

ETHICS IN SPEECH-LANGUAGE PATHOLOGY:
SERVICE PROVISION AND CULTURALLY AND LINGUISTICALLY DIVERSE
INDIVIDUALS

by

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Abstract

Background

The ethics and appropriateness of speech-language pathology service provision to culturally and linguistically diverse (CLD) individuals in largely monolingual countries has been called into question in the past several years. This paper outlines methods for appropriate service provision and considerations that need to be made during provision of services to these individuals.

Aims

This study explores perceptions of speech-language pathologists (SLPs) concerning the ethics of their own service provision and those of the discipline as a whole. This study also aims to explore the relationship between clinical preparedness in SLPs and the resulting ethics of their own clinical practices.

Methods and Procedures

An online survey of SLPs was conducted, with particular emphasis on the recruitment of bilingual SLPs or those interested and involved in multicultural/multilingual issues (MMI). Results from this study were statistically analyzed using descriptive and inferential statistics.

Outcomes and Results

Participants included 88 SLPs practicing in the United States. Responses from these participants indicated that SLPs believe their own services to be more ethical than that of the general field. A significant correlation was found to exist between greater levels of preparedness in SLPs and more ethical service provision. A significant disparity was found to

exist between the level of confidence with which SLPs provide services to CLD individuals and the level at which they rate their own ethics.

Conclusions

Greater preparation of SLPs to provide services to CLD populations results in higher levels of ethical practices. However, further research is needed to explore the correlation between perceptions of confidence and ethical services, as well as how to improve preparedness of SLPs.

Keywords: Speech-language pathology (SLP), Cultural and linguistic diversity (CLD), Multicultural/multilingual issues (MMI), Bilingual speech-language pathology

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Ethics in Speech-Language Pathology: Service Provision and Culturally and Linguistically Diverse Individuals

Introduction

The topic of service provision to culturally and linguistically diverse (CLD) individuals is a very pivotal and important one in the field of speech-language pathology and one that is personally important to me as well. This topic is one of particular significance to me as I have had close relationships with CLD individuals and I hope one day to be an advocate for others like them. I have been very interested in the topic of bilingual speech-language pathology since I was first introduced to the field of speech-language pathology and was lucky enough to complete a number of my undergraduate clinical observation hours with a bilingual speech-language pathologist. Throughout my experiences I have seen, heard, and personally experienced some of the pitfalls associated with this topic. As a hopeful bilingual speech-language pathologist, I wanted to explore this topic more in depth and ask why it has been such a struggle for our field to find out how to resolve it. It is my hope that one day other hopeful bilingual speech-language pathologists like me will find it easier to enter into this field and that these diverse individuals will receive the services that they need and deserve, 100% of the time.

Review of Literature

Diverse Populations and Service Provision

Diversity in the United States is continually on the rise. According to the United States Census Bureau (2012) the population of racial minorities is expected to double by the year 2060. By the year 2043, the United States will be considered a “majority-minority”

nation, meaning that no single racial group will hold the majority of the population (U.S. Census Bureau, 2012). These racial minority groups differ not only in their racial identities, but often are culturally and linguistically diverse (CLD) as well. Ethnicity, religion, sexual orientation, socioeconomic status, education, and disability, among other components, contribute to cultural diversity (American Speech-Language-Hearing Association, 2004a). Linguistic diversity, which often coincides with cultural diversity, indicates that the individual speaks a dialect other than the standard of the community (ASHA, 2004a; D'Souza, Kay-Raining Bird & Deacon, 2012).

The growth of diversity in the United States has implications for those working in fields that provide a multitude of services to individuals, spanning from consumer-related services to human services to health services, and everything in between. One such field in health services is that of Speech-Language Pathology. Hambly, Wren, McLeod, and Roulstone (2013) found that of the speech-language pathologists (SLPs) working in countries where English is the most widely spoken language, most provided services to at least one bilingual child. In a study by Kritikos (2003), American SLPs were surveyed, and it was reported that as many as 95% had caseloads with at least one child from a non-English speaking home. This trend applies even to states with low rates of diversity, such as Michigan (Caesar & Kohler, 2007), indicating that any SLP could be faced with the challenge of providing services to the linguistically diverse. With this diversity growing particularly in the younger populations, linguistically diverse and developing bilingual individuals will be referred to SLPs working in the school systems in greater numbers, thus increasing their representation on caseloads and putting a greater demand on the preparation needed by SLPs (Bedore, Pérez & White, 2008; U.S. Census Bureau, 2012). Therefore,

speech-language pathologists should be aware of these changes and how they will affect the profession as a whole.

Bilingualism and language acquisition. Bilingual individuals differ from monolingual individuals beyond the number of languages they speak. The linguistic system of the bilingual speaker is a complex entity that many researchers have attempted to define. Caesar and Kohler (2007) stated that in the United States, where their research was conducted, a bilingual individual is someone who has had exposure “to a language other than English in one or more functional communicative environments” (p. 191). Kohnert (2010) adds that for a child to be considered bilingual, this multilingual input should generally occur before adolescence, during what she calls “the most dynamic period of communication development” (p. 457). Other researchers give more encompassing definitions of bilingualism. Bilingualism, to some, means that the individual must be completely fluent in two languages, while others view any level of competency in a second language as sufficient for obtaining the label of bilingual (DeLamo White & Jin, 2011). Others use the term multilingual in order to include those individuals who use more than two languages. However, some researchers, such as Stockman, Boulton, and Robinson (2008) believe that even the term multilingual may be too narrow in some cases, as it excludes those who may be referred to as bidialectal speakers as well as those who use non-speech language systems such as American Sign Language (ASL). In the United States, these linguistically diverse individuals are often seen as the exception. However, when looking at the global population, it becomes clear that they are indeed the norm (Kohnert, 2010). In countries such as the United States where one language is used in nearly all interactions, even those who do not speak the language must quickly attempt to pick it up, or face becoming alienated from the

world around them. For this reason, speakers of languages other than Standard American English must find a way to gain the skills needed in English to conduct their day-to-day business, in an environment where their accents, dialects, and difficulties in English make them stand out from those around them.

The difficulty in defining bilingualism is matched with the difficulty of trying to understand the bilingual speaker by any strict definition. Bilingualism is not a static concept. Individuals who are bilingual differ from one another just as much as individuals of any other population. No two speakers are exactly the same, and neither are their language systems. Grosjean (1989) warned against treating the bilingual language system as two monolingual systems in one, as many researchers and teachers are apt to do. The holistic view that he recommended defines the bilingual system as one that is dynamic, sophisticated, and able to evolve to suit the needs of the speaker in different environments and with different audiences (Grosjean, 1989). The two languages interact and even combine at times, and the speaker is often not equally fluent in both, only developing the competencies in each that are required by the contexts in which they are used (Grosjean, 1989). Thus, it is important to keep in mind that while observing speakers of more than one language, any given communicative event will not be representative of the entire repertoire of the individual's abilities or skills in either language.

Systems of language differ for many reasons. One of the first steps to understanding why is to understand typical models of language acquisition. Whether it is the first language learned, or one of any number of subsequent languages developed, individuals follow a general pattern when learning new languages. This is described as occurring in three phases (Hambly et al., 2013). The first phase, called input, requires the perception and recognition of

speech by the learner. The next step involves the processing ability of the learner and is referred to as the storage stage. Lastly, the output phase is the one in which speech production occurs (Hambly et al., 2013). Each of these phases must be mastered skillfully and fully in order for language acquisition to occur. Although these basic stages of acquisition are the same across all speakers and languages, the context and timing of acquisition differ greatly among individuals.

There are two generally accepted timelines by which bilinguals acquire a second language, simultaneous and sequential acquisition. Simultaneous acquisition occurs when both languages are being developed at the same time. Simultaneous acquisition is most commonly seen in children raised in an environment where exposure and support of both languages are equal (Roninson, 2003). According to Roninson (2003), simultaneous acquisition occurs in three phases. In phase one, the individual has not yet differentiated the two languages present in the language system and may mix words from both languages (Roninson, 2003). In phase two, mixing continues with the individual using aspects such as prosody, syntax, phonological systems, and lexicons from the two languages interchangeably (Roninson, 2003). The final phase is marked by the differentiation between the two languages and their respective rules and structures within the language system of the child (Roninson, 2003). True simultaneous acquisition results in an individual with “near-native command” of both of their languages, deemed a “balanced bilingual” by Roninson (2003, p. 42). In the United States, this type of acquisition is not seen as commonly because rarely do children have equal exposure and access to both languages from birth. Often, children whose native language is not English receive little to no exposure to English until reaching school age. Conversely, parents who are bilingual may choose to raise their children to speak only

the language that is the majority language of the community. This may be due in part to the pressure put on non-English speakers by society to abandon their native languages in favor of the majority language, English (Roninson, 2003).

A sequential acquisition of language is more commonly seen in developing bilinguals. Sequential acquisition is when the second language is not introduced until after the individual has developed a base of knowledge and rudimentary control of the first, or “home” language, usually after the age of three (Roninson, 2003). Sequential bilingualism is common in the United States, seemingly due in part to the numbers of non-English speaking children who enter English dominant schools without having previously had sufficient exposure for English language acquisition. Upon entering English-speaking classrooms, these children begin the process of the sequential acquisition of English. This also occurs in monolingual families that do not speak English when the eldest child begins school and begins learning English, thus exposing siblings and parents to English. Most immigrants to the United States, that do not already hold a level of proficiency in English, will also begin their process of sequential acquisition in order to interact with the community around them.

The process of learning languages sequentially is more complex due to a number of factors (Roninson, 2013). Roninson (2003) describes this method of acquisition as occurring in four phases. Initially, the developing bilingual interacts with the language socially, either directly with speakers of the second language, or indirectly through television or other methods in the preproduction stage (Roninson, 2003). Any productions made at this level will be commonly heard phrases in the form of chunks, not necessarily fully understood at the word level by the individual (Roninson, 2003). Thus, the individual is not yet developing their expressive lexicon, but instead using repetition and phrases to begin interacting in the

new language. The second phase, early production, is characterized by a “silent period” during which the individual, aware of limitations in communicative abilities, focuses on developing receptive skills before attempting to speak the second language (Derr, 2003; Roninson, 2003). Because this silent period can last for several months and because the first language may be vulnerable to losses at this stage due to lack of reinforcement, children may be erroneously referred for evaluation to an SLP by individuals who are not familiar with this process of acquisition (Roninson, 2003; Roseberry-McKibbin, 1994). Phase three is referred to as the speech emergence stage because it is at this point that the language-learner begins to develop expressive language skills (Roninson, 2003). Typical patterns seen in these individuals may include transferring rules between languages or code switching, a behavior where the individual may alternate between the language used within a sentence, neither of which are indicative of an underlying disability (Roninson, 2003). The fourth and final stage of sequential language acquisition as defined by Roninson (2003) is fluency, or bilingualism. Those at this stage of development can be further categorized, depending on the level of skill they acquire in each of their languages. At the highest level are the balanced bilinguals, characterized by an equal command of each language in their repertoire (Roninson, 2003). Individuals at this level can also hold either additive or subtractive fluencies, with the first language being stronger than the second, or vice versa (Roninson, 2003). Balanced bilinguals are much less common, as individuals rarely receive equal amounts of input or opportunity to use both languages. Frequently as children grow up in English-dominant schools and learn English as a second language, use of their first language will diminish and complete loss of language is possible (Roseberry-McKibbin, 1994).

Because the acquisition of languages has such a variable component, it is important to discuss proficiency in each language when discussing the languages of bilingual individuals. Proficiency is a measure that takes into consideration fluency and competence and is dependent on age, context of acquisition, language exposure, and the opportunity and motivation the individual has to use the language in question (DeLamo White & Jin, 2011; Kohnert, 2010; Roseberry-McKibbin, 1994). As long as input in both languages is continued and there are sufficient opportunities for the linguistic systems to be formed, simultaneous bilinguals will become proficient in speaking both languages (Kohnert, 2010). As for sequential bilinguals, second language acquisition normally begins with increased social interaction with the second language in the community or in school and, therefore, proficiency in each language will be dependent on degree and length of exposure (Kohnert, 2010). If one language, often the minority or home language, is not reinforced, the individual will lose proficiency in that language and gain proficiency in the language that is given priority. Consequently, if children receive input and support in the majority language of the community in only one context, such as the classroom, development of that language may be arduous for the individual. Therefore, for purposes of testing and service provision, it is important to determine the dominant language of an individual (Roseberry-McKibbin, 1994). The dominant language is considered the one in which the individual has the highest level of confidence and proficiency and is not necessarily the one that is most used by the community in which the individual lives and interacts (Kohnert, 2010; Roseberry-McKibbin, 1994). Often the first language learned by bilingual individuals is considered a minority language, due to the lack of opportunities for use and development, as well as the lower social value it holds when compared to the majority language of the community (Kohnert, 2010). Language

dominance is not the only important consideration. Ability depends on exposure and use of language across varying contexts, linguistic partners, topics, and other factors. Therefore, these factors may influence the language preference of the individual (Kayser, 1989). While it is important to keep in mind that having a level of proficiency in more than one language has been correlated to cognitive and metalinguistic advantages (Roseberry-McKibbin, 1994), it does create a more complicated linguistic system which may make it necessary for SLPs working with bilingual individuals to undergo specialized training to understand their unique qualities (Byers-Heinlein & Lew-Williams, 2013).

