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Importance of Cultural Awareness in Speech Language Pathology Education

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Importance of Cultural Awareness in Speech Language Pathology Education

Introduction

Cultural awareness is a necessity when providing services to a culturally and linguistically diverse population. Culture influences a family's' values, religion, language preference, kin structure, child-rearing practices, roles and responsibilities of family members, and perception of health and behavior; specifically, the perception of disability (McLeod, Verdon et. al 2017). Cultural beliefs can also influence which therapy assessments are used and whether a parent chooses to access services (McLeod et. al, 2017). Cultural awareness includes knowledge and understanding of the values and norms of different cultural groups, recognition of culturally based assumptions and biases and demonstrating skills that meet the need of clients from a diverse background (Lemmon& Jackson-Bowen,2013). In order to serve diverse students, professionals should be able to recognize how their own identity has influenced their learning opportunities. Professionals must be able to assess their own attitudes towards issues of diversity and be willing to transform views that create difficulty.

Being a culturally sensitive clinician is vital in establishing trust and open communication with patients and in order to effectively diagnose and treat an individual (Lemmon& Jackson-Bowen,2013). An intervention that is not relevant to the client and not functional for their participation in daily life is not valuable (Verdon, McLeod, & Wong, 2015). Culturally and linguistically diverse children and families may not speak the dominant language or share the same culture within their social context. This also includes those exposed to multiple linguistic and cultural influences. Both of these groups have limited cultural and linguistic services available in speech language pathology services (Verdon, McLeod, Wong, 2015). The prevalence of speech sound disorders is similar in monolingual and multilingual populations; however, multilingual children are at greater risk for being both over-referred and under-referred for speech language pathology (SLP) and special education services (McLeod et. al, 2017).

As of 2010, The American Speech Language Hearing Association (ASHA) Code of Ethics holds licensed and practicing speech language therapists accountable for maintaining multicultural competence (The American Speech Language Hearing Association, 2017). Although it was implied prior to 2010, it was not explicitly required. Multicultural competencies are now incorporated throughout each of the nine content areas of knowledge and skill acquisition that are needed to obtain a Certificate of Clinical Competence in Speech Language Pathology (CCC-SLP). The Multi-Cultural Issues Board also increases cultural awareness for ASHA by developing policies and procedures that are responsive to cultural and linguistic influences, particularly those present in underrepresented populations (Lemmon& Jackson-Bowen,2013).

Cultural Intelligence (CQ)

Griffer and Perlis (2007) emphasize the development of cultural intelligence of speech language pathologists and educators. Cultural intelligence (CQ) is one component of cultural competence that is crucial for SLP's and educators. CQ focuses on the awareness of multicultural identity, the understanding of privilege and difference, the development of diversity consciousness, and respect for the guiding principles of cultural competence. CQ allows for the

understanding of others. It is defined as one's capability to adapt effectively to new cultural contexts. It is broken into four concepts—CQ-strategy, CQ-knowledge, CQ-motivation, and CQ-behavior. CQ-Strategy is the ability to make sense of culturally diverse experiences which utilize metacognitive and cognitive processes to acquire cultural information, form judgements, and make decisions. CQ-knowledge is one's ability to learn about similarities and differences between cultures with regard to cultural parameters within specific cultural groups. This includes learning about various cultures' language, health, religion, rituals, family dynamics etc. CQ-motivation refers to an individuals' interest and energy in learning about different cultures as well as functioning in diverse situations. Finally, CQ-behavior involves an individuals' capacity to develop a flexible repertoire that can be used appropriately in various verbal and nonverbal situations (Griffer and Perlis, 2007). It is important to encourage the development and understanding of one's multi-perspective identity and how differences in culture alter this identity. The multi-perspective identity theory was developed by Griffer and Perlis (2007) and states that, "characteristics of our own identity that enable each individual to view reality through specific perspectives [are] based upon ability, age, gender, ethnicity, race, sexual orientation, religion, or socioeconomic class" (p.29). Assessing how groups perceive cultural differences between members and how those differences may or may not be interconnected to each other is known as the multi-perspective identity theory.

Barriers and Facilitators in Rehabilitation Services

Providing culturally competent services can be challenging for a multitude of reasons. These factors can impact treatment, compliance, and ultimately, affect a successful outcome. Grandpierre, Milroy, Sikora, Fitzpatrick, Thomas, and Potter (2018) conducted research on barriers and facilitators in rehabilitation services. This research looked at the effect of language barriers and cultural barriers in service delivery of occupational therapy, physical therapy, and speech language pathology services. Barriers noted by clinicians ranged from linguistic barriers where effective communication was difficult and hindered rapport, to cultural barriers surrounding the use of certain intervention strategies such as child play, a common technique used to encourage children to use expressive language.

Additionally, clinicians felt that gender roles across cultures impacted service delivery. Grandpierre et. al (2018) noted that when a father and a mother attended an appointment for their child, often times the father was the 'designated' spokesperson even though the mothers were the primary caregivers and spent more time with the children, and one could assume would be able to better inform practitioners of the child's abilities. The clinicians observed differences in decision-making between genders, stating that most patients trusted the decisions of the experts although females tended to inquire for more information. Clinicians also stated that male service recipients often requested a male practitioner.

Clinicians reported that there were some things that facilitated cultural awareness. One thing they discussed was learning more about the role of religion and traditional healing methods. They also felt it was important to understand that in some cultures, the perception of illness is intertwined with religion and other traditions. Clinicians concluded that understanding holistic views allowed them to better understand their patients' goals and offer more appropriate recommendations (Grandpierre et. al, 2018).

Barriers of culturally competent services as described by patient/caregivers included similar answers to those of the clinicians. Patients reported that being unable to communicate

their feelings and thoughts properly hindered their appointment success. Additionally, Grandpierre et. al (2018) found that when clinicians used unfamiliar language with patients, it reinforced that they were a minority, and felt discriminatory. Patients also noted that access to interpreters and written handouts in their native language(s) was limited. Patients, however, also praised the cultural awareness of some practitioners who greatly considered cultural differences such as perception of disability, etiology, and use of play. Patients and caregivers also reported that when the clinician included details about themselves, it allowed them to establish familiarity and comfort (Grandpierre et. al, 2018). Finally, patients seemed to greatly appreciate when clinicians provided them with a brief overview and explanation of the healthcare system, as it might be unfamiliar to them. Information should include the length of therapy, the purpose of therapy, the roles that family members provide in supporting the patient, and benefits of intervention. It is also recommended that information discussed be written down for patients of culturally and linguistically diverse backgrounds in their native language.

