Speech-Language Pathologists’ Professional Efficacy Beliefs about
Assessing the Language Skills of Bilingual/Bicultural/Bidialectal Students

by

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A dissertation submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy
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Date of Approval:
December 16, 2004

Keywords: culturally and linguistically diverse, cultural competence, assessment, English
language learners, diversity, interpreters, ASHA focused initiative

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Dedication

To my parents, Clarence Sr. and Cynthia Harris, thank you for your unconditional love and endless encouragement.

To the late Reverend Paul Matthews, you planted the seed and God yielded the increase. I dedicate this dissertation in honor of your memory.
Acknowledgements

I would like to give honor to my Lord and Savior, Jesus Christ, for His strength throughout this journey.

Ann Cranston-Gingras: Thank you for your patience with me and your confidence in my abilities. You put up with my idiosyncrasies without passing judgment. Your calming personality helped me to see the bigger picture. I am grateful to you.

Deirdre Cobb-Roberts: Thank you for fueling my passion for research centered on a social justice agenda.

Arthur M. Guilford: Thank you for the insight you brought to the dissertation as a fellow speech-language pathologist.

Patricia Alvarez McHatton: You have encouraged me when I felt hopeless and assured me when my self-confidence needed boosting. I have learned much from you.

Anthony Onwueguzie: I am grateful to you for agreeing to commit yourself to my dissertation in the middle of the process. Without you, I doubt that I would have defended the proposal when I did.

Carolyn Laveley, Jack and Alice Richardson, and Brenda L. Townsend: Your funding assistance was instrumental in getting me to this point. Thank you.

Robert Dedrick: Thank you for your commitment to a quality product. You are truly appreciated.

John Niles: Thank you for your contribution.
Thank you to my cheerleaders: Brenda Curtwright, Gwendolyn Smith and Michael Smith. I am blessed to have friends like you. You made time for me in the midst of your own commitments.
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Speech-Language Pathologists’ Professional Efficacy Beliefs about Assessing the Language Skills of Bilingual/Bicultural/Bidialectal Students

Karen Patricia Harris

ABSTRACT

Like educators, speech-language pathologists can anticipate working with culturally and linguistically diverse students and their families. Data reported from the Study of Personnel Needs in Special Education (SPrNSE), 1999-2000, revealed that during the years 1999-2000 speech-language pathologists’ caseloads included students from various culturally and linguistically diverse groups (U.S. Department of Education, Office of Special Education Programs, 2001). Furthermore, on average, more than one-fourth of students seen by speech-language pathologists were from a culturally and/or linguistically diverse group than their own and 8.8% were English language learners (U.S. Department of Education, 2001). Thus, guaranteeing a highly qualified pool of speech-language pathologists to meet these students’ needs is essential.

This study examined speech-language pathologists’ (a) beliefs about the language assessment of bilingual/bicultural/bidialectal students, (b) professional efficacy beliefs (both personal and general) as they relate to assessing the language skills of bilingual/bicultural/bidialectal students, and (c) reported supports and barriers to assessing the language skills of bilingual/bicultural/bidialectal students. It involved a mixed method research design (Tashakkori & Teddlie, 1998, 2002) and was organized into three central components that included a quantitative phase and a qualitative phase:
(a) survey administration, (b) reflective analysis of the researcher’s experience as a speech-language pathologist, and (c) follow-up semi-structured interviews.

Quantitative analyses of speech-language pathologists’ professional efficacy beliefs revealed that most speech-language pathologists believed they personally, and the field in general, were “somewhat competent” in assessing the language skills of bilingual/bicultural/bidialectal students. While none of the predictor variables were significantly related to personal efficacy, one of the predictor variables (Hispanic/Latino) was significantly related to general efficacy.

Qualitative analysis of speech-language pathologists’ professional efficacy beliefs varied as a function of race/ethnicity. Higher beliefs of personal efficacy existed among speech-language pathologists of color. Perceived supports and barriers as well as the demographics of survey respondents, which highlight low numbers of speech-language pathologists from bilingual/bicultural/bidialectal backgrounds, confirmed the need to address assessment and intervention practices of bilingual/bicultural/bidialectal students.
CHAPTER I

Introduction

The demographics of American society are rapidly changing. Approximately one million immigrants settle in the United States every year (Martin & Midgley, 1999). Further, greater than 7.5 million registered or documented immigrants made the United States their home between 1991 and 1998 (Riche, 2000). In 1998, the U.S. Bureau of the Census correctly predicted the inordinate increase in its number of citizens from diverse racial, ethnic, and cultural backgrounds. Two years later, the U.S. Bureau of the Census report (2000) confirmed this previous prediction when it projected that people of color will comprise 28% of the American population by 2000. Moreover, this report foretold of a continuance towards this trend when it stated that people of color would comprise 38% of the American population by 2025 and 47% by 2050.

