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## An Exploratory Study of Speech-Language Pathologists' Perceptions of Multicultural Counseling in Communication Sciences and Disorders

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## **An Exploratory Study of Speech-Language Pathologists' Perceptions of Multicultural Counseling in Communication Sciences and Disorders**

### **Cover Page Footnote**

A special thanks goes to the speech-language pathologists who took the time to complete the survey for this research.

## Introduction

As the United States' (U.S.) population becomes more culturally diverse, speech-language pathologists (SLPs) and audiologists (AuDs) who are culturally competent becomes a necessity. SLPs across many settings (e.g., schools, hospitals, home health) are challenged to address the needs of diverse clients regarding many factors, such as, but not limited to, ethnicity, socioeconomic status (e.g., [SES], years of education), English Proficiency, and dialect. For example, Spanish is the second most common language spoken after English in the U.S. (U.S. Census Bureau, 2010). English Language Learners (ELL) in the U.S. accounted for 9.4 % (4.6 million) of public school students during the 2014-2015 school year (National Center for Education Statistics, 2017). Individuals from Asia constitute the largest source of immigration in the U.S. and are projected to be the largest immigrant group by 2055 (Pew Research Center, 2016). Additionally, the number of individuals identifying as transgender has nearly doubled in the last decade to 1.4 million (Flores, Herman, Gates, & Brown, 2016). In contrast, this trend of increasing minorities evidenced above is not represented in the membership of the American Speech-Language Hearing Association (ASHA). In 2016, approximately 7.9% of ASHA's membership identified as a racial minority compared to the 28.6% identified racial minorities of the U.S. population (ASHA, 2017a; US Census Bureau, 2010). As the needs of the population diversify, so do the implications for higher education including curriculum development, educational instruction, and clinical methods.

In a previous survey, 75% of SLPs indicated that they were not qualified/semi-qualified in the area of cultural competence (ASHA, 2009). In a more recent survey, 61% of SLPs rated their qualifications to address cultural and linguistic influences on assessment and treatment from '1-3' based on a 5 point Likert-scale; 1 = 'Not at all qualified' to 5 = 'Very qualified' (ASHA, 2015). The above findings are concerning given the increasingly diverse population in the U.S. Counseling individuals, including those from culturally and linguistically diverse (CLD) populations, with communication and swallowing needs is a clinical responsibility (ASHA, 2016a) that requires an ongoing review of current policies, administrative resources, and input from clinicians (Cross, Bazron, Dennis, & Isaacs, 1989). Further, providing emotional support (i.e., counseling) to CLD populations requires an additional layer of knowledge concerning multiculturalism. Multicultural counseling (MC; also termed cross-cultural counseling) can be described as counseling that occurs when the counselor and the client originate from different cultural groups, and it accounts for the effect cultural differences may have on the counseling relationship (Sue, Arredondo, & McDavis, 1994; Sue & Sue, 2007). Implementation of MC may include individuals from various categories of cultural groups: religion, gender, sexual orientation, language background, and SES.

To understand the pedagogy and implementation of MC, it is important to distinguish the following terms: MC, cultural competency (i.e., multicultural competency), and multicultural education. MC, in addition to the definition given above, requires that the counselor (i.e., SLP) is culturally aware and acknowledges cultural differences between herself and the client. ASHA does not use the term MC in documentation, but instead discusses counseling as a key issue of cultural competence (ASHA, n.d.). Within the discussion of counseling, most of the tenets of MC as documented in the counseling and psychology fields are addressed and include the following features: 1) self-awareness of one's biases and beliefs, 2) ongoing professional development during one's career, and 3) ethical responsibility (Sue et al., 1994; Sue & Sue, 2007). Although MC is not explicitly stated, it can be inferred in the

“Cultural Competence” document (ASHA, n.d.).

In order to implement MC and recognize cultural differences, the SLP must be culturally competent. Cultural competency is not easily defined because of its multidimensionality (Sue, 2001). It requires the SLP to first self-assess and understand her own culture; in addition, to understanding the culture of others (ASHA, n.d.). Cultural competency is described as “... a dynamic and complex process requiring ongoing self-assessment and continuous expansion of one's cultural knowledge (ASHA, n.d., para. 3). For example, a culturally competent SLP would recognize that dialects are not disorders (Bernthal, Bankson, & Flipsen, 2016; Oetting, Gregory, & Riviere, 2016), acknowledge that certain religions may disallow therapy during certain hours of the day, and routinely self-assess cultural understanding. The Council for Academic Accreditation in Audiology and Speech-language Pathology (CAA, 2017) clarified the definition as it related to accreditation standards for graduate programs.

Cultural and linguistic competence is an asset of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. ‘Culture’ refers to integrated patterns of human behavior that include the language, thought, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. ‘Competence’ implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities (p. 38).

Organizational cultural competency is another necessary dimension and requires that cultural competency permeates every aspect of the organization by providing related professional development or education, acknowledging cultural differences of individuals within and outside of the organization, and regularly assessing the cultural competence within the organization (Betancourt, Green, Carrillo, & Owusu Ananeh-Firempong, 2016). The teaching of MC may be more effectively facilitated through multicultural education, which “refers to any form of education or teaching that incorporates the histories, texts, values, beliefs, and perspectives of people from different cultural backgrounds” (Hidden Curriculum, 2014, para. 1). The National Association for Multicultural Education (NAME, 2017) extends the definition above to emphasize core principles; multicultural education should permeate every aspect of school policies by ensuring that staff are trained in cultural and linguistic diversity and acknowledge cultural differences between the teacher and students among others.

Becoming culturally competent is an ongoing and developmental process that operates on a continuum (Cross, et al., 1989). This continuum ranges from cultural destructiveness (i.e., attitudes, behaviors, and beliefs destructive to culture) to cultural proficiency. Because cultural competency is a continual process, one must engage in educational endeavors that expand on cultural awareness and competence. Reaching cultural proficiency requires that the organization in which an individual works includes the following elements as outlined in Cross and colleagues (1989): 1) value diversity; 2) have the capacity for cultural self-assessment; 3) be conscious of the dynamics inherent when cultures interact; 4) have institutionalized cultural knowledge; and 5) have developed adaptations to diversity. To achieve cultural proficiency as a career discipline, ASHA must further support cultural and linguistic competency in clinicians by specifying MC in research, policies, curriculum, and practice.

## Insufficiencies in Policies, Guidelines, and Procedures for Multicultural Counseling

ASHA acknowledges the significance of and supports cultural competence in instruction, academic research (e.g., SIG 14: Cultural and Linguistic Diversity), and clinical practice in various documents (e.g., CAA standards, Code of Ethics) and policies by supporting initiatives that promote cultural competency within the field of communication sciences and disorders (CSD). The CAA mandates that the curriculum and practicum include opportunities for students to gain content knowledge and demonstrate clinical skills related to counseling and cultural competence when serving clinical populations (CAA, 2017). The CAA 2017 standards present the demonstration of counseling and cultural competency as separate skills. For example, Standard 3.1.6B in SLP states that students must acquire knowledge in providing counseling to individuals with a variety of communication and swallowing disorders (CAA, 2017). Standard 3.1.1B in SLP specifies that students must be able to demonstrate cultural competence (CAA, 2017). It is also important to note that organizational competency is addressed in the standards; programs are required to provide a culturally sensitive environment for students, faculty, staff, and other departmental members.