Difference or disorder. English-language learners (ELLs) do not interact with English in the same way as native monolingual speakers, because the two languages in their repertoire have influences on each other (Byers-Heinlein & Lew-Williams, 2013; Peña & Halle, 2012). When interacting and providing services to bilingual or developing bilingual individuals, it is important to keep this in mind. Grosjean (1989) says that as a consequence of viewing bilinguals in light of monolingual standards, as professionals have been apt to do, many professionals see the impact that the languages have on each other as accidental and even atypical, but this is not the case. In fact, these effects of bilingual systems are normal and common in the speech of bilinguals, because they do not have two completely separate language systems, as many may believe (Grosjean, 1989). Grosjean (1989) explains the language system of the bilingual as a continuum upon which the individual moves, using different speech modes for different situations. On one end of the continuum lies the monolingual speech mode, where the bilingual operates when speaking to monolingual speakers of either language (Grosjean, 1989). At the opposite end of the spectrum lies the bilingual mode in which the individual is speaking to other bilinguals with whom they share

both languages (Grosjean, 1989). In this mode, code switching and borrowing between languages is completely normal and may even facilitate and enhance communication between the conversational participants (Grosjean, 1989). Each bilingual differs in the amount and extent to which they traverse the different speech modes along the continuum; therefore, it is very important to understand the general patterns of speech use as well as the mode currently being used before coming to conclusions about the individual's language system (Grosjean, 1989).

Some processes and communicative behaviors used by bilingual individuals cause concern in SLPs and other professionals familiar with the normal developmental milestones of language. The language development in a developing bilingual will often differ from that of a monolingual learner of either language; thus, variety in the form, content, and use of language is commonly seen (Hambly et al., 2013; Kayser, 1989). Roseberry-McKibbin (1994) describes some common processes and differences seen in bilingual language learners. As mentioned before, a silent period may occur during acquisition of a second language and last for several months, causing concern for some professionals, such as monolingual classroom teachers or other healthcare professionals, despite its normalcy in the course of language learning (Roseberry-McKibbin, 1994). Code switching is another common process that should not be misconceived as confusion as it is a device used by many bilingual individuals, even among those who are fluent and sophisticated speakers (Byers-Heinlein & Lew-Williams, 2013; Roseberry-McKibbin, 1994). Interference from the first language can cause errors in the second language, but is not necessarily a sign of disorder (Roseberry-McKibbin, 1994). Another more lasting process is that of fossilization. Fossilization is when a certain structure that is incorrect in the language in which it is used

becomes a habit and is therefore unable to be corrected after fluency is obtained (Roseberry-McKibbin, 1994). While noticeable to native speakers, these fossilizations are simply quirks in the language that do not interfere with the effectiveness of communication. Interlanguage refers to the steps taken to achieve competency in a new language in which structures used by the individual are in transition and are not yet being formed correctly (Roseberry-McKibbin, 1994). This process is temporary and is caused by a language system that is in an impermanent state of flux. Better understandings of normal processes and how languages interact to create these processes may help better prepare professionals to work with this population.

Nonetheless, concerns caused by the variety of differences manifested in the approximations of language learners are not always unfounded. These processes and errors common to developing bilinguals often appear to SLPs who lack knowledge of the effects of bilingualism on language as indicators of disorder when compared to monolingual individuals (O'Toole & Hickey, 2012). Roseberry-McKibbin (1994) defined a language disorder as an "underlying inability to learn and process any language adequately," and stated that the "disability will be manifest [*sic*] in both languages" (p. 81). If evidence of a disorder is not seen in both or all of the languages spoken by the individual, it is most likely that the errors being seen are due to the normal processes of an incomplete command of a new language and, therefore, the language of the individual should not be labeled as disordered (Kohnert, 2010; Roseberry-McKibbin, 1994). Kayser (1989) indicated the presence of a disorder when the receptive and expressive skills are "sufficiently deviant" from their communicative partners and peers to the extent of interfering with effective communication (p. 227). Occurrences of foreign accents, atypical prosody, utterances that are semantically

and grammatically abnormal, and performances that are better when more context is provided, are, however, all examples of language differences (Roninson, 2003). These considerations, along with silent periods, code switching, interference, and fossilization should not be the basis for suspecting a disorder. Phenomena such as limited expressive and receptive vocabularies, phonological errors, incorrect syntactical and morphological structures, abnormal pragmatics, and word-finding difficulties are commonly seen in both typical and disordered individuals (Roninson, 2003). These characteristics of language may indicate a disorder but more investigation is needed in these cases, as they may be occurring simply because of a language difference. Evidence for a disorder may include concern expressed by parents due to difficult communication in the home environment, a history of delays in development, prior medical or developmental difficulties, family history of delays, academic difficulty, processing difficulties, slower rates of acquisition, persisting social difficulties in the second language after a year of exposure, and difficulties in speech production as shown in both languages (Roninson, 2003). Concern may also be expressed when delays appear with no evident cause (Kohnert, 2010). In order to diagnose an individual as having a disorder, delays and difficulties caused by a language difference must be ruled out.

Determining whether an individual is exhibiting a language disorder or a language difference requires specialized knowledge on the part of the professional. Knowledge of cultural, linguistic, and socioeconomic background, as well as how the first language of the individual influences the production of English, are all important factors in distinguishing whether language is disordered or simply different (Crowley, Guest & Sudler, 2015). The professional must determine whether errors displayed are a result of interference between the

sounds, words, or grammar systems of the two languages (Byers-Heinlein & Lew-Williams, 2013; Derr, 2003). In order to determine the level of interference that is taking place, phonology, morphology, and syntax of the two languages should be compared, and if errors are due to differences between the two languages, it is indicative of a normal process of acquisition rather than a disorder (Derr, 2003). The United States Department of Education's Office of English Language Acquisition (2015) sought to explain the difference between behaviors indicative of differences and those indicative of disorders in order to help professionals in the school systems correctly categorize developing bilingual children. For example, when given verbal instructions, the child with a language difference may lack understanding in English, but understand the same information in their primary language; whereas a disordered child will demonstrate confusion when presented with information in both languages, indicating an underlying processing deficit or low cognition (U.S. Department of Education, Office of English Language Acquisition, 2015). When speaking, a child exhibiting a language difference may lack self-confidence, vocabulary, and correct sentence structure. However, if speech is incomprehensible in both languages, it is more likely that an impairment exists (U.S. Department of Education, Office of English Language Acquisition, 2015). Thus, when difficulties are seen only in the second language and can be explained due to normal processes of learning, a disorder should not be assumed. Yet when complications are the same across languages, it is more likely that the individual is expressing an underlying disorder or disability.

Beneficial or detrimental. Some researchers and professionals believe that early bilingualism can cause negative effects on a young language-learner. Grosjean (1989) says that this is due to the fact that some hold the biased monolingual view that bilingualism is the

exception when in reality, on a global scale, bilingualism is much more prevalent than many individuals living in a monolingual context realize. These negative views of bilingualism are not based in fact and research has not been able to find the existence of causal evidence between bilingualism and cognitive or developmental deficits (Byers-Heinlein & Lew-Williams, 2013; Grosjean, 1989). Some studies have suggested that learning more than one language at an early age correlates with difficulties in production of one or both of the languages, but it has yet to be seen if these correlations are the impact of bilingualism or if they are due to other linguistic or sociocultural factors such as the language used to test the individuals, the socioeconomic backgrounds of the individuals, or incorrect comparisons to monolingual norms (Hambly et al., 2013; Grosjean, 1989). While qualitative differences and variations in the production of speech have been documented in developing bilinguals, there is no evidence supporting that these individuals develop speech at either a slower or faster rate than monolingual peers (Hambly et al., 2013; Kohnert, 2010). It is vital that professionals keep in mind that similar proportions of monolinguals and bilinguals present with delays or disorders: bilingual individuals have no greater likelihood of having a disorder than do monolingual individuals (Byers-Heinlein & Lew-Williams, 2013; McLeod, Verdon & Brown, 2013).

Considerations for SLPs Working with Diverse Populations

The American Speech-Language-Hearing Association. In the United States, the American Speech-Language-Hearing Association (ASHA) certifies SLPs and regulates competent clinical practices. When it comes to providing services to diverse populations, ASHA has established principles and guidelines. ASHA asserts that in order to provide the quality of service that all individuals deserve, services must be culturally and linguistically

appropriate and that SLPs should “consider the impact of culture and linguistic exposure/acquisition on all our clients/patients,” (ASHA, 2004a, p. 1). ASHA’s Code of Ethics supports these assertions. In their Principle of Ethics I, ASHA holds that all services provided must be done so competently and without discrimination in delivery based on race, ethnicity, national origin, culture, language, dialect, or any other personal characteristic (American Speech-Language-Hearing Association, 2016). This is in accordance to Title VI of the Civil Rights Act of 1964, which guarantees that no individual will “be excluded from participation in, be denied benefits of, or be subjected to discrimination” based on race, color, or nationality (Civil Rights Act of 1964). ASHA (2016) also requires professionals to use every resource available as well as work collaboratively with other professionals in order to provide the highest quality of service. In order to keep competencies in service and knowledge up to date, professionals should engage in continuing education experiences (ASHA 2016). These overarching principles established by ASHA guide all services provided by SLPs in the United States.

Certain cultural competencies are expected of clinicians to ensure that appropriate services are being provided. It is important that clinicians recognize their own limitations when serving diverse populations (ASHA, 2004a). For the average clinician who only speaks English, certain knowledge and competencies are still required. When serving linguistically diverse individuals, clinicians should obtain information on the development of the other language, familiarize themselves with the sociolinguistic features of the other culture, and work with interpreters to facilitate communication when necessary (ASHA, 2004a). It is important for professionals to learn about the culture and language system of the individuals they are serving in order to maximize the quality of service, as well as ensure that

interactions are culturally appropriate and respectful. Sociolinguistic and cultural competencies include knowledge about interactions within speech communities such as rules governing discourse; effective procedures for interviews and obtaining information; the impacts of diagnostic labeling; how cultural differences influence interactions with clinicians; and attitudes and values concerning augmentative/alternative communication methods (ASHA, 2004a). SLPs should also be knowledgeable about certain aspects of language such as the typical language development of those acquiring the language, the normal processes associated with learning the language, and the difference between accents, dialects, and languages (ASHA 2004a). Professionals should be competent at using resources and research available and applicable to the field to determine accurate diagnoses of diverse individuals (ASHA, 2004a).

In 2013, ASHA published an “Issues in Ethics” statement (Cultural and Linguistic Competency) to give further guidance to professionals working with diverse populations, as diversity in the United States was growing. This document acknowledged that, although behaviors of individuals may vary due to culture and language, the quality of care should not (American Speech-Language-Hearing Association, 2013). Cultural differences may affect how individuals view services such as those provided by SLPs. Nonetheless, professionals are still required to provide competent services that respect and take into consideration the language, preferences, and values of their client (ASHA, 2013). This document also interprets several of the rules from the ASHA Code of Ethics, explaining how they relate specifically to the provision of services to CLD populations. According to ASHA (2013), if a professional does not feel able to provide competent services to a diverse individual, they may make an appropriate referral, or choose another option such as seeking additional

training, or using an interpreter. ASHA (2013) stresses the importance of lifelong learning, especially as it pertains to the knowledge and skills needed to serve CLD populations.

Clinicians must remain up-to-date on recent findings and the current evidence-based practice (EBP) that dominates the field for serving these individuals. Professionals who present themselves as bilingual clinicians are held to higher standards by ASHA (ASHA, 2013).

These SLPs must hold native or near-native proficiency in both languages as well as have knowledge about second language acquisition, bilingualism, and other issues associated with cultural and linguistic diversity (ASHA, 2013).

Another resource developed by ASHA in order to guide practice is the Office of Multicultural Affairs (OMA). This office is dedicated to the appropriate and competent provision of speech, language, and hearing services to bilingual individuals in the United States. The OMA seeks to assist with difficulties that arise among professionals and their CLD clients who present with communication disorders and differences (ASHA, 2017b). The goal of the OMA is to bring multicultural issues to light in the overarching operations of ASHA as well as to advocate for quality in services provided to diverse populations (ASHA, 2017b). Another objective of this office is to create opportunities for continuing education in creating multicultural literacy through current knowledge, skills, and technological advances (ASHA, 2017b).

Special interest groups (SIG) within the ASHA governing body include SIG 14, Cultural and Linguistic Diversity. The vision of this group is “to be a leading resource for (a) advancing knowledge regarding the importance of cultural and linguistic diversity and its influence of human communication and (b) the infusion of this knowledge into research, education, and clinical practice” (ASHA, 2017a). SIG 14 seeks to advocate and provide

leadership for the use of best practices in service as well as to encourage research (ASHA, 2017a). This group also attempts to create opportunities for networking, collaboration, the sharing of information, and mentoring among those involved (ASHA, 2017a). In addition, this group encourages participation of professionals who are diverse or who are interested in the issues of diversity facing the profession, and advocates for the study and dissemination of information about diversity in the organization at large (ASHA, 2017a). Group members who are invested in the topic of cultural and linguistic diversity aim to be advocate for the topic of diversity in the ASHA organization as a whole (ASHA, 2017a).

