

# **Speech-Language Pathologists and Culturally Competent Intervention**

by

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## Abstract

The purpose of this study was to explore speech-language pathologists' (SLPs) demonstration of cultural competence during the intervention process. A 22-item Qualtrics survey was distributed to investigate if SLPs consider culture broadly when choosing therapy materials, if race and/or ethnicity is the most commonly considered cultural facet, and if SLPs agree to conducting research on a new student's culture to have a better understanding of their student's beliefs. Results indicate that SLPs consider culture prior to choosing therapeutic materials and that family structure is the most commonly chosen facet when demonstrated with a provided stimulus. Most SLPs agreed in conducting research on a multicultural client's culture prior to intervention.

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## List of Abbreviations

AAE	African American English
ASHA	American Speech Language and Hearing Association
CCAI	Cultural Competence Assessment Instrument
CEU	Continuing Education Units
CLD	Cultural and Linguistically Diverse
CHS	Cultural Humility Scale
CRT	Culturally Responsive Teaching
MAE	Mainstream American English
SLP	Speech Language Pathologist

## **Chapter I**

### **Introduction**

It is the ethical responsibility as a speech-language pathologist (SLP) to demonstrate respect for an individual's cultural composition (American Speech Hearing Association [ASHA], N.D.a). While some may limit cultural factors to ethnicity, race, gender, sex, and origin, cultural components include a much larger variety of cultural facets. Cultural diversity incorporates but is not limited to ethnicity, gender, age, disability, gender identity, national origin (including culture, language, dialect, language, immigration status, and other related factors), religion, sex, sexual orientation, veteran status, and more (ASHA Issues in Ethics, 2017.).

While the population of the United States (U.S.) grows and its cultural diversity expands, it is pivotal that speech-language pathologists recognize the cultural and linguistic differences that make up their clients, to provide competent care (ASHA Issues in Ethics, 2017). The U.S. Census Bureau reported a prediction that by 2060, more than half of the population will be comprised of children who are part of a minority race or ethnic group (U.S. Census Bureau, 2000). It is therefore likely that an SLP will be working with an individual whose cultural and linguistic background is different than their own. In their survey, Guiberson and Atkins (2012) found that 83% of the respondents' caseloads were made up of racially diverse clients and families. Only 17% of respondents reported working with primarily White individuals (Guiberson and Atkins, 2012). Kritikos (2003) noted in their study that 95% of SLPs reported working with at least one client from a different cultural and linguistic background (Kritikos, 2003). This information provides an idea of the prevalence of working with culturally and linguistically diverse (CLD) individuals, but there is a lack of literature on the demonstration of SLPs and culturally competent practices.

ASHA defines CLD individuals on the basis of age, gender, occupation, sexual orientation, disability, socioeconomic status, religion, ethnicity, and more; however, culture can be representative of any type of group (ASHA, N.D.). Some of these cultural identities that don't fall within the majority group are not always considered. CLD individuals can include groupings of one or more of the previously mentioned factors. Therefore, when discussing CLD individuals throughout this paper, CLD represents any/all of the previously mentioned cultural facets.

In their survey, Campbell and Taylor (1992) investigated self-perceived cultural competence of SLPs and found that SLPs felt the least competent with evaluation and treatment of CLD individuals. Therefore, SLPs who do not feel comfortable evaluating the CLD student might face difficulty with diagnosis, goal making, establishment of client rapport, and as mentioned, treatment. This is further evidenced by the findings of the 2011 SLP Health Care Survey. SLPs rated their self-perceived notions on providing competent services to culturally and linguistically diverse clients on a five-point scale, 1 being not at all qualified and 5 being very qualified (ASHA, 2011). Approximately 75.5% of participants rated themselves a 3 or above.

A review of the literature was conducted to provide information regarding the current research on the topic of cultural competence in speech-language pathology. The studies reviewed are older in nature as recent studies on cultural competence of SLPs are limited. This literature review will define cultural competence, briefly examine cultural competence in helping professions, and discuss cultural competence in the field of speech-language pathology on the basis of intervention practices.

## **Literature Review**

### **Cultural Competence**

Culture, defined by Vafadar and Utt (1992) is a system of behaviors, emotions, and objects. Language is a part of culture, being a system of symbols, which represent ideas and emotions (Vafadar and Utt, 1992). Cultural competence is commonly defined as a set of agreeable behaviors, beliefs, and policies that are shared amongst professionals and allow groups to work efficiently with individuals of culturally different backgrounds (Cross et al., 1989). Obtaining cultural competence is a continuous and ongoing process, not just a destination (Campinha-Bacote, 2002). ASHA states that cultural competence is a stage of understanding and acceptance for difference, which includes frequent self-assessment of one's cultural responsiveness, continuous education on cultural competence, and making modifications to service delivery models dependent on cultural diversity (ASHA, N.D.a). This concept of cultural competence includes acknowledging and incorporating the importance of culture, assessment of cross-cultural relations, cultural diversity, expansion on cultural knowledge, and adaptation of services to meet the needs of culturally unique individuals (Betancourt et al., 2003). Culturally competent professionals should be able to view cultural groups as different from another, each having their own distinct cultural characteristics in order to avoid generalization and stereotypes of CLD individuals (Cross et al., 1989).

### ***Cultural Competence in Helping Professions***

In the helping professions, such as educators, therapists, psychologists, and other professionals, it is critical to be culturally competent. It is evident that cultural components of students, clients, patients, and other individuals who are receiving services are important factors to consider (Grandpierre et. al, 2018; Kadyamusuma, 2016; Kritikos, 2003; Maul, 2015; Ulrey

and Amason, 2001). If the cultural composition of these individuals is not taken into consideration, then assessment, diagnoses, and treatment outcomes might be inaccurate (Grandpierre et. al, 2018; Gutierrez-Clellen and Quinn, 1993, Kritikos, 2003).

