2010

A Speech-Language Pathologiest Perspective on the Referral and Assessment of Bilingual Children whose Primary Language is not English

Kathleen M. Schulte
Western Kentucky University

Follow this and additional works at: http://digitalcommons.wku.edu/stu_hon_theses

Part of the Bilingual, Multilingual, and Multicultural Education Commons, and the Speech and Rhetorical Studies Commons

A SPEECH-LANGUAGE PATHOLOGIST PERSPECTIVE ON THE REFERRAL AND ASSESSMENT OF BILINGUAL CHILDREN WHOSE PRIMARY LANGUAGE IS NOT ENGLISH

A Capstone Experience/Thesis Project

Presented in Partial Fulfillment of the Requirements for

the Degree Bachelor of Science with

Honors College Graduate Distinction at Western Kentucky University

By

Kathleen M. Schulte

*****

Western Kentucky University
2010

CE/T Committee:

Professor Leisa Hutchison, Advisor

Professor Mary Lloyd Moore

Nicole Stratten

Approved by

Leisa A. Hutchison

Advisor
Department of Communication Disorders

ABSTRACT

This study presents the results from a survey issued to speech-language pathologists in the state of Kentucky regarding their perspectives on referral and assessment of bilingual speakers whose primary language is not English. The study was conducted to determine methods for decreasing the over-identification of bilingual students served for speech and language disorders. Literature review indicates an over-identification of non-English speakers in special education and related services programs nationwide. There are many possible reasons for this over-identification some of which include: lack of English instruction prior to testing in English, Speech-Language Pathologists' preparation level, and shortage of appropriately normed assessment tools. This study specifically addresses Kentucky Speech-Language Pathologists' preparation and comfort level with referral and assessment of non-English speaking students.

Keywords: Bilingualism, Communication Disorders, Referral and Assessment

ACKNOWLEDGEMENTS

VITA

September 10, 1988……………………………Born – Edgewood, Kentucky

2006…………………………………………...Notre Dame Academy, Park Hills,

Kentucky

FIELDS OF STUDY

Major Fields: Communication Disorders, Spanish

TABLE OF CONTENTS

LIST OF FIGURES

CHAPTER 1

INTRODUCTION

Background

        Currently, there are an estimated "5.2 million bilingual children enrolled in

schools in the United States". This is a 61% increase since 1994 (Goldstein 2007).

Individuals of Hispanic origin are one of the largest and fastest growing minority groups

within the United States and the majority of the bilingual population of children within

the schools. Recent population estimates indicate that the nation's Hispanic population

grew "much faster than the population as a whole, increasing from 35.3 million in 2000

to 38.8 million in 2002, and approximately 66% of the Hispanic population is of Mexican

origin" (Kummerer 2007).

        There are numerous benefits to these children being able to speak two languages.

Research has shown that, prior to age 3, simultaneous acquisition of two languages may

occur systematically and without negative influence of one upon another (Kolnert 2005).

Successive acquisition takes place when the children acquire a second language after the

onset of development of the first language. Learning a second language may result in

modified brain organization involving right brain mechanisms not involved in single

language learning. Research has shown that bilinguals are superior in some cognitive

functions such as classification, memory, problem solving, and creativity. Even though

there are many advantages to being able to speak two or more languages, there is still a

strong chance that a majority of these bilingual children will be referred to a Speech Language Pathologist because they are considered to have speech and language disorders. Although this may seem as if it would be beneficial to these children, the main problem is that there is a lack of knowledge about the current best practices related to the assessment of and intervention for bilingual children (Goldstein 2007). Also, despite evidence that "all minorities seem to suffer when their test scores are compared with those of majorities" the proposals for alternative or unconventional tests that are free of bias are in short supply (Campbell 1997). Because little knowledge is available about treating bilingual children, many educators and health care professionals even counsel parents of these children who show signs of language delay or impairment to stop raising the children bilingually and to choose only one language to use with that child. More research needs to be done; however there should be no reason not to raise the children bilingually, even if they have language impairments (Paradis 2003). These professionals believe that children who are bilingual are at a higher risk of having language disorders because of their bilingualism. If minority children are not to be "over-identified" as having language impairments and if language intervention is to be directed at children with truly impaired language it is crucial that Speech Language Pathologists and other professionals be able to distinguish between children whose language differences reflect their differing experiences and backgrounds and children who have fundamental language disorders reflecting basic deficits in their ability to represent and manipulate linguistic information. This can be accomplished through understanding the referral and assessment process the children go through.

<u>Defining Bilingual Versus Monolingual</u>

To understand the problems associated with bilingual children, it is necessary to know how bilingual, monolingual, and culture are defined and how they are interrelated. In the text Human Communication Disorders: An Introduction (2007), culture is defined as the set of "values, perceptions, beliefs, institutions, technology, survival systems, and codes of conduct used by members of a specific group to ensure the acquisition and perpetuation of what they considered to be a high quality of life". Culture is arbitrary and changeable. Many different cultures can overlap over one another and they all have internal variations. Culture is learned by the people who share it. Some form of language is used by every known group on the planet, regardless of its race, region, education, economic, or technical development. Even though there are thousands of languages in the world, all of them share a common set of universal rules. The patterns of acquisitions of all languages are universal. It is also true that social and cultural factors universally affect the nature and use of language within a human group. Within a culture, there is great loyalty to language. This is because language is one of the major unifying forces for the people.

According to Merriam-Webster, being bilingual is "using or able to use two languages especially with equal fluency". Monolingual means "having or using only one language" (Merriam-Webster). There are many different ways to define bilingualism. The Journal of Speech, Language, and Hearing Research states that bilingual "refers to children who have learned their two languages simultaneously from birth or shortly after" (Paradis 2003). Still there are many other children who have learned a different language

later in their life who also could be considered bilingual. Greater than one half of the world's population is "bilingual or multilingual at some level of proficiency" (Tzivinikou 2004). Although there is research about bilingualism, it is still poorly understood. However, research has been done to show that social factors such as age, education, and situation influences an individual's efficiency in learning a second language. Also, it is known that a person's skill in using a second language is usually determined by the frequency with which a person hears and interacts within the second language code and also the nature of instruction. If a person uses a second language more than a first language, facility in the native language might be lost if it is not reinforced at home. It is crucial for educators and professionals to gain a better understanding about bilingualism because the world is increasingly becoming more bilingual. Speech Language Pathologists need to know how to treat these individuals to help better their condition in any way. One of the first steps towards this is differentiating a language difference from a language disorder.

Language Difference Versus a Language Disorder

One important fact that is known about bilingual children is that it is essential for Speech Language Pathologists to distinguish a disorder from a difference when dealing with children who are bilingual. According to Brooke Meztler of Rockhurst University, a language disorder is "impaired comprehension and/or use of spoken, written, and/or other symbol systems" and a language difference "can be a result of cultural differences or limited exposure and lack of facility with English" (2006). Also according to Meztler, these differences that bilingual children display can be seen in the areas of sentence

structure, vocabulary, speech sound production, and pragmatics, which is the "aspect of language that is concerned with use within a communication context" (Anderson 2006). A difference can be seen as a disorder to people who are not aware of what a language difference is and the different aspects of language in which it can be found. This is why it is extremely important for professionals who are dealing with bilingual children to be educated on the causes of language difference. Also, that these differences could occur in a bilingual child's language and where they occur specifically within the child's language.