Comprehensive Language Profile

McLeod, Verdon et. al (2017) noted a comprehensive case history should be completed even more thoroughly with a diverse client. The case history should include child/family demographics, developmental milestones, family needs and concerns, and a comprehensive language profile. The comprehensive language profile should contain the clients current and past linguistic environments, the age of the client when exposed to each language, the amount of language exposure per day, the settings and contexts in which each language is used, the child's conversational partners in each language, and the client's dominant language. Language dominance often fluctuates depending on time, age, task, and language input/output proficiency and should be reassessed by the clinician each session. It is important to encourage parental involvement regardless of language used; however, clinicians' must also recognize the family and cultural attitudes related to acceptance and interpretation of diagnosis and disorder labels.

As previously mentioned, culturally and linguistically diverse children are at higher risk for under and over referral for special education and speech services. Speech acquisition may present differently in a multilingual child vs. a monolingual child which may result in over referral. An example of this could be a child presenting with what seems to be delayed development of cluster sounds; however, it may be due to the language transfer of the client's first language that does not utilize consonant clusters. All languages differ in phonological and phonotactic structures: consonants, vowels, syllable types, word shape, and suprasegmental features. Because multilingual children acquire each language at different rates, they may not exhibit the same phonological skills in each language. Communication difficulties may also be misinterpreted or misdiagnosed as features of multilingualism and may result in not being referred for a speech sound disorder (McLeod et. al, 2017).

The Scope of Assessment for an SLP working with a diverse client includes: speech production at single-word level and connected speech in each of the child's languages, intelligibility and acceptability in each language, stimulability in each language, speech perception and phonological awareness in each language, hearing and oramotor structure and function, nonverbal intelligence, and participation (McLeod,2017). This research supports Verdon et al (2015), which states that dynamic assessment is a culturally sensitive approach as it supports observation of performance and competence regardless of language spoken. Dynamic

assessment can be used in unstructured and structured settings to identify a child's current skills, learning potential, progress made, and potentially highlight effective teaching methods.

Serving English Language Learners with Communication Disorders

Rosa-Lugo & Fradd (2000) researched the preparation of professionals to serve English Language Learners (ELL) with Communication Disorders. This study focused on providing appropriate services that are responsive to a student's disabilities, language needs, and cultural characteristics while simultaneously adhering to local, state, and federal regulations. Three commonalities across professional areas were identified when looking at the needs of ELL students: the emerging paradigm of literacy development of the ELL student, a common knowledge base of professionals working with ELL's, and the attitudes of professionals toward language services. The researchers suggest that SLPs are able to provide a unique contribution in facilitating literacy because of the reciprocal relationships between written and spoken language (Rosa-Lugo& Fradd, 2000). Four competencies have been identified for preparing professionals to work with ELLs. The primary competency areas are (1) having an understanding of the process of second language acquisition, (2) skills in assessing academic and social language development, (3) awareness of appropriate materials and strategies for language learning and literacy, and (4) cross cultural communication when working with diverse students. These skills are necessary for comprehensive cross-disciplinary personnel to be adequately prepared. This research specifically addresses a multitude of professions that interact with ELL students such as general education teachers, ESOL (English for Students of Other Languages) teachers, bilingual teachers, special education teachers and speech language pathologists. For the purposes of this research, the primary competency areas of SLP's were examined.

Speech language pathologists play an important role in the assessment and determination of academic placement for ELLs with communication disorders. SLPs are expected to identify and evaluate children with communication disorders and implement interventions based upon their findings. The four competencies were discussed in terms of each professions' contributions to ELL success and learning opportunities were identified in each field. In the first competency related to the process of second-language acquisitions, the major contribution of an SLP is providing an understanding of normal and pathological language development. Learning opportunities discussed are the differentiation of language differences and disabilities, as well as understanding similarities and differences in first and second language acquisition (Rosa-Lugo, 2000). The second competency addressed was skill in academic and social language assessment. A SLP contributes to this competency by using assessments to determine if there is a communication disorder and obtaining language information from a variety of samples. SLP's could demonstrate more cultural competence in their practices by using interpreters and translators during an assessment, and using alternative measures of language, literacy and academic learning. The third competency, knowledge of materials and strategies for literacy and academic learning, would also increase learning opportunities through using interpreters and translators for instruction and appropriate instructional methods for ELL learners. SLP's contribute to the knowledge of intervention of language-related learning issues and methods to address communication disorders. Finally, the fourth competency of cross-cultural communication and understanding relies upon the SLP's knowledge of ELLs when divided into small groups. SLP's could enhance their learning by understanding interactional styles of diverse

groups and encouraging collaboration across instructional disciplines. (Rosa-Lugo & Fradd, 2000).

Limited Culturally Competent Services for SLP Services

Verdon, McLeod, and Wong (2015) identified a lack of services available for culturally diverse populations. They noted a lack of culturally appropriate assessment tools, a lack of developmental norms for a linguistically diverse population, a lack of services available in a child's primary language, a lack of professional support and training on cultural diversity and a lack of time to undertake any additional element of practice needed to work with diverse families. The research addresses the issue of using 'one gold standard' to assess diverse clients. Using a gold standard fails to acknowledge the variation and complexity of language, as well as individual strengths that exist among clients. When there are two or more cultures intersecting on a daily basis, the 'one gold standard' no longer fits, as attributes from each culture will be adopted which in turn impacts the original cultures.

In therapy, it is important to identify culturally appropriate and motivating goals such as achieving specific language targets, functional communication goals, developing phonological awareness, and recognizing cross linguistic influences on speech. Even as a mono-linguistic clinician, a high degree of cultural knowledge is needed in order to make informed decisions of best practice. This article begins to touch upon using dynamic assessment and community developed resources to work across linguistic boundaries. Verdon et. al (2015) defines dynamic assessment as "an approach to assessment that can be used as an alternative to standardized tests, by examining children's modifiability or ability to learn new concepts, rather than testing their current knowledge which may be based on limited exposure to language" (p. 83). The research also suggests summarizing a child's conceptual scores and competencies across all languages as this can account for a more accurate reflection of a multilingual child's language ability (Verdon et. al, 2015).