The public school system has increasingly reflected the diversity of our national population. The students in our classrooms are representative of the vast variety of cultures now present in the American society (Blair, 2003). From 1940 to 1960, students of color represented only 12% of the student population. In 1996, their numbers tripled to 36% of the student population. Since 1968, Hispanic/Latino enrollment has increased by 218% and African American enrollment by more than 20% (Johnson, Dupuis, Musial, Hall, & Gollnick, 2002). Students of color represent at least half of the public school students in some of our nation’s largest cities and metropolitan areas, such as Chicago,
Los Angeles, Washington, D.C., New York, Seattle, and San Francisco (Irvine, 2003). According to Irvine (2003), 40% of the U.S. student population in 2001 was representative of students of color. This statistic has primarily resulted from the growth of Latino students (Martinez & Curry, 1999). Moreover, nearly one-fifth of school age children in the United States speak a language other than English at home (U.S. Bureau of the Census, 2000). According to the College Board and the Western Commission for Higher Education as cited by Garcia (1995), by 2026 the United States will witness a reverse in the demographic breakdown of students as we knew it in 1990: Hispanic and non-White students will make up 70% of the enrolled K-12 population.

Further, Garcia (1995) states that “in the decades to come it will be virtually impossible for a professional educator to serve in a public school setting, and probably any private school context, in which his or her students are not consequentially diverse-racially, culturally, and/or linguistically (p. 373).” Irvine (2003) concurs that most preservice and inservice educators will more than likely have students from diverse racial, ethnic, linguistic, and religious backgrounds in their classrooms during their careers. However, this issue is not solely isolated to educators.

Like educators, speech-language pathologists can anticipate working with increasing numbers of culturally and linguistically diverse students and their families. School-based speech-language pathologists share the responsibility of ensuring an adequate education for students with disabilities and those placed at risk in the least restrictive environment. Specifically, these practitioners are responsible for identifying, assessing, and providing therapeutic intervention strategies to students with disabilities.

Data reported from the Study of Personnel Needs in Special Education (SPeNSE),
1999-2000, revealed that speech-language pathologists primarily served students with speech or language impairments, learning disabilities, mental retardation, and autism (U.S. Department of Education, Office of Special Education Programs (OSEP), 2001). During the years 1999-2000, 1,089,964 students were diagnosed as having speech or language impairments as their primary disability. This accounted for 19.2% of all students, aged 6-21 years with disabilities served under the Individuals with Disabilities Education Act (IDEA) (U.S. Department of Education, Office of Special Education Programs, 2001). Many other students were diagnosed with speech and language impairments as secondary and tertiary disabilities. Additionally, ample evidence verifies the frequent occurrence of communication disorders with adolescents in the juvenile justice system (Sanger, Creswell, Dworak, & Schultz, 2000; Sanger, Hux, & Belau, 1997; Sanger, Moore-Brown, Magnuson, & Svoboda, 2001; Sanger, Moore-Brown, Montgomery, Rezac, & Keller, 2003). Larson and McKinley (1995) conducted a literature review. They found that as many as 5% of youth in the general population demonstrates a need for services. Further, 14% to 22% of adolescents in correctional facilities exhibit a language disorder (Sanger et al., 2000, 1997, 2001), as compared to the 5% to which Larson and McKinley (1995) made reference. This substantiates a high incidence of speech and language impairments.

SPeNSE data further revealed that speech-language pathologists’ caseloads included students from various culturally and linguistically diverse groups. On average, more than one-fourth of students seen by speech-language pathologists were from a culturally or linguistically diverse group than their own and 8.8% were English-language learners (U.S. Department of Education, Office of Special Education Programs, 2001).
Thus, guaranteeing a highly qualified pool of speech-language pathologists to meet these students’ needs is essential. However, the above statistics suggest a mismatch between these students and the professionals responsible for their academic growth.

In addition to the above demographics of the student population, the academic, social, and economic conditions of culturally and linguistically diverse students are a vital concern (Irvine, 2003; Ladson-Billings, 1999). Data reveal the social, economic, and academic hardships under which many students of color live. For example, a young African American male has a better chance of serving time in a state prison (Irvine, 2003), where African American men now make up 50% of the prison population (McWhorter, 2000), than attending a college or university. Moreover, children who experience poor economic and social hardships face “daymares” -- from the effects of poverty, violence, hunger, poor health, drug addiction, inferior schools, and insensitive policies (Irvine, 2003).