Referral Process of a Bilingual Child

One important reason why bilingual children are thought to be more prone to speech and language disorders than monolingual children comes from the referral process that they go through before they are assessed for a disorder. The referrals for bilingual children to Speech Language Pathologists come from "health visitors, education services, medical services, including general practitioners, and parents" (Stow 2005). It has been proven that bilingual children have a more than "eight times higher relative risk of being referred by preschool staff compared to monolingual children and a more than three times higher risk of being referred through other sources" (Salameh 2004). Significantly more bilingual children are referred after five years of age, which is a later referral rate than monolingual children. This could be caused by the "wait and see" policy that many professionals adopt when referring bilingual children. It is interesting also to note that they also have a higher rate of refusal of assessment. This could be because there are few

norms for bilingual language acquisition known and many Speech Language Pathologists do not feel comfortable in assessing the children. Also, the children have a higher rate of discharge within twelve months due to nonattendance to therapy sessions, which could be attributed to the fact that few Speech Language Pathologists are educated in undergraduate and graduate schools about children who are from culturally and linguistically diverse backgrounds.

As stated previously, it is imperative for professionals who are exposed to bilingual children to be educated about the distinction between a language disorder and a language difference especially in the assessment process. What these people may think of as a disorder in the bilingual child's speech is usually a language difference that is a result of being fluent in the two different languages. Some professionals adopt what is called a "wait and see" policy, as mentioned earlier, when it comes to referring bilingual children because they are unsure if the child displays a language disorder or if it is a language difference. If this happens, a bilingual child will not be referred to a Speech Language Pathologist until it is obvious that the child's difficulties are persistent and have grown worse (Salameh 2004). This is challenging because the child may in fact have a speech or language disorder and it would be significantly more difficult to treat them once the disorder has been embedded in their speech for some time. These professionals need to be educated about every bilingual child that they deal with daily and their normal speech development in both languages. Speech Language Pathologists must view language diversity as a normal phenomenon and not as a sign of a communication problem. Since disordered communication is considered to be a deviation

from the norm, that "norm" that Speech Language Pathologists use has to be culturally based. In the text *Human Communication Disorders* (2007), Anderson gives an excellent example. The /s/ phoneme is typically pronounced as the voiceless "th" and other palatal sounds are dentalized in Castillian Spanish. The same would be considered to be a lisp for English speakers. There is also some evidence that societies have different standards and ideas for defining what normal communication is and, more importantly, what to do if there are conditions with abnormal communication (Anderson 2006).

However, professionals are not exposed to these children daily. The parents of children who are bilingual need the most education to become aware about language differences and language disorders. Parents in many cases are aware of the child's difficulties, but do not accept the intervention offered for numerous reasons (Salameh 234). They may speak little or no English, and may not understand what is happening to their child, including what the concept of a speech or language disorder is. If this is the case, the Speech Language Pathologist cannot communicate with the parent directly to explain what the child is experiencing. To improve participation, collaboration, and service delivery with families from diverse backgrounds, Speech Language Pathologists must understand and respect culturally specific beliefs and values. To provide valid assessment and intervention practices, it is highly recommended that clinicians learn about the families they serve (Kummerer 2007). To increase parental participation among diverse cultural groups, clinicians are encouraged to interview parents and observe interactions to discern the value of communication and beliefs related to language facilitation routines. There is also evidence that bilingual children with speech disorders

are "being overlooked and are not accessing services" (Stow 2005). These children tend to come from families who are of lower socioeconomic status, especially within the United States. Their families may not be able to afford the treatment that the child may need, or may not see the importance of the child receiving therapy for something that they do not view as a disorder, particularly if it does not impact their ability to function from day to day.

Importance of Testing in Both Languages

Another important reason why children who are bilingual are thought to have more speech and language disorders than their monolingual peers is because they are not being tested in both of the languages they speak when being assessed for disorders. It is necessary to assess the bilingual child in both of the languages that she knows, not just her native language or the one that she uses most commonly in her primary environment. It has been proven that the structure of each language spoken is different; therefore development is not the same in each language (Goldstein 2007). Also, the traditional norm-referenced assessment tools rely heavily on children's previous experience, or "world knowledge". When these children differ in their exposure to concepts, words, or activities, as is often the case in children from different ethnic, cultural, or economic backgrounds, any assessment tool that uses the child's existing knowledge may increase the number of instances where "difference" is confused with "disorder". That is, poor performance may actually reflect the child's relative lack of experience with the test's format, rather than indicating a more fundamental deficit (Campbell 1997).

Defining Phonology

To understand the problems that occur within the assessment process, it is necessary to have an understanding of the concept of phonology. A general definition for phonology is that it is the aspect of language "that is concerned with units such as features, segments, syllables, words, and phrases, the representation of these units and the rules that govern their combination and form." Each language has specific speech sounds or phonemes and sound combinations that are characteristic of that language. Phonemes are the smallest meaningful units of speech sound, and are combined in specific ways to form words. Phonological rules "govern the distribution and sequencing of phonemes within a language". This is an important part of the language acquisition process because it involves learning the sounds, rules, or patterns, and the rhythm specific to the language of the environment. Phonology influences the order and ease of acquisition of some other language features. The vast majority of children acquire the phonology of their first language without direct instruction, and without any difficulty. Most of the information that is known about phonology and phonological development concerns "individuals who speak a single language; individuals who are monolingual" (Anderson 2006).

Children who are bilingual do not acquire phonology in exactly the same way as monolingual children. They use different phonological processes that are specific to each of their languages. Depending on the social situation, bilingual children may code-switch, where features of the first language are mixed with features of the second language. An example of this would be a child using one or two Spanish words while talking to someone in English. Phonology and syntax in the second language may be affected by the first language because of this. Alison Holm found in her article "Identification and

Differential Diagnosis of Phonological Disorders in Bilingual Children" that when "two

different phonological processes are used across two languages, they cannot be used in

the same way" (1999). The surface speech errors that the bilingual children make are

therefore specific to each of their languages. This information indicates that it is

"essential for Speech Language Pathologists to evaluate the children in both of the

languages they are fluent in" because they develop a different phonological system for

each language (Holm 1999). Also, as stated previously, the normal phonological

development of bilingual children is not the same as monolingual development in each of

the languages. Some of the errors the children make are considered to be atypical for

monolingual English-speaking children. "There are certain error patterns that are specific

to only bilingual development" (Holm 1999). For example, a child "may have phonology

without final consonants, which would be normal if the child were acquiring a language

that typically does not have word-final consonants (Spanish or Italian), but it is a disorder

for a child acquiring English" (Anderson 2006).