Given the most recent CAA standards, a notable concern may be the lack of specificity within the field of CSD describing how to teach and implement MC in CSD programs. The CAA's standards for accreditation provide guidelines for supporting evidence for teaching and implementing MC (CAA, 2017). The suggested evidence includes descriptions of procedures used to teach and provide opportunities for MC. There are no means (e.g., rating scales) to evaluate the descriptive evidence given, that may be considered by some to be subjective in nature. However, the descriptive evidence, minimally, informs CAA officials that MC is being addressed. Currently, there are no standards for the teaching and implementation of MC. Therefore, the effectiveness of teaching and implementing MC is not able to be measured, qualitatively or quantitatively. Promoting teaching strategies in MC that have limited pedagogical research is concerning given the unknown efficacy outcomes (Torres, Rodriguez, & Payne, 2011) and may result in clinicians providing insufficient MC strategies to students and supervisees. Moreover, clients may detect this insufficiency and perceive clinicians to lack cultural proficiency (Fuentes & Brobst, 2002; Pope-Davis, et al., 2002).

Another concern is that the lack of specificity may facilitate wide-ranging pedagogical methods and notions of MC. One document within the ASHA website attempts to provide more specific details related to cultural competency. This document, titled "Cultural Competence" is included as a professional issues topic in the *Practice Portal*. Within the document, cultural competence is defined and key issues (e.g., counseling) that are related to the assessment, treatment, and state and federal legislation are discussed (ASHA, n.d.). Additionally, cultural competence within counseling is discussed. Some of the highlights include the influence of culture on the views of communication disorders, the acceptance of technology for treatments with CLD clients, and the comfort of implementation of certain treatments with CLD clients.

Another ASHA document that encourages cultural competency is the *Code of Ethics* (ASHA, 2016b). However, upon searching the *Code of Ethics* for information related to cultural competency or MC, it was found in a separate but related document (ASHA, 2017b). It is important to note that implicit inclusion of MC may be gleaned from the *Principles of Ethics I*, item *M* which states individuals shall

use, "... evidence-based clinical judgment, keeping paramount the best interests of those being served" (ASHA, 2016b). The implementation of MC is evidence-based and providing MC keeps the best interest of CLD clients paramount. Discriminatory behaviors are forewarned in the *Code of Ethics* in the delivery of professional services, conduct of research, and interactions among colleagues, students, support personnel, and other professionals. Combining the two documents may increase clarity and continuity for ASHA members.

### Teaching and Learning MC in CSD

Though CAA requires the inclusion of MC in CSD programs, the teaching and learning may vary by programs and institutions (Stockman, Boulton, & Robinson, 2008). The inconsistencies in teaching methods may considerably effect students' learning of MC resulting in insufficient clinical practices in CLD populations. Another concern is the implementation of counseling, which is listed as one of eight domains for SLPs and AuDs in their respective Scope of Practice documents (ASHA, 2016a). In order to provide effective MC, one must be sufficient in providing counseling services. Despite the inclusion of counseling within the Scope of Practice, clinicians may feel inadequately trained to provide counseling (Holland, 2007; Lutterman, 2001), especially within CLD populations (Rosenberry-McKibbin & O'Hanlon, 2005; Stockman, et al., 2008). Additionally, the instruction of counseling as a part of academics and clinical practicum may not be a standard inclusion in graduate programs (Friehe, Bloedow, & Hesse, 2003; Kaderavek, Laux, & Mills, 2004; Millar, Harrow, & Morgan, 2010; Stockman, et al., 2008). The lack of sufficient instruction in and implementation of counseling may further compound the successful implementation of MC.

**Academic curriculum and clinical practicum.** Stockman and colleagues (2008) collected surveys regarding multicultural instruction from over 180 graduate programs to report pedagogical methods used in the U.S. and Puerto Rico. An infused model of instruction that embedded cultural training within academic courses was the most noted and faculty who taught a culturally-focused course (versus an embedded course) reported better outcome measures. Within the infusion model, instructors incorporate cultural topics that pair with the content of the course. A similar and more recent study queried SLPs experience with MC in their graduate programs and discovered three trending pedagogical strategies used to teach MC: an infusion model, a self-directed study, and a direct approach (Revel, 2015). The infusion model was found to be the most implemented pedagogical strategy in this study, as well.

In a more recent study, Horton-Ikard & Muñoz (2010) surveyed 133 CSD programs regarding MC instruction to examine general themes. First, a varied approach to teaching and assessing student performance was noted and only 35 programs identified that cultural topics were integrated in all courses. Second, 85% percent of the programs did not have a cultural affairs committee to provide guidance and support relating to multicultural concerns. Horton-Ikard, Muñoz, Thomas-Tate, and Keller-Bell (2009) proposed an adapted model for MC instruction in CSD taken from the literature in counseling psychology. The adapted pedagogical framework for MC is based upon three relevant dimensions: knowledge, awareness, and skills. Within this model, five key components were identified: teaching philosophy, defining learning objectives, choosing topics, implementing instructional practices, and evaluating competency. It is not accidental, but purposeful, that the first component is teaching. The value of instruction and its relevance to learning and clinical application cannot be overemphasized. Another vital component of the adapted model is the inclusion of an

ongoing evaluation of cultural competence.

Competence in clinical practice does not always reflect competence in clinical instruction. Clinical supervision is a specialized area of practice that requires pedagogical training (e.g., teaching methodologies, student learning styles) to be proficient in effective instruction (ASHA, 2013). Clinical supervisors are educators who teach specialized skill sets, explain challenging concepts, facilitate problem solving, and model interprofessional practice and professionalism (Council of Academic Programs in Communication Sciences and Disorders, 2013). Culturally competent supervisors participate in conversations about cultural differences that provide students with a model for self-reflection and opportunities to develop MC skills (Tummala-Narra, 2004; Victor, 2012); whereas, supervisors who lack cultural competence often avoid discussions about cultural differences with students and may not acknowledge cultural concerns within the supervisor, student, and client dynamic (Burkard et al., 2006; Moore, 2012). In a recent study, SLPs revealed that clinical supervisors were the most notable source for learning MC (Revel, 2015).

The need for MC pedagogy in academic curriculum and clinical practicum is inherent; the fundamental inquiry is how do educators (academic and clinical) effectively teach MC skills that facilitate competency (Clark, 2002; Franca & Harten, 2016). This is an eminent concern given the number of professors and supervisors who may feel unprepared to implement MC in clinical practice (Centeno, 2009; Cornish & White, 2016; Levey & Sola, 2013; Randolph & Bradshaw, 2016), but are still required to instruct MC in the classroom and clinical settings. One possible solution is the implementation of scholarship of teaching and learning (SoTL) in the area of MC. SoTL emphasizes teaching as an evolving, scholarly progression with the intent to enhance student learning (Huber & Morreale, 2002).

**MC and SoTL.** Ernest Boyer, an early advocator of SoTL and an audiologist, noted four areas of scholarship within higher education: scholarship of discovery, integration, application, and teaching (Boyer, 1990). The ultimate goal of teaching MC is application. However, the most effective pedagogical strategies used to teach MC must be explored (Revel, 2015) to enhance clinical practice techniques with CLD clients. Techniques in clinical practice change as research in various discipline-specific topics are studied (i.e., application of SoTL); the same expectation should apply to teaching content in both the classroom and clinical settings. However, CSD educators may often instruct in the methods that they learned as students, which may negatively affect student engagement and learning of MC.