Competency. Growing diversity demands ever increasing knowledge and competency of professionals. In the past, preparation of these professionals has not been able to keep up with the needs of these populations (Rosa-Lugo & Fradd, 2000). The field of speech-language pathology has been faced with the question of “how to prepare a largely white, English-speaking workforce to deliver professional services to a culturally diverse population” (Stockman et al., 2008, p. 242). In the past, most SLPs had very little to no training or experience in serving these diverse individuals (Bedore et al., 2008; Hammer, Detwiler, Detwiler, Blood & Qualls., 2004; Rosa-Lugo & Fradd, 2000; Roseberry-McKibbin 1994). This trend has continued over the years (Byers-Heinlein & Lew-Williams, 2013; Kimble, 2013; Levey & Sola, 2013). McLeod et al. (2013) highlighted the importance of training and education in preparing SLPs to work with diverse populations, yet SLPs are still struggling to provide services to these individuals. Compounding this issue is the fact that many SLPs do not have access to research, mentors with knowledge and experience in these areas, or other types of support for serving these individuals (Kimble, 2013). In many cases, even those professionals who have had some sort of training or education feel unprepared to

work with diverse populations (Kimble, 2013; Rosa-Lugo & Fradd, 2000), indicating that the current methods and programs designed to teach and train SLPs may not be adequate. It is important to keep in mind that even professionals who are bilingual are not necessarily culturally competent when providing services (Kritikos, 2003; Roseberry-McKibbin, Brice, & O'Hanlon, 2005). Cultural competence encompasses an array of necessary skills and knowledge that can be difficult to achieve and maintain. While it is obvious that opportunities for training and experience need to be improved and expanded, there has been much debate about how this is best done.

Pre-professional education. Before becoming certified SLPs, students must receive education and training in the field of speech-language pathology. In the United States, this means obtaining a master's degree in Speech-Language Pathology, followed by a clinical fellowship year (CFY) in which the pre-professional receives hands-on training and experience. Due to the less than optimal preparation of SLPs in serving diverse populations (Stockman et al., 2008), the education and training of aspiring SLPs should be improved. Research shows that more pre-professional education produces SLPs who are more knowledgeable and prepared to provide services to diverse individuals. Hammer et al. (2004) emphasized the importance of incorporating multicultural/multilingual issues (MMI) in both undergraduate and graduate speech-language pathology programs, with the focus on a broader range of cultural and technical competencies rather than solely on distinguishing difference from disorder. Research found that those students who had taken a course on bilingualism scored higher on a test of general bilingual and linguistic information, showing that these students were generally more knowledgeable about MMI than students who did not participate in such a course (Levey & Sola, 2013). In a survey conducted by Roseberry-

McKibbin, Brice, and O'Hanlon (2005), clinicians who had coursework in service delivery to bilingual individuals reported having difficulties less frequently during service provision than those who had not received such coursework. These clinicians were also able to provide services to diverse individuals with greater comfort (Roseberry-McKibbin et al., 2005).

Even with evidence that more coursework leaves clinicians feeling more prepared, Stockman et al. (2008) found that most programs do not require students to take even one MMI-dedicated class at the undergraduate or graduate level. This occurs most commonly due to the fact that programs do not offer such a course (Stockman et al., 2008). Reasons given for the absence of such a class included lack of qualified faculty, lack of funds, and a curriculum that was already taxed by other required material (Stockman et al., 2008).

Although the lack of these types of classes is concerning, perhaps even more so is the state of the classes that are available. The programs that do offer MMI instruction were generally found to be less than optimal (Stockman et al., 2008). In most cases, MMI instruction was not given as a separate course, but was instead integrated into existing classes, where faculty admitted to devoting little time to it in comparison to other topics (Stockman et al., 2008). In a survey administered by Caesar and Kohler (2007), only 28% of respondents indicated that they believed their graduate education to be adequate in areas of theoretical knowledge of diverse populations. Even less (11%) reported that their practical training was adequate when conducting language assessments with bilingual individuals (Caesar & Kohler, 2007). Thus, even those students who have participated in courses and practicum experiences feel as if their training has left them ill-prepared to serve diverse individuals, alluding to the fact that graduate programs may not be preparing professionals to serve these populations (Caesar & Kohler, 2007; Centeno, 2015). The phenomenon of SLPs feeling as if previous training has

been insufficient is also relevant in other countries with similar linguistic makeups, such as Australia (Williams & McLeod, 2012), proving that this issue is not occurring solely in the United States.

Researchers and professionals have made several recommendations as to how this issue of preparation should be improved. Levey and Sola (2013) stated that education on MMI should be made mandatory for all students of speech-language pathology. Respondents in a study by Centeno (2015) also supported modifications of academic and clinical education in order to increase preparedness in future professionals. MMI should be present in education from the onset and continue through graduate school (Caesar & Kohler, 2007; Centeno, 2015; Marshall, 2003). Caesar and Kohler (2007) suggest that programs ensure that “exposure to diverse populations becomes an academic requirement similar to what already exists regarding individuals with a variety of communications disorders across the age span” (p. 197). Thus, considerations for diverse individuals would be highlighted in the education of all SLPs, creating more competent professionals. Stockman et al. (2008) suggests a method of instruction called “integral infusion,” with MMI content infused into all courses in a way that incorporates it into existing theories and practices as it applies. Centeno (2015) proposes a similar structure, where coursework will be infused with information on cultural awareness, as well as with sections of courses devoted to how considerations for services provided to CLD populations pertain to the subject matter at hand. These suggestions follow ideologies that believe MMI to be best handled when every case is treated with sensitivity to cultural differences. Utilizing the definition of cultural competence suggested by Marshall (2003), cultural competence should be a consideration with every client, and using their own characteristics as a norm by which to judge others is a practice that SLPs should avoid. If this

is the case, it is also necessary that faculty be given the information and preparation they need about MMI so that they are able to confidently infuse it into their courses and devote adequate time to it (Stockman et al., 2008). It is also important for the development of competent clinicians that students be given opportunities to develop practical experience with diverse populations as a part of their training, in addition to formal teaching (DeLamo White & Jin, 2011; Stow & Dodd, 2003). Training should focus on creating a deeper understanding of MMI, including clinical hours devoted to the application of knowledge through hands-on interactions with bilingual individuals (Centeno, 2015; Kimble, 2013). Marshall (2003) asserted that the way to correct this issue in service delivery is to stop viewing bilingualism in speech-language pathology as a specialty in the field and to start preparing all aspiring SLPs to treat these individuals, beginning with their education.

Professional development. Although many SLPs do not feel as if their education and training has been adequate in this regard, there is evidence that things have improved slightly. Hammer et al. (2004) found that SLPs are receiving more training on MMI than those in the past. However, improvements in training and subsequent service provision are still needed (Hammer et al., 2004). Professionals should strive to continue learning about new advances and research in their field even after their formal education is over. This is vital to remaining a competent clinician. Continuing education about the languages and cultures of diverse individuals that they may be expected to serve is also pertinent for SLPs who wish to remain culturally competent (Crowley et al., 2015; Derr, 2003). As more research is conducted and new information is gained about bilingual individuals and their development, evaluation and treatment for those individuals will only continue to improve, as long as SLPs continue to integrate these new findings into their service provision (Derr,

2003). When professionals are not aware of new findings in the field, they are not as prepared to handle new situations that may arise, and when presented with these issues, disparities in the services they provide may occur (Centeno, 2015).

Many SLPs in educational settings report low confidence in their service provision due to a lack of training, indicating a pressing need for more MMI education (Hammer et al., 2004). The development of knowledge of ELLs is important to improving cultural attitudes, bettering practices used, and developing confidence in service delivery (Kimble, 2013). Nonetheless, many SLPs still report not having much education in these areas of study (Centeno, 2015; Hammer et al., 2004). Opportunities for continuing their education on these topics are scarce, even though professionals rate them as important in supporting their work with these diverse populations (D'Souza et al., 2012; McLeod et al., 2013). A study conducted by Kimble (2013) found that professionals do not feel prepared to provide services to these diverse individuals due to a lack of opportunities for professional development, in addition to inadequate pre-professional education, as mentioned above. In a survey of SLPs in Australia, all respondents indicated interest in expanding their knowledge of diverse individuals (Williams & McLeod, 2012). Whether due to a lack of knowledge or a desire for the most up-to-date information, many SLPs are committed to continuing their education (Williams & McLeod, 2012). As many as 68% of SLPs in a study conducted by Centeno (2015) reported being moderately to extremely motivated to participate in continuing education opportunities that presented information about bilingual adults. SLPs in a study conducted by Kritikos (2003) reported believing that more seminars and courses were part of the solution to this lack of knowledge. Thus, a desire and need for more continuing education opportunities for professionals is highlighted.

Many professionals continuously seek out new information and procedures in serving diverse populations, although the task is formidable. SLPs most often reported reading about MMI in book chapters or articles, or attending conferences or workshops in order to learn more about serving diverse individuals (Hammer et al., 2004). Further development can be targeted through publications, conferences dedicated to MMI, or workshops, which have been demonstrated to increase comfort levels (Hammer et al., 2004, Kimble, 2013). Networking and collaboration between professionals can also help with difficulties and gaps in knowledge that may arise (Derr, 2003). In particular, professionals have requested more extensive training as well as training for alternative testing procedures such as dynamic assessment, utilization of interpreters, and development of important cultural competencies such as communication, beliefs, and attitudes toward education as they pertain to other cultures (Caesar & Kohler, 2007; Hammer et al., 2004). These resources are being requested continuously by SLPs, and as continuing professional development is one way to improve the equality and competence in services provided, more opportunities should be created to increase knowledge and training for service provision to diverse populations.

Service Provision to Diverse Individuals

Considerations for serving diverse individuals. Monolingual SLPs born in the United States may not always be aware of the many unique needs of their diverse clients and therefore often face challenges in assessing and treating these individuals (Roseberry-McKibbin, 2013). SLPs must be careful to consider cultural and linguistic diversity in all aspects of the interactions with their clients, and not make assumptions based on prior biases. For example, it is inappropriate for the professional to assume the level of fluency the individual has in understanding or speaking English (Roseberry-McKibbin, 2013).

Linguistically diverse clients may not fully understand complicated jargon or lengthy explanations of technical aspects of service and may find paperwork difficult to complete, as these can be challenging even for native English speakers to understand (Roseberry-McKibbin, 2013; Stow & Dodd, 2003).

Some CLD individuals may not be familiar with the profession of speech-language pathology or the services provided by an SLP, and others may not view the services in a positive light due to cultural stigmas attached to having a disability (Roseberry-McKibbin, 2013; McLeod et al., 2013; Verdon, McLeod & Wong, 2015). Use of certain labels to describe diagnoses, failure to show appropriate levels of respect to older individuals or those of the opposite sex, and even a lack of “warmth” in interactions with individuals can be interpreted as disrespectful or inappropriate behaviors by a professional in some cultural groups, further complicating service delivery (Roseberry-McKibbin, 2013; Verdon et al., 2015).

When a language barrier exists between clinician and client and an interpreter is necessary to facilitate service provision, it can be even more difficult for the clinician to develop a trusting relationship with the client (McLeod et al., 2013). These and several other considerations are important in service provision to diverse individuals, as building rapport and trust between client and clinician is vital for effective service delivery. SLPs must be knowledgeable about these possible difficulties in order to prevent their occurrence and avoid disrespecting or alienating the populations they are tasked to serve.

Providing equitable services. SLPs are required to provide appropriate, quality services that are equally accessible to all individuals (D’Souza et al., 2012; Kimble, 2013). This can be challenging at times due to the nature of aforementioned issues with training and

preparation of professionals, as well as individual differences between clients. Therefore, many SLPs may feel uncomfortable or anxious when serving diverse individuals (Kimble, 2013). As the numbers of CLD individuals on the caseloads of SLPs grow, this challenge only increases (Verdon et al., 2015). Due to the amount of heterogeneity that exists, even within cultural and linguistic groups, it is not feasible to develop one general strategy that would work for all of these groups (Verdon et al., 2015). Nonetheless, some professionals and researchers attempt to apply a one-size fit all approach to working with diverse populations causing further issues. This strategy has often led to practices that are based on the dominant cultural and linguistic group and do not take into consideration the complexity and variations that exist between and within cultural and linguistic groups (Verdon et al., 2015). It has been suggested that the definition of culture should be expanded so that each individual, regardless of age, gender, socio-economic status, sexuality, disability, language, or any other factor is treated as an individual rather than as a member of a larger, heterogeneous group, and provided with services that are fair and unbiased (Marshall, 2003). These are considerations that are important for all practicing SLPs as most SLPs will have diverse individuals on their caseloads.

Winter (1999) found that, rather than one specialist SLP working with all of the bilingual individuals in an area, it was much more common for these individuals to be spread among the caseloads of several SLPs. Therefore, few SLPs have truly specialized bilingual caseloads and most have too few of these individuals to devote substantial time and energy into making services provided to them as individualized as possible (Winter, 1999). Service provision to a few diverse individuals is too often not prioritized by SLPs who already have full caseloads (Winter, 1999) although this can negatively impact the quality of services

provided to those individuals. Frequently in the United States, clinicians who speak the language or languages of the individual are difficult to locate, so it is often not as easy as simply making a referral to a professional who is better prepared to handle the case (D'Souza et al., 2012). This calls into question whether the current state of CLD service provision by monolingual SLPs can be called competent or equal.

One consequence that may result from failing to take linguistic and cultural differences into consideration during service provision is the misdiagnosis of individuals. In this case, bilingual children with a disorder may be mislabeled as exhibiting a language difference, or children who are not disordered may be incorrectly labeled as disordered. This can be a very serious issue, as misdiagnosis can lead to children not receiving therapy when they need it (Mennen & Stansfield, 2006; Winter, 1999). On the other hand, many bilingual children receive unnecessary therapy when they are inappropriately referred and assessed, and found to exhibit a disorder when one does not exist (Mennen & Stansfield, 2006; Winter, 1999).