The "Correct Approach" to Assessment

It is important for Speech Language Pathologists to take a correct approach to

assessing, treating, and diagnosing children who are bilingual. Recognizing that there

may be "no ultimate solution to the problem of a 'fair' cultural measurement," it is still

important to consider a variety of methods with the potential to reduce bias in language

assessment (Campbell 1997). Because there are different communication rules among

cultural groups, examination and diagnosis of a person with a communication disorder is

much more likely to be effective if the clinician uses instruments, interpersonal interaction, testing, and interpretation of findings that are consistent with the client's cultural norms. Effective testing and diagnostic work are directly related to the sensitivity and use of culturally relevant materials and clinical orientations. The standardized tests used by Speech Language Pathologists are based on Northern Midland Standard English. They give the inaccurate impression of communication disorder when no pathology exists.

According to Anderson (2006), seven distinct sources of bias in standardized tests have been identified. These are biases within social situations, values, phonology, grammar, vocabulary, pragmatics, and the format of the actual test. Social situational bias is when violation of a situation/context rule for the test taker occurs. The value bias is a mismatch between values assumed in test items and the values of the test taker. Grammatical bias is the mismatch between grammatical rules assumed in a test item and the grammatical rules of the test taker, which may include underlying cognitive mismatches. Pragmatic bias is a mismatch between rules of communication interaction between test maker and test taker. The final bias is direction or format bias. This is a confusion or misunderstanding created for the test taker by the use of unfamiliar or ambiguous directions and/or test formats.

Since these biases have been identified, it is necessary that any Speech Language Pathologist make modifications to the standardized test being given to take the given information into account. There are many different modifications to tests that Anderson (2006) gives within her book. It may be necessary to alter the scoring procedures to credit

biased items, alter biased items such as pictures and linguistic features, allow additional time if needed, allow alternative responses, eliminate biased items from the test, elicit responses by other means than the test, repeat test items to allow code-switching and check reliability, develop additional practice items, demonstrate desired response, relate and reword directions, continue testing beyond the ceiling, allow the client to explain answers, obtain one score for first language and one for Standard English.

Anderson also recommended the following pre-assessment procedures when modification of a test is selected: review the test to identify potentially biased items, including linguistic features, stimulus items, wording of directions, and value conflicts. Review the norming statistics to determine if members of the cultural group were included in the standardization sample. List all predictable responses for each potentially biased item. Review the potentially biased items and predictable responses with a family member or professional member of the client's cultural group. Assess the effect on scoring for the potentially biased items, which includes the total number of items and weight of each item.

Another effective way to assess children who are bilingual is through a dynamic approach. The aim of this assessment is to examine how receptive the child is to adult mediation. It can reveal the cognitive process involved in language production and comprehension, whereas a standardized test can only compare a finite sample of language to that of peers. According to a study done by Mennen, Pena, Quinn, and Iglesias, dynamic assessment is recommended to "distinguish second language development from communication disorders in bilingual children" (2006).

12

<u>The Cultural Influences of the Spanish Language</u>

It is imperative that Speech Language Pathologists be educated on the cultural influences of the Spanish language. Spanish speakers tend to learn better from hands-on activities and observation than verbal interactions with adults. The children verbally interact more often with peers or siblings. Spanish speaking adults typically neither ask children to foretell what they will do nor repeat facts. Children may not perform as well on tasks that involve competition. The population as a whole tends to have a more flexible attitude toward time. Children usually learn best in environments which provide frequent attention and warmth. The father figure is typically the authority figure within the family. Children tend to use many gestures. Adults do not always translate actions into words, consider children equal conversational partners, or regard play routines as significant. Children, in turn, are cautioned not to interrupt when an authority figure is speaking and do not typically retell understood events (Kummerer 2007).

The clinical implications of these language features and cultural differences are crucial to Speech Language Pathologists working with bilingual children whose primary language is Spanish. These provide a norm so that Speech Language Pathologists can compare the clients they have to what is considered to be normal. Children often provide functions for objects instead of names. Adjectives often follow the noun. An example of this would be the car red instead of the red car. Adverbs will often follow verbs. For example, instead of saying he drives his sports car very fast; they would say he drives very fast his sports car.

<u>Treating Language Differences</u>

It is important to know that bilingual children who are found to have language differences can still be treated by Speech Language Pathologists. This occurs through a process known as language education. This is the term used to denote services by Speech Language Pathologists to children who do not have communication disorders. It is completely different from special education and the related service of speech therapy. The American Speech-Language-Hearing Association's (ASHA) view on dealing with children who are bilingual needs to be taken into account when a Speech Language Pathologist is considering treatment of a language difference. Increasingly, Speech Language Pathologists are being requested to assume a role in providing English as a Second Language instruction to children who are developing English proficiency. ASHA clarifies this role for clinicians in keeping with district, state, and federal regulations. According to "Children and Bilingualism" (2004), Speech Language Pathologists with appropriate English as a Second Language (ESL) training beyond the usual academic preparation may provide the primary direct ESL instruction. However, Speech Language Pathologists without the requisite training can assume a collaborative role along with trained ESL instructors. Requisite knowledge includes second language acquisition theory, comparative linguistics, and ESL methodologies.

Conclusion

In conclusion, the area of bilingualism in children and the effects that it has on their language development definitely requires more research. It is important to understand bilingualism and, also, how to treat children who are bilingual because they are a rapidly growing number of the United States population, and almost a majority in

14

the world. Children who are bilingual are referred more often to Speech Language Pathologists. For this fact to be understood, it is necessary that Speech Language Pathologists become more comfortable catering to the bilingual population, as the number of both children and adults who speak more than one language will continue to rise in the future. Speech Language Pathologists must be able to work with children whose primary language is not English, and must be prepared to work with their parents, who may not even be able to speak any English. Also, the other professionals who work with the children, and even their own parents, will need to be educated about the distinction between a language disorder and a language difference. This is the only way to know whether or not children who are bilingual have more speech and language disorders than their monolingual peers.

CHAPTER 2

METHODOLOGY

This study was conducted to find reasons for the over-identification of bilingual

children currently within the public school system. In order to do this, it was decided to

poll the general Speech Language Pathologist population within the state of Kentucky on

their comfort level in assessing this population and also what could be done, according to

them, in order to make them more prepared to deliver services to these bilingual speakers.

It was also decided that the most effective way to poll the general SLP population in the

state of Kentucky would be to create a questionnaire with specific questions addressing

the issue of over identification of bilingual children in the school system. A questionnaire

was created specifically for Speech Language Pathologists practicing in the state of

Kentucky. It was also decided that collecting feedback from the SLPs would be vital in

making decisions about changing the current idea of thought about treating and assessing

the culturally and linguistically diverse population. The questionnaire was distributed to

the SLPs within the state of Kentucky through the Kentucky Speech Language-Hearing

Association email listserv. The questionnaire contained six items. Four of these items

were based upon a five point Likert scale, one was a multiple choice question, and the

final question was an open response. The questions were as follows:

1.) How comfortable are you in assessing a child who is bilingual with their primary
language being something other than English?
Scale Example:_____5 _____4 _____3 _____2 _____1

Very uncomfortable (5) Somewhat uncomfortable (4) Neutral (3) Somewhat comfortable (2)
Very comfortable (1)

2.)   a.) How long have you been a practicing Speech Language Pathologist in
Kentucky?