Culturally responsive teaching (CRT) is one way that teachers implement multicultural education in school settings (Bonner et al., 2018; Gay, 2002; Acquah and Szelei, 2020; Portes et al., 2018; Phuntsog, 2001). Phuntsog (2001) investigated the perceptions of elementary school teachers on the importance of culturally responsive teaching. Results of the study reported 96% of respondents considering CRT to be important while 3% reported CRT was “moderately important.” No respondents in the study stated CRT to be “unimportant.” Bonner et al., (2018) studied the perceptions of 430 teachers and their abilities to use CRT in the classroom. The findings from the quantitative survey revealed a strong commitment to CRT, sense of efficacy in teaching multicultural students, and positive results when diverse students’ needs were considered and addressed (Bonner et al., 2018).

Education on how to work with a CLD population is important for professionals in the helping fields. Sumpter and Carthon (2011), in their focus group interview, studied nursing programs’ preparation and education on working with CLD individuals. This study showed that although students were educated on the subject of cultural competence, they did not feel like they achieved mastery to work with this population. Results from the interviews suggested nursing students felt that a clear definition of cultural diversity, cultural sensitivity, and cultural competence was not comprehensive and were understood relative to race and no other cultural variables. Since cultural diversity is continuing to grow in the United States, this study was important to evaluate nurses’ cultural competence. Findings of the study revealed there was a need for more education on the preparation of nurses to work with multicultural populations. In

response to such findings, the University of Pennsylvania School of Nursing added multicultural education and a minor in Multicultural/Global Healthcare to the nursing school curriculum. This study implies that there is a need to evaluate more nursing programs, in addition to other clinical programs on how they are preparing their students on working with multicultural populations (Sumpter and Carthon, 2011).

In their study, Flynn and Betancourt (2019) investigated the relationship between cultural competence and negative health care encounters. Participants included 335 Latina and non-Latino White American women. They found that 236 individuals reported one or more negative encounters with medical examinations. Both groups of participants reported less shame and embarrassment when their provider presented culturally competent. These findings show that cultural competence in the health care field has an impact on patients' attitudes and experiences when receiving services from clinical professionals (Flynn and Betancourt, 2019; Kang et al., 2016).

In their scoping review, Grandpierre et. al. (2018) found that speech-language pathologists, physical therapists, and occupational therapists reported cultural variables having an impact on service. Therapists reported having varied cultural views on the topics of parenting, caregiver views of disability, decision-making, gender roles, and independence. By being knowledgeable of the vast multicultural dimensions, a practitioner will likely not encounter as many problems impacting service (Grandpierre et. al, 2018; Guiberson and Atkins, 2012; Lindsay et al., 2014). Being knowledgeable of patients' cultural backgrounds was shown to improve practitioner's understanding of patient goals, offer more appropriate recommendations, and provide overall competent care. This study did not include an investigation on the

perceptions of either the patient/caregiver or practitioners which reveals a gap in the literature (Grandpierre et. al, 2018).

The literature summarized in this section discussed the practices, education, and importance of culturally competent services in helping professions. Insight is provided on the positive outcomes of culturally competent practices in these professions. The literature suggests that education on the topic of cultural competence should be emphasized more during schooling, training, and practice (Grandpierre et. al., 2018; Sumpter and Carthon (2011).

### ***Cultural Competence in Speech-Language Pathology***

The importance of cultural sensitivity in the field of speech-language pathology is emphasized by ASHA on the basis of culture, race, ethnicity, gender, sexual-orientation, socioeconomic status, beliefs, values, religion, and more (ASHA, N.D.a). ASHA explains that cultural competence is important to improve overall quality of services and health outcomes, meet legislative, regulatory, and accreditation mandates, answer to changes of demographics in the United States, and importantly disregard long-standing biases in the health status of people on the basis of race, culture, or ethnicity (ASHA, 2004). To be able to do this, SLPs must have the proper education and training on how to work with individuals of different cultural backgrounds.

**Education, Training, and Exposure.** Education, training, and exposure to CLD populations is likely introduced through university instruction. Some universities might incorporate a large portion of their curriculum on the subject of cultural sensitivity while some might only meet minimal criterion suggested by ASHA (Guiberson and Atkins, 2012; Howells et al., 2016; Kritikos, 2003; Matteliano & Stone, 2014). Roseberry-McKibbin and Eicholtz (1994) reported in their survey that 76% of respondents had no coursework or education on providing

services to CLD individuals. More recently, Hammond et al., (2009) surveyed accredited SLP graduate school program directors throughout the United States on their views on academic instruction and clinical experiences with CLD populations. Results suggested that most felt their programs adequately prepared their students to provide services to CLD populations. Two questions provided differences that were statistically significant across geographic regions in the United States. One question related to the amount of education on cultural and linguistic diversity and the other to the amount of CLD individuals seeking therapy. This implies that students coming from different universities will most likely have different amounts of training and experience with CLD populations. Finally, depending on the geographical location of the university, some students might have more interaction and exposure with individuals from a CLD background than others (Pickering and McAllister, 2000).

**Cultural Factors Addressed.** Though there are an abundance of cultural factors that should be considered when discussing cultural competence, very few of these have been addressed in the literature. Most studies address cultural facets on the basis of language, and by proxy/ race and ethnicity (Pickering and McAllister, 2000). Race and ethnicity can be indirect factors studied as they frequently align with use of certain linguistic features, be this within a language or a language variation. For example, Kritikos (2003) mentions that bilingual SLPs are typically more sensitive to cultural differences on language use when compared to monolingual SLPs. Parveen and Santhanam (2020) found that bilingual SLPs reported higher perceived competence with non-English speaking individuals during service delivery, including assessment of speech and language, working through challenging clinical situations, and responding to questions about outcomes of intervention. Dialect is another important cultural difference to consider. Craig-Unkefer and Camarata (2010) discuss how clinicians must consider lexical,

grammatical, and cultural differences when working with clients who are learning African American English (AAE) as their primary dialect and have a language impairment. They studied two different intervention methods that have been supported for speakers of MAE and used them with 4 children who speak AAE. These intervention methods included conversational recast and imitation. Results from the study showed a positive effect on the AAE-speaking children after the two intervention methods were used. More research is needed to determine the relationship between other interventions strategies used with MAE speakers and their potential uses on AAE speakers. While language, race, and ethnicity are very important cultural factors to consider, cultural domains are vast and include a lot more variety than these components.