Over-representation on the caseloads of SLPs can be damaging to the self-esteem of a typically developing child, who is labeled incorrectly as disordered, but also to other children who need services and resources that are being drained by children who do not need them (Winter, 1999). This over-identification of individuals as disordered can stem from several sources, such as a lack of knowledge of the second language on the part of the SLP, or assessment tools that do not accurately differentiate disorder from difference (Mennen & Stansfield, 2006; U.S. Department of Education, Office of Language Acquisition, 2015). Over-representation often occurs when standardized tests that were normed on standard English-speakers are given to diverse individuals (Derr, 2003). Specifically during

assessment, over-identification can occur when children are penalized for exhibiting a language difference, due to insensitivity of testing materials or the SLP's lack of knowledge of differences versus disorders (Muñoz, White, & Horton-Ikard, 2014). Winter (2001) found that over-representation might be the norm, alerting to a serious issue of inequality in service to diverse populations.

Under-representation occurs when a particular group is not represented at a level that is proportionate to the population of the group (Derr, 2003). When this occurs, individuals are at a disadvantage. They may not receive important intervention, causing possible lasting effects on self-esteem, educational achievement, and achievement later in life (Winter, 2001). Under-representation may occur for a number of reasons. Limited understanding of language development, as well as factors that cause over-identification such as insensitive tests and difficulty differentiating disorder from difference can also cause under-identification (Kohnert, 2010). When SLPs are not knowledgeable about the development of languages, they may delay identification or identify only the most serious of cases (Kohnert, 2010). SLPs may feel justified in delaying intervention until they are sure that it is necessary, but this practice is still unfair to those children who need early intervention in order to minimize effects of delays and disorders later in life. Often families who are recent immigrants do not realize the extent of the services that are available to them, while some may not value or feel comfortable with the services offered by SLPs (Derr, 2003). Because of this lack of knowledge, some families may not be able to advocate for their children who need services but are not referred.

Kritikos (2003) found that nearly 40% of SLPs admitted that they were not equally likely to suggest intervention for bilinguals as they were for monolinguals. This suggests that

diverse individuals may not be as likely to receive needed intervention, undermining the equality of service provision (Levey & Sola, 2013). If this is because SLPs know service provision to these bilingual individuals will be more difficult, bilingual individuals are at an extreme disadvantage when compared with monolingual peers, which is counterintuitive to equitable service provision (Winter, 2001). Unfortunately, some SLPs who want to improve these issues feel powerless to do so (Winter, 2001). Nonetheless, it is an extremely important issue to address, as populations of diverse individuals are only going to continue to grow.

Demonstrating competency in service provision. SLPs must be aware of and take into consideration cultural factors that could affect their services to diverse individuals. This is referred to as cultural competence. A call for cultural competence requires professionals to be aware of the “breadth of diversity” which includes factors such as variations in dialect, acculturation, age, and other small differences that may occur between individuals or groups (Levey & Sola, 2013). Understanding of these factors and of the development of language in bilingual individuals helps SLPs assess and interpret observations more accurately (Derr, 2003; Muñoz et al., 2014). However, maintaining competence in a world of ever-increasing diversity and knowledge is often a challenge for SLPs.

Newly certified clinicians may be knowledgeable and hold a high degree of cultural competence, but this is difficult to maintain (Crowley et al., 2015). One difficulty these professionals face is providing appropriate services in settings where colleagues and supervisors do not hold knowledge or skills that are up to date (Crowley et al., 2015). Being new to the field, it can be difficult for these professionals to go against the recommendations of their supervisors or colleagues with more experience, even if they are following practices and utilizing skills learned in their training.

SLPs may feel they lack competence if they are unfamiliar with the languages and cultures of the individuals they are serving or if they are not equipped with appropriate tools for assessment (Kimble, 2013). SLPs report feeling more competent when working with individuals who speak English as their primary language or when interpreters who speak the other language of the individual are available to assist with service provision than when the primary language of the individual is Spanish or when parents do not speak English (Hammer et al., 2004; Kimble, 2013). Williams & McLeod (2012) found that in a survey of Australian SLPs many reported feeling only minimally competent working with bilingual clients, even those reporting some level of competence in a language other than English. Kritikos (2003) surveyed American SLPs to assess beliefs about efficacy in the field of speech-language pathology. Of those who completed the survey, 55% reported they spoke and understood a second language (Kritikos, 2003). Whether bilingual or monolingual, most SLPs reported being somewhat or not competent in the assessment of development of a language they did not speak, thus having low personal efficacy (Kritikos, 2003). This finding was consistent when the SLPs were asked about general efficacy of services, yet participants judged the efficacy of the field as lower than their own personal efficacy (Kritikos, 2003). The monolingual participants reported that they perceived their competency as being low due to lack of knowledge, while bilingual participants reported proficiency and experience as the reasons for their low efficacy (Kritikos, 2003). These studies by Williams and McLeod (2012) and Kritikos (2003) suggest that hiring more bilingual SLPs, a practice that is commonly believed to be an effective method of improving service provision to diverse individuals, may not be as effective as often believed. Williams and McLeod (2012) suggest instead, that a more valuable resource is those SLPs who are “pro-active [*sic*] and confident”

and “who apply their existing skills, knowledge, and ability to consider the evidence to working with multilingual clients” (p. 304).

Provision of services. Service provision to bilingual individuals follows a general pattern described by Byers-Heinlein and Lew-Williams (2013) as a five-step process. In step one, the SLP must assess the language abilities for each language used by the individual (Byers-Heinlein & Lew-Williams, 2013). Next, the abilities and disabilities in the sounds, words, grammar, and conversation skills of both languages must be integrated into a whole, creating a coherent picture of the language of the individual (Byers-Heinlein & Lew-Williams, 2013). Once the languages of the individual are taken as one whole unit, the SLP will evaluate whether or not a delay or disorder exists (Byers-Heinlein & Lew-Williams, 2013). In the fourth step, the cognitive and linguistic capacities of the individual should be compared to typical and atypical, monolingual peers as well as bilingual peers, when possible (Byers-Heinlein & Lew-Williams, 2013). Lastly, the SLP will create a plan for intervention that encompasses the range of linguistic and cognitive competencies in the languages of the individual (Byers-Heinlein & Lew-Williams, 2013).

Information and research needed for the provision of services to diverse populations is often inadequate in the United States (McLeod et al., 2013; Stow & Dodd, 2003). Thus, appropriate service delivery is often not provided to those who need it. Lack of knowledge of grammatical characteristics of languages and of developmental norms for languages; lack of tools for assessment and intervention in languages other than English; and lack of professionals with knowledge of other languages are all contributing factors to why service delivery is often not adequate (D’Souza et al., 2012). In most cases, services provided to diverse individuals will not involve SLPs who speak their native languages (Williams &

McLeod, 2012). Therefore, in order to improve this issue of service delivery inadequacy, SLPs need to strive for the ability to support even those languages that they do not speak (Williams & McLeod, 2012).

Assessment. ASHA provides a document outlining preferred practice guidelines. In section 19, titled “Speech-Language Assessment for Individuals Who Are Bilingual and/or Learning English as an Additional Language,” ASHA (2004b) breaks down each component of assessment and lists relevant considerations that must be made. Assessment includes the identification of language use and proficiency as well as possible deficiencies, limitations, and barriers in both or all languages (American Speech-Language-Hearing Association, 2004b). These services are provided by professionals who are credentialed and trained as SLPs, either in collaboration with other relevant professionals, such as interpreters and medical personnel, or as an individual (ASHA, 2004b). The purpose of assessment is to uncover strengths and weaknesses in the underlying foundations of language, as well as pinpoint any existing impairments in order to determine how they affect communication (ASHA, 2004b). Other results of assessment include diagnosis of disorders, clinical description of abilities in each language, effectiveness of any interventions administered previously, prognosis and recommendations for subsequent services, and any other relevant referrals (ASHA, 2004b).

This document also describes the clinical process recommended for assessing bilingual individuals, including extra considerations to ensure that the SLP is sensitive to the diversity exhibited by the individual. Assessments should include a preliminary inspection of auditory, visual, motor, and cognitive systems (ASHA, 2004b). They should also include a case history that determines exposure to all languages, including information from parents,

caregivers, teachers, and any other individual familiar with the communication of the individual being assessed, as well as the individual's own opinions and beliefs about their communication (ASHA, 2004b). The professional will then decide what types of standardized or nonstandardized tools will be the most appropriate for the specific individual in question (ASHA, 2004b). Assessments should be conducted in varied settings, including environments that simulate the native or home speech community in order to obtain representative samples of languages used in all contexts (ASHA, 2004b). A report should document the information learned about the individual during assessment as well as provide suggestions for intervention or further referrals, if necessary. Documentation should include background and case history information; a description of the procedures used to determine proficiency in each language; results and interpretations from the assessment process; prognosis; and if relevant, information about intervention, such as frequency and duration, as well as context in which therapy would best be provided (ASHA, 2004b).

When assessing voice, fluency, and hearing in diverse individuals, many of the same strategies used to assess monolingual individuals are sufficient for determining whether or not a disorder is present (Roseberry-McKibbin, 1994). However, when assessing for a language or articulatory disorder, SLPs encounter more difficulty due to the nature and language specificity of these types of disorders (Roseberry-McKibbin, 1994). When assessing diverse individuals, SLPs must take into consideration many language characteristics such as languages spoken, the length and amount of exposure the individual has had to each language, the age of the individual, and other personal characteristics that may affect language production or processing, in order to rule out the possibility of a language difference (Hambly et al., 2013). True delays or disorders will present themselves

in all languages spoken by an individual (Gillam, Peña, Bedore, Bohman & Mendez-Perez, 2013). It is also important to note that bilinguals often have concepts and skills that are more developed in one language than the other (Kohnert, 2010; Peña & Halle, 2012).

Because of these characteristics of the languages of bilinguals, it is recommended that assessment be provided in both or all languages used by the individual, even if one language appears to be more dominant than the other (Gillam et al., 2013; Gross, Buac & Kaushanskaya, 2014; Kohnert, 2010). Even with this knowledge, 75% of the respondents to a survey conducted by Caesar and Kohler (2007) reported that they most often used English tests when assessing bilinguals and Williams and McLeod (2012) found that this same practice was common in Australia. Often SLPs assess and treat only in the language or languages that they speak. This is likely due to the lack of resources needed to conduct services that are considered best practice (D'Souza et al., 2012).

Assessment of diverse individuals should include both direct and indirect language measures including interviews of those familiar with the communication of the individual; histories of development, social behavior, educational development, immigration background, and medical considerations; observations that vary across environments and communicative partners; and direct language testing (Kohnert, 2010). Kayser (1989) recommends a framework of assessment made up of three components: language status, assessment battery, and documentation of differences. Determining language dominance and other information about language use helps guide further assessment and service provision. Assessment batteries created for monolingual English speakers are not appropriate for CLD individuals and, therefore, should not be used to assess them as they would monolinguals (Kayser, 1989). Tests can potentially be modified, but this must be done carefully and with

consideration of the characteristics of the individual for which they are being modified (Kayser, 1989). A language sample is an important piece in determining a difference or disorder as it supplements findings from other types of tests that may not be as sensitive when used on diverse individuals (Kayser, 1989). The fact that an individual is culturally and socioeconomically different alone is not an acceptable reason for the individual to receive services (Kayser, 1989). In fact, if these are the only reasons an individual is being referred or treated, services are considered to be discriminatory (ASHA, 2016; Civil Rights Act of 1964). Therefore, a documentation of these differences, including ethnic background, level of acculturation, and socioeconomic status, and how they each affect language should be included in the assessment of an individual (Kayser, 1989).

Muñoz et al. (2014) says that “conducting a rich, multifaceted speech-language assessment that draws from multiple unbiased sources is key to avoiding over- and under-identification” (p. 50). SLPs should consider communicative information represented by academic tasks, communication in context, standardized tests as well as nonstandardized tests to provide an overall description of language, and tests that show decontextualized language skills (Muñoz et al., 2014). A variety of strategies should be used to gather as full of a picture of the strengths and weaknesses of an individual as possible as a single test or approach on its own is not enough to determine difference versus disorder in diverse individuals (DeLamo White & Jin, 2011; Roninson, 2003) and bias in assessment can cause under- or over-identification of disorder (Kohnert, 2010).

Assessment is a complex process, and many SLPs encounter similar types of problems when conducting assessments with diverse individuals. This issue is not a new one; Grosjean addressed the fact that bilinguals were being tested by monolingual standards as

early as 1989. It appears that many assessments are still being conducted inappropriately by SLPs years after Grosjean addressed this problem (Caesar & Kohler, 2007). The most common reasons stated for conducting assessments that clearly do not follow recommended practices are a lack of knowledge on the part of the SLPs conducting the assessments, as well as a lack of appropriate tools and tests, and a lack of norms for the development of other languages (Caesar & Kohler, 2007; Gillam et al., 2013; Kritikos, 2003; McLeod et al., 2013; Roseberry-McKibbin et al., 2005).

While gaps in knowledge of cultural and linguistic diversity can affect practice in all areas of service delivery, assessment may be the area most significantly and commonly impacted. Most SLPs in the United States do speak only English, which can sometimes lead to the inappropriate assessment of bilinguals in only one language (Caesar & Kohler, 2007; Gillam et al., 2013; Kritikos, 2003; Roseberry-McKibbin et al., 2005). More influential is the overarching lack of data and information on the development of other languages on the part of the field of speech-language pathology (Byers-Heinlein & Lew-Williams, 2013; D'Souza et al., 2012; Roseberry-McKibbin, 1994). Derr (2003) said "a basic understanding of the normal process of second language acquisition is essential before undertaking an evaluation with a bilingual child" (p. 7). Without access to these patterns of development in typical bilingual individuals, it is extremely difficult to identify when productions and processes are atypical (Hambly et al., 2013; O'Toole & Hickey, 2012). Even with this knowledge, very little research has been done with the aim of creating developmental norms for these languages (Byers-Heinlein & Lew-Williams, 2013). This in conjunction with a lack of awareness of cultural biases on the part of SLPs often leads to the use of biased assessment

tools and, consequently, biased and possibly inaccurate identification of disorders in diverse individuals (Kimble, 2013).