 Under 5 years   5-10 years   10-15 years   15-20 years   More than 25
years

b.) How many bilingual/culturally and linguistically diverse (CLD) clients have been
referred to you total in your career?
   Less than 5   5-10 clients   10-15 clients   15-20 clients   More than 25

3.)   What percentage of these clients referred resulted in placement in special education
and/or related services?
        Under 5%   10-20%   20-30%   40-50%   More
than 50%

4.)   What would improve your level of comfort in assessing bilingual/CLD clients?
        a.) The use of an interpreter
        b.) Appropriate assessment tools normed for the specific language needed
        c.) More specific classes at the college level
        d.) Training/certification
        e.) Other. Please specify.

5.)   Please provide any additional information that you feel will be helpful in addressing
these issues with assessment of bilingual/CLD clients.

        Of the 2,500 questionnaires sent to the members, 150 were returned for a six

percent sample size. The SLPs on the listserv were allotted one month to respond to the

questionnaire. Following the collection of the completed questionnaires, the data was

disaggregated based upon the type of question. The responses to the Likert scale

questions were grouped together and tallied, as well as the responses to the multiple

choice question. The open response question answers were collected and grouped based upon the content of the response.

CHAPTER 3
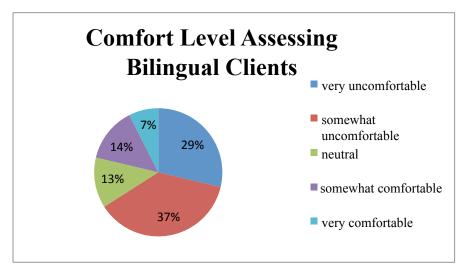
DISCUSSION OF FINDINGS

After the completed questionnaires were studied, the answers were categorized according to the Likert scale or possible answer choices. Other significant data was collected through anecdotal comments and/or suggestions provided by the SLPs in the open response question. The results are given and depicted in the figures that follow.

Question 1: 1.)   How comfortable are you in assessing a child who is bilingual with their primary language being something other than English?

When asked about their comfort level when assessing a bilingual child, 29% of Kentucky SLPs were very uncomfortable and 37% were somewhat uncomfortable.
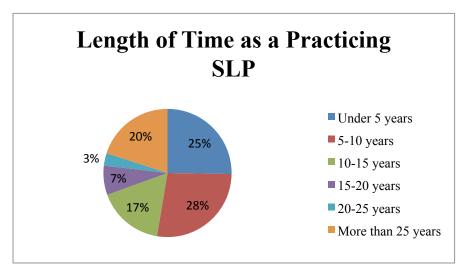
Figure 3.1

Question 2 a.): How long have you been a practicing Speech Language Pathologist in Kentucky?

28% of SLPs responding to the questionnaire had been practicing Speech-Language Pathology for 5-10 years. The second highest percentage was 25% with less than 5 years practicing and the third was 20% over 25 years of experience.

Figure 3.2

Length of Time as a Practicing SLP

- Under 5 years
- 5-10 years
- 10-15 years
- 15-20 years
- 20-25 years
- More than 25 years

25%
28%
17%
7%
3%
20%
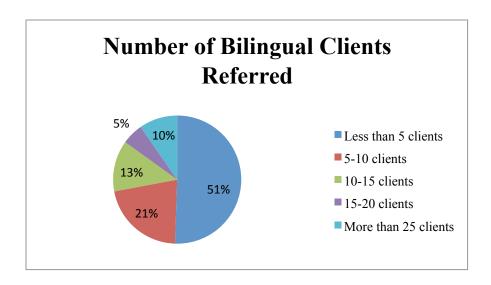
Question 2 b.): How many bilingual/culturally and linguistically diverse (CLD) clients have been referred to you total in your career?

More than half (51%) of the SLPs participating in the survey had only assessed less than 5 clients in their career as an SLP.

Figure 3.3

Number of Bilingual Clients Referred

- Less than 5 clients — 51%
- 5-10 clients — 21%
- 10-15 clients — 13%
- 15-20 clients — 5%
- More than 25 clients — 10%

Question 3: What percentage of these clients referred resulted in placement in special education and/or related services?

About 42% of the SLPs had placed under 5% of these children into special education and/or related services within the school systems.

Figure 3.4

Percentage of Referred Clients in Special Education services

- Under 5% — 42%
- 10-20% — 9%
- 20-30% — 9%
- 15%
- 25%
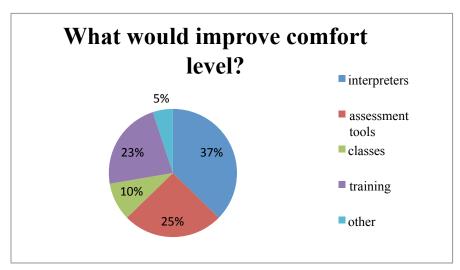
Question 4: What would improve your level of comfort in assessing bilingual/CLD clients?

The SLPs were asked what would improve comfort level of assessing bilingual clients. The two highest responses were: the use of interpreters (37%), appropriate assessment tools normed for the specific language needed (25%).

Figure 3.5

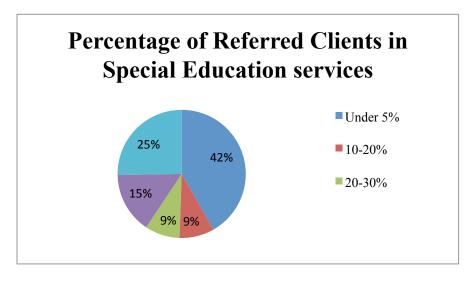**Question 5**: Please provide any additional information that you feel will be helpful in addressing these issues with assessment of bilingual/CLD clients.

Most SLPs responded by stating that they had certain issues with the use of interpreters (availability, bias, the need for appropriate training, and children translating for parents). Most noted that the school population did not have great diversity in the past. However, the more rural areas of the state are becoming increasingly diverse. They expressed the need for specific studies on language acquisition and development of bilingual children and studies on cultural issues that affect the acquisition of language. Also, numerous SLPs stated that set rules were needed for the referral and assessment process of bilingual

speakers. There were questions raised about designating SLPs to receive specific training

and to work only with Culturally and Linguistically Diverse (CLD) clients.

CHAPTER 4

CONCLUSIONS

There were numerous statistically relevant results generated by this questionnaire. Many of the responses generated by the open ended questions reaffirmed the results of the research given about dynamic assessment. To help improve comfort level in dealing with this bilingual population, numerous SLPs commented on the need for interpreters to be familiar with language development and the developmental norms of the child being tested, the need to have basic knowledge of the primary language themselves, and more specific guidelines from the State contained within the KEGs (Kentucky Eligibility Guidelines). Also, the SLPs expressed the need for specific protocols as to what to do in certain situations. For example, what if an interpreter is not available?