Although there can be tension between rules and policy differences, flexibility within organizational and funding rules can enhance practice in terms of maintaining multilingual development and preserving Indigenous cultures. In Verdon et. al (2015) the SLP talked about how being able to run a community-based model in an Indigenous community allowed for increased engagement and exposure to family's real-world context. An SLP working in multiple languages allows for recognition of cross-linguistic influences on speech patterns. One of the SLP's stated that cross-linguistic knowledge is essential in identifying the child's competencies across all languages and avoid a misdiagnosis of a speech sound disorder. Environmental and personal factors are considered along with social and cultural contexts in order to view a client in a holistic manner. Community-based models also presented sensitive issues surrounding the revitalization of community languages. Maintenance of language and culture is integral to ones' sense of self and cultural identity; however, because some native groups see language as an intimate part of religion, they do not want language classes to be available for everyone (Verdon et. al, 2015).

Initiatives toward preparing culturally competent clinicians have recently been increasing. Assessment tools in multiple languages are being made available for individuals to test in their primary language as well as including alternative approaches such as dynamic assessment and parent/adult contrastive analysis. Colleges and universities are making an effort to provide multicultural service specialty tracks. There is also an abundance of online resources

such as screening tools available in other languages. Information on the components and structure of other languages are necessary in order to help distinguish the difference between genuine speech, language, communication difficulty, and/or the result of multiple language and cultural influences (Verdon, McLeod, and Wang,2007).

Multicultural Educational for CSD Students

Horton-Ikard, Munoz, Thomas-Tate, and Keller-Bell (2009), provided an overview model for teaching a multicultural course and how it can be modified and utilized in the communication sciences and disorders (CSD) field. With the substantial increase in racially, ethnically, and linguistically diverse populations, communication sciences and disorders training programs are devoting more time and attention to multicultural issues. The majority of education programs use an infusion model to disseminate multicultural content with the idea that communication is culturally embedded, meaning clinical and academic learning is inherently multicultural (Horton-Ikard et. al, 2009). Infusion dictates that every aspect of course content considers the cultural context as a variable relevant in building a foundation of knowledge about that content (Horton-Ikard et. al, 2009). However, there are limitations such as a scarcity of resources on culturally competent curriculum design, scant evidence to support 'effective instructional strategies', and minimal multicultural specialists in the CSD field whom are teaching. Ridley, Mendoza, & Kanitz (1994) aided in the development of the pedagogical framework discussed in Hotron-Ikard et. al (2009). Although the framework followed in Ridley et. al (1994) was developed for counseling psychology, the multicultural cross-over allows for smooth adaptation for use in CSD curriculum.

ASHA states that slight modifications must be made to the organizational framework to include critical skills of developing cultural competence. The three focused competencies are awareness, knowledge and skills. Awareness refers to the clinician's abilities to recognize how personal bias/values could interact with service delivery, as well as the clinician's ability to develop a positive orientation with culturally diverse perspectives. Knowledge refers to the understanding of culturally relevant issues and sociocultural factors that influence communication cross-culturally. Skills are the specific abilities necessary to provide culturally relevant and appropriate services. With infusion of culture being so heavily influenced by the social and cultural composition of the classroom (students/teachers), a stronger focus must be placed on disseminating information that increases of cultural and societal factors that differ from the cultural context. This influences interactions between and opinions of differing cultures (Horton-Ikard,2009). Students must take preliminary communication disorders courses as a foundation necessary for higher level speech classes, otherwise the content material would be beyond the student's realm of understanding. Building a foundation of knowledge to expand upon has proven to prepare students to treat and assess clients; however, multicultural education/awareness should be emphasized with equal importance.

Reflecting upon new concepts, ideas, and experiences allows students to make meaningful connections between the concepts and themselves. Chabon and Lee-Wilkerson (2006), examined communication disorder students' achievement of desired learning outcomes of diversity training through journaling. The study included 18 communication sciences and disorders graduate students who completed written reflections in student journals that illustrated how class material applied to their personal and professional experiences. There is overwhelming

support that reflective journals encourage self-awareness and facilitate the assimilation of new concepts. Participants in this research were provided learning outcomes prior to attending lectures, taking part in class discussions and activities, and completing online discussion threads. Written reflection emphasizes association between material in the classroom and experiences of working with those who have communication disorders, which, in turn, encourages active engagement in the learning process.

McNeilly (2015) encouraged utilizing support personnel such as speech language pathology assistants (SLPA's), caregivers in the child's home and community, and other staff across the service delivery continuum. This research aimed to educate globally conscious SLPs to prepare them for collaborative professional practice. Interprofessional education (IPE) has yielded effective patient/student outcomes in acquiring competencies to work in collaborative practices and is more recently beginning to emerge in curricula of graduate and continuing education programs. Interprofessional collaborative practice (IPP) and IPE maximize the expertise of providers from interdisciplinary teams which enhances service delivery and offers unique methods for effective functioning. IPE is "when students from two or more professions learn about, from, and with each other to enable effective collaboration and improve health outcomes," (McNeilly, 2015, p.208). The purpose of IPE is to engage in IPP in the workplace which improves patient care and outcomes. The Interprofessional Education Collaborative (IPEC) has established competencies for collaborative practice which is available for professional development. McNeilly (2015) also emphasized that sharing information relevant to assessment tools, procedures, and intervention strategies with colleagues from other countries allows SLP's to meet expectations and provide services that meet the needs of patients from other countries.

Recognizing Non-Racial Cultural Differences

A recent study by Hancock & Haskin (2015), noted that the LGBTQ (lesbian, gay, bisexual, transgender, queer) culture is under addressed in SLP literature despite ASHA incorporating it into several of the policies. The Office of Multicultural Affairs (OMA) of ASHA defines multiculturalism as including race, ethnicity, national origin, culture, language, dialect, gender, gender identity, age, sexual, orientation, socioeconomic status, religion, and ability. It was noted that in 13 courses offered by OMA, bilingual and bicultural information was included; however, just one of these courses addressed LGBTQ culture. Hancock & Haskin (2015) highlight the uniting factor of the LGBTQ community, "they live in heteronormative culture in which heterosexuality is considered the normal sexual orientation and sexual and gender minorities are considered abhorrent and stigmatized" (p. 207). In a survey of LGBTQ people, the majority of respondents considered disclosing their LGBTQ culture important in speech services, as it allowed the opportunity to comfortably include partners in the evaluation and treatment process. However, in the same survey, just 35% and 43% of LGBTQ respondents disclosed their orientation, despite feeling it was important (Hancock,2015). SLP's play a large role in improving the quality of life of LGBTQ people, specifically in the transgender community.