Educators who use SoTL research to guide course development and implementation are teaching from an evidence-based education (EBE) that will better influence student learning and performance outcomes (Ginsberg, Friberg, & Visconti, 2011). For example, SoTL literature recognizes teaching strategies that facilitate active learning in which the student is not a passive audience member, but considered a capable participant (Meyers & Jones, 1993). Without EBE, SLPs may continue to feel ill-prepared when providing MC. Although the exact pedagogical strategy to include MC in the CSD curriculum is unclear, there are evidence-based techniques that have been shown to increase student learning (e.g., authentic learning, problem-based learning). Problem-based learning is a student-focused approach that uses small groups to promote critical thinking skills through problem solving scenarios (McKinney, 2007). Using problem-based learning to teach MC may prove to be effective.

Integration of SoTL research not only benefits course development, but also demonstrates to the students, the value of empirical research and how it connects to evidence-based practice (Ginsberg, 2010). Faculty who engage in SoTL research are those who develop, analyze, and apply teaching strategies that encourage the growth of pedagogical content knowledge (PCK; Shulman, 2004). PCK is a foundational element for evidence-based practice in CSD. It is insufficient to only have a comprehensive understanding of content knowledge; the ability to teach the content in a manner that influences application is also essential. Researchers, faculty, and clinicians can provide substantial input to their perspective of learning, of how others learn, and of how to use instructional methods to support MC.

## **Purpose of the Study**

Multicultural education and MC have important implications in CSD. These implications may vary slightly depending upon the individual's role(s) as a student, professor, supervisor, or clinician. The implementation of MC is two-fold; MC must be incorporated into the graduate curriculum/practicum and must be provided to clients as required by ASHA policy (ASHA, 2016a; CAA, 2017). Vital aspects of MC include the acknowledgment of one's own cultural biases, the ability to modify the behaviors as needed, and the understanding of how cultural differences may impact students' learning and clinical practice (Perry, 2012).

Researchers in the field of CSD have examined the multicultural competence of CSD programs (Horton-Ikard, et al., 2009) and have evaluated the practices of CSD faculty relative to the inclusion of multiculturalism in the curriculum (Stockman, et. al., 2008). Given the limited SoTL research related to MC pedagogy in CSD, it is necessary to investigate SLPs' perceptions of the need for, access to, and levels of comfort concerning MC. The purpose of the current research was to explore SLPs' perceptions of the accessibility and the implementation of MC in CSD based on various experiences: education, participation in graduate curriculum/practicum, and clinical practice. The following questions were addressed:

1. What are SLPs' perceptions of the need for MC in CSD?
2. What are SLPs' perceptions of their access to (i.e., curriculum access) MC in CSD?
3. What are SLPs' perceptions of their levels of comfort when engaging MC?

## **Method**

The Institutional Review Board at a public university in the southeast region of the United States granted approval for the implementation of the current research. A consent statement was embedded at the beginning of the survey for participants to give prior approval.

**Participants.** Twenty-eight SLPs, 1 male (3.6%) and 27 females (96.4%) completed an online survey to measure their perspectives of MC in CSD. To be included in the study, SLPs must have received the certificate of clinical competence (CCCs) or were completing their clinical fellowship (CF). Demographic information was gathered from the participants at the beginning of the survey. Two of the 28 SLPs were completing their CF and the remaining SLPs had their CCCs from ASHA. The participants' highest level of degree included a master's (n = 22) or doctoral (n = 6) degree. All of the participants possessed a master's (n = 28). Seventeen participants reported to have supervised SLP students.



The participants reported working in a variety of settings including schools, early intervention, skilled nursing facilities, rehabilitation centers, universities, hospitals, and private clinics. Approximately, 42% of the participants worked in multiple settings. The number of years of experience as an SLP ranged from 0 to 26+ years. Most participants reported to have 0 to 5 years of experience. Additional demographic data are reported in Table 1.

**Table 1**  
*Participants' Demographic Information*

Category	Item	Frequency
Age	20-29 years	11
	30-39 years	13
	40-49 years	3
	50-59 years	1
Gender	Male	1
	Females	27
Ethnicity	White	20
	Black or AA	5
	Hispanic	2
	Asian Pacific Islander	1
Years of experience	0-5 years	12
	6-10 years	8
	11-15 years	5
	21-25 years	2
	26+ years	1
Category	Item	Frequency
Do you have an undergraduate degree in CSD?	Yes	24
	No	4
Have you ever supervised students?	Yes	17
	No	11
Work setting	School	10
	Skilled nursing facility	3
	Rehabilitation	5
	University-CF	3
	Hospital	3
	Early intervention	2
	Private clinic	2
	University faculty	8

*Note.* CSD = communication sciences and disorders; AA = African American; CF = clinical fellowship

**Survey.** The survey was created online using Qualtrics (Qualtrics, 2005), an online survey software. The survey consisted of five main sections, which contained statements related to MC, counseling, multicultural experiences or a combination of the three (Appendix). The statements queried the following experiences of SLPs' roles as students in the classroom, graduate clinicians, supervisors, professors/faculty, and clinicians: educational, supervisee, supervisory, academia (teaching), and

clinical practice, respectively.

Participants rated their perspectives by using a 5-point Likert-type scale, which included the following response options: 1 = strongly agree, 2 = agree, 3 = neither agree nor disagree, 4 = disagree, and 5 = strongly disagree. All participants completed the following sections: educational experience, clinical practice experience, and supervisee experience. However, participants only completed the academic (teaching) experience and supervisory experience sections, if they had taught a CSD course or supervised a CSD student, respectively. Not all statements within each section were applicable to the purposes of the study. The appendix contains statements from each section that were used for analysis in the current study.

**Study Design and Data Analysis.** Random sampling procedures were used for data collection. The researchers recruited SLPs via email and social media sites (e.g., Facebook, Instagram). The completion time of the questionnaire was estimated to be 20-30 minutes.

A series of chi-square goodness of fit tests were used to analyze data using the Statistical Package for the Social Sciences (SPSS-21) software (IBM Corporation, 2012). The *strongly agree* and *agree* and the *strongly disagree* and *disagree* categories were subsumed to increase the frequency count of each cell for the chi-square analysis. Survey questions eliciting a *yes* or *no* response (e.g., enrolled in a cultural or multicultural course) did not include *strongly agree* or *strongly disagree* categories. Collapsing Likert-scale data for data analysis is considered to be an acceptable practice (Allen & Seaman, 2007; Jacoby & Matell, 1971); however, it may result in a loss of analytical value (Bertram, 2009). For responses that exhibited a cell count of zero, the category was excluded before completing the chi-square analysis. For responses that resulted in two categories with a cell count of zero, frequency data are reported. The output and code for data analyses were generated using Qualtrics software (Qualtrics, 2005).

## Results

The results are summarized according to the research questions of the study. The data have been collapsed for data analysis and represent three categories: 1 = agree, 2 = neutral, and 3 = disagree. The results were analyzed based on SLPs' educational, supervisee, supervisory, academic, and clinical experiences in educational and clinical settings.