In large measures, culturally and linguistically diverse students have not fared well in our nation’s classrooms. Schools with high concentrations of Black and Hispanic students are typically taught by teachers with the least experience and the least qualifications for the subject they teach (Darling-Hammond, 1998). Additionally, enormous differences exist between their outcomes and those experienced by their White counterparts (Townsend, 2002a). Disparate outcomes between certain groups of students of color and White student learners exist in the areas of grade-level retention, suspensions and expulsions, and drop out rates (Townsend, 2000). Nationwide, the high school dropout rate is approximately 28%; however, cities with particularly high numbers of African Americans and Latinos, such as New York and Chicago, demonstrate dropout
rates more than 40% (Wilson, 1998). Most achievement indicators reveal African American and Latino students are performing below their White and Asian peers (Jencks & Phillips, 1998).

The gap in achievement between Blacks and Whites, specifically, is not a new issue. In 1910, one of the earliest reports on this issue documented the disparity in reading achievement between African American and their White counterparts (Fishback and Baskin, 1991 as cited in Harris, Kamhi, & Pollock, 2001). As part of a report to the general assembly in the state of Georgia, it gave details of a “literacy gap” between African American and White children. Specifically, this report described the difficulty of African American students in learning to read as well as their overall underachievement (Fishback & Baskin, 1991 as cited in Harris et al., 2001).

While the gap has lessened somewhat over the past 8 decades, it remains a critical issue among educators (Harris et al., 2001). Gains made by African American students on standardized test scores have been moderately small and not consistent over time (Irvine, 2003). At one point, the Black-White achievement gap tapered in the 1970s and African American students even surpassed their White counterparts in the 1980s (Harris et al., 2001). However, this would not remain constant. The reason for the short-lived achievement in reading performance and improved standardized test scores among African American students is unclear (Harris et al., 2001). Since 1988, the Black-White achievement gap has once again widened, to the detriment of Black students. Specifically, Black students’ scores in reading and math have declined (Nettles, 1997). According to the National Center for Education Statistics (2000), the achievement gap between Whites and students of color, namely, African Americans and Latinos, has
widened from 1988 to 2000. Only 10% of African American and 13% of Latino students in the fourth grade demonstrate the ability to read at the proficient level. Remarkably, the overall average reading and math scores for 17-year old African American students are equivalent to the averages for 13-year old White students (Hoff, 2000). The most frequently cited indicator of inequitable outcomes experienced by African American and Hispanic students is the disproportionate rate at which these learners are referred and placed in special and remedial classes (Artiles & Trent, 1994; Donovan & Cross, 2002; Harry & Anderson, 1994; Osher, Woodruff, & Sims, 2002; Skiba, Michael, Nardo, & Peterson, 2002; Townsend, 2000).

In contrast to the changing demographics of the student population, the U.S. Department of Education (2001) reported that 86% of all elementary and secondary teachers are White. The percentage of African-American teachers has declined from 12% in 1970 to 7% in 1998. Hispanic and Asian/Pacific Islander Americans represent 5% and 1% of the teaching force, respectively. Native Americans represent less than 1% of the teaching population.

This is not solely a teacher-isolated issue. Similar to teachers, the diversity seen in the American population is by no means reflected among speech-language practitioners, graduate students, or faculty members (Whitmire & Eger, 2003). Despite the increase in culturally and linguistically diverse speech-language pathologists and the rapidly expanding diverse multicultural population within the United States, there remains a gross disparity between the ethnic backgrounds of speech-language pathologists and the students they serve. More specifically, an underrepresentation of speech-language pathologists of color exists in comparison with the number of culturally and linguistically
diverse people diagnosed with a communication disorder. According to the U.S. Bureau of the Census (2000), 77.5% of the American population is White while membership counts reflect that 93% (n = 70,024) of American Speech, Language, and Hearing Association (ASHA) members are White (American Speech Language Hearing Association, 2004). Only 2.8% of ASHA members identified their ethnicity as Hispanic or Latino, compared to 12.5% of the U.S. population. Further, 0.3% of ASHA members identified their ethnicity as American Indian or Alaskan Native, 1.6% identified as Asian, 2.3% identified as African American or Black, 0.1% identified as Native Hawaiian or Other Pacific Islander, and 2.8% identified as Multi-racial. Data from the Council of Academic Programs in Communication Sciences and Disorders reveal that 93% of faculty in communication sciences and disorders and 89% of students at the master’s level are White, respectively (Whitmire & Eger, 2003). Additionally, anecdotal reports reveal that many graduate students of color do not remain in these programs long enough to graduate (Deal-Williams, 2002).