SLP's play a large role in the lives of transgenders, as alignment of the visual gender and voice can be crucial in a successful transformation for many individuals. Hancock & Haskin (2015) note that the goal of therapy should not be to conform to binary gender expressions that are expected by the social majority, but rather to identify a comfortable gender expression. SLPs are expected to teach speech patterns and conversational characteristics of males or females,

educate relating to nonverbal communication style, and support safely adjusting pitch. The study notes that approximately 46% of transgender women seek voice feminization services. Unfortunately, the transgender community still reports it can be difficult to find providers who are supportive and skilled in the area of transgender communication, and often times the community finds themselves fearing homophobic reactions and fear of being stigmatized. LGBTQ education is encouraged for students working in health care and is being incorporated more recently into higher education curricula for speech language pathology.

Reality vs. Perception

The study addresses the 2008 U.S. Census Bureau which indicates that the minority population will expand in the United States by at least 44% by the year 2050. This spike in the minority population demonstrates the increasing need for clinicians to have culturally and linguistically diverse knowledge. Lemmon and Jackson-Bowen (2013), researched speech language pathology students' cultural competence in reality versus their perception of cultural competence. In this study, 54 graduate and undergraduate speech language pathology students from two higher education institutions in South Carolina were surveyed. The study measured the students' perception of their own cultural awareness and tested the reality of the student's cultural competence. The questionnaire was developed based on the multicultural IQ test developed by Andrea Moxley (2003) and included specific demographic questions relevant to the cultural context in the area.

In this study, graduate students were less likely to have a multicultural course prior to beginning their SLP program; however, they scored significantly higher on the multicultural assessment then the undergraduate participants. This was most likely due to more life experiences and self-awareness. Only 9-15% of the respondents identified sexual orientation, religious beliefs, socioeconomic levels, regionalisms, ability/disability, educational background, age-based peer groups, and race/ethnicity as the factors shaping cultural diversity. Students initial perceptions of their own cultural competence were lowered after completing Moxley's assessment tool. Sixty-five percent of the graduate students reported being culturally competent prior to completing the multicultural IQ test, which decreased to 46% after completing the questionnaire. Similarly, 61% of the undergraduate students reported being culturally competent prior to the assessment tool, which was changed to 43% after completing the questionnaire. This survey also yielded results that students who had taken a multicultural course prior to the IQ test received higher scores then those who had not previously taken a multicultural course.

Method

A total of 69 graduate and undergraduate speech language pathology/communication disorders students from five higher education institutions in Massachusetts participated in this study. 69 survey questionnaires were completed in entirety. The department chair of each program was asked to distribute the link of the online survey. The survey link was accompanied by a short paragraph regarding the purpose of the survey and a brief overview of the concepts surveyed. Implicit consent was provided when students opted to begin and complete the survey. Participants were able to withdraw at any point. The respondents consisted of 61 females, 8 males, and 1 gender variant/nonconforming participant.

Seventy-two percent of the participants were Caucasian (N=50), 9% were Asian(N=6), 6% were Hispanic(N=4), 4% were African American(N=3), 4% were Bi-racial(N=3), and 4%

identified as other (Black Caribbean(N=1), Native American(N=1), and Native American and White(N=1)). Sixty-seven percent of the participants were undergraduate students(N=46) and 33% of the participants were graduate students(N=23). Of the undergraduate participants, 10% were freshmen(N=7), 16% were sophomores (N=11), 20% were juniors(N=14), and 20% were seniors(N=14). This study design was a survey administered using an online questionnaire (See Table 1). The multicultural IQ test developed by Moxley (2003) and Lemmon & Jackson-Bowen's (2013) study provided a foundation for the multicultural IQ questionnaire developed. Data was collected and analyzed using Qualtrics.

Results

At the time of survey submission, 51% percent of the participants had completed a class dealing with multiculturalism in their program of study. Only fifty-nine percent of participants felt they were culturally competent at this point in their field of study. Table 2 represents the multicultural questions of the questionnaire along with the percentage of participants that rendered correct answers. Following the multicultural questions, participants were asked questions related to their perception of their own preparation, the importance of cultural awareness in SLP, and educators' incorporation of multicultural content throughout the curricula. As noted in Table 3, most students at the graduate level have completed a multicultural education course, though there were still 8 students who had not.

Of the participants, 36% confidently responded that they were prepared to work with culturally diverse clients, while 39% noted it depended upon the culture of the client, and 25% of students felt they were not yet prepared to work with a diverse client base. Overwhelming agreement was shown by the students when asked how important cultural competence is in the field of speech language pathology. Ninety percent of the participants felt cultural competence was very important, while 9 percent, felt it was moderately important and 1% felt it was unimportant. When inquiring if students felt there should be a curriculum course dedicated to cultural competence, 94% of the respondents said yes. With 72% of the participants stating, "educators are encouraging cultural awareness throughout their classrooms," it is fair to say that educators appear to be doing a fairly effective job. However, given that 28% of students felt that this was not the case, we can also assume that there is more work to be done.

The participants were given the opportunity to write a short response explanation regarding specific ways they felt their educators have encouraged cultural awareness. With just 45 responses to this question, their answers were qualitatively coded and assessed. Two responses were not included when analyzing results as the responses did not provide productive feedback. The remaining responses could be categorized into four major learning techniques that were viewed as successful from the student's point of view. The techniques are as follows (A.) class examples/lectures leading to discussions of culture, (B.) workshops/guest speakers that address cultural differences, (C.) specifically bringing awareness to major issues of diversity and (D.) addressing how culture impacts language. While only 43 responses were coded, there were multiple responses that touched upon multiple categories.