The lack of tests and assessment procedures for diverse individuals is a problem encountered by many SLPs. It is against standards of best practice to assess and diagnose diverse individuals by comparing them to models that do not display the same cultural and linguistic diversity (Crowley et al., 2015). However, due to the lack of resources available, many SLPs do administer standardized tests developed for individuals of the mainstream American culture to individuals from non-mainstream American backgrounds (Crowley et al., 2015). These “static, standardized, quantitative, norm-referenced approaches” (Caesar & Kohler, 2007, p. 191) have been proven to be inadequate in providing accurate diagnoses as they are not sensitive to the development of bilinguals or to normal variations in language and experience exhibited by bilinguals (Muñoz et al., 2014).

The validity of a test is threatened when the way a test is administered leads to outcomes that do not accurately represent the abilities of the individual being tested (Peña & Halle, 2012). Therefore, tests used to assess bilinguals are not valid if the expectations of the test do not match the cultural experiences of the individual, if the items on the test are not culturally relevant to the individual, or if the test was normed on individuals that are not representative of the individual being tested (Peña & Halle, 2012). Some tests may assume procedures or methods that are unfamiliar to individuals from certain groups. For instance, some testing procedures may require an individual to answer in a way that is not reflective of an interaction style used in their culture. Some cultures do not use the one-on-one, question-and-answer structures between adult and child that are commonly utilized in testing procedures (Peña & Halle, 2012; Roseberry-McKibbin, 1994). Cultural rules often dictate

communicative exchanges, especially among children and adults or other persons in positions of respect; therefore SLPs must not assume that children will be familiar with test-taking situations that are common in mainstream American culture (Roseberry-McKibbin, 1994). Specific items on tests may also pose difficulties for diverse individuals. Test items are generated based on developmental data, so that they may be used to indicate at what level a child is operating, depending on how they perform on certain items (Peña & Halle, 2012). However, developmental norms created for one group are not appropriate for all individuals (Peña & Halle, 2012). Problems may also arise when test items are translated, as this can change the level of difficulty or the meaning of the task, interfering with the validity of the test even further (Peña & Halle, 2012).

One of the most common problems with these types of probes is the population that they are normed on. As previously established, using middle-class English-speaking individuals as the norm makes materials inadequate for any individual other than that specific population (Kayser, 1989). As most tests are normed primarily on these populations, discriminatory and biased assessment may result when they are used on diverse individuals (Peña & Halle, 2012; Roseberry-McKibbin, 1994). This discrimination occurs because the experiences and linguistic knowledge of a diverse individual are different enough from those on whom the test was normed that the diverse individual is penalized unfairly for their lack of knowledge, resulting in a phenomenon referred to as content bias (DeLamo White & Jin, 2011; Roseberry-McKibbin, 1994). Standardized tests may also invoke linguistic biases, due to the strict manner in which they are scored, leaving no room for variations that may occur due to culture, dialect, or language (DeLamo White & Jin, 2012). Some tests are available in languages other than English, but even these tests are commonly normed on monolingual

English-speakers, making them inappropriate to use with any population other than monolingual English-speakers (D'Souza et al., 2012; Peña & Halle, 2012). Hambly et al. (2013) and Peña and Halle (2012) recommend development of norms for different diverse groups, but because of heterogeneity even among individuals of the same group, this does not fully solve the problems associated with using standardized tests with bilinguals (Kohnert, 2010).

Other methods for improving upon standardized test use with bilingual individuals have been proposed. Often SLPs are pressured by supervisors or agencies to provide standardized language scores, even for diverse individuals (O'Toole & Hickey, 2012). Because of this, SLPs may resort to using informal translations of tests (O'Toole & Hickey, 2012). However, test translations are not necessarily the same as the original test in content, difficulty, validity, or reliability, and scores derived from these tests should not be reported for the determination of ability and subsequent service delivery (DeLamo White & Jin, 2011; Derr, 2003; Roseberry-McKibbin, 1994). Therefore, translating standardized tests is not a recommended practice, and in fact is one that many students are warned against doing (DeLamo White & Jin, 2011; Stow & Dodd, 2003). Yet, SLPs still use this method during assessment of bilinguals (Stow & Dodd, 2003). Criterion-referenced (CR) measures are one method that can be used in place of norm-referenced measures in order to better evaluate diverse individuals (DeLamo White & Jin, 2011). CR measures are informal assessments that allow for more variation in the "correct" response and use materials and interaction styles that correspond to the cultural or linguistic group of the individual in order to help alleviate bias in testing (DeLamo White & Jin, 2011). One example of a CR measure would be a language sample. Dynamic assessment (DA) is another alternative to standardized testing.

DA assesses the individual's ability to learn language over time with intervention and other supports and is based on Vygotsky's theory of the "zone of proximal development" (DeLamo White & Jin, 2011, p. 620; Roseberry-McKibbin, 1994). DA assesses the individual's "potential for learning" when problems that may affect language are targeted and language development is supported (DeLamo White & Jin, 2011, p. 620; Roseberry-McKibbin, 1994).

Unfortunately, these methods can be extremely time-consuming (DeLamo White & Jin, 2011) and as Verdon et al. (2015) found, many research-based alternatives to typical, inadequate assessments are not implemented due to time constraints put on SLPs. Thus, even with these well-documented issues proving that they are inadequate in testing CLD individuals, formal, standardized tests are still used frequently by SLPs (Caesar & Kohler, 2007). In order to improve assessment, better tests need to be developed and more time and resources need to be allocated to the assessment of diverse individuals (Roseberry-McKibbin et al., 2005; Verdon et al., 2015).

Intervention. Best current practice dictates that intervention is provided in all languages spoken by the individual, or at least in the native language (Derr, 2003; Kohnert, 2010; Thordardottir, Cloutier, Ménard, Pelland-Blais & Rvachew, 2015). Bilingual intervention is the most beneficial, as it targets both languages (Thordardottir et al., 2015). Intervention is not effective unless improvement is shown in both languages (Thordardottir et al., 2015). When therapy targets only the stronger language, there is some evidence that the overall language system is strengthened, but each language must be targeted in order to improve them individually (Thordardottir et al., 2015). However, even with this knowledge, most SLPs target only one language, which frequently happens to be the majority language of the community and the weaker language of the CLD individual (Thordardottir et al.,

2015). Due to the fact that most SLPs are monolingual English-speakers, intervention is most often provided only in English (Kohnert, 2010; McLeod et al., 2013; Thordardottir et al., 2015; Williams & McLeod, 2012). This occurs because SLPs have difficulty providing therapy in a language that they do not speak, and bilingual SLPs and other bilingual support staff, such as interpreters, who speak the languages of all clients, are not readily available (Derr, 2003; Kohnert, 2010; McLeod et al., 2013; Thordardottir et al., 2015; Williams & McLeod, 2012). However, Kohnert (2010) reiterates that SLPs do not have to speak both languages of the individual in order to support the development of that language. Even so, SLPs who lack training and necessary resources may find it very difficult to develop intervention plans and set therapy goals, especially when developmental norms for the other language are not available (McLeod et al., 2013; Winter, 1999).

Therapy should be sensitive to cultural and linguistic differences between groups and individuals as well. Intervention should consider language status and learning styles of the individual as well as the beliefs and goals of the parents (Derr, 2003). Yet, in some cases, parental values and wishes for intervention may go against what SLPs know to be the best EBP (Derr, 2003). Thus, SLPs may provide therapy only in English due to requests from the parents to target only that language (Williams & McLeod, 2012). Parents often do not have knowledge about how bilingual therapy works and may not understand why targeting both languages is so important during therapy (McLeod et al., 2013). Decisions to abandon their native language during service provision may stem from attitudes felt from the dominant language community and wishes for their children to improve in the majority language as they feel as if this will be best for their future success (McLeod et al., 2013). Thus, contradictions may arise between what SLPs know to be the best practice for these diverse

individuals and the wishes of parents that their children become monolingual English-speakers (Verdon et al., 2015). Nonetheless, SLPs should strive to follow what they know to be the best EBP when providing intervention to diverse populations. Better resources and developmental norms, as well as supports for SLPs conducting intervention in languages they do not speak, are important for improving the current condition of intervention for CLD populations.

Ethics of Current Bilingual Service Provision

In many cases, SLPs are not providing services that are consistent with guidelines from ASHA and the current EBP. As the field of speech-language pathology grows, so must the competencies of SLPs, to ensure they are providing ethical services (Crowley, 2004). Oftentimes, SLPs are not supported or provided with the resources and knowledge they need to provide the best services possible.

In this study, a survey of SLPs will be conducted to explore questions raised by other studies concerning ethics in current service provision. Information will be gathered on the caseloads and service provision provided to CLD populations by these SLPs, as well as their perceptions of their own service provision and how it compares to that of the field. Opinions and beliefs for how these issues can be solved and what the field of speech-language pathology should be doing about these issues will also be collected.

This study will address the following questions:

- Are services provided to CLD individuals by SLPs ethical?
- Do SLPs with higher levels of preparation to serve this population provide more ethical services than do those with lower levels of preparation?
- Do SLPs feel as if stricter guidelines for serving CLD populations are needed?

Methodology

Survey Instrument

Data for this study were collected through the a survey entitled “Ethics in Service Provision to Bilingual Individuals” and practicing SLPs served as the participants for the survey. This survey was developed through the online Qualtrics survey software and consisted of a total of 24 questions and five sections. Yes/No, multiple choice, Likert-type, and open-ended question formats were used in the development of this survey. This survey can be seen in its entirety in appendix A of this document.

This survey was conducted electronically in a manner that made all responses completely anonymous and was considered exempt by the Institutional Review Board at Appalachian State University in Boone, North Carolina.

Due to the nature of certain questions, display logic was applied so that based on the answers given, more information would be requested of the participant, if appropriate. For instance, if the participant indicated that he or she was an SLP holding the ASHA Certificate of Clinical Competence (CCC-SLP; section 2, Q2.1, see appendix A), more questions would follow, whereas if he or she indicated the contrary, no further questions would be displayed.

The first section of the survey requested the participant’s consent in continuing the survey and consisted of one question. This section provided information about the purpose, procedure, risks, benefits, participation, and contact information relevant to the survey. A response of “No, I do not consent,” for this question would conclude the survey session for the participant, not allowing the display of any further survey questions.

Section two of the survey collected the demographic and caseload information of the participant and consisted of a total of seven questions. The first question determined whether

or not the participant was a practicing SLP. If the participant indicated that he or she was a practicing SLP, further questions about the state in which he or she practiced, the number of years he or she had been practicing, and whether or not the individual spoke any language other than English were displayed. If the participant indicated that he or she did speak a language other than English, further information was requested.

Section three of the survey collected personal response information on the caseload, education, and service provision of the participants and consisted of seven questions. Participants were asked to indicate the percentage of their caseloads made up of linguistically diverse individuals as well as their preparation and education in areas related to serving these individuals.

Section four of the survey collected opinions of the ethics of service provision to CLD populations and consisted of four questions. In this section, participants were asked about the ethics of their own practices, the ethics of current EBP and knowledge in the field, and the ethics of services provided by SLPs in the United States.

Section five of the survey collected opinions on how the field of SLP should proceed in relation to this issue and consisted of five questions. Participants were asked about how education should be improved and whether or not ASHA would benefit from imposing stricter guidelines. The survey concluded with two open-ended questions allowing the participants space to respond to how they believed ASHA should improve upon education and preparation of SLPs (if they responded “Yes” when asked whether there should be stricter guidelines, Q5.3, see appendix A) and to add any additional comments, suggestions, or concerns.

The survey in its entirety was subjected to review by two licensed SLPs working on the committee for this undergraduate thesis project. Based on feedback from these professionals in the areas of content and organization, revisions were made resulting in the final version of the survey that was administered. Even so, there were some errors in the survey that were brought to the attention of the principle investigator during the survey administration. One such error was in section 2, where the question between Q2.2 and Q2.3 was numbered incorrectly as Q24. This should be changed to reflect the correct numbering sequence. As well, in Q3.1 the answer choice “26-40%” should have appeared as “26%-40%” and the answer choice “Greater that 70%” should have appeared as “Greater than 70%.” The Likert-scale in Q3.7 was incorrectly represented as “Very Confident, Somewhat Confident, Slightly Confident, Slightly Unconfident, Somewhat Confident, Very Unconfident” when it should have appeared as “Very Confident, Somewhat Confident, Slightly Confident, Slightly Unconfident, Somewhat Unconfident, Very Unconfident.” These errors have been fixed in the version of the survey that has been included in appendix A.

Recruitment of Participants

Survey links were posted along with a request for participation in this research (see appendix B) in online forums. This includes the ASHA Community forums for Early Intervention, Health Care, Private Practice, Research, Schools, and Special Interest Group 14: Cultural and Linguistic Diversity; Facebook groups “Speech-Language Pathologists,” “Medical SLP Forum,” and “The American Speech-Language-Hearing Association”; and Reddit subreddits of “SLP” and “TheMulticulturalSLP.” Email requests were also made of specific parties to distribute the survey further.