**RQ1: What are SLPs' perceptions of the need for MC in communication sciences and disorders?** Based on their educational, academia, supervisory, supervisee, and clinical experiences, a majority of SLPs agreed that MC is needed in CSD. A breakdown of SLPs' perceptions according to their various experiences is presented below.

**Educational experience.** A chi-square test of goodness of fit was performed to determine SLPs' perceptions of MC as an embedded component in the curriculum, and preference for a multicultural course at the undergraduate and graduate levels. Figure 1 depicts the results from the educational experience section. Most SLPs agreed that MC should be included in the CSD curriculum; however, there was a discrepancy between whether MC should be included at the graduate or undergraduate level. SLPs' agreement as to whether MC should be included in the undergraduate curriculum was equally distributed,  $\chi^2(2, N = 24) = 3.25, p > 0.05$ . Most SLPs agreed that MC should be included in

the graduate curriculum and preferences for this option were not equally distributed,  $\chi^2(2, N = 24) = 9.25, p < 0.05$ .

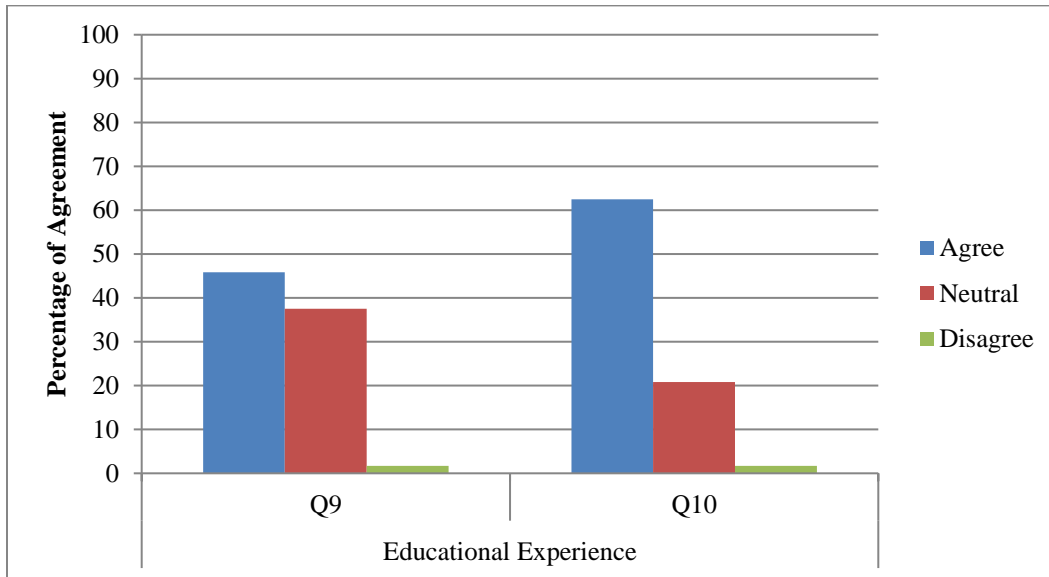


Figure 1. Percentage of SLPs' perception of the inclusion of MC at the undergraduate and graduate levels. Q9 = MC should be a required component of the undergraduate curriculum in CSD. Q10 = MC should be a required component of the graduate curriculum in CSD

**Academia (teaching and learning) experience.** All SLPs completed the academia questions regardless of whether they had teaching experience. Although the survey questions were intended to query faculty only, the questions asked in the academia section were not specific to faculty only. A comparison of faculty and non-faculty perceptions of teaching and learning experiences are shown in Figure 2.

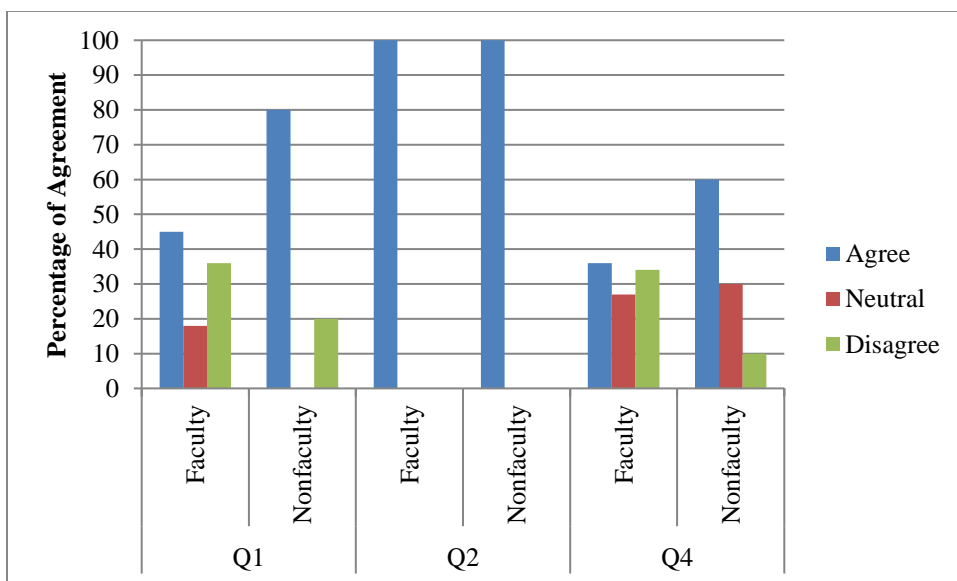


Figure 2. Comparison of Faculty and Non-Faculty Perceptions of the need for MC in CSD. Q1 = I feel MC should be a required course in the CSD curriculum. Q2. MC should be embedded in the courses taught in CSD curriculum. Q4. MC should be offered as an elective course.

University faculty and non-faculty (i.e., students) were analyzed together to assess the perception of MC teaching and learning experiences. SLPs (i.e., faculty and non-faculty) significantly agreed that MC should be a curriculum course,  $\chi^2(2, N = 21) = 8.86, p < 0.05$ . All of the SLPs ( $N = 21$ ) responding to question two agreed that MC should be embedded in curriculum courses. A chi-square analysis could not be completed due to the lack of cell counts in the disagree and neutral cells. There was not a significant difference between SLPs' preferences for MC to be taught as an elective course,  $\chi^2(2, N = 20) = 2.50, p > 0.05$ . Figure 3 presents perceptions of faculty and non-faculty combined.

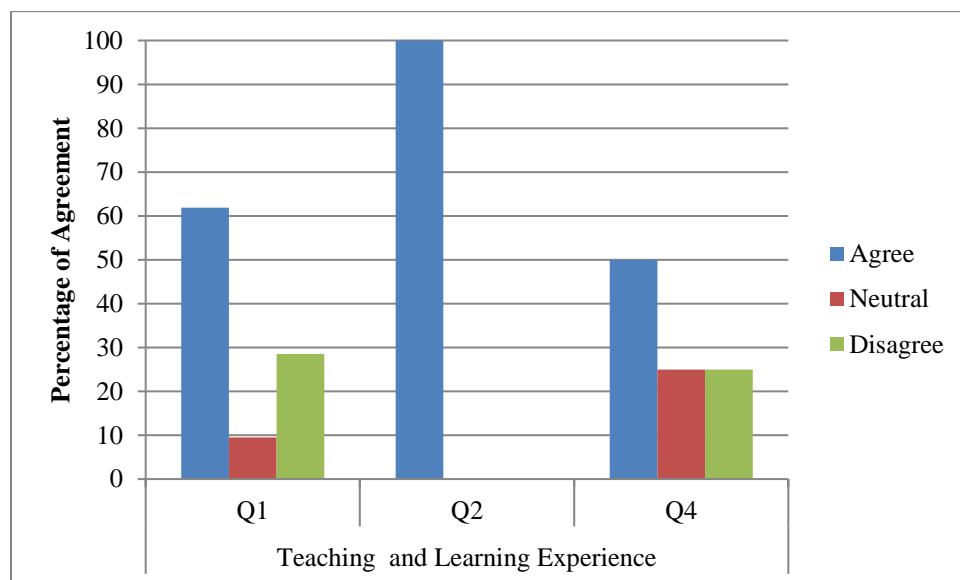


Figure 3. SLPs' perception of the inclusion of MC in academic courses. Q1 = I feel MC should be a required course in the CSD curriculum. Q2. MC should be embedded in the courses taught in CSD curriculum. Q4. MC should be offered as an elective course.