A. Class Examples, Lectures and Discussions

Fifteen of the 43 respondents noted that class examples, lectures and discussions encouraged cultural competence. Class discussion allows students and professors to discuss diversity and incorporate personal experiences. Students made note that most lectures included general

instruction of how to meet the needs of patients of various cultures; however, students also voiced they would benefit from a more in-depth discussion on topics concerning culture. While students reported that culture is addressed, discussion was often brief and general.

B. *Workshops and Guest Speakers*

Five participants stated workshops focusing on cultural awareness or guest speakers of varying backgrounds have visited their campus to educate students. Students noted that in specific multicultural courses, speakers of varying ethnicities have spoken to their classes about their culture and language. They emphasized their own personal experiences and interactions that contributed to cultural misunderstanding, as well as aspects of their cultures that are considered to be significant. Cultural panels and events are also held and available to students to further educate themselves.

C. *Awareness and Acceptance of Diversity*

Eight students discussed specific aspects of cultural awareness that have been particularly useful and impactful. One respondent the importance of understanding cultural traditions outside of Western culture. Understanding such cultural traditions can aid in providing the most beneficial therapeutic options for a client. Other respondents noted that being encouraged to see something from the point of view of other cultures was emphasized when talking about diversity and inclusion. Students seemed to feel as though their education properly prepared them to work with the Deaf community; however, education about LGBTQ communities is an overlooked part of the curriculum. One particular response advocated for further education regarding proper usage of pronouns to promote acceptance of transgender individuals. Students felt that educators were making a greater effort to promote cultural diversity during Multicultural Awareness Month to promote globally conscious initiatives being led by the students.

D. *Culture and Language*

Fifteen participants made reference to understanding language and how culture impacts language, specifically multilingual development. Three participants attribute their understanding of language and culture to an English Language Learners (ELL) class, while others noted that linguistics, language acquisition, and phonetics classes have aided their understanding of language development and cultural influences on language and dialect. Dialectal differences were noted as a topic of frequent discussion. This included understanding the sounds that occur in the English language which may not occur in other languages and vice versa. Others noted that differences in grammar, structure and language variations must be taken into consideration when working with culturally diverse clients. One participant shared their professor's emphasis on the importance of understanding the cultural impact on language when assessing disorders and determining whether there is a speech disorder or that symptoms are a result of their first language and second language interacting.

Lemmon and Jackson-Bowen (2013) vs. the Current Study

Lemmon and Jackson-Bowen (2013) used the Multicultural IQ Test developed by Moxley (2003) and surveyed speech language pathology students from two higher education institutions in South Carolina. In comparing the percentage correct from Lemmon and Jackson-Bowens'(2013) study to the percentage correct in the current study (see table 4), the students

showed significant discrepancy in the percentage correct on six questions (numbers 1,3, 6, 7, 10, and 14) while highlighting the remarkable similarities in percentage correct of the six of the remaining questions (numbers 2, 4, 9, 12, 15, 16). When comparing both studies, a discrepancy was characterized as a difference of 20% or more in the resulting percent correct. A similarity was identified as having a difference of 5% or less in the percentage correct. One question resulted in the exact same percentage correct (number 9). Three questions resulted in less than 10% of the respondents answering correctly (numbers 7,9 and 16;1%, 9%, and 1% respectively). Two of these were questions requiring students to select all of the answers that apply, requiring multiple answers likely resulted in a lower probability of correctness, as respondents must choose **all** of the correct answers or else the responses are counted as incorrect. The third question was a true or false question. Despite the type of question, the low percentages suggest a need for a deeper focus on these populations, i.e. the LGBTQ population, African American English speakers and Spanish speakers. The low percentages are slightly concerning considering that the two largest ethnic/racial groups in the United states are African Americans and Hispanics. According to the Bureau of Labor Statistics in 2012, nearly 75 percent of the United States population are white Americans; however, by 2050 it is predicted that this number will be reduced to about 50 percent of the population due to immigration patterns and birth rates of Hispanic, Asian, and African American populations (Haynes, Moran, &Pindzola, 2012). Both African Americans and Hispanics have distinct dialects which are influenced by region, social class, peer groups, and context.

TABLE 2. Average Scores for All Students on Multicultural IQ Test of the Questionnaire

Multicultural Questions	Type of Question	Correct Answer	Percentage Correct
1. Which aspects do you feel shape cultural diversity?	CAA	All Apply	68%
2. A bilingual clinician needs to be fluent in the language spoken by the client but does not need to understand normal language acquisition in the language spoken.	TF	False	95%
3. If you are working with same-sex parents, it is only important to get the medical information about the biological parents.	TF	False	82%
4. There are universal gestures to indicate agreement, such as nodding the head to indicate "yes."	TF	False	28%
5. In Hispanic communities, it would be appropriate to initiate an assessment sharing meeting with a personal conversation rather than to immediately provide the results.	TF	True	78%
6. Monolingual language learners and bilingual language learners should have the same emerging language milestones.	TF	True	38%
7. The use of African American English is influenced by many different variables including:	CAA	**	1%
8. Speech-language and hearing difficulties are more prevalent among Native Americans.	TF	True	25%
9. It is possible that 1%-2% of your clients will be gay, lesbian, bisexual, or transgendered.	TF	False	9%
10. If a family member or friend speaks English as well as the client's native language, and is willing to act as an interpreter, this is the best possible solution.	TF	False	72%
11. When conducting a language assessment on a client with limited ability to speak English, which one of the following is LEAST useful?	MC	**	54%
12. Cultural and linguistic biases may occur in testing tools and have an impact on an appropriate differential diagnosis between a language disorder and a language difference. Cultural biases do NOT include the following:	MC	**	31%
13. An audiologist must be aware of the influences of different races and ethnicities when completing an audiologic evaluation.	TF	True	83%
14. Fitting considerations for personal assistive devices may vary across races and ethnicities.	TF	True	83%
15. When working with an interpreter, the interpreter makes diagnoses.	TF	False	99%
16. Variations in dialects of the Spanish language are reflected in:	CAA	1&2	1%