Analysis

Analysis was conducted using the IBM SPSS Statistics software. For the majority of the analyses, descriptive statistics were computed for each of the variables. In order to compare correlations between independent variables, independent t-tests were run.

Results

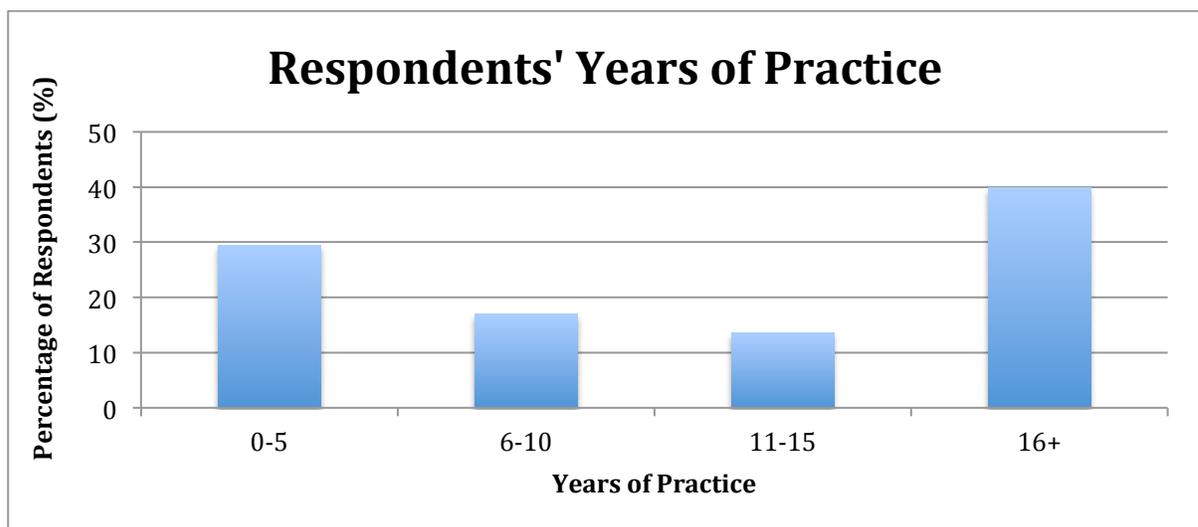
A total of 101 surveys were electronically submitted. Of the 101 surveys that were submitted, 88 were completed without an excessive number of blank items and thus considered valid for the purpose of analysis.

Results are presented in 3 sections, outlining findings as they pertain to demographic and caseload information, beliefs about ethics, and the impact of personal factors on beliefs about ethics.

Demographics and Caseload

Of the 88 valid responses, all (100%) were SLPs holding the certificate of clinical analysis from ASHA. The greatest number of respondents indicated that they had practiced for 16 or more years (35 respondents, 39.8%), followed by 0-5 years (26 respondents, 29.5%; See Q 2.3). See the chart below for a visualization of the years of practice.

Figure 1. Respondents' years of practice.



Respondents were asked to indicate the state in which they practiced. The most common states were California with 12 respondents (13.6%), Texas with 9 respondents (10.2%), and Illinois with 7 respondents (8.0%; See Q 2.2). See the chart below for a comprehensive list of the states of practice represented by these respondents.

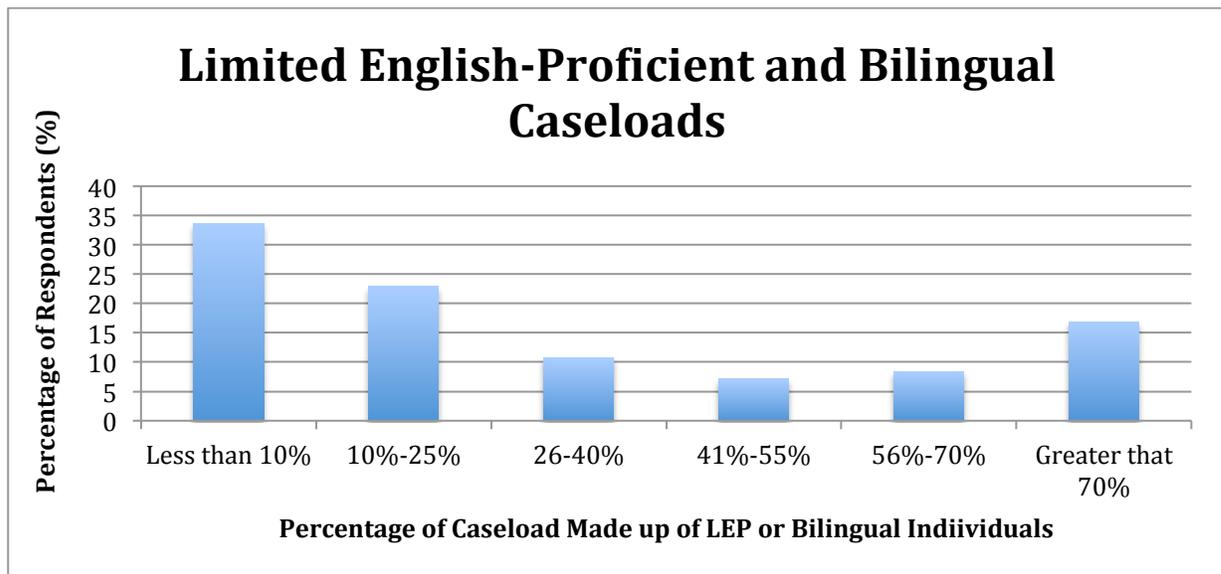
Table 1. Respondents' state of practice.

| State | Number of Respondents (n) | Percentage of Respondents (%) |
|----------------|----------------------------------|--------------------------------------|
| Alaska | 2 | 2.3 |
| Arizona | 2 | 2.3 |
| Arkansas | 1 | 1.1 |
| California | 12 | 13.6 |
| Colorado | 2 | 2.3 |
| Connecticut | 2 | 2.3 |
| Delaware | 1 | 1.1 |
| Florida | 5 | 5.7 |
| Illinois | 7 | 8 |
| Indiana | 2 | 2.3 |
| Iowa | 1 | 1.1 |
| Louisiana | 1 | 1.1 |
| Maryland | 1 | 1.1 |
| Massachusetts | 4 | 4.5 |
| Michigan | 1 | 1.1 |
| Minnesota | 1 | 1.1 |
| Missouri | 1 | 1.1 |
| New Jersey | 1 | 1.1 |
| New Mexico | 1 | 1.1 |
| New York | 5 | 5.7 |
| North Carolina | 4 | 4.5 |
| Ohio | 4 | 4.5 |
| Oregon | 3 | 3.4 |
| Pennsylvania | 6 | 6.8 |
| Rhode Island | 1 | 1.1 |
| Tennessee | 1 | 1.1 |
| Texas | 9 | 10.2 |
| Utah | 1 | 1.1 |
| Virginia | 1 | 1.1 |
| Other | 5 | 5.7 |

| | | |
|-------|----|-----|
| Total | 88 | 100 |
|-------|----|-----|

Of these 88 respondents, 58 (65.9%) reported that they speak a language other than English with some level of proficiency (See Q 2.4). Respondents indicated the following about the percentage of limited-English proficient and bilingual individuals making up their caseloads: 28 (33.7%) indicated having less than 10%, 19 (22.9%) indicated having 10-25%, 9 (10.8%) indicated having 26-40%, 6 (7.2%) indicated having 41-55%, 7 (8.4%) indicated having 56-70%, and 14 (16.9%) indicated having greater than 70% (See Q 3.1).

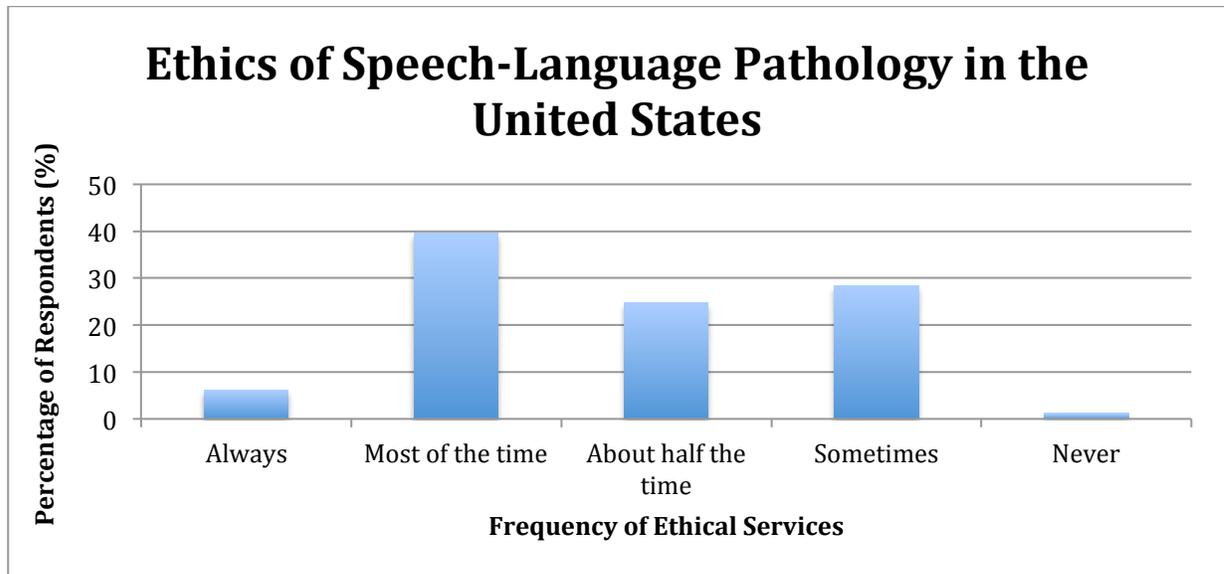
Figure 2. Percentage of caseload made up of LEP or bilingual individuals.



Beliefs About Ethics and Current Practice Guidelines

Respondents were asked to rate how often they felt that services provided to CLD populations by SLPs in the United States were ethical, as defined by ASHA (See Q 4.3). The majority of respondents felt as if services to this population are ethical “Most of the time” (39.5%) or “Sometimes” (28.4%), followed by “About half the time” (24.7%). Fewer respondents felt as if these services are ethical “Always” (6.2%) or “Never” (1.2%).

Figure 3. Frequency of ethical service provision.

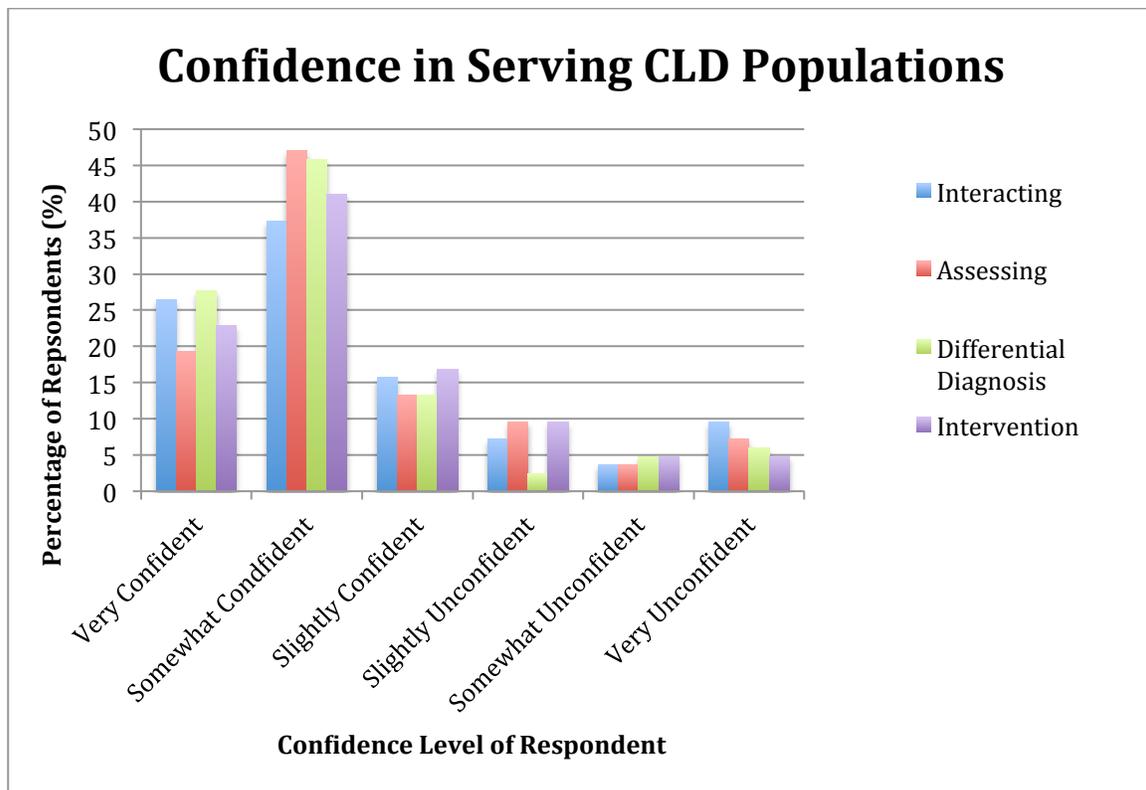


Respondents were also asked to rate how often the services that they provide themselves to CLD populations followed current EBP guidelines (See Q 4.1). The majority of respondents (51.9%) felt as if they followed EBP “Most of the time.” Other respondents felt as if they followed EBP “Always” (19.8%), “About half the time” (13.6%), “Sometimes” (13.6%), or “Never” (1.2%).

