpret, as needed.**

1= strongly disagree   2=disagree   3= Neutral   4= agree   5=strongly agree

o. **I provide written information for clients to take home in their native language(s).**

1= strongly disagree   2=disagree   3= Neutral   4= agree   5=strongly agree

p. **I consider the cultural and linguistic background of my clients when I select treatment materials (e.g., pictures, books/workbooks, flashcards, videos, music, food).**

1= strongly disagree   2=disagree   3= Neutral   4= agree   5=strongly agree

q. **Compared to other speech-language pathologists, I am very skilled in clinical interactions with culturally & linguistically diverse clients.**

1= strongly disagree   2=disagree   3= Neutral   4= agree   5=strongly agree

r. **When serving culturally and linguistically diverse clients, I prefer to collaborate with another professional with expertise in this area.**

1= strongly disagree   2=disagree   3= Neutral   4= agree   5=strongly agree

s. **It is acceptable for speech-language pathologists who are not native speakers of Standard American English to provide clinical services to clients who speak only Standard American English.**

1= strongly disagree   2=disagree   3= Neutral   4= agree   5=strongly agree

t. **It is acceptable for speech-language pathologists who speak Standard American English only to provide clinical services to clients who are not native speakers of Standard American English.**

1= strongly disagree   2=disagree   3= Neutral   4= agree   5=strongly agree

u. **I consider all of the available research evidence.**

1= strongly disagree   2=disagree   3= Neutral   4= agree   5=strongly agree

Professional Perspectives: Educational Training

33. Please use the following scale to react to statements a. – j.

   a. **I have sufficient training in serving culturally and linguistically diverse clients.**

   1= strongly disagree 2=disagree 3= Neutral 4= agree 5=strongly agree

   b. **I am aware of laws, regulations, and employment policies pertaining to services for culturally/linguistically diverse population.**

   1= strongly disagree 2=disagree 3= Neutral 4= agree 5=strongly agree

   c. **Special knowledge and skills are needed to diagnose or treat individuals from non-mainstream backgrounds.**

   1= strongly disagree 2=disagree 3= Neutral 4= agree 5=strongly agree

   d. **Special knowledge and training is needed in order to provide services to foreign-born clients who want to improve their English skills.**

   1= strongly disagree 2=disagree 3= Neutral 4= agree 5=strongly agree

   e. **Improving services to the culturally/linguistically diverse populations is an appropriate initiative for ASHA.**

   1= strongly disagree 2=disagree 3= Neutral 4= agree 5=strongly agree

   f. **Bilingual and multicultural issues should be considered specialty areas of clinical practice.**

   1= strongly disagree 2=disagree 3= Neutral 4= agree 5=strongly agree

   g. **I could benefit from post-graduate training in cultural/linguistic diversity.**

1= strongly disagree 2=disagree 3= Neutral 4= agree 5=strongly agree

h. Bilingual and multicultural issues should be an integrated part of graduate programs in speech-language pathology.

1= strongly disagree 2=disagree 3= Neutral 4= agree 5=strongly agree

i. Bilingual and multicultural issues should be taught as a special course in graduate programs in speech-language pathology.

1= strongly disagree 2=disagree 3= Neutral 4= agree 5=strongly agree

Professional Perspectives: Educational Training

34. If you provide clinical services to individuals who are from culturally/linguistically diverse backgrounds, please use the following scale to indicate the frequency with which you encounter the challenges indicated in a – s:

a. Don't speak the language(s) of the client

1= rarely   2=sometimes   3= often   4= usually   5=almost always

b. Lack of knowledge of individual's cultural characteristics

1= rarely   2=sometimes   3= often   4= usually   5=almost always

c. Lack of general knowledge of bilingualism

1= rarely   2=sometimes   3= often   4= usually   5=almost always

d. Lack of methods to separate a language difference from a language disorder

1= rarely   2=sometimes   3= often   4= usually   5=almost always

e. Lack of knowledge of the developmental norms in the individual's first language

1= rarely   2=sometimes   3= often   4= usually   5=almost always

f. **Lack of knowledge of the nature of second language acquisition by children**

    1= rarely   2=sometimes   3= often   4= usually   5=almost always

g. **Lack of knowledge regarding appropriate procedures for treating individuals from non-mainstream cultural groups**

    1= rarely   2=sometimes   3= often   4= usually   5=almost always

h. **Lack of relevant research in serving culturally and linguistically diverse children**

    1= rarely   2=sometimes   3= often   4= usually   5=almost always

i. **Lack of information available to me**

    1= rarely   2=sometimes   3= often   4= usually   5=almost always

j. **Lack of appropriate assessment instruments**

    1= rarely   2=sometimes   3= often   4= usually   5=almost always

k. **Lack of treatment materials in other languages**

    1= rarely   2=sometimes   3= often   4= usually   5=almost always

l. **Lack of interpreters/translators**

    1= rarely   2=sometimes   3= often   4= usually   5=almost always

m. **Lack of other professionals who speak individual's languages (e.g., resources specialists, psychologists)**

    1= rarely   2=sometimes   3= often   4= usually   5=almost always

n. **Limited family resources (e.g., transportation, insurance)**

    1= rarely   2=sometimes   3= often   4= usually   5=almost always

o. **Lack of family involvement**

    1= rarely   2=sometimes   3= often   4= usually   5=almost always

p. **Low family/client literacy (in any language)**

    1= rarely   2=sometimes   3= often   4= usually   5=almost always

q. Other (please describe)

_____

Continuing Education

35. Are you interested in obtaining additional multicultural training?

   o Yes

   o No

36. Please indicate three continuing education topics of greatest interest to you

   o 1. _____

   o 2. _____

   o 3. _____