It is evident that a better streamlined assessment and referral process is needed for bilingual children. The American Speech-Language-Hearing Association (ASHA) has not given clear cut directions as to what to do when working with clients who are bilingual. As one SLP put it "even specialists in the area of testing bilingual students find a lot of grey areas". There is much more research that needs to be done over the coming years, especially with the increasing linguistically and culturally diverse within Kentucky school systems. However according to Anderson (2006), the best known practice for assessing bilingual students continues to be dynamic assessment in which the aim is to examine how receptive the child is to adult mediation. Also to provide valid assessment

and intervention practices, clinicians must continue to learn about the families who they serve.

Possible Implications for future research includes:

- Development of standardized tests for both articulation and language.

- Specific training for interpreters who work with Speech-Language Pathologists.

- Pre-service modules for instructors in Communication Disorders, Modern Languages, and interpreters focused on cross-training between disciplines.

- Development of programs to prepare SLPs as English as a Second Language Instructors.

Speech-Language Pathologists must always view language diversity as a normal phenomenon and not as a sign of a communication problem. Professionals who work with bilingual clients need to be educated about the distinction.

BIBLIOGRAPHY

Anderson, N., & Shames, G. (2006). *Human Communication Disorders: An Introduction* (7th ed.). Boston: Pearson Education.

Campbell T., Dollaghan C., Needleman H., & Janosky J.(1997, June). Reducing bias in language assessment: processing-dependent measures. *Journal Of Speech, Language, And Hearing Research, 40*(3), 519-525.

Children and bilingualism. (2004). *ASHA Leader, 36*(4), 57-58.

Goldstein, B., & Fabiano, L. (2007). Assessment and intervention for bilingual children with phonological disorders. *AHSA Leader, 12*(2), 6-31.

Holm, A., Dodd, B., Stow, C., & Pert, S. (1999). Identification and differential diagnosis of phonological disorder in bilingual children. *Language Testing, 16*(3), 271-292.

Kohnert, K., Yim, D., Nett, K., Kan, P. F., & Duran, L. (2005, July). Intervention with linguistically diverse preschool children: A focus on developing home language. *Language, Speech, and Hearing Services in Schools, 36*, 251-263.

Kummerer, S., Lopez-Reyna, N., & Tejero Hughes, M. (2007, August). Mexican immigrant mothers' perceptions of their children's communication disabilities, emergent literacy development, and speech-language therapy program. *American Journal of Speech-Language Pathology, 16*, 271-282.

Meltzer, B. (2006). An inservice about language differences versus language disorders. *Communication Sciences and Disorders*.

Mennen, I., & Stansfield, J. (2006). Speech and language theory service delivery for bilingual children. *Internal Journal of Language & Communication Disorders, 41*(6), 635-652.

Merriam Webster. (2007). Bilingual. In *Merriam Webster Online*. Retrieved November 15, 2008, from http://www.merriam-webster.com/dictionary/bilingual

Merriam Webster. (2007). Monolingual. In *Merriam Webster Online*. Retrieved

 November 15, 2008, from http://www.merriam-

 webster.com/dictionary/monolingual

Paradis, J., Crago, M., Genesee, F., & Rice, M. (2003). French-English bilingual children

 with SLI: how do they compare with their monolingual peers? *Journal of Speech,*

 Language, and Hearing Research, 46(1), 113-127.

Restrepo, M., & Silverman, S. (2001, November). Validy of Spanish preschool language

 scale-3 for use with bilingual children. *American Journal of Speech-Language*

 Pathology, 10, 382-393.

Salameh, E., Hakansson, G., & Nettelbladt, U. (2004). Developmental perspectives on

 bilingual Swedish-Arabic children with and without language impairment.

 International Journal of Language and Communication Disorders, 39(1), 65-90.

Stow, C., & Dodd, B. (2005). A comparison with monolingual children referred in one

 area of England. *Journal of Multilingual Communication Disorders, 3*(1), 1-23.

Tzivinikou, S. (2004). Intervention for a bilingual child with developmental speech

 problems. *Early Child Development & Care, 174*(1), 607-619.

APPENDIX A

Bilingual Speech-Language Pathologists and Audiologists: Definition

ASHA Committee on the Status of Racial Minorities

About this Document

The following definition, drafted by the Committee on the Status of Racial Minorities, was adopted as an official statement of the American Speech-Language-Hearing Association by its Legislative Council in November 1988 (LC 17-88). Members of the committee during development of the definition were Lorraine Cole (ex officio), Lupe L. Delgado, Gladys F. DeVane, Doreen G. Holliman, Hortencia Kayser (chair), Jeniece E. Nelson, William T. Simpkins, Jr., and Deborah W. White, under the guidance of Robert L. Douglass, monitoring vice president.

Speech-language pathologists or audiologists who present themselves as bilingual for the purposes of providing clinical services must be able to speak their primary language and to speak (or sign) at least one other language with native or near-native proficiency in lexicon (vocabulary), semantics (meaning), phonology (pronunciation), morphology/syntax (grammar), and pragmatics (uses) during clinical management.

To provide bilingual assessment and remediation services in the client's language, the bilingual speech-language pathologist or audiologist should possess:

1. ability to describe the process of normal speech and language acquisition for both bilingual and monolingual individuals and how those processes are manifested in oral (or manually coded) and written language;
2. ability to administer and interpret formal and informal assessment procedures to distinguish between communication differences and communication disorders in oral (or manually coded) and written language;
3. ability to apply intervention strategies for treatment of communication disorders in the client's language; and
4. ability to recognize cultural factors which affect the delivery of speech-language pathology and audiology services to the client's language community.

Knowledge and Skills Needed by Speech-Language Pathologists and Audiologists to Provide Culturally and Linguistically Appropriate Services

ASHA's Multicultural Issues Board

Introduction

The ethnic, cultural, and linguistic makeup of this country has been changing steadily over the past few decades. Cultural diversity can result from many factors and influences including ethnicity, religious beliefs, sexual orientation, socioeconomic levels, regionalisms, age-based peer groups, educational background, and mental/physical disability. With cultural diversity comes linguistic diversity, including an increase in the number of people who are English Language Learners, as well as those who speak non-mainstream dialects of English. In the United States, racial and ethnic projections for the years 2000–2015 indicate that the percentage of racial/ethnic minorities will increase to over 30% of the total population. The makeup of our school children will continue to diversify so that by 2010, children of immigrants will represent 22% of the school-age population (U.S. Bureau of the Census, 2000).

As professionals, we must be prepared to provide services that are responsive to this diversity to ensure our effectiveness. Every clinician has a culture, just as every client/patient has a culture. Similarly, every clinician speaks at least one dialect of English and perhaps dialects from other languages, as does every client/patient. Given the myriad factors that shape one's culture and linguistic background, it is not possible to match a clinician to clients/patients based upon their cultural and linguistic influences. Indeed, recent ASHA demographics indicate that only about 7% of the total membership are from a racial/ethnic minority background and less than 6% of ASHA members identify themselves as bilingual or multilingual (ASHA, 2002).