One cultural factor that an SLP may not consider is how one's socioeconomic status (SES) upbringing may also play a role in some expressive and receptive language tasks on a standardized assessment. If the child has not had exposure to certain objects and experiences in their culture, it might be unfamiliar to the client, thereby making the task culturally inappropriate. Maul (2015) investigated in their qualitative study, perceptions of 9 SLPs and their interactions while working with CLD populations. Several SLPs reported diversity based on their clients' cultures as well as their SES and educational levels. These findings suggest that CLD individuals come from vastly diverse backgrounds that include their family upbringing and socioeconomic standing. Still, there are few studies that discuss cultural components like socioeconomic status along with areas such as religion, gender, and family structure.

The following sections discuss the relevant literature regarding culturally competent service delivery of SLPs. While research on culturally competent assessment is vast, less research has been conducted on the basis of cultural competence during intervention.

### ***Culturally Competent Intervention***

Culturally competent intervention has implications on client motivation and effectiveness of therapy itself (Beach et al., 2005; Ulrey and Amason, 2001). The Cultural Humility Scale (CHS) (Hook et al., 2013) is a quantitative measure that allows clients to report their own perceptions of their therapists' cultural humility (Hook et al., 2013). While developing the CHS, developers found that clients who stated their therapists had higher cultural humility also had stronger work alliances with their therapists and better therapeutic outcomes (Hook et al., 2013). Kimble (2013), in their study, investigated 192 SLPs' comfort levels on the basis of assessment and intervention after attending a workshop on working with CLD individuals. The results suggested that while assessment was the most uncomfortable part of service with CLD students, it was found that there was a correlation between workshops attended and comfort levels when working with these students during assessment *and* intervention. This implies that workshops, classes, and other continuing education units on cultural competence have a positive effect on skills and knowledge needed for assessing *and* treating CLD individuals (Kimble, 2013).

The current literature provides ideas on how to respond to the needs of CLD individuals during intervention (Inglebret et al., 2008; Kadyamusuma, 2016; Kritikos, 2003; Maul, 2015; Ulrey and Amason, 2001; Verdon et al., 2015; Williams and McLeod, 2012). Verdon et al., (2015) identified in their ethnographic study six principles for working with CLD populations; (1) identification of therapy goals that are culturally responsive and motivating, (2) knowledge of diverse languages and culture, (3) the use of resources that are culturally appropriate, (4) cultural, social, and political considerations, (5) family consultation, and (6) interprofessional collaboration. These principles provide ways for SLPs to enhance their culturally competent services on the diverse facets of culture.

These current principles can be added to ones made previously by other researchers (Robinson & Crowe, 1998; Seymour, 1986; Verdon et al., 2015) for a more wholistic framework. For example, Seymour (1986) presented six principles that may be used with CLD children specifically during language intervention. These principles discussed that intervention strategies should be (1) multidimensional, (2) interactive, (3) generative, (4) child-centered, (5) bidialectal, and (6) diagnostic (Seymour, 1986). Robinson and Crowe (1998) discussed a framework for stuttering intervention with African American children and their families. The authors provided ways for SLPs to incorporate culture-based strategies into intervention. Considerations of culture emphasized integrating both the child and their family during intervention practices. This specific model discussed could easily be adapted and used for other multicultural clients and their own communication disorder (Robinson and Crowe, 1998).

Another way an SLP might support CLD students and their speech, language, and communication needs is by collaborating with families through interpreters (Kadyamusuma, 2016; Maul, 2015; McLeod, 2012). Verdon et al. (2015) found collaboration with families increased understanding of diverse cultural expectations and processes to family involvement and helped build relationships with CLD families to work towards common goals (Verdon et al., 2015).

**Treatment Materials in Speech-Language Pathology.** While the above principles seem helpful, it can often be difficult to set up a culturally responsive therapy session for multicultural students if there are not appropriate intervention materials. The current research presents ways to practice cultural competence during assessment and treatment, but there is slim evidence regarding specific therapeutic materials that are culturally responsive. Williams and McLeod (2012) found in their questionnaire that many respondents made their own materials to use with

CLD individuals. Few respondents implemented language specific resources, however, some of these individuals reported making efforts to make sure they were culturally responsive (Williams and McLeod, 2012). These findings imply that while some efforts are being made by clinicians to ensure culturally competent intervention, some are not as aware.

In their study, Moodley et al. (2005) aimed to explore responses of 10-year-old mainstreamed students after reading folktales to them that represented a variety of cultures. This study included a questionnaire, focus group interview, and audio-visual recordings. Findings from the data showed that participants responded positively when the folktales represented their culture, gender, or physical characteristics. This data shows that folktales that were representative of the readers' lives were more interesting to them, encouraging participation in discussion. From this study, the importance of using materials that represent students' own culture is emphasized (Moodley et al., 2005).

Inglebret et al. (2008) discussed how there is limited literature on providing culturally responsive intervention with American Indian and Alaska Native children. The authors provide ways for SLPs to be culturally responsive during intervention with these specific populations. They suggest using culturally based stories that are appropriate for the child during intervention to improve oral language and emergent literacy skills for children. From this research, one may conclude that culturally based stories representative of that individual's culture may be beneficial during language and literacy intervention with other multicultural individuals. Current literature focuses on culturally competent intervention, includes ideas on how to respond to the needs of CLD individuals, framework for working with CLD individuals, the use of interpreters, and vaguely, the use of culturally responsive materials.

## **Justification**

While the literature on conducting culturally responsive assessments for CLD populations is evident, less research has been done on the demonstration of cultural competence during intervention. Being culturally competent during this stage of service is just as important because by being a culturally competent clinician during intervention, an SLP might feel more comfortable interacting, building rapport, and working with CLD students (Grandpierre et. al, 2018; Hook et al., 2017; Kang et al., 2016). This is an important concept as the population of culturally diverse individuals continues to grow.