**Supervisee experience.** The majority of SLPs felt that MC was an essential component of the supervisory process (See Figure 4). Agreement among participants was significantly different,  $\chi^2(2, N = 24) = 15.75, p < 0.01$ .

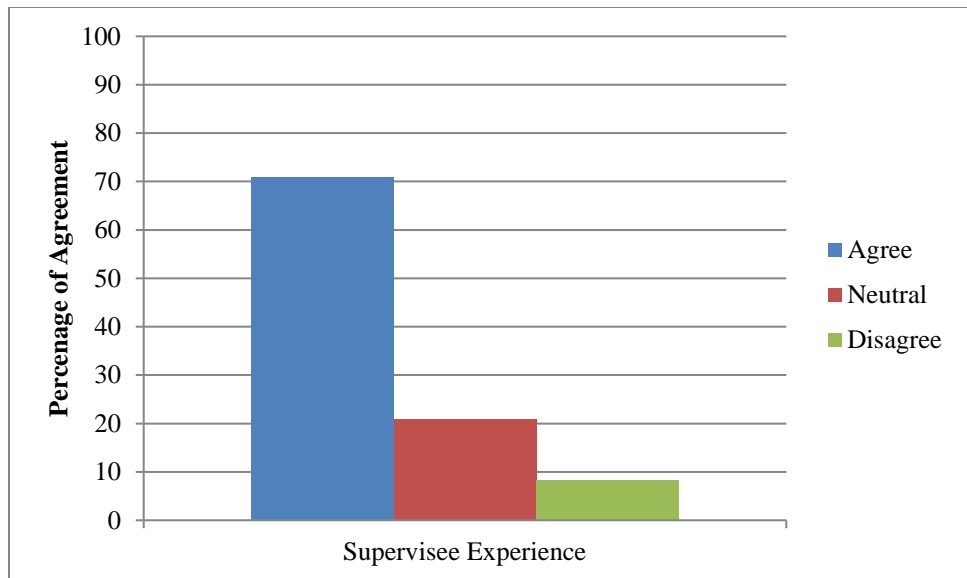


Figure 4. SLPs' perception of whether MC is an important component of the supervisory process.

**Supervisory experience.** Most SLPs perceived facilitating the implementation of MC and implementing MC with supervisees to be an important process in the supervisory experience. No SLP disagreed that the above processes were unimportant (See Figure 5). SLPs' agreement was significantly different,  $\chi^2(1, N = 17) = 2.12, p > 0.01$ .

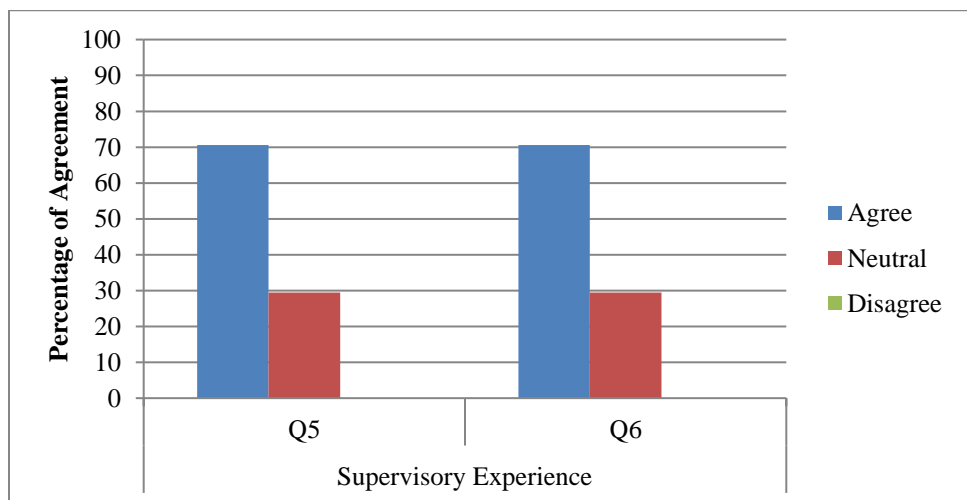


Figure 5. SLPs' perception of MC during their supervisory experiences. Q5 = As a supervisor it is important to facilitate implementation of MC. Q6 = As a supervisor, it is important to implement MC with my supervisee.

**Clinical experience.** Most SLPs perceived MC to be an important component of assessment and intervention (See Figure 6), and preferences were not equally distributed,  $\chi^2(1, N = 17) = 7.12, p = 0.01$ .

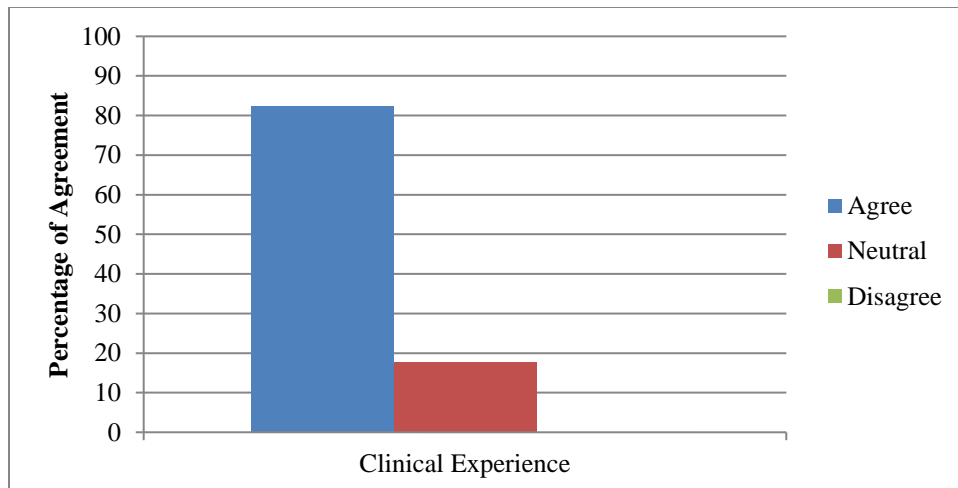


Figure 6. SLPs' perception of MC in clinical practice. Q2 = MC is an important component of assessment and intervention.