Only by providing culturally and linguistically appropriate services can we provide the quality of services our clients/patients deserve. Regardless of our personal culture, practice setting, or caseload demographics, we must strive for culturally and linguistically appropriate service delivery. For example, we must consider how communication disorders or differences might be manifested, identified, or described in our client's/patient's cultural and linguistic community. This will inform all aspects of our practice including our assessment procedures, diagnostic criteria, treatment plan, and treatment discharge decisions.

This document sets forth the knowledge and skills that we as professionals must strive to develop so that we can provide culturally and linguistically appropriate services to our clients/patients. The task may seem daunting at first. Given the knowledge and skills needed, we may shy away from working with clients/patients from certain cultural or linguistic groups. We may question whether it is ethical for us to work with these clients/patients. These guidelines provide a way to answer that question for each clinician.

It is true that "Individuals shall engage in only those aspects of the profession that are within the scope of their competence, considering their level of education, training, and experience" (ASHA Principles of Ethics II, Rule B). So, without the appropriate knowledge and skills, we ethically cannot provide services. Yet, this does not discharge our responsibilities in this area. The ASHA Principles of Ethics further state, "Individuals shall not discriminate in the delivery of professional services" (ASHA Principles of Ethics I, Rule C). Thus, this ethical principle essentially mandates that clinicians continue in lifelong learning to develop those knowledge and skills required to provide culturally and linguistically appropriate services, rather than interpret Principles of Ethics II, Rule B as a reason not to provide the services. This document sets forth those knowledge and skills needed to provide culturally and linguistically appropriate services. It can be used to identify one's strengths and weaknesses, and to develop a plan to fill in any gaps in one's knowledge and skills in this area (ASHA, December 2001).

Cultural Competence

- 1.0 **Role:** Sensitivity to cultural and linguistic differences that affect the identification, assessment, treatment and management of communication disorders/differences in persons. This includes knowledge and skills related to:
- 1.1 Influence of one's own beliefs and biases in providing effective services.
- 1.2 Respect for an individual's race, ethnic background, lifestyle, physical/mental ability, religious beliefs/practices, and heritage.
- 1.3 Influence of the client's/patient's traditions, customs, values, and beliefs related to providing effective services.
- 1.4 Impact of assimilation and/or acculturation processes on the identification, assessment, treatment, and management of communication disorders/differences.
- 1.5 Recognition of the clinician's own limitations in education/training in providing services to a client/patient from a particular cultural and/or linguistic community.
- 1.6 Appropriate intervention and assessment strategies and materials, such as food, objects, and/or activities that do not violate the patient's/client's values and/or that may form a constructive bridge between the client's/patient's home culture and community or communication environment.
- 1.7 Appropriate communications with clients/patients, caregivers, and significant others, so that the values imparted in the counseling are consistent with those of the client/patient.

- 1.8 The need to refer to/consult with other service providers with appropriate cultural and linguistic proficiency, including a cultural informant/broker, as it pertains to a specific client/patient.
- 1.9 Ethical responsibilities of the clinician concerning the provision of culturally and linguistically appropriate services.
- 2.0 **Role:** Advocate for and empower consumers, families, and communities at risk for or with communication/swallowing/balance disorders. This includes knowledge and skills related to:
- 2.1 Community resources available for the dissemination of educational, health, and medical information pertinent to particular communities.
- 2.2 High risk factors for communication/swallowing/balance disorders in particular communities.
- 2.3 Prevention strategies for communication/cognition/swallowing/balance disorders in particular communities.
- 2.4 The impact of regulatory processes on service delivery to communities.
- 2.5 Incidence and prevalence of culturally-based risk factors (e.g., hypertension, heart disease, diabetes, fetal alcohol syndrome) resulting in greater likelihood for communication/cognition/swallowing/balance disorders.
- 2.6 Appropriate consumer information and marketing materials/tools for outreach, service provision, and education.

Language Competencies of the Clinician

- 3.0 **Role:** Ability to identify the appropriate service provider for clients/patients.
- 3.1 *Bilingual/Multilingual clinician.* Native or near-native proficiency in the language(s) spoken or signed by the client/patient. Knowledge and skills related to the impact of the differences between the dialect spoken by the clinician and by the client/patient on the quality of services provided.
- 3.2 *Clinician without native or near-native proficiency in the language(s)/dialect(s) spoken or signed by the client/patient.*

Knowledge and skills related to:

1. Obtaining information on the features and developmental characteristics of the language(s)/dialect(s) spoken or signed by the client/patient (see Language section).
2. Obtaining information on the sociolinguistic features of the client's/patient's significant cultural and linguistic influences.
3. Developing appropriate collaborative relationships with translators/interpreters (professional or from the community):
   1. Maintain appropriate relationships among the clinician, the client/patient, and interpreter/translator.
   2. Ensure that the interpreter/translator has knowledge and skills in the following areas:

1. Native proficiency in client's/patient's language(s)/dialect(s) and the ability to provide accurate interpretation/translations.
2. Familiarity with and positive regard for the client's/patient's particular culture, and speech community or communicative environment.
3. Interview techniques, including ethnographic interviewing.
4. Professional ethics and client/patient confidentiality.
5. Professional terminology.
6. Basic principles of assessment and/or intervention principles to provide context to understand objectives.

Language

- 4.0 **Role:** Obtain knowledge base needed to distinguish typical and disordered language of clients/patients. This includes knowledge and skills related to:
- 4.1 Sociolinguistic and cultural influences including:
    1. Client's/patient's speech community or communication environment, including its discourse norms, and the impact of topic, participant, setting, and function on language use.
    2. Effective interviewing techniques so caregiver/parent and/or client/patient feels comfortable providing accurate and complete information.
    3. Impact of social and political power and prestige on language choice and use.
    4. Impact of sociolinguistics on code-switching and code-mixing.
    5. Language socialization patterns that affect language use in the clients/patient's speech community. Types of language socialization patterns include narrative structure; importance of labeling; attitudes toward appropriateness of child-adult and child-child communications, ways of gathering information, and ways of giving commands such as known questions and veiled commands/indirect speech acts.
    6. Cultural differences and similarities held by both client/patient and clinician, with resultant impact on language use in all communicative environments.
    7. Impact of client's/patient's attitudes, values, and beliefs toward non-oral approaches to communication such as augmentative/alternative communication, sign language, and assistive listening devices.
- 4.2 Language and linguistics including:
    1. Typical language development in simultaneous and sequential bilinguals.
    2. Normal processes of second-language acquisition, including language transfer, language attrition, interlanguage, and affective variables.
    3. Difference between an accent and a dialect, and a language and a dialect.
    4. Patterns of language recovery following neurological insult.
    5. Grammatical constraints on code-switching and code mixing.