Respondents were asked to rate how confident they felt in their own practices for several activities that related to serving CLD populations (See Q 3.7). While interacting with and gathering information from parents or guardians who do not speak English or are LEP, respondents indicated that they felt: “Very Confident” (26.5%), “Somewhat Confident” (37.3%), “Slightly Confident” (15.7%), “Slightly Unconfident” (7.2%), “Somewhat Unconfident” (3.6%), “Very Unconfident” (9.6%). While assessing CLD individuals, respondents indicated that they felt: “Very Confident” (19.3%), “Somewhat Confident” (47.0%), “Slightly Confident” (13.3%), “Slightly Unconfident” (9.6%), “Somewhat Unconfident” (3.6%), “Very Unconfident” (7.2%). In differentiating between a language difference and a true disorder, respondents indicated that they felt: “Very Confident”

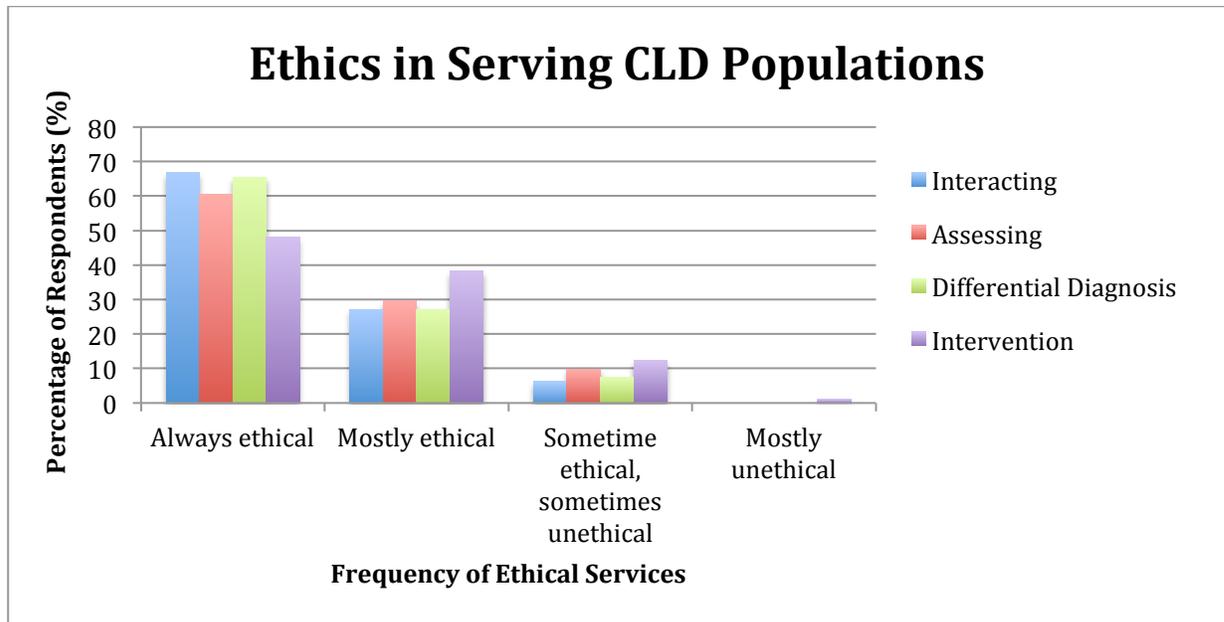
(27.7%), “Somewhat Confident” (45.8%), “Slightly Confident” (13.3%), “Slightly Unconfident” (2.4%), “Somewhat Unconfident” (4.8%), “Very Unconfident” (6.0%). While providing intervention to CLD populations, respondents indicated that they felt: “Very Confident” (22.9%), “Somewhat Confident” (41.0%), “Slightly Confident” (16.9%), “Slightly Unconfident” (9.6%), “Somewhat Unconfident” (4.8%), “Very Unconfident” (4.8%).

Figure 4. Confidence levels of SLPs in serving CLD populations, where “Interacting” represents “Interacting with and gathering information from parents/guardians who do not speak English or who are limited English-proficient (LEP),” “Assessing” represents “Assessing individuals who are CLD,” “Differential Diagnosis” represents “Differentiating between difference and disorder,” and “Intervention” represents “Providing intervention to individuals who are CLD.”



Respondents were asked to rate how ethical their own practices were for several activities that related to serving CLD populations (See Q 4.4). While interacting with and gathering information from parents or guardians who do not speak English or are LEP, respondents indicated that they felt: “Always ethical” (66.7%), “Mostly ethical” (27.2%), “Sometimes ethical, sometimes unethical” (6.2%). While assessing CLD individuals, respondents indicated that they felt: “Always ethical” (60.5%), “Mostly ethical” (29.6%), “Sometimes ethical, sometimes unethical” (9.9%). In differentiating between a language difference and a true disorder, respondents indicated that they felt: “Always ethical” (65.4%), “Mostly ethical” (27.2%), “Sometimes ethical, sometimes unethical” (7.4%). While providing intervention to CLD populations, respondents indicated that they felt: “Always ethical” (48.1%), “Mostly ethical” (38.3%), “Sometimes ethical, sometimes unethical” (12.3%), “Mostly unethical” (1.2%).

Figure 5. Ethics of SLP practice when serving CLD populations, where “Interacting” represents “Interacting with and gathering information from parents/guardians who do not speak English or who are limited English-proficient (LEP),” “Assessing” represents “Assessing individuals who are CLD,” “Differential Diagnosis” represents “Differentiating between difference and disorder,” and “Intervention” represents “Providing intervention to individuals who are CLD.”



Respondents were asked whether or not they believed that ASHA should have stricter guidelines for the education and preparation of SLPs serving CLD populations (See Q5.3). 43 respondents (53.1%) indicated that, yes, they believed stricter guidelines needed to be made, while 38 respondents (46.9%) indicated that they believed the guidelines were strict enough as they are.

Individual Impact on Ethics

Independent-samples *t*-tests were conducted through the SPSS Statistics software program to answer the question of whether or not SLPs who have been properly prepared through their training to serve CLD populations are more ethical in their services to these individuals.

First, an independent-samples *t*-test was conducted to compare the ethics of practice during interactions and the gathering of information from parents or guardians who do not speak English or are LEP for SLPs who rated themselves in the “properly prepared to serve CLD individuals” condition and for SLPs who rated themselves in the “not being properly

prepared to serve CLD individuals” condition. There was not a significant difference ($p>0.05$) in the scores for being prepared ($M=1.31$, $SD=0.508$) and not being prepared ($M=1.53$, $SD=0.718$) conditions; $t(79)=1.653$, $p=0.102$. These results suggest that preparation does not have an effect on the ethics of service provision of SLPs when interacting with parents or guardians who do not speak English.

A second independent-samples *t*-test was conducted to compare the ethics of practice during the assessment of CLD individuals for SLPs who rated themselves in the “properly prepared to serve CLD individuals” condition and for SLPs who rated themselves in the “not being properly prepared to serve CLD individuals” condition. There was a significant difference ($p<0.05$) in the scores for being prepared ($M=1.35$, $SD=0.561$) and not being prepared ($M=1.72$, $SD=0.772$) conditions; $t(79)=2.509$, $p=0.014$. These results suggest that preparation does have an effect on the ethics of service provision of SLPs when assessing CLD populations. Specifically, it suggests that those with more preparation are more ethical when assessing these individuals.

A third independent-samples *t*-test was conducted to compare the ethics of practice during differentiating between a difference and a disorder for SLPs who rated themselves in the “properly prepared to serve CLD individuals” condition and for SLPs who rated themselves in the “not being properly prepared to serve CLD individuals” condition. There was a significant difference ($p<0.05$) in the scores for being prepared ($M=1.27$, $SD=0.491$) and not being prepared ($M=1.66$, $SD=0.745$) conditions; $t(79)=2.850$, $p=0.006$. These results suggest that preparation does have an effect on the ethics of service provision of SLPs when differentiating between a difference and a disorder. Specifically, it suggests that those with more preparation are more ethical when differentiating between diagnoses.

A fourth independent-samples *t*-test was conducted to compare the ethics of practice during the provision of intervention to individuals who are CLD for SLPs who rated themselves in the “properly prepared to serve CLD individuals” condition and for SLPs who rated themselves in the “not being properly prepared to serve CLD individuals” condition. There was a significant difference ($p < 0.05$) in the scores for being prepared ($M = 1.53$, $SD = 0.649$) and not being prepared ($M = 1.88$, $SD = 0.833$) conditions; $t(79) = 2.085$, $p = 0.040$. These results suggest that preparation does have an effect on the ethics of service provision of SLPs when providing intervention to CLD populations. Specifically, it suggests that those with more preparation are more ethical when providing intervention to these individuals.

Discussion

The results of this study appear to support the results of previous studies in the ethics of service provision to CLD populations, especially in how beliefs about personal ethics compare to beliefs about the ethics of the field as a whole. The results of this study appear to add to the knowledge of how preparation of SLPs in serving CLD population effect the ethics of the services provided.

Survey data provided information about the demographics of the SLPs who responded as well as the basis for answers to the following questions: “Are services provided to CLD individuals ethical?,” “Do SLPs with higher levels of preparation to serve this population provide more ethical services than do those with lower levels of preparation?,” and “Do SLPs feel as if stricter guidelines for serving CLD populations are needed?”

Demographics

The number of years of practice of the respondents of this survey appears to replicate findings in previous works (D’Souza et al., 2012; Kritikos, 2003). Kritikos (2003) found that

55% of respondents had practiced for more than 11 years, while 45% had practiced for 10 years or less. D'Souza et al. (2012) had similar findings, in that approximately half of the respondents (50.8%) had practiced for more than 10 years, while the other half (49.2%) had practiced for less than 10 years. In the current study, 53.4% of the respondents had practiced for more than 11 years while approximately 46.6% had practiced for 10 years or less.

The number of respondents who indicated that they spoke another language in the current study differed from findings in previous studies (Centeno, 2015; D'Souza et al., 2012; Kritikos, 2003; Williams & McLeod, 2012). A study conducted in 2015 by Centeno of SLPs in California, Florida, New York, and Texas found that 20.8% of respondents spoke a language other than English. A study by Kritikos in 2003 surveying similar states (California, Florida, Michigan, New Mexico, New York, and Texas) found that 55% of respondents spoke in different languages. Kritikos (2003) offered as a caveat that this number could be higher than previous studies due to purposeful targeting of bilingual SLPs. A study conducted by Williams and McLeod (2012) with Australian SLPs found similarly high rates (48.4%). The study at hand found higher rates than any of these studies, with 65.9% of respondents indicating their ability to speak a language other than English. However, a study conducted by D'Souza et al. (2012) in Canada found astonishingly high rates of bilingual SLPs (78.1%), possibly due in part to the greater linguistic diversity of a county with multiple official languages. It is possible that the study at hand had higher rates of bilingualism than did other similar, American-based surveys in part due to the targeting of bilingual SLPs during recruitment for the survey (as seen in Kritikos 2003). Other differences between the rates of the current study and the study conducted by Kritikos (2003) could be

accounted for by the time that has passed between the two studies, allowing for greater diversity of languages within the field.

In the current study, over half (56.6%) of the respondents indicated that they had 15% or less of their caseload made up limited LEP or bilingual individuals. This is consistent with the findings of Winter (1999) that it is common for CLD individuals to be spread among the caseloads of multiple SLPs rather than being concentrated on the caseload of a single SLP.

Ethics of Current Services

When SLPs were asked to rate how ethical the practices of SLPs in serving CLD populations were as a whole, the majority (92.6%) said that practices were ethical only sometimes, half of the time, or most of the time. This contrasts with what they reported about their own personal ethics. When rating the frequency at which personal service provision followed EBP, the majority of respondents rated themselves as doing this always or most of the time (71.6%). Their ratings of personal ethics were also rated much higher than that of the field as a whole (interactions with parents, 93.8% always or mostly ethical; assessment, 90.1% always or mostly ethical; differentiating between a difference and disorder, 92.6% always or mostly ethical; intervention, 86.4% always or mostly ethical). In the study conducted by Kritikos (2003) a similar trend can be seen: SLPs rate their personal efficacy as significantly higher than that of the field (general efficacy). This suggests that the respondents felt as if their own service provision was more ethical than that of the field as a whole. These results could be a factor of the higher rates of bilingual SLPs who responded to this survey (due to purposeful recruitment practices), or it could suggest a more general trend of survey respondents.

In addition, there is a contrast between how respondents rated the ethics of their services and the level of confidence they felt in that area of service provision. While 93.8% felt as if they were ethical in their interactions with CLD parents or guardians, 36.1% felt only slightly confident to very unconfident in this area. When assessing, 90.1% rated their services as mostly or always ethical, 33.7% felt only slightly confident to very unconfident in this area of service provision. While it cannot be assumed that higher confidence in these areas of service provision leads to more ethical services, this trend could indicate a deeper issue. When asked, SLPs may be more comfortable rating their confidence levels in serving this population as lower, but not in indicating that the services they provide are less ethical than they believe they should be. The stigma attached to admitting that their services are less than ethical could lead SLPs to rate the ethics of their services as higher than they really are. Conversely, some SLPs may rate their confidence levels as lower than they actually are due to doubts and lack of preparedness in serving these populations. This may stem from the discomfort or anxiety that derives from serving this population, as described by Kimble (2013). Hammer (2004) found that SLPs felt more confident in less technical aspects of serving these individuals, such as interacting with parents and guardians (especially with the assistance of an interpreter), but rated their confidence as much lower for activities such as assessment.