**RQ2: What are SLPs' perceptions of their access to MC in communication sciences and disorders?** Data were analyzed based on SLPs' educational, supervisory, and supervisee experiences. Based on SLPs' educational and supervisee experiences, most SLPs perceived to have limited access to learning MC in their academic curriculum (i.e., classroom and clinical curricula). However, most supervising SLPs agreed to encouraging students to implement MC as needed. A breakdown of SLPs' perceptions of learning MC in their academic curriculum is presented below.

**Educational experience.** Table 2 displays the results of the chi-square analyses for SLPs' distribution of perceptions regarding their educational, supervisory, and supervisee experiences. Data for questions 3 and 6 were not equally distributed indicating a lack of MC in SLPs' curriculum courses.

**Table 2**

*Chi-square results for SLPs' perceptions of access to learning MC*

	Variable	Chi-square	df*	<i>p</i>
Educational experience	Q3 Enrolled in a MC course	22.75	2	0.0001
	Q6 MC was embedded in course content	7.00	2	0.0302
	Q7 I had no experience with MC in the classroom	1.75	2	0.4169
Supervisee experience	Q2 My supervisor appeared knowledgeable in MC	0.75	2	0.6873
	Q8 I had no experiences with MC as a supervisee	4.00	2	0.1353
Supervisory experience	Q1 I advised supervisees to implement MC as needed	2.12	1	0.1454

Note. df = degrees of freedom

Although not enrolled in a MC course, most SLPs agreed to have experiences with MC. Furthermore, MC was not embedded in courses for most of the SLPs (See Figure 7).

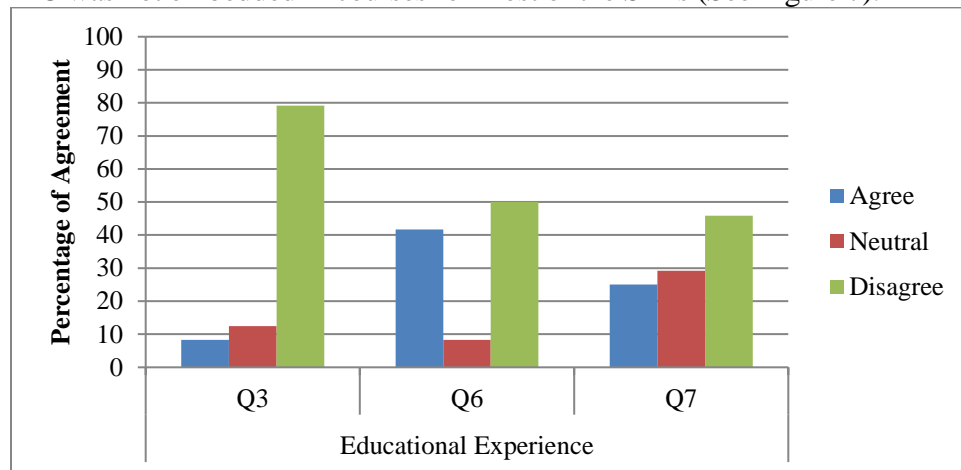


Figure 7. SLPs' perception of their access to MC training in academics. Q3 = Enrolled in a MC course. Q6 = MC was embedded in courses. Q7 = I had no experience with MC.

**Supervisee experience.** An equal percentage of SLPs agreed and disagreed as to whether they felt their supervisor appeared to be knowledgeable in MC. Most of the SLPs reported to have had experience with MC during the supervisory process (See Figure 8).

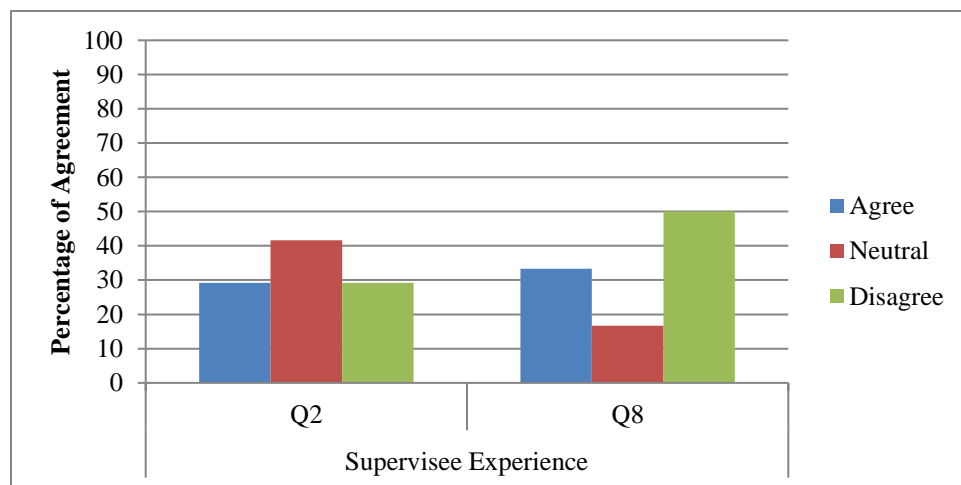


Figure 8. SLPs' perceptions of their access to MC training as supervisees. Q2 = My supervisor appeared to be knowledgeable in MC. Q8 = I had no experience with MC as a supervisee.

**Supervisory experience.** Supervisors mutually agreed and were neutral as to whether they advised students to implement MC (See Figure 9).

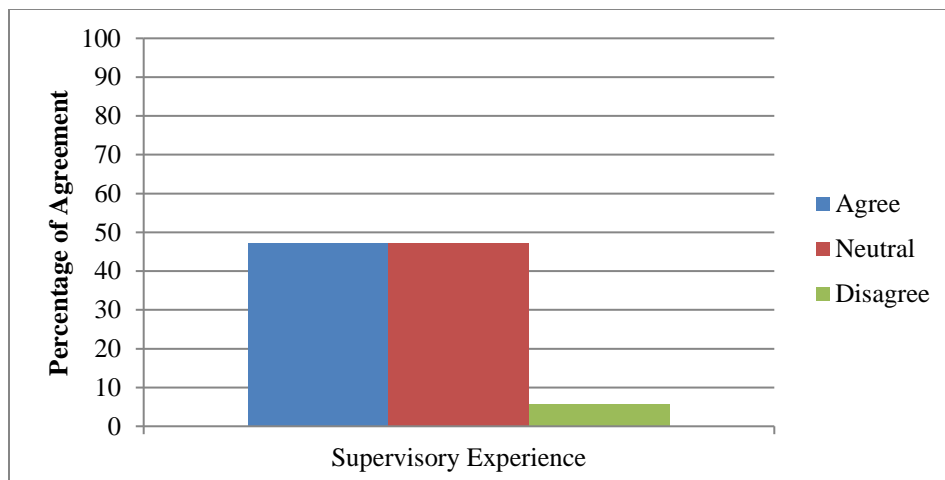


Figure 9. Supervising SLPs' agreement on whether they informed supervisees to implement MC as needed.

**RQ3: What are SLPs' perceptions of their levels of comfort when engaging in MC?** Based on their educational, supervisee, and supervisory experiences, SLPs' levels of comfort when engaging in MC varied according to their engagement and acknowledgement of MC.

**Educational experience.** SLPs were asked if they felt competent in implementing MC based on their educational experiences. There was a significant difference in agreement with a majority of SLPs indicating neutrality in regard to their competency in implementing MC,  $\chi^2(2, N = 24) = 7.00, p < 0.05$ . Figure 10 displays the percentage of agreement among SLPs.