6. Typical development in the client's/patient's language(s)/dialect(s) in all areas (see 4.3).
- 4.3 Identifying, obtaining and integrating available resources to determine what is typical speech/language development in the client's/patient's speech community and communication environment, including:
    1. Research on the client's/patient's culture(s), speech community, or communication environment.
    2. Interview with a parent or other caregiver on how the client's/patient's speech/language development compares to peers in his/her speech community or communication environment.
    3. Interview with a family member, or other person who knew the client/patient previously, to describe and compare the client's/patient's language skills before the insult or injury that may have led to an acquired language disorder.
    4. Family history of speech/language problems or academic difficulties.
    5. Cultural informant/broker to gain insight into the impact of culture on the client's/patient's communication skills.
    6. Linguistic/sociolinguistic informant/broker from the client's/patient's speech community or communication environment, such as for grammaticality judgments and for judgments based upon sociolinguistic considerations related to the client's/patient's speech community or communication environment.
    7. Use of speech/language data provided by translator/interpreter.
    8. Clinician's personal knowledge base.
    9. Application of the clinician's clinical judgment to synthesize, evaluate, analyze, and make determinations based upon all the data/information gathered.
- 5.0 **Role:** Identification/Assessment of typical and disordered language. This includes knowledge and skills related to:
- 5.1 *Foundational content:*
    1. Current research and preferred practice patterns in the identification/assessment of language disorders/delays.
    2. Legal, regulatory, ethical, and professional guidelines relating to language assessment.
    3. Appropriate criteria for distinguishing a disorder from a difference by using the norms of the client's/patient's speech community as the standard.
    4. Appropriate ethnographic interviewing techniques, such as knowing effective ways to ask for crucial but sensitive information so the caregiver/parent and/or client/patient, is comfortable enough to provide that information.
    5. Impact on language use by the client/patient with regard to topic, participants, setting, and function on the linguistic interaction, based upon knowledge of the standards of communicative competence in the client's/patient's speech community or communication environment (see 4.3).

- 5.2 *Assessment materials/tests/tools:*
    1. Appropriate use of published test materials in language assessment including standardized norm-referenced tests and criterion-referenced tests, including analyzing normative sampling limitations, general psychometric issues especially related to validity and reliability, and inherent cultural and linguistic biases in these test materials.
    2. Application of appropriate criteria so that assessment materials/tests/tools that fail to meet standards be used as informal probes, with no accompanying scores.
    3. Inherent problems in using translated tests so that translated tests are used only as informal probes, with no accompanying scores.
    4. Appropriate use of alternative approaches to assessment including dynamic assessment, portfolio assessment, structured observation, narrative assessment, academic and social language sampling, interview assessment tools, and curriculum-based procedures, including analysis of validity, reliability, and inherent cultural and linguistic biases.
    5. How cultural and linguistic biases in assessment tools impact on an appropriate differential diagnosis between a language disorder and a language difference.
        1. Cultural biases include question types, content, specific response tasks, and test formats that are not commonly used in the client's/patient's speech community or communication environment.
        2. Linguistic biases include differences in when certain features of language are acquired and/or in certain linguistic forms that may not be common, or present at all, in the language(s) and/or dialect(s) spoken or used by the client/patient.
- 5.3 Differential diagnosis:
    1. How linguistic features and learning characteristics of language differences and second-language acquisition are different from those associated with a true learning disability, emotional disturbance, central auditory processing deficit, elective mutism, or attention deficit disorder. (Diagnoses that might be confused with a linguistic or cultural difference or second language learning.)
    2. Preparation of written reports that incorporate information about the client's/patient's cultural and linguistic influences.
    3. Determination of whether a language disorder is present based upon one's clinical judgment after reviewing and analyzing all the critical information (See 4.3).
    4. Determination of the severity level of any identified language disorder.
    5. Ethical issues raised if scores are provided for tests that are psychometrically flawed, translated and not adapted, culturally biased, and/or linguistically biased.
- 6.0 **Role:** Treatment/Management of disordered language. This includes knowledge and skills related to:

1. Current research and best practices in the treatment/management of language disorders/delays, including various delivery models and options for intervention.
2. Appropriate language(s)/dialect(s) to use in treatment and management.
3. Impact of the client's/patient's current and historical language/dialect exposure and experience.
4. Standards of the client's/patient's speech community or communication environment in determining discharge/dismissal criteria, rather than base that decision on the client/patient mastering the clinician's or interpreter's/translator's language(s)/dialect(s) and language socialization practices.
5. Integration of the client's/patient's attitudes, values, and beliefs toward non-oral approaches to communication such as augmentative/alternative communication, sign language, and assistive listening devices when those approaches are incorporated into treatment.
6. Consideration of client's/patient's and/or parent's/caregiver's desire and need for fluency in the native language and/or English when considering the language for intervention.
7. Legislative and regulatory mandates and limitations to resources that may impact the language used for intervention.

Articulation and Phonology

- 7.0 **Role:** Identification/Assessment of individuals at risk for articulation/phonological disorders. This includes knowledge and skills related to:
    1. Current research and best practices in the identification/assessment of articulation/phonological disorders in the languages(s) and/or dialect(s) spoken by the client/patient.
    2. Phonemic and allophonic variations of the language(s) and/or dialect(s) spoken in the client's/patient's speech community and how those variations affect a determination of disorder or difference.
    3. Difference between an articulation disorder, phonological disorder, an accent, a dialect, transfer patterns and typical developmental patterns.
    4. Standards of the client's/patient's speech community or communication environment to determine whether he or she has an articulation or phonological disorder/delay. Identifying and using available resources to determine what is typical speech development in the client's/patient's speech community or communication environment (See 4.3).
- 8.0 **Role:** Treatment/Management of individuals with articulation or phonological disorders. This includes knowledge and skills related to:
    1. Current research and best practices in the treatment/management of articulation and phonological disorders/delays in the languages(s) and/or dialect(s) spoken by the client/patient.

2. Community standards of typical articulation and phonology patterns, so that in treatment/management dialect, and accent features are not treated as articulation or phonological disorders.
3. Standards of the client's/patient's speech community in determining discharge/dismissal criteria so that discharge/dismissal is based upon whether the client/patient is speaking his/her dialect appropriately.

Terminology

Accent: (1) A set of shared variables, related to pronunciation, common to a particular speech community. It is standard practice to distinguish *accent* from *dialect*. Accent refers only to distinctive features of pronunciation, whereas *dialect* refers to distinctive lexical, morphological, and syntactical features. (2) A set of phonetic traits of one language that is carried over into the use of another language a person is learning (foreign accent).

Bidialectalism: The use of two different dialects of a given language. In terms of linguistic structure, one dialect of any language is not "superior" to another; however, from a social point of view, several dialects are considered to be prestigious and others are considered to be non-prestigious.

Bilingualism: The use of at least two languages by an individual. The degree of proficiency in the languages can range from a person in the initial stages of acquisition of two languages to a person who speaks, understands, reads, and writes two languages at native or near-native proficiency.