While a review of the current literature on cultural competence has been completed, several questions remain on how SLPs are being culturally competent in their choices of therapy materials. There is a lack of research demonstrating how SLPs are choosing therapy materials to target intervention goals with CLD individuals. The current research provides information on common definitions of cultural competence, how other helping professions are implementing cultural competence in their fields, and ways SLPs are assessing and intervening with CLD individuals. However, there is a gap in the literature providing information on the use of culturally appropriate materials in therapy. Therefore, the following research questions and aims were studied:

1. Do SLPs consider culture when choosing therapy materials?
  - Hypothesis- The majority of SLPs do not consider cultural facets when choosing therapy materials.
2. Are race and/or ethnicity the most commonly considered cultural facets in the selection of therapy materials?

- Hypothesis- SLPs who consider cultural facets are more likely to consider race and/or ethnicity when considering selection of therapy materials.
3. Do SLPs agree on conducting research on the culture(s) of their CLD students prior to intervention to have a better understanding of their student's beliefs?
- Hypothesis- SLPs will report that they conduct research prior to providing services to CLD individuals to have a better understanding of their beliefs.

## **Chapter 2**

### **Methods**

#### **Participants**

To meet inclusion criteria of the study, participants were clinicians who work/have worked with preschool to school-aged children in the past year and have graduated with their Masters in Speech-Language Pathology. Participants who did not meet inclusion criteria were directed to the end of the survey and their responses were not included in data analysis.

#### **Materials**

A 22-item survey was administered via Qualtrics software and targeted five main research areas of interest: (a) race, (b) gender, (c) religion, (d) socioeconomic status, and (e) family structure. A stimulus that represented a therapeutic material and represented these five cultural facets was embedded into the survey. This stimulus was shared with committee members prior to embedding it into the survey. Committee members agreed on its representation of all five cultural facets. Prior to beginning the survey, the letter of consent was presented.

Part I of the survey collected demographic data of the participating speech-language pathologists. The demographic questionnaire collected data from participants regarding their age, race, ethnicity, gender identity, religion, sexual identity, language, and geographical region where they have lived majority of their lives. Questions regarding race, ethnicity, gender identify, sexual orientation, and religion had a response option as “prefer not to answer” if they did not feel comfortable answering the question. Information about participant’s education/training on multicultural competence was also collected in this section of the survey.

Part II of the survey developed to answer research questions 1 and 2 asked respondents questions related to an embedded stimulus. The stimulus included a photo of a commonly used

therapy material. Questions targeted different cultural factors including gender, religion, socioeconomic status, family structure, and race (and/or ethnicity). The question presented with the stimulus and read “Select the cultural facets (family structure, gender, race (and/or ethnicity), religion, socioeconomic status) you would consider prior to using this material in therapy.” All of the above, none of the above, and other (please specify) were also answer choices.

Part III of the survey included 25 questions adapted from the Cultural Competence Assessment Instrument (CCAI) (Cicolini et al., 2015; Doorenbos et al., 2005). Doorenbos et al (2005) developed this tool to measure cultural awareness and cultural sensitivity which lined up with the interests of the current study. Caricati et al. (2015) described this instrument as having a focus on healthcare professionals and settings, supportive of a broad definition of culture, and is short and easy to administer. Cicolini et al., (2015) used this instrument in their survey to investigate Italian nurses’ cultural competence and found that nurses’ cultural competence was moderately acceptable but should be better based on the vastly growing multicultural population. This survey was chosen because of its target on cultural awareness and cultural sensitivity. Respondents rated how likely they agreed or disagreed with the statements on a 1-7 Likert scale. Prefer not to answer was also an answer choice for each question for those who did not feel comfortable answering or those who were not applicable to answer.

## **Procedures**

After obtaining approval from the Auburn University Institutional Review Board (IRB), participants were recruited three ways. The first method of recruitment was through ASHA Special Interest Groups (SIGs) Cultural and Linguistic Diversity (14) and Language Learning and Education (1). An information letter containing the linked survey and consent was sent via email to group coordinators then posted online. SIGs Cultural and Linguistic Diversity, and Language Learning and Education were chosen because their members were likely to work in the school setting. A brief description of the survey was posted on the ASHA Community website and several SLP Facebook pages the primary investigator and/or faculty advisor were members of as another recruitment attempt. The post included the embedded link for potential participants to click to be directed to the survey. The post was made public and shareable to the Facebook community. Once potential participants clicked on the link, the information letter and permission of consent was present. Participants were able to provide consent by responding with “yes” or “no” to participate. Once two weeks passed from the initial posting, another announcement was posted as a reminder on both the Facebook pages as well as ASHA Community website, containing the same information that was included in the first post.

## **Data Analysis**

After data was collected, a spreadsheet was used to analyze the quantitative data from the survey. Since the option “prefer not to answer” was included, some questions were not answered by all participants. For each item, an average was obtained to determine the means. For questions that participants prefer not to answer, the average mean was calculated using the number of participants who answered that question rather than the number who completed the survey. The

data was analyzed by using descriptive statistics which allowed for frequency counts, percentages, and averages of the data collected.

## **Chapter 3**

### **Results**

Responses from the survey were filtered for completion. After closing the survey on Qualtrics, data was extracted to an Excel spreadsheet for analysis to answer the three quantitative aims of the study. To determine a mean response for each survey item, responses from participants who responded were averaged. If participants did not respond to an item, averages were obtained using the number of respondents who answered that item rather than the number of individuals who completed the survey.

#### **Background information**

One hundred and thirty-three participants completed the survey and met inclusion criteria. Respondents represented all regions of the United States (Midwest, Northeast, South, and West); most participants being from the South. With regard to the languages spoken by respondents, 132 participants answered this question. The largest percentage of participants reported that they spoke one primary language (67%; n=89). Thirty-three percent (n=43) responded that they speak 2 or more languages. Participants were also asked to report the dialect for which they speak (Table 1). While 62 respondents answered this question, several reported to speak more than 1 dialect. See table 2 and table 3 for the age and race of the participants, respectively.