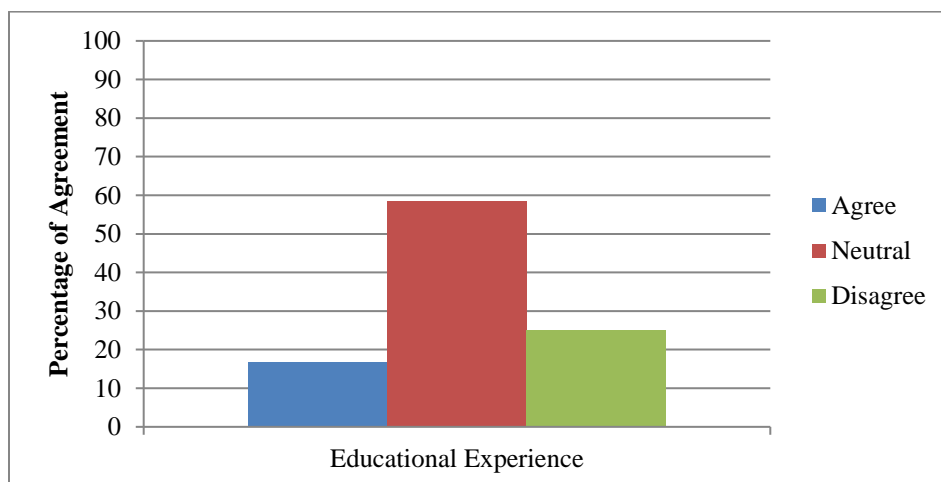


Figure 10. SLPs' implementation of MC in their clinical experiences. Q1 = I feel competent in implementing MC.

**Supervisee experience.** Supervisees (i.e., graduate clinicians) were queried about their level of comfort when interacting with their supervisors and their clients. Supervisees significantly agreed that they felt comfortable discussing MC with their supervisors,  $\chi^2(2, N = 24) = 7.00, p < 0.05$  and implementing MC with their clients,  $\chi^2(2, N = 24) = 7.75, p < 0.05$ . However, there was not significant agreement among supervisees concerning their acknowledgment of the cultural differences between their



supervisors and themselves,  $\chi^2(2, N = 24) = 4.75, p > 0.05$  nor was there significant agreement among supervisees concerning their perceptions of their supervisors' acknowledgement of cultural difference between supervisors and supervisees,  $\chi^2(2, N = 24) = 0.25, p > 0.05$ . Figure 11 displays supervisees' level of comfort with MC.

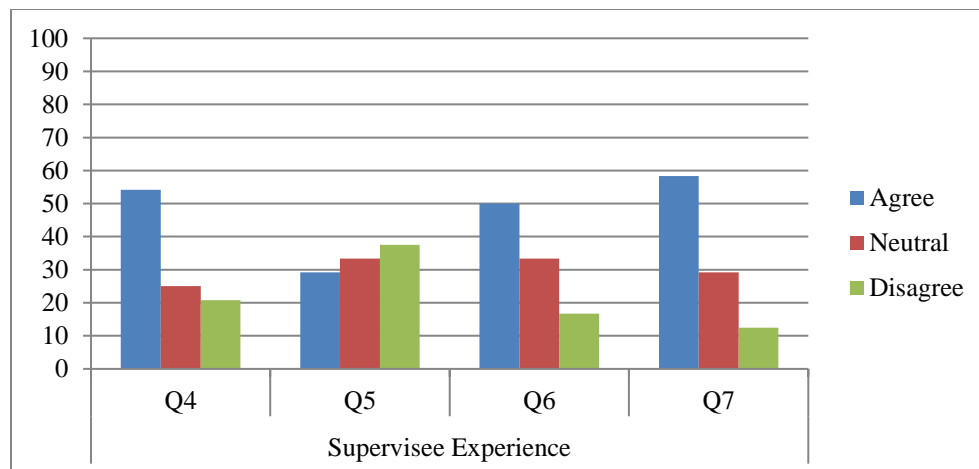


Figure 11. Supervisees' perceptions of comfort with MC. Q4 = I acknowledged cultural differences between my supervisor and me; Q5 = My supervisor acknowledged cultural differences between herself and me; Q6 = I felt comfortable discussing MC with my supervisor; Q7 = I felt comfortable implementing MC with my clients

**Supervisory experience.** Based on their supervisory experiences, there was not significant agreement among supervisors about whether they felt comfortable when discussing MC with their supervisees,  $\chi^2(2, N = 17) = 4.35, p > 0.05$ . There was also not significant agreement among supervisors about whether they acknowledged cultural differences between their supervisees and themselves,  $\chi^2(2, N = 17) = 0.53, p > 0.05$ . Figure 12 displays supervisors' level of comfort when engaging in MC.



Figure 12. Supervisors' perceptions of comfort with MC. Q2 = I felt comfortable discussing MC with my supervisee; Q3 = I acknowledged cultural differences between my supervisee and me

## Discussion

MC is an imperative practice that must permeate every role fulfilled by SLPs. Accordingly, every SLP should continually strive to increase and maintain cultural competence; and EBE in the area of multiculturalism must be implemented so that the increasingly diverse clientele that is served receives appropriate MC. In the current study, SLPs' perceptions of MC in CSD varied according to their educational, supervisee, supervisory, academic, and clinical experiences.

The first question queried SLPs' perceptions of the need for MC in CSD. SLPs in the current study felt that MC should be included in the curriculum on the graduate level rather than the undergraduate level. SLPs may prefer that MC is added to the graduate curriculum due to the relatively shorter amount of time between the graduate program and clinical practice (i.e., CF). Undergraduate students, on the other hand, are building foundational skills needed for the graduate curriculum and may not retain information related to MC due to the lack of immediate application. When queried about the methods in which MC should be implemented, there was some disagreement among faculty and non-faculty (i.e., students) when asked if MC should be included as a separate course in the curriculum; non-faculty favored this method over faculty. Students may not perceive infusion, which is the most frequently implemented method of teaching MC (Horton-Ikard, et al., 2009; Stockman, et al., 2008), to be as effective as a separate MC course. Conversely, faculty may feel that infusing MC is effective and sufficient. Further research needs to be conducted to affirm the aforementioned suspicions. This affirmation may suggest the implementation of SoTL to further examine the most effective teaching practices for MC. This proposed SoTL research is suggested to include problem-based learning to promote critical thinking skills relevant to implementing MC (McKinney, 2007). An unremarkable finding was that all of the SLPs in the study agreed that MC should be embedded in courses taught in CSD. Current CAA standards require that MC be addressed in CSD curricula and practicums (CAA, 2017). However, evidence to support implementation of MC presented by CSD programs may not be sufficient based on the perception of SLPs in the current study. In relation to clinical practice, supervisors and supervisees feel MC is an important part of the supervisory process, which is consistent with Revel's (2015) findings in which SLPs felt that their supervisors played an invaluable role in training them in MC. Supervisors have a unique context in which MC can be trained; supervisees are able to immediately apply MC techniques taught or demonstrated by supervisors. The above finding is consistent with the triadic relationship among the supervisor, supervisee, and client described by Bradshaw and Randolph (2016). Lastly, SLPs feel MC is an important part of the assessment and intervention process, which is not surprising. CLD clients' language background and dialectal differences is especially important to consider when differentiating disorders from differences (Oetting et al., 2016). Likewise, a culturally competent SLP recognizes the impact of her culture on the client; prior research reported that the dialect density of an evaluator may cause an increase in the client's dialect density during the assessment of speech sound disorders (Bernthal, et al., 2016).