CAA=Choose All the Apply TF=True/False MC=Multiple Choice

TABLE 3: Multicultural Education
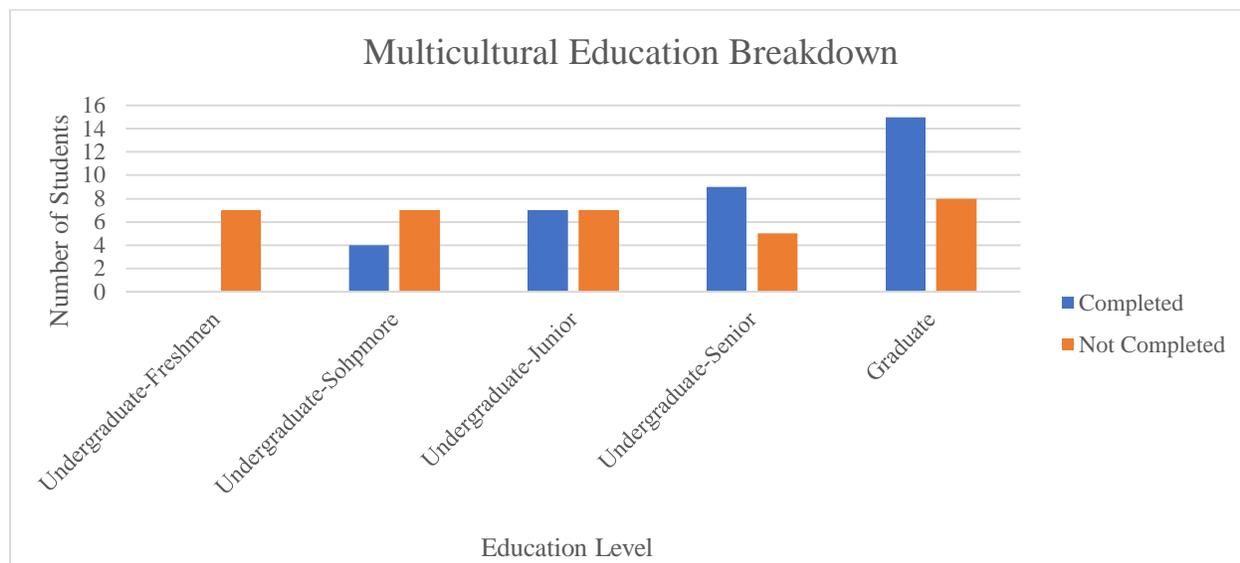
TABLE 4: Table 4: Comparison with Lemmon& Jackson-Bowen (2013)

Question #: Corresponding with Table 2	Lemmon & Jackson-Bowen (2013) Percentage Correct	Current Study Percentage Correct
1.*	48%	68%
2.^	93%	95%
3.*	61%	82%
4.^	30%	28%
5.	67%	78%
6.*	59%	25%
7.^	2%	1%
8.	37%	25%
9.^	9%	9%
10.*	52%	72%
11.	37%	54%
12.^	26%	31%
13.	74%	83%
14.*	57%	83%
15.^	94%	99%
16.^	6%	1%

Key:

*= Discrepancy
^= Similarity

Discussion

Moxley's (2003) Multicultural IQ Test has allowed students in the speech language pathology field to assess their own multicultural awareness. Lemmon and Jackson-Bowen's (2013) study indicated that students were using knowledge acquired throughout general education courses and personal experiences to demonstrate cultural competence. The results of the current study show that SLP educators have been making strides towards incorporating cultural awareness in the classroom through lectures, guest speakers and workshops. Educators have also been specifically highlighting language variances, dialects, and cultural differences throughout class material; however, the results show that there is still room for improvement. A multicultural course dedicated to understanding diversity and cultural differences should be a prerequisite class to high level courses. A broad foundation of cultural awareness is necessary to grasp the cultural impacts seen throughout higher levels of practice. The idea of building a pedagogical framework to incorporate a multicultural perspective throughout the SLP curriculum offers students an effective opportunity to shape their understanding of multicultural perceptions, and more adequately prepare them for diverse clients. In order to establish a strong researcher awareness, the Multicultural IQ test developed by Moxley (2003) was analyzed. Analyzing the results allows other researchers, educators, colleagues and students to further their own competencies. For this purpose, the multicultural questions shown in Table 2 must be understood.

Question one stated 'Which factors shape cultural diversity: Choose all that apply". All of the factors listed—Sexual orientation, religious beliefs, regionalisms, socioeconomic status, ability/disability, race/ethnicity, and educational backgrounds—are all factors that shape cultural diversity. As noted by Maul (2015) "people can be considered culturally diverse if their beliefs and values have been influenced by more than one culture, as reflected in their race/ethnicity, sexual orientation, religious or political affiliations, or gender identity." In this study, 68% of the students were able to identify all of the aspects of cultural diversity.

For number two the statement 'A bilingual clinician needs to be fluent in the language spoken by the client but does not need to understand normal language acquisition in the language spoken.' is false. As noted in Moxley (2003), a bilingual professional must be able to (1) describe the process of normal language acquisition for monolingual and bilingual individuals, (2) understand how language is orally or manually coded, and (3) have command of the written language. The results of the survey show that participants understood this concept with 95% of students answering correctly.

Number three states, 'If you are working with same-sex parents, it is only important to get the medical information about the biological parents.' Eighty-two percent of the participants answered this statement correctly—false. It is important to include the health history of all primary caregivers (Moxley, 2003). Specifically, for SLP's, knowledge of primary caregivers' worldview, culture, and language all aid in providing meaningful and relevant services (McLeod et. al, 2017). According to Grandpierre et. al (2018), cultural differences occur in the caregiver's views of disability, independence, decision making, and gender roles, all of which could play a factor in treatment compliance.

Number four proved difficult with only 28% of the participants answering correctly, it states 'There are universal gestures to indicate agreement, such as nodding the head to indicate "yes."' This claim is false. Moxley (2003) states, "In many Asian communities, bowing, smiling and nodding do not necessarily indicate agreement or understanding. In many Arab communities, responding 'yes' to a request may be an expression of good will rather than an indication that the

request will be carried out." While it is recognized that these are not absolutes for the communities, it is intended to show variance.

Question five states, 'In Hispanic communities, it would be appropriate to initiate an assessment sharing meeting with a personal conversation rather than to immediately provide the results.' This is true, as initiation of business talk may be considered rude (Moxley, 2003). Seventy-eight percent of the participants answered this question correctly. According to English League (2010) it is important to take time and develop personal relationships with members of the Hispanic community and communicate in an indirect style. In these communities it can often be considered culturally insensitive to be too direct and to do business without establishing a personal rapport first.