Preparation and Ethics

Results from this study suggest that for most activities, SLPs who feel as if they have been adequately prepared to serve CLD populations rate their services as more ethical than those who do not feel prepared. This is the case when SLPs are assessing, differentiating between a difference and a disorder, and when providing intervention. Thus, it would follow

that an increase in preparation of SLPs in serving CLD populations could improve the ethics of service provision in the field of speech-language pathology.

Other studies have cited a lack of pre-professional education as well as a lack of opportunities to continue education on topics related to CLD as reasons contributing to the lack of preparedness of SLPs on this issue (Centeno, 2015; D'Souza et al., 2012; Hammer et al., 2004; Kimble, 2013; McLeod et al., 2013). Perhaps an increase in these types of opportunities could increase the overall preparedness of the field to serve CLD populations.

ASHA Guidelines

Respondents of this survey reported mixed opinions on the role of the American Speech-Language-Hearing Association in increasing the education and preparation guidelines of SLPs serving CLD populations. While a greater number of SLPs in the current study felt as if ASHA should create stricter guidelines concerning this topic (53.1%), many felt as if stricter guidelines are not necessary (46.9%).

Implications and Future Directions

Information found in the course of this study indicates the need for greater preparation of SLPs to work with CLD individuals in order to improve the ethics in this area of service provision. However, the mixed findings about respondents' belief that ASHA should create stricter guidelines for education and preparation seem to indicate the need for more investigation of this issue.

A better understanding about the perceptions of "confidence" versus "ethics" in SLPs is also needed. Information found in this study suggest that SLPs are much more likely to rate their confidence as lower than their ethics. This could pose a great problem if it is found

that SLPs are rating their ethics as higher than they actually are. Thus further studies should be conducted to understand the perceptions of ethical services in SLPs.

In order to improve upon the ethics of service provision to CLD populations, the field needs to have a better understanding of how professions perceive ethics, especially as it pertains to their own service provision, as well as how this issue can be improved.

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Appendix A

Survey Instrument

Consent

Purpose of this Research. This survey is being conducted as a component of an undergraduate thesis about service provision to culturally and linguistically diverse individuals. Your responses can help us to better understand how speech-language pathologists feel about this issue and how the profession as a whole can be more prepared to serve these individuals. Appalachian State University's Institutional Review Board has determined this study to be exempt from IRB oversight.

Procedure. This brief electronic survey consists of multiple choice, likert-style rating, and open-ended questions and should take ten minutes, or less to complete . If you choose to participate, you will indicate your consent below and answer the questions as they pertain to you. No personal information will be collected during the survey procedures and your email address will not be stored or connected with your responses in any way. Your responses will be completely anonymous.

Risks. The researchers do not anticipate that the risk of harm and discomfort while completing this survey is any greater than you would experience in your everyday life.

Benefits. There may be no personal benefit or compensation correlated with your participation in this survey, but your responses could contribute to the literature on service provision to culturally and linguistically diverse populations and help researchers and professionals better understand this issue in order to improve upon it.

Participation. Your participation in this research is completely voluntary. If you decide to take part in this survey, you may decide at any point that you no longer wish to participate, without penalty or loss of benefits. By giving your consent below

and beginning the survey, you are indicating that you have read and understood the information provided above, and been provided with an opportunity to have any questions answered by the researchers.

Contact. If you have any questions or concerns about this survey or the research being conducted before, during, or after participating in this survey, you may contact the undergraduate principle investigator, Erica Baker at bakerem1@appstate.edu, the faculty director of the undergraduate thesis, Jennifer C. Dalton, Ph.D., CCC-SLP at daltonjc1@appstate.edu, or the Appalachian Institutional Review Board Administrator at irb@appstate.edu, or by phone at (828)262-2130 if you have any further questions about your rights as a research participant or this research project in particular.

By continuing on to the survey, you acknowledge you have read and agree to the descriptions and terms outlined in this consent form, and voluntarily agree to participate in this research, and are at least 18 years of age.

Please acknowledge the informed consent above by clicking the appropriate response below.

- Yes, I consent.
- No, I do not consent.

Demographic Information

Are you a speech-language pathologist holding the American Speech-Language-Hearing Association's (ASHA) Certificate of Clinical Competence (CCC-SLP)?

- Yes
- No

In which state do you currently practice?

If other, please explain.

How many years have you been practicing as a Speech-Language Pathologist?

- 0-5
- 6-10
- 11-15
- 16+

Do you speak any languages other than English with any level of proficiency?

- Yes
- No

If yes, which language(s) do you speak?

Please mark all that apply.

- Spanish
- French
- German
- Italian
- Chinese dialects
- If other, please list:

With what proficiency do you speak each of your additional languages?

| | | | | | | |
|-------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Other <input type="text"/> | <input type="radio"/> |
| Other <input type="text"/> | <input type="radio"/> |
| Other <input type="text"/> | <input type="radio"/> |
| Other <input type="text"/> | <input type="radio"/> |

Personal Responses

Approximately how much of your caseload has been made up of limited English-proficient, or bilingual individuals?

- Less than 10%
- 10%-25%
- 26-40%
- 41%-55%
- 56%-70%
- Greater than 70%

Do you feel as if you have been properly prepared through your training to serve individuals from culturally and linguistically diverse (CLD) populations?

- Yes
- No

What types of pre-service education have you had on serving individuals from culturally and linguistically diverse (CLD) populations?

Please mark all that apply.

- None
- One or two lectures during undergraduate or graduate education
- Multiple lectures in multiple classes during undergraduate or graduate education
- One course dedicated to CLD issues during undergraduate or graduate education
- Multiple courses dedicated to CLD issues during undergraduate or graduate education
- Clinical experience with CLD populations during graduate education
- Other (Please explain)

What types of professional development have you had on serving individuals from culturally and linguistically diverse (CLD) populations?

Please mark all that apply.

- None
- Reading articles or book chapters
- Attending workshops focused on multicultural/multilingual issues (MMI)
- Attending local conferences on multicultural/multilingual issues (MMI)
- Attending state conferences on multicultural/multilingual issues (MMI)
- Attending national conferences on multicultural/multilingual issues (MMI)
- Attending international conferences on multicultural/multilingual issues (MMI)
- Other (Please explain)

Which topics have you received adequate education/information on (as an undergraduate, graduate, or professional)?

Please mark all that apply.

- None
- Cultural differences that may affect services (religion, communication styles, etc.)
- Differentiating between difference versus disorder
- Effects of bilingualism/second language acquisition
- Normal processes of bilingualism/second language acquisition
- Developmental norms for languages other than English
- Assessment of culturally and linguistically diverse individuals
- Intervention with culturally and linguistically diverse individuals
- How to utilize an interpreter

Which topics would you like more information on?

Please mark all that apply.

- None
- Cultural differences that may affect services (religion, communication styles, etc.)
- Differentiating between difference versus disorder
- Effects of bilingualism/second language acquisition
- Normal processes of bilingualism/second language acquisition
- Developmental norms for languages other than English
- Assessment of culturally and linguistically diverse individuals
- Intervention with culturally and linguistically diverse individuals
- How to utilize an interpreter
- Other (Please explain)

What is your overall confidence level in serving individuals from culturally and linguistically diverse (CLD) populations?

Please rate your level of confidence for each task.

| | Very Confident | Somewhat Confident | Slightly Confident | Slightly Unconfident | Somewhat Confident | Very Unconfident |
|--|-----------------------|-----------------------|-----------------------|-------------------------|-----------------------|-----------------------|
| Interacting with and gathering information from parents/guardians who do not speak English or who are limited English-proficient (LEP) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Assessing individuals who are CLD | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Differentiating between difference and disorder | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Providing intervention to individuals who are CLD | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Ethics in Service Provision

Do you feel as if the services you provide to culturally and linguistically diverse individuals consistently follow current evidence based practice guidelines?

- Always
- Most of the time
- About half the time
- Sometimes

Never

Do you feel as if it is difficult to find current evidence based practice and other relevant information about culturally diverse individuals that are necessary to providing ethical services?

Always

Most of the time

About half the time

Sometimes

Never

The American Speech-Language-Hearing Association states:

"Individuals shall provide all clinical services and scientific activities competently."
(Principle of Ethics 1A.)

and

"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." (Principle of Ethics 1C.)

Do you feel as if services provided to linguistically and culturally diverse populations in the United States are ethical?

American Speech-Language-Hearing Association (2016). Code of ethics [Ethics]. Available from www.asha.org/policy/.

Always

Most of the time

About half the time

Sometimes

Never

For the following activities, please indicate how ethical you feel your own practices are.

| | Always ethical | Mostly ethical | Sometime ethical, sometimes unethical | Mostly unethical | Always unethical |
|--|-----------------------|-----------------------|---------------------------------------|-----------------------|-----------------------|
| Interacting with and gathering information from parents/guardians who do not speak English or who are limited English-proficient (LEP) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Assessing individuals who are CLD | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Differentiating between difference and disorder | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Providing intervention to individuals who are CLD | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Remaining culturally competent by seeking out new information and current evidence based practices and incorporating them into your own practice | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

How Should We Proceed?

In order to improve upon services provided to culturally and linguistically diverse

individuals, where do you believe knowledge and skills about serving these individuals should be targeted?

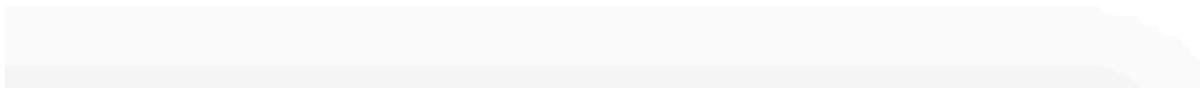
Please mark all that apply.

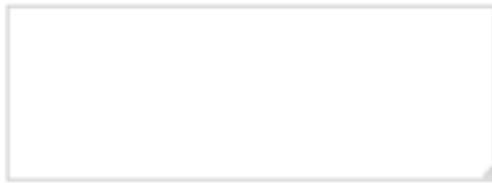
- None
- Undergraduate education
- Graduate education
- Clinical experience
- Continued professional development
- Other

On which topics do you believe speech-language pathologists would benefit from more knowledge and training?

Please mark all that apply.

- None
- Cultural differences that may affect services (religion, communication styles, etc.)
- Differentiating between difference versus disorder
- Effects of bilingualism/second language acquisition
- Normal processes of bilingualism/second language acquisition
- Developmental norms for languages other than English
- Assessment of culturally and linguistically diverse individuals
- Intervention with culturally and linguistically diverse individuals
- How to utilize an interpreter
- Other (please indicate your answer in the text box provided)

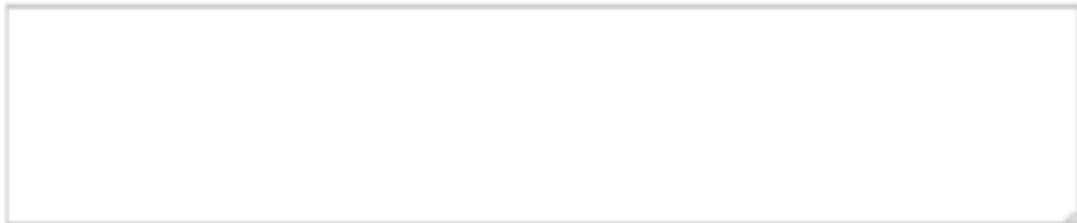




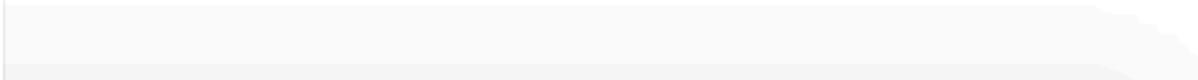
Do you feel as if the American Speech-Language-Hearing Association (ASHA) should have stricter guidelines on education and preparation of speech-language pathologists serving culturally and linguistically diverse populations?

- Yes
 No

Please explain how you think the American Speech-Language-Hearing Association (ASHA) should go about improving education and preparation of speech-language pathologists serving culturally and linguistically diverse populations (ex. mandating classes for multicultural/multilingual issues (MMI) in graduate education, accrediting bilingual graduate programs, etc.).



Please use the space provided below to document any further comments, suggestions, or concerns that pertain to this topic.





Survey Powered By [Qualtrics](#)

Appendix B

Recruitment

Invitation to Participate in Research

My name is Erica Baker and I am an undergraduate Communication Sciences and Disorders student at Appalachian State University in Boone, North Carolina. I am currently working on my honors thesis titled *Ethics in Speech-Language Pathology: Service Provision and Culturally and Linguistically Diverse Individuals*.

As a component of this research, I am surveying certified speech-language pathologists, especially those interested in multicultural/multilingual issues, in order to learn more about the education received in regards to this topic as well as how it has influenced their service provision to these individuals. This research has been determined to be exempt by the Institutional Review Board at Appalachian State University.

Thus, I am inviting you to follow the link provided below to participate in this short, 10-minute survey. Your participation is completely voluntary and all responses will be completely anonymous.

Survey Link: (link appended here here)

Your response and time is greatly appreciated. Please do not hesitate to email the undergraduate principle investigator, Erica Baker at bakerem1@appstate.edu, the faculty thesis director, Jennifer C. Dalton, Ph.D., CCC-SLP at daltonjc1@appstate.edu, or contact the Appalachian Institutional Review Board Administrator at irb@appstate.edu, or by phone at (828)262-2130 if you have any further questions about your rights as a research participant or this research project in particular.