Table 1: *Reported dialects spoken by participants*

<b>Dialect</b>	<b>n</b>	<b>%</b>
Mainstream American English	20	32
Spanish	12	19
African American English	9	15
Mexican	9	15
Southern American English	9	15
Northeastern American English	4	6
N/A	3	5
Columbian	2	3
Midwestern	2	3
New England	2	3
Cajun Influenced English	1	2
Midland American English	1	2
Moravian	1	2
Ukrainian	1	2
West Coast English	1	2
Western	1	2
Yiddish Influenced English	1	2

*Note.* *n*=number of participants, %= percentage of participants. Due to some respondents

speaking more than one dialect, the number of participants (*n*) exceed the sample size of 62.

Table 2: *Ages of Participants*

<b>Ages of Participants</b>	<b>n</b>	<b>%</b>
20-25	16	13
26-30	30	24
31-35	18	14
36-40	12	9
41-45	18	14
46-50	5	4
51-55	13	10
56-60	10	8
61-65	2	2
66 and above	2	2

*Note.* *n*=number of participants, %= percentage of participants. 126 participants answered this question.

Table 3: *Reported race of participants*

<b>Race</b>	<b>n</b>	<b>%</b>
White	103	75
Black or African American	21	15
Asian	6	4
Other	6	4
American Indian or Alaska Native	1	1
Native American or Pacific Islander	1	1

*Note.* *n*=number of participants, %= percentage of participants. Some participants answered with more than one response.

**Research Question 1: Do SLPs consider culture when choosing therapy materials?**

One hundred thirty participants responded to a provided visual stimulus, representing potential therapy materials, to determine the cultural facets they would consider prior to using the stimulus materials in therapy (see Figure 1). Cultural facets represented in the therapy materials included family structure, gender, race (and/or ethnicity), religion, socioeconomic status, all of the above, none of the above, or other (please specify). Two percent % (n=3) selected one cultural facet they would consider, 10% (n=13) selected 2, 12% (n=15) selected 3, 13% (n=17) selected 4, and 63% (n=82) selected 5 or more. No participants selected none of the above. Respondents who selected 3 or more cultural facets were reported to be “considering culture”. The number 3 was chosen because it represents the majority of the facet options. One hundred and fourteen (88%) selected 3 or more cultural facets and were reported to be considering culture.

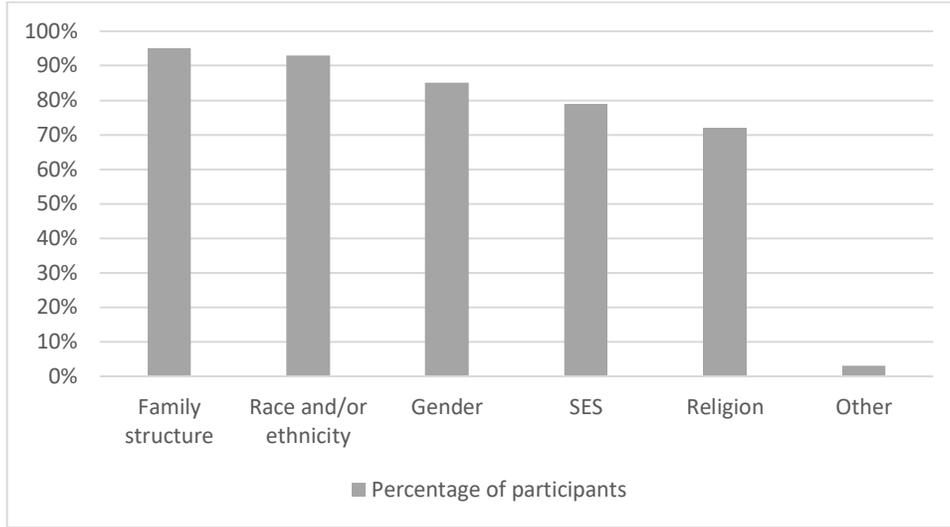
Figure 1: *Stimulus representing therapy material*



**Research question 2: Are race/ethnicity the most commonly considered cultural facet in the selection of therapy materials?**

The cultural facets chosen by participants are shown in Figure 2. When analyzing which specific cultural facets were selected, majority of participants selected family structure (95%; n=124) however, race (and/or ethnicity) was the second most commonly chosen cultural facet (93%; n=121). The least chosen facet was religion (72%, n=93). Four participants chose “other (please specify)” which were not included in the list of choices. These responses included other cultural facets that participants reported should be considered prior to using the stimuli in therapy and included “family and child preferences”, “disability”, “familial expectations”, and “sexual orientation”.

Figure 2: *Cultural Facets Chosen by Participants*



**Research question 3: Do SLPs agree with conducting research on the culture(s) of their students and adapt intervention as needed?**

There were 5 options in the form of a Likert-scale, option 1) strongly agree, option 2) agree, option 3) neither agree nor disagree, option 4) disagree, or option 5) strongly disagree. Participants were presented a questionnaire to determine if SLPs agree that when receiving a new client on their caseload, they conduct research on a student’s culture to have a better understanding of their beliefs. One hundred and nine participants answered this question. Ninety participants (83%) “strongly agree” or “agree”. The results of this data are portrayed in Table 4.

Table 4: *SLPs Who Agree with Conducting Research on Client’s Culture prior to Intervention*

	n	%
Strongly agree	38	35
Agree	52	48
Neither agree nor disagree	12	11
Disagree	7	6
Strongly disagree	0	0

*Note.* n=number of participants, %= percentage of participants

## **Chapter 4**

### **Discussion**

The purpose of this study was to explore SLP's demonstration of cultural consideration during the intervention process. This was done by investigating if SLPs consider culture broadly when choosing therapy materials, if race/ and or ethnicity is the most commonly considered cultural facet, and if SLPs agree to conducting research on a new student's culture to have a better understanding of their beliefs.