The second question queried SLPs' perceptions of their access to MC in CSD. A majority of SLPs in the current study agreed that they were not enrolled in a MC course and there was mixed agreement on whether MC was embedded in CSD courses. This finding is consistent with Horton-Ikard & Muñoz's (2010) research, which found only 25% of programs integrated multicultural issues into courses. Additionally, Horton-Ikard and colleagues (2009) found several limitations with embedding MC training into courses and suggested a more effective modeling for MC training. On the contrary, most SLPs disagreed that they had no experience with MC. The varying agreement on whether MC

was embedded may be due to the assumption that infusion of MC may assume implicit teaching methods that are not explicitly recognized by students in the classroom. A similar trend can be observed with supervisees who were mostly unsure (i.e., neither agreed nor disagreed) if their supervisor was knowledgeable in MC. This could be due to the supervisees' lack of experience and knowledge in MC as there was inconsistencies in their agreement on whether they had experience with MC as supervisees. The aforementioned assumption is confirmed by the inconsistencies in supervisors' perceptions on whether they advised their supervisees to implement MC. The findings mentioned above confirm that MC is being implemented in practicum and practice, but begs the question, "Is MC training in CSD practice and practicums effective and sustained?"

The last research question queried if SLPs felt comfortable when engaging in MC. A majority of SLPs were neutral as to whether they felt competent in implementing MC with their clients. Most supervisees were in agreement that they acknowledged the cultural differences between themselves and their supervisors, but were not in agreement about their perceptions on whether their supervisors acknowledged cultural differences. This was confirmed by supervisors' neutrality on whether they acknowledged cultural differences. One of the key characteristics in implementing MC effectively is being culturally competent, which consists of acknowledging one's own cultural biases and characteristics (ASHA, n.d.; Cross et al., 1989). Despite the uncertainty of their supervisors' acknowledgment of cultural differences, a majority of supervisees felt comfortable with discussing MC with their supervisors and with implementing MC with their clients. Likewise, a majority of supervisors felt comfortable discussing MC with their supervisees.

### **Limitations**

Due to the exploratory nature of the current research, there are substantial limitations. First, the number of participants represents a miniscule sample of the professionals (~186,000) represented by ASHA. Due to the small sample size, the categories of responses were collapsed to analyze data. Collapsing data from a small sample presents a few challenges; a loss is seen in the analytic detail of responses given a 5-point scale and a decrease in the number of scales may affect reliability and validity. The inherent bias of some of the survey questions may have also influenced reliability and validity of responses. Second, some of the participants did not complete all of the questions in the survey or completed survey questions not related to roles in which they had served. As the initial study of this kind, the reliability and validity of the survey questions need to be examined. Prior studies examined cultural awareness (i.e., multicultural competence) rather than MC (Horton-Ikard, et al., 2009; Stockman, et al., 2008). Lastly, the survey questions were quantitative in nature inhibiting further descriptive analyses that would allow for explanations of responses and qualitative perspectives of MC in CSD.

### **Future Research**

The researchers are currently working to replicate the current study by surveying substantially more SLPs and AuDs. Additionally, survey questions will be examined to exclude those that are "leading" or biased. Future studies should also investigate the effectiveness of the training and implementation of MC by examining academic and clinical practice perspectives (i.e., educational, supervisee, supervisory, and clinical experiences). Furthermore, CSD clients' perceptions of the appropriateness of the delivery of MC should also be examined; it may be that SLPs' delivery of MC is not as effective

they perceive. Although studies in which clients' perspectives of MC have not been completed in the CSD field, this type of study has been completed in the psychology and counseling fields (e.g., Fuertes & Brobst, 2002; Pope-Davis, et al., 2002). The findings of these future studies may help guide the teaching and training of MC. Future SLPs (i.e., current undergraduate and graduate students) should be surveyed to determine their perspectives of access to MC in their current curriculum. This will allow for a current rather than retrospective perception of SLPs' access to MC.

## Conclusion

Based on the findings of the current study, SLPs received the most notable MC training during the supervisory process. Furthermore, it seems that CSD students would prefer a separate course in MC at the graduate level; however, CSD faculty appears to prefer MC to be embedded in CSD courses. Due to the exploratory nature and the limited number of participants in the current study, the above generalizations are restricted to this study's population. The findings of the current study help to facilitate the increased awareness of MC in CSD. This awareness is evident in the research and in documents and policies (e.g., ASHA Code of Ethics) created for CSD. The increasing CLD population necessitates standardized educational procedures and formal evaluation of the implementation of these procedures to ensure SLPs (i.e., students and professionals) receive evidence-based MC instruction. Re-examining the proposed pedagogical framework for a MC course in CSD may be the first initiative to implement (Horton-Ikard, et al., 2009). Moreover, procedures that facilitate MC training (e.g., seminars, online courses, or other educational avenues) for SLPs is essential for those who may need more resources to be cultural competent. The above mechanisms will ensure CLD persons with communication disorders will receive effective and appropriate MC that is consistent with a culturally competent system of care (Cross et al., 1989).

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## Appendix

### *Survey Questions used in Data Analysis by Survey Sections and Research Questions*

Survey Sections	Research Questions		
	RQ1	RQ2	RQ3
<b>Educational experience</b>	<p>MC should be a required component of the undergraduate curriculum in CSD (9)</p> <p>MC should be a required component of the graduate curriculum in CSD (10)</p>	<p>Enrolled in a MC course (3)</p> <p>MC was embedded in courses (6)</p> <p>I had no experience with MC (7)</p>	<p>I feel competent in implementing MC (8)</p>
<b>Supervisee experience</b>	<p>Incorporating MC is essential to the supervisory experience (3)</p>	<p>My supervisor appeared to be knowledgeable in MC (2)</p> <p>I had no experience with MC as a supervisee (8)</p>	<p>I felt comfortable discussing MC with my supervisor (6)</p> <p>I felt comfortable implementing MC with my clients (7)</p> <p>I acknowledged cultural differences between my supervisor and me (4)</p> <p>My supervisor acknowledged cultural differences between herself and me (5)</p>
<b>Supervisory experience</b>	<p>As a supervisor it is important to facilitate implementation of MC (5)</p> <p>As a supervisor, it is important to implement MC with my supervisee (6)</p>	<p>I advised graduate clinicians to implement MC when needed (1)</p>	<p>I felt comfortable discussing MC with my supervisee (2)</p> <p>I acknowledged cultural differences between my supervisee and me (3)</p>
<b>Academia (teaching) experience</b>	<p>I feel MC should be a required course in the CSD curriculum (1)</p> <p>MC should be embedded in courses taught in the CSD curriculum (2)</p> <p>MC should be offered as an elective course (4)</p>		
<b>Clinical Practice experience</b>	<p>MC is an important component of assessment and intervention (2)</p>		

*Note.* Numbers in parentheses after each statement indicates survey question numbers for each section. RQ = research question; RQ1 = What are SLPs' perceptions of the need for MC in CSD?; RQ2 = What are SLPs' perceptions of their access to MC in CSD?; RQ3 = What are SLPs' levels of comfort when implementing MC?