Question six only 38% of the participants answered correctly. The question states, 'Monolingual language learners and bilingual language learners should have the same emerging language milestones.' According to Moxley (2003), studies show that children will babble, use their first words, and develop two-word utterances within the same age range, making this statement true. In a study on traditional measures of phonological ability for bilingual preschoolers and kindergarteners, researchers concluded that, although not identical, monolingual and bilingual preschoolers develop similarly (Fabiano-Smith & Hoffman, 2018). Understanding this concept is crucial as a successful SLP. As of 2010, ASHA reports that nearly 64% of school-based SLP's work with bilingual students. Fabiano-Smith &Hoffman (2018) also report that bilingual preschoolers are at a high risk for misdiagnosis due to variability in production of speech sounds and lower levels of consonant accuracy.

For question seven the statement was as follows, 'the use of African American English is influenced by many different variables including (select all that apply):' with the options of age, race, geographic location, intelligence, income, occupation, education, and religion. The correct response for the variables that influence African American English (AAE) are age, geographic location, occupation, income, and education. According to Bauman-Waengler (2016), age and socioeconomic status are the two variables that influence AAE most significantly. This study resulted in just one percent of the respondents generating correct answers. While some respondents correctly identified that age, geographic location, occupation, income and education were influential factors on AEE, they may have selected other answers as well which results in an incorrect answer. While gender was not an option for this particular survey, gender differences in the usage of AAE also result in a clear distinction.

Question eight states, 'Speech-language and hearing difficulties are more prevalent among Native Americans.' Moxley (2003), states that the prevalence of speech, language, and hearing difficulties is five times greater in Native Americans. Rowden-Racette (2013) notes that there is a higher incident of cleft lips and cleft palates among the Native American population, both of which require SLP services.

Number nine states 'It is possible that 1%-2% of your clients will be gay, lesbian, bisexual, or transgendered.' Nine percent of the participants answered this correctly with an answer of false. Approximately 5-10% of clients may be lesbian, gay, or bisexual, and 1-10% may be transgendered. It is becoming especially important to be aware that even though children are children, they may know their sexual orientation or gender identification (Moxley, 2003). Hancock and Haskin (2015) also noted that approximately 46% of transgender women seek voice feminization services.

Question 10 states, 'If a family member or friend speaks English as well as the client's native language, and is willing to act as an interpreter, this is the best possible solution.' Seventy-

two participants answered this correctly with a response of false. As supported by Moxley (2003), it is best to use someone experienced in the specific field, in this case SLP, as experienced interpreters and translators have targeted training to aid in assessments and interventions. It is important to note that although the use of interpreters is encouraged, family members can be utilized to compare child language samples to an adult language sample to identify phonetic differences, acoustic differences, and correct pronunciation (McLeod et. al 2017).

       Question 11 asks which option is least useful when conducting a language assessment on a client whose ability to speak English is limited. The options were as followed:

    a. Research on the client's culture(s), speech community, or communication environment
    b. An interview on how the client's language development compares to peers in his/her speech community or communication environment.
    c. An interview with a family member, or other person who knew the client previously, to describe and compare the client's language skills before the insult or injury that may have led to an acquired language disorder.
    d. Information on the family history of speech/language problems or academic difficulties
    e. Competent use of a linguistic/sociolinguistic cultural informant/broker to gain insight into the impact of culture on the client's communication skills
    f. Use of language data received from the interpreter/translator
    g. Standard scores from a translated battery of assessments

The correct answer to this question is g. standard scores from a translated battery of assessments. If the assessment was translated, then the standardized scores were based upon a population sample with which the client does not identify. Understanding this is critical as an SLP, as the scores of the translated assessment will not be valid. Unfortunately, just over half (54%) of the participants answered correctly. McLeod et. al (2017) noted that adapting assessments from one language to another could lead to communication disorders due to linguistic transfer, exclusion of phonemes from the nondominant languages spoken by the child, omission of particular diagnostic markers and/or confusion with clients as a result of the use of culturally insensitive methods and materials.

       Question 12 stated 'Cultural and linguistic biases may occur in testing tools and have an impact on an appropriate differential diagnosis between a language disorder and a language difference. Cultural biases do NOT include the following:' The answers included a. question types, b. differences in features of language, c. specific response tasks, and d. test format. Thirty one percent of students chose the correct answer, b. differences in features of language. This is a linguistic bias meaning that the language used is reflective of a specific social group, often divided by age, gender, race, ethnicity, or social class (Moxley, 2003). Major assessment issues arise in the areas of phonology and language when a test is administered to a multilingual client. When a test is developed in English, the norms are based on proficient English-speaking individuals. The assessment will be difficult for those whose primary language is not English because they are being tested in a language which is unfamiliar to them (Haynes et. al, 2012). Linguistic bias, or the presumption that the child is a standard English speaker, is just one of many types of bias that standardized tests can have towards culturally diverse children. Other types of bias can include situational bias, directions bias, value bias, stimulus bias, and cultural misinterpretations (Haynes et. al, 2012).

Number 13 was answered correctly by 83% of the participants. The statement was, 'An audiologist must be aware of the influences of different races and ethnicities when completing an audiologic evaluation.' This statement is true as there is variability and etiology of hearing disorders may be more prevalent in specific ethnic communities. Martin and Clark (2015) point out that some cultures, such as Hispanics and Asians, often feel that only overtly visible physical disabilities warrant intervention, which could impede strides for hearing rehabilitation.

Question 14 follows the same trend as the previous question. The question states, 'Fitting considerations for personal assistive devices may vary across races and ethnicities.' Eighty-three percent of participants responded 'true' which is the correct answer. Moxley (2003) notes that this includes being aware of the availability of ear molds and hearing aids in varying skin tones for greater cosmetic appeal

Ninety-nine percent of participants answered question 15 correctly. It stated, 'When working with an interpreter, the interpreter makes diagnoses.' Only the qualified examiner makes the diagnosis proving this statement false.