#### **Research question 1:**

This study adds to the literature by finding that SLPs are considering culture specifically during the intervention process. ASHA (2004) explains that it is necessary for SLPs to be culturally competent because it 1) improves overall quality of services and health outcomes; 2) meets legislative, regulatory, and accreditation mandates; 3) answer to changes of demographics in the United States; 4) and importantly disregards long-standing biases in the health status of people on the basis of race, culture, or ethnicity. Grandpierre et. al. (2018) found that speech-language pathologists, physical therapists, and occupational therapists reported cultural variables having an impact on service. The primary barriers experienced included language barriers, the influence of cultural diversity on service delivery, and the limited resources available to provide care that is culturally competent. By being knowledgeable of the vast multicultural variables, a practitioner will likely not encounter as many problems impacting service (Grandpierre et. al, 2018; Guiberson and Atkins, 2012; Lindsay et al., 2014). Since SLPs were found to be considering culture, it is hopeful that therapists will not encounter the problems impacting service with CLD students that have been reported in previous studies. While several cultural facets were considered, there are still vast cultural components remaining.

## **Research question 2:**

This study supports previous knowledge from the literature by revealing while other cultural facets are being considered prior to intervention, race and/or ethnicity is still a more commonly considered facet of culture. As reviewed by Pickering and McAllister (2000), most studies address cultural facets on the basis of language, and by proxy/ race and ethnicity. While this study disproved hypothesis II, race and/or ethnicity was still the second most commonly chosen cultural facet. This study adds to the literature by revealing another cultural facet that SLPs are considering prior to intervention, family structure. It is suggested that family structure was most commonly chosen due to the nature of the stimulus and that use of a different stimulus may have resulted in different findings. While there is scarce literature focusing on family structure as a cultural consideration, this implies there is a need for research on other cultural facets than race and/or ethnicity. Williams and McLeod (2012) found in their questionnaire that many respondents made their own materials to use with CLD individuals to represent their diverse caseload. It was not specified in their study which facets of culture were considered, however, it was a specific step in their process of intervention planning to consider the cultural composition of the CLD individual. This could be implied as participants considering the most common cultural facets such as age, gender, occupation, sexual orientation, disability, socioeconomic status, religion, ethnicity, and more (ASHA, N.D.c). The study by Moodley and colleagues (2005) that explored 10-year-olds' reactions to folktales representing each of their culture, gender, or physical characteristics helps demonstrate the significance of considering multiple cultural facets for use in therapy materials. These were the cultural facets selected to be considered by authors, and participants had a positive reaction when these facets of culture were considered.

### **Research question 3:**

The current study aligns with the literature in proving that SLPs agree to conducting research on their multicultural students. Verdon et al., (2015) identified in their ethnographic study six principles for working with CLD populations; (1) identification of therapy goals that are culturally responsive and motivating, (2) knowledge of diverse languages and culture, (3) the use of resources that are culturally appropriate, (4) cultural, social, and political considerations, (5) family consultation, and (6) interprofessional collaboration. To first identify goals that are culturally responsive and motivating, one must have the knowledge of the diversity of the culture. SLPs may do this by conducting research on their students' culture prior to serving them. Since SLPs agree to conducting research on the culture(s) of their students and adapting intervention as needed, it is anticipated that the framework of Verdon et al., (2015) may be efficient in working with CLD populations. If SLPs are confident in their ability to conduct research on their CLD students, it is anticipated SLPs will use resources that are culturally appropriate, consider their students' cultural, social, and political considerations, and appropriately consult family and other professionals. While majority of participants agreed to conducting research, there is still a number that disagreed. While the importance of evidence-based practice has continued to grow over time, SLPs who have been practicing longer may not have received as much education on conducting efficient research when compared to newer SLPs. Another reason some SLPs disagreed to conducting research prior to intervention with CLD individuals could potentially be due to lack of access to recent evidence-based practice on the subject of culturally competent intervention with multicultural populations.

## **Strengths and Future Directions**

There are several strengths this study presents with. This study had a high participation rate (over 100 participants) and represented all four regions of the United States. All race/ethnicities listed were also represented by participants. Approximately 1/3 (33%) of participants spoke more than one language which incorporated more cultural variety.

Another strength of the present study includes the use of a visual stimulus. This was a strategy that is not commonly used. The visual stimulus helped provide participants with an example of a therapy material where they were able to demonstrate what cultural facets they would choose prior to using the material in therapy.

While the strengths of the study are mentioned, it is also important to discuss the limitations this study presents with. The primary limitation is the inability to operationally define what it means to be culturally competent. One aim of the study was to investigate if SLPs are considering culture. While the stimulus was intended to be representative of the 5 cultural facets mentioned, if respondents answered with three or more cultural facets, they were reported to be considering culture.

There is also a chance that that the questions of the study were leading. For example, the question embedding the stimulus asks respondents to “please select the cultural facets you would consider prior to using this material in therapy”. This implies that SLPs should choose at least one cultural facet when answering this question. The possibility exists that respondent’s answers were primed by the way this question was worded and may not generalize for what SLPs are actually doing during intervention. There is also a chance that more aspects of culture were more evident than others.

Another limitation to this study is the possibility that only SLPs interested in multicultural competence may have participated in the survey. Participants who took the survey may have an increased knowledge on working with multicultural populations due to an increased interest in the subject. The results may therefore be over representative of the cultural competence of SLPs as a whole

While the primary intention was to use materials commonly found in every speech room, this was not possible as a result of COVID-19. Due to protocol of the pandemic, the clinic's materials closet was not accessible. A stimulus was created to use for the survey in exchange.

A possible future direction of this study would be to have SLPs participate in a fine motor task where clinicians could sort therapy materials into different buckets that represent a variety of cultural facets. This would provide a real-life demonstration of cultural consideration.