Code mixing: (1) Code-switching. (2) Term used to describe the mixed-language utterances used by a bilingual individual. It involves the utilization of features of both languages (usually at the lexical level) within a sentence (intra-sentential level).

Code switching: The juxtaposition within the same speech exchange of passages belonging to two different grammatical systems. The switch can be intrasentential, (within a sentence) (Spanish-English switch: *Dame a glass of water. "Give me a glass of water")*. It can be intersentential, across sentence boundaries (Spanish-English switch: *Give me a glass of water. Tengo sed. "Give me a glass of water. I'm thirsty"*). The switches are not random; they are governed by constraints such as the Free Morpheme Constraint and the Equivalency Constraint. Many who are bilingual and/or bidialectal are self-conscious about their code switching and try to avoid it with certain interlocutors and in particular situations. However, in informal speech it is a natural and powerful feature of a bilingual's/bidialectal's interactions.

Communication environment: The communicative environment of users of assistive or augmentative communication systems, and some forms of manual communication.

Communicative competence: The ability to use language(s) and/or dialect(s) and to know when and where to use which and with whom. This ability requires grammatical, sociolinguistic, discourse, and strategic competence. It is evidenced in a speaker's unconscious knowledge (awareness) of the rules/factors which govern acceptable speech in social situations.

Cultural informant/broker: A person who is knowledgeable about the client's/patient's culture and/or speech community and who provides this information to the clinician for optimizing services.

Culturally diverse: When an individual or group is exposed to, and/or immersed in more than one set of cultural beliefs, values, and attitudes. These beliefs, values, and attitudes may be influenced by race/ethnicity, sexual orientation, religious or political beliefs, or gender identification.

Dialect: A neutral term used to describe a language variation. Dialects are seen as applicable to all languages and all speakers. All languages are analyzed into a range of dialects, which reflect the regional and social background of their speakers.

Linguistic/sociolinguistic informant/broker: A trained and knowledgeable person from the client's/patient's speech community or communication environment who under the clinician's guidance can provide valuable information about language and sociolinguistic norms in the client's/patient's speech community and communication environment. A properly trained informant/broker can provide information such as grammaticality judgments as to whether the client's/patient's language and phonetic production is consistent with the norms of that speech community or communication environment; information on the language socialization patterns of that speech community or communication environment; and information on other areas of language including semantics and pragmatics.

Interlanguage: An intermediate-state language system created by someone in the process of learning a foreign language. The interlanguage contains properties of L1 transfer, overgeneralization of L2 rules and semantic features, as well as strategies of second language learning.

Interpreter: A person specially trained to translate oral communications or manual communication systems from one language to another.

Language loss (also known as language attrition): A potential consequence of second-language acquisition whereby a person may lose his/her ability to speak, write, read, and/or understand a particular language or dialect due to lack of use or exposure.

Linguistically diverse: Where an individual or group has had significant exposure to more than one language or dialect.

Sequential bilingualism (also known as successive bilingualism): Occurs when an individual has had significant exposure to a second language after the first language is well established.

Simultaneous bilingualism: Occurs when a young child has had significant exposure to two languages simultaneously, before one language is well established.

Speech community: A group of people who share at least one speech variety in common. Members of bilingual/bidialectal communities often have access to more than one speech variety. The selection of the specific variety depends on such variables as the participants, the topic, the function, and the location of the speech event.

Translator: A person specially trained to translate written text from one language to another.

References

American Speech-Language-Hearing Association. (1996, spring). Scope of practice in audiology. *Asha 38*((Suppl. 16)), 12–15.

American Speech-Language-Hearing Association. (2001). *Scope of practice in speech-language pathology*. Rockville, MD: Author.

American Speech-Language-Hearing Association. (1997a). *Preferred practice patterns for the profession of audiology*. Rockville, MD: Author.

American Speech-Language-Hearing Association. (1997b). *Preferred practice patterns for the profession of speech-language pathology*. Rockville, MD: Author.

American Speech-Language-Hearing Association. (1997a). (1997b). *Preferred practice patterns*. Rockville, MD: Author.

American Speech-Language-Hearing Association. (2001, December 26). Code of ethics (revised). *The ASHA Leader, 6*(23), 2.

American Speech-Language-Hearing Association. *Communication development and disorders in multicultural populations: Readings and related materials*. 2002. Available online at http://www.asha.org/about/leadership-projects/multicultural/readings/OMA_fact_sheets.htm

National Standards for Culturally and Linguistically Appropriate Services in Health Care. (2001, March). Washington, DC: U.S. Department of Health and Human Services, OPHS Office of Minority Health.

U.S. Bureau of the Census. (2000). *Statistical abstract of the United States* (119th ed.). Washington, DC: U.S. Department of Commerce.

 American Speech-Language-Hearing Association. (2004). *Knowledge and Skills Needed by Speech-Language Pathologists and Audiologists to Provide Culturally and Linguistically Appropriate Services* [Knowledge and Skills]. Available from www.asha.org/policy.

APPENDIX C

Questionnaire sent to SLPs in the KSHA email listserv during October 2009

My name is Kathy Schulte and I am an undergraduate student at Western Kentucky University working on my thesis. I am doing research to find Speech Language Pathologists' perspectives on the referral and assessment of bilingual children whose primary language is not English. In order to do this, I have created a questionnaire. If you would please take a few minutes and answer the following questions, it would be very valuable to my research. When you finish, just email it back to me at Kathleen.schulte570@wku.edu by **November 1st**. Thank you for your time in supporting my efforts.

Instructions: To answer these questions, fill out the survey, copy it and paste it into a new email message, and then send it to Kathleen.schulte570@wku.edu by **November 1st**. To mark your answers please type an "X" (please use lower case) on the line to the left of the appropriate answer. In the scale below, please put an "X" on the line next to the number that represents your best answer. Please answer all questions. If the survey in the e-mail message is not very clear, then please use the survey in the attached word document.

1.)   How comfortable are you in assessing a child who is bilingual with their primary language being something other than English?
Scale Example:_____5 _____4 _____3 _____2 _____1

Very uncomfortable (5) Somewhat uncomfortable (4) Neutral (3) Somewhat comfortable (2) Very comfortable (1)

2.)   a.) How long have you been a practicing Speech Language Pathologist in Kentucky?   Under 5 years   5-10 years   10-15 years   15-20 years   More than 25 years

        b.) How many bilingual/culturally and linguistically diverse (CLD) clients have been referred to you total in your career?
                Less than 5   5-10 clients   10-15 clients   15-20 clients
        More than 25

3.)   What percentage of these clients referred resulted in placement in special education and/or related services?

Under 5%   10-20%   20-30%   40-50%   More than 50%

4.)   What would improve your level of comfort in assessing bilingual/CLD clients?
   a.) The use of an interpreter
   b.) Appropriate assessment tools normed for the specific language needed
   c.) More specific classes at the college level
   d.) Training/certification
   e.) Other. Please specify.

5.)   Please provide any additional information that you feel will be helpful in addressing these issues with assessment of bilingual/CLD clients.