Question 16 was the final question and it stated 'Variations in dialects of the Spanish language are reflected in:' with options of a. pronunciation, b. vocabulary, c. grammar, and d. structure of language. One percent of the respondents selected only the correct answers, a. pronunciation and b. vocabulary. While many respondents were able to identify that pronunciation and vocabulary reflected dialectal variations, they also selected an incorrect response. United States Spanish, Latin America Spanish, Castilian Spanish, and Neutral Spanish are the most common Spanish dialects. All of these dialects differ in vocabulary influence, expressions, and verb tense usage (Foreign Translations, 2010). It is crucial to understand that linguistic changes are part of complex behaviors that define a culture. Every racial or ethnic group has different social uses of language, unique vocabulary items, sentence structures and ways of changing the sounds of the English language (Haynes et. al, 2012).

Conclusion

In conclusion, this research has given deeper insight into effective multicultural education strategies. Students' responses were able to be categorized into four major groups, (1) class examples, lectures and discussions (2) workshops and guest speakers (3), awareness and acceptance of diversity, and (4) culture and language. Students' responses proved that educators at the participating institutions have been integrating multicultural material into the classroom. While the need for multicultural education in SLP students has been recognized, the continuous effort to understand culture is far from over. Immigrants and refugees from East Asia, Southeast Asia and the Pacific Islands speak major languages such as Mandarin, Cantonese, Taiwanese, Tagalog, Japanese, Korean, Hakka, Ilocano, Samoan, Vietnamese, Lao, Hmong, Hindi, and Khmer. Most Americans have probably never heard many of these languages before, and they understand even less about the cultures from which they originate (Haynes, et. al, 2012). With the rapidly growing rates of diverse populations, educators in the field of speech language pathology are expected to teach students the clinical knowledge they need to succeed in the field, but with such a diverse range of clients, it feels seemingly impossible to cover each race/ethnic background as in depth as is necessary to foster cultural competence.

At the time of the survey, just over half (51%) of the participants had completed a course on multicultural education, yet 94% of the students felt that they should be required to complete a multicultural course. With 90% of the students agreeing that cultural competence is very important in the field of speech language pathology, it is clear that students have an

understanding of why and how cultural awareness impacts service delivery; however, the current education curriculum for communication disorder undergraduate students is not built to disseminate the amount of information that needs to be covered to properly prepare students to work in the field. Future research on developing a pedagogical framework for SLP education to disseminate multicultural instruction is needed. Future research is also needed to pinpoint the most significant information regarding social interaction in each culture.

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Table 1
Multicultural Assessment Questionnaire

1. What is your race?
    - African-American
    - Caucasian
    - Hispanic
    - Latino
    - Asian
    - Bi-Racial
    - Other
2. Are you bilingual?
    - Yes
    - No
3. To which gender identity do you most identify with?
    - Female
    - Male
    - Transgender male
    - Transgender female
    - Gender Variant/ Nonconforming
    - Not listed
    - Prefer not to answer
4. What is your current academic status?
    - Undergraduate-Freshmen
    - Undergraduate-Sophomore
    - Undergraduate-Junior
    - Undergraduate-Senior
    - Graduate
5. Have you completed a class dealing with multiculturalism/cultural variations in your program of study?
    - Yes
    - No
6. Do you consider yourself to be culturally competent at this point in your field of study?
    - Yes
    - No
7. Which aspects do you feel shape cultural diversity? (circle all that apply):
    - Sexual orientation
    - Religious beliefs
    - Socioeconomic levels
    - Regionalisms
    - Age-based peer groups
    - Educational Background
    - Ability/disability

- Race/ethnicity

8. A bilingual clinician needs to be fluent in the language spoken by the client but does not need to understand normal language acquisition in the language spoken.
   - True
   - False
9. If you are working with same-sex parents, it is only important to get the medical information about the biological parents.
   - True
   - False
10. There are universal gestures to indicate agreement, such as nodding the head to indicate "yes."
    - True
    - False
11. In Hispanic communities, it would be appropriate to initiate an assessment sharing meeting with a personal conversation rather than to immediately provide the results.
    - True
    - False
12. Monolingual language learners and bilingual language learners should have the same emerging language milestones.
    - True
    - False
13. The use of African American English is influenced by many different variables including (circle all that apply)

    - Age
    - Race
    - geographic location
    - occupation
    - intelligence
    - income
    - education
    - religion
14. Speech-language and hearing difficulties are more prevalent among Native Americans.
    - True
    - False
15. It is possible that 1%-2% of your clients will be gay, lesbian, bisexual, or transgendered.
    - True
    - False
16. If a family member or friend speaks English as well as the client's native language, and is willing to act as an interpreter, this is the best possible solution.
    - True
    - False

17. When conducting a language assessment on a client with limited ability to speak English, which one of the following is LEAST useful?
    h. Research on the client's culture(s), speech community, or communication environment
    i. An interview on how the client's language development compares to peers in his/her speech community or communication environment.
    j. An interview with a family member, or other person who knew the client previously, to describe and compare the client's language skills before the insult or injury that may have led to an acquired language disorder.
    k. Information on the family history of speech/language problems or academic difficulties
    l. Competent use of a linguistic/sociolinguistic cultural informant/broker to gain insight into the impact of culture on the client's communication skills
    m. Use of language data received from the interpreter/translator
    n. Standard scores from a translated battery of assessments

18. Cultural and linguistic biases may occur in testing tools and have an impact on an appropriate differential diagnosis between a language disorder and a language difference. Cultural biases do NOT include the following:
    - question types
    - differences in features of language
    - specific response tasks
    - test format

19. An audiologist must be aware of the influences of different races and ethnicities when completing an audiologic evaluation.
    - True
    - False

20. Fitting considerations for personal assistive devices may vary across races and ethnicities.
    - True
    - False

21. When working with an interpreter, the interpreter makes diagnoses.
    - True
    - False

22. Variations in dialects of the Spanish language are reflected in (circle all that apply):
    - Pronunciation
    - Vocabulary
    - Grammar
    - structure of language

23. Would you feel prepared to work with culturally diverse clients?
    - Yes
    - No
    - Depends on the culture

24. How important would you say cultural competency is in the field of Speech Language Pathology?
    - Very important

- Moderately Important
- Important
- Not Important

25. Do you think there should be a curriculum course dedicated to cultural competence?
    - Yes
    - No

26. Do you feel as though your educators are encouraging cultural awareness?
    - Yes
    - No

27. If so, what is one way they encouraged cultural competency? Please explain.

_____