### **Clinical Implications**

One may use the findings from this study to realize the need to spend time investigating their student's cultural composition, spending extra time on the facets likely not considered. For example, since religion was the least commonly considered facet when choosing therapy materials, an SLP may now realize the increased need to consider the cultural composition of their student's religious beliefs prior to planning holiday-themed intervention sessions.

Professors and other educational leaders may better prepare SLPs to provide culturally responsive services by incorporating multicultural education into their curriculum and inviting their students to think of culture in a more in-depth way with multiple facets.

Clinicians should spend time while planning sessions considering the cultural upbringing of all students. Educational leaders in the field of speech-language pathology may use the findings of this study to determine the importance of evidence-based practice in our field. By

teaching future SLPs to conduct efficient research, an SLP would have a better chance of finding the research they need to find to support their multicultural caseload during intervention.

### **Conclusion**

The current investigation offers insight to the demonstration of cultural responsiveness during intervention and SLPs and their consideration in researching the cultural background of CLD students prior to service. Results indicate that SLPs consider culture prior to choosing therapeutic materials and that family structure is the most commonly chosen facet when demonstrated with a provided stimulus. Most SLPs agreed in conducting research on a multicultural client's culture prior to intervention. The results showed that while culture is being considered, certain cultural facets are focused on more than others. It was found in this study that SLPs agreed to conducting research on their culturally diverse student, therefore, SLPs should have an increased awareness to what materials are culturally inclusive and/or appropriate and those that are not.

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## Appendix A. Survey

### *Speech-Language Pathologists and Culturally Competent Intervention*

#### Start of Block: Personal Background Information

- 1. Did you graduate with your master's degree in Speech-Language Pathology 2015 or later?**
  - Yes
  - No
- 2. In the past year, have you had preschool to school-aged children (ages 3-21) on your caseload?**
  - Yes
  - No
- 3. Where did you find your invitation to complete the survey? Choose all that apply.**
  - ASHA Special Interest Group (SIG) 14: Cultural and Linguistic Diversity
  - ASHA Special Interest Group (SIG) 1: Language Learning and Education
  - ASHA Special Interest Group (SIG) 16: School Based Issues
  - ASHA Facebook page
  - ASHA Community Website
  - Email
  - Facebook
  - Other (Please specify)
- 4. What year did you graduate from a graduate-level speech-language pathology program?**
- 5. Please select which age range you fall into.**
  - Under 20
  - 20-25
  - 26-30
  - 31-35
  - 36-40
  - 41-45
  - 46-50
  - 51-55
  - 56-60
  - 61-65
  - 66 and above
- 6. Choose one or more races that you identify as.**
  - American Indian or Alaska Native
  - Asian
  - Black or African American
  - Native Hawaiian or Pacific Islander
  - White
  - Other (Please specify)
  - Prefer not to answer
- 7. Do you consider yourself as having a Hispanic, Latino, or Spanish background?**
  - Hispanic, Latino, or Spanish

- Not Hispanic, Latino, or Spanish
- Other (Please specify)
- Prefer not to answer

**8. Which of the following languages do you speak?**

- Arabic
- English
- French
- German
- Korean
- Madarin, Cantonese, and other varieties
- Russian
- Spanish
- Tagalog (including Filipino)
- Vietnamese
- Other (Please specify)

**9. Please describe the dialect(s) for which you speak.**

**10. Please select the gender for which you identify.**

- Female
- Male
- Non-binary
- Other (Please specify)
- Prefer not to answer

**11. Which of the following sexual identities do you identify with?**

- Asexual
- Bisexual
- Gay
- Lesbian
- Pansexual
- Straight
- Other (Please specify)
- Prefer not to answer

**12. Which of the following best describes your spirituality/religion? Choose all that apply to you.**

- Buddhist
- Christian (Please specify)
- Hindu
- Islam
- Jehovah's Witness
- Jewish
- Nonreligious (Atheist)
- Spiritual
- Other (Please specify)
- Prefer not to answer

- 13. Select the geographical region where you have lived the majority of your life.**
- The Midwest (Ohio, Michigan, Indiana, Wisconsin, Illinois, Minnesota, Iowa, Missouri, North Dakota, South Dakota, Nebraska, and Kansas)
  - The Northeast (Maine, New Hampshire, New York, Connecticut, Vermont, Massachusetts, Rhode Island, New Jersey, and Pennsylvania)
  - The South (Delaware, Maryland, Virginia, West Virginia, Kentucky, North Carolina, South Carolina, Tennessee, Georgia, Florida, Alabama, Mississippi, Arkansas, Louisiana, Texas, and Oklahoma)
  - The West (Montana, Idaho, Wyoming, New Mexico, Colorado, Arizona, Utah, Nevada, California, Oregon, Washington, Alaska, and Hawaii)

- 14. What geographical location do you currently work in?**
- The Midwest (Ohio, Michigan, Indiana, Wisconsin, Illinois, Minnesota, Iowa, Missouri, North Dakota, South Dakota, Nebraska, and Kansas)
  - The Northeast (Maine, New Hampshire, New York, Connecticut, Vermont, Massachusetts, Rhode Island, New Jersey, and Pennsylvania)
  - The South (Delaware, Maryland, Virginia, West Virginia, Kentucky, North Carolina, South Carolina, Tennessee, Georgia, Florida, Alabama, Mississippi, Arkansas, Louisiana, Texas, and Oklahoma)
  - The West (Montana, Idaho, Wyoming, New Mexico, Colorado, Arizona, Utah, Nevada, California, Oregon, Washington, Alaska, and Hawaii)

- 15. Please estimate the number of undergraduate-level credit hours received in the following categories:**

- **Required Credit Hours (Credit Hours Dedicated to Multicultural Competence; Credit hours in Courses with Multicultural Competence infused throughout Curriculum)**
- **Elective Credit Hours (Credit Hours Dedicated to Multicultural Competence; Credit hours in Courses with Multicultural Competence infused throughout Curriculum)**

- 16. Please estimate the number of graduate-level credit hours received in the following categories:**

- **Required Credit Hours (Credit Hours Dedicated to Multicultural Competence; Credit hours in Courses with Multicultural Competence infused throughout Curriculum)**
- **Elective Credit Hours (Credit Hours Dedicated to Multicultural Competence; Credit hours in Courses with Multicultural Competence infused throughout Curriculum)**

- 17. Please estimate the number of Continuing Education Units (CEUs) received in the following categories since you began practicing:**

- **Hours (Hours Dedicated to Multicultural Competence; Hours in Courses with Multicultural Competence infused throughout Course)**

Start of Block: Stimulus question



**18. Please select the cultural facets (family structure, gender, race (and/or ethnicity), religion, socioeconomic status) you would consider prior to using this material in therapy.**

- Gender
- Race (and/or ethnicity)
- Religion
- Socioeconomic status
- All of the above
- None of the above

**19. To what extent do agree/disagree to the following statements?**

**I openly discuss with others obstacles I face in developing multicultural awareness.**

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Prefer not to answer

**Race is the most important factor in determining someone's culture.**

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Prefer not to answer

**I believe that everyone should be treated with respect no matter their cultural background.**

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Prefer not to answer

**I think it is important to be knowledgeable of other cultures.**

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Prefer not to answer

**I frequently examine my own beliefs related to culture that may influence my behavior as a service provider.**

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Prefer not to answer

**I am sensitive to respecting cultural differences between my own background and my client's cultural heritage.**

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Prefer not to answer

**I feel that I can learn from my culturally and linguistically diverse clients.**

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Prefer not to answer

**It is difficult for me to accept that religious beliefs may influence how ethnic minorities respond to illness and disability.**

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Prefer not to answer

**I find it difficult to put my own religious beliefs aside when working with someone from a different culture.**

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree

- Strongly disagree
- Prefer not to answer

**At work, I use pictures, printed materials, and toys that reflect diverse and cultural and ethnic backgrounds.**

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Prefer not to answer

**The way services are structured in my setting makes it difficult to identify the cultural values of my clients.**

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Prefer not to answer

**I feel that I have limited experience working with ethnic minority clients.**

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Prefer not to answer

**I feel comfortable in my ability to evaluate a culturally and linguistically diverse client including those who speak a different language than me.**

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Prefer not to answer

**I feel comfortable in my ability to evaluate a culturally and linguistically diverse client including those who speak a different dialect than me.**

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Prefer not to answer

**I feel comfortable in my ability to appropriately treat a culturally and linguistically diverse client by adapting therapy materials and tools when needed.**

- Strongly agree

- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Prefer not to answer

**When receiving a new culturally diverse client on my caseload, I conduct research on that culture to have a better understanding of the client's beliefs.**

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Prefer not to answer

**I include cultural assessment when I do individual or group evaluations.**

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Prefer not to answer

**I use a variety of sources to learn about the cultural heritage of other people.**

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Prefer not to answer

**I avoid using generalizations to stereotype groups of people.**

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Prefer not to answer

**I recognize potential barriers to service that might be encountered by people of different cultures.**

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Prefer not to answer

**I remove obstacles for people of different cultures when I identify barriers to services.**

- Strongly agree

- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Prefer not to answer

**I remove obstacles for people of different cultures when people identify barriers to me.**

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Prefer not to answer

**I welcome feedback from clients about how I relate to people with cultural differences.**

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Prefer not to answer

**I document adaptations I make with clients when assessing them.**

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Prefer not to answer

**Culture is more than race, ethnicity, and language and includes other factors such as socioeconomic status, family makeup, religion, socioeconomic status, and gender.**

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Prefer not to answer

Start of Block: Open-ended questions

**20. In 2-3 sentences, define cultural competence and what it means to you.**

**21. In 2-3 sentences, describe any culturally responsive practices you currently use when selecting therapy materials.**

## **Appendix B. Letter of Consent**

**You have been invited to participate in a research study** to examine the culturally competent practices of speech-language pathologists during intervention. This study is being conducted by Anna Mixson, Master's student at Auburn University, and Dr. Megan-Brette Hamilton, assistant professor at Auburn University's department of Speech, Language, and Hearing Sciences. You were selected as a participant because of your involvement in the school system as a speech-language pathologist.

**What will be involved if you participate?** If you decide to participate in this research study, you will be asked to complete an online survey. Your total time commitment will be approximately 15 minutes.

**Are there any risks or discomforts?** With surveys, there is always a risk of breach of confidentiality which is being minimized by keeping all responses completely anonymous and using all reasonable and customary security measures. The data will be stored behind a secure firewall, and all security updates are applied in a timely fashion.

**Are there any benefits to yourself or others?** There is no direct benefit to you for participating in this study, but it is hoped that the results of this study will add to the current knowledge of the culturally competent practices of speech-language pathologists during intervention with preschool to school-age students.

**Will you receive compensation for participating?** There is no compensation for completing this survey; however, your participation would be greatly appreciated.

**Are there any costs?** There are no costs associated with this survey, except for the time you give to complete the survey. There are three parts to this survey. Estimated time of completion for this survey is approximately 15 minutes.

**If you change your mind about participating,** you can withdraw at any part of the survey by closing your browser window. Once you have submitted anonymous data, it cannot be withdrawn due to it being unidentifiable. Your decision about whether or not to participate or to stop participating will not jeopardize your relations with Auburn University or the Department of Speech, Language, and Hearing Sciences.

**Any data obtained in connection with this study will remain anonymous.** We will protect your privacy and the data you provide by not asking for any identifiable information. Information collected through your participation may be presented at state or national conferences and may be published in a professional journal.

**If you have questions about this study,** please contact Anna Mixson at [agm0072@auburn.edu](mailto:agm0072@auburn.edu).

If you have any questions about your rights as a research participant, you may contact the Auburn University Office of Research Compliance or the Institutional Review Board by phone (334) 844-5966 or email at [IRBadmin@auburn.edu](mailto:IRBadmin@auburn.edu) or [IRBChair@auburn.edu](mailto:IRBChair@auburn.edu).