As the student population is becoming increasingly diverse, the teaching and speech-language pathology workforce are becoming increasingly homogenous, monocultural, and monolingual. As urban schools increasingly serve more culturally and linguistically diverse student learners, the need becomes greater to accommodate these differences in the current monocultural classrooms. The implication is that in order for teachers to be successful, they will need to be prepared to teach children who are not White (Ladson-Billings, 1994). The same is assumed to be true for speech-language pathologists. According to Banks (1991):
Even if we are successful in increasing the percentage of teachers of color from the projected 5% in [the year] 2000 to 15%, 85% of the nation’s teachers will still be white, mainstream, and largely female working with students who differ from them racially, culturally, and in social class status. Thus, an effective teacher education policy for the 21 century must include as a major focus the education of all teachers, including teachers of color, in ways that will help them receive knowledge, skills, and attitudes needed to work effectively with students from diverse racial, ethnic, and social class groups. (pp. 135 -136)

With the contrast in demographics between educators and their students comes a fear by researchers that children of other cultures will lose their cultural identities in the majority culture classroom (Irvine, 2003; Nelson, 1995). Further, several authors agree that a cultural conflict exists between some students and the typical learning experiences in schools (Anderson, 1988; Anyon, 1997; Irvine, 2003; Kea & Utley, 1998; McIntyre, 1996a; 1996b; Vasquez, 1990). Research has documented that usual classroom practices favor one cultural group at the expense of others (Anderson, 1988; Irvine, 2003; McIntyre, 1996a; 1996b; Vasquez, 1990).

Traditionally, the primary focus of research has been on preservice teacher education and inservice teacher practices, with limited focus on related professionals such as speech-language pathologists. Consequently, research focused on speech-language pathologists’ preservice education and inservice practices in the K-12 educational system is minimal. The latest research studies have placed an emphasis on strategies utilized by school districts to recruit and retain qualified personnel, namely classroom teachers (Bergeson, Douglas, & Griffin, 2000; Darling-Hammond, 2001; Urban Teacher
Collaborative Report, 2000). Anyon (1997) studied a large urban school district. As a participant observer for four years, she discovered an infrequent use of stories that featured characters of color. Further, textbooks used were a microcosm of White middle-class interests and situations. Of the 24 teachers questioned at one particular school, none supplemented the written curriculum with Black studies in a systematic way. Exceptions to this occurred during Black History Month and varied across classrooms. Additionally, textbook authors write these texts in Standard American English (SAE) (Anyon, 1997). In some instances the vocabulary in which some users of African American Vernacular English (AAVE) think, are the opposite of what they read in textbooks (Anyon, 1997).

Dialect differences can affect the academic and social quality of education received by some students (Labov, 1995). Solely using Standard English in written materials interferes with reading achievement (Baratz, 1970; Labov, 1969; Wiener & Cromer, 1967). Dialectal differences may interfere with the acquisition of information and with various educational skills such as reading (Christian, 1997).

A group of African-American parents sued the local Ann Arbor (MI) school system on behalf of their children in 1979. In this lawsuit, these parents claimed that students were being denied equal educational opportunity because of their language background (Chambers & Bond, 1983; Farr Whiteman, 1980). Specifically, these parents asserted that the schools were failing to provide their children with adequate reading instruction because the language differences represented by their children's vernacular dialect were not taken into account. The parents won their lawsuit, and the schools were subsequently ordered to provide staff training specifically related to dialects and the teaching of reading (Chambers & Bond, 1983; Farr Whiteman, 1980).
Teachers, related professionals, other school personnel, and other students’ attitudes toward speakers of a different dialect group can have a remarkable impact on the education process (Christian, 1997). People often make erroneous assumptions about the intelligence, motivation, and even morality of individuals who speak a vernacular dialect (Christian, 1997). If an educator has low expectations of a student's ability because of dialect differences, the student will perform less well in school. Perhaps, this is a direct result of the negative expectations (Christian, 1997). In some cases, students’ vernacular speech patterns result in them being "tracked" with lower achievers or even placed in special education classes (Christian, 1997).

Negative views about speech begin with the belief that vernacular dialects are linguistically inferior to standard versions of the language. While language systems of various groups of speakers may differ, no one system is inherently better than any other (Christian, 1997). Research undoubtedly supports the position that variety in language is a natural manifestation of cultural and community differences (Labov, 1972). Baratz (1970) argued that the continued perception of nonstandard dialects as inferior to Standard American English (SAE) is an insult to students who do not speak the Standard English dialect.

Similar to reading, a student who speaks Ebonics or African American Vernacular English (AAVE) can exhibit difficulty with mathematical thinking in educational contexts. Further, SAE and forms of thought rule mathematical thinking in textbooks (Orr, 1987). The grammar between SAE and AAVE is distinct, the lexicons overlap, and the unconscious rules that govern AAVE often conflict with the rules that govern SAE (Orr, 1987).
There has been a great focus on the importance of implementing culturally responsive teaching practices in K-12 classrooms, particularly in urban school settings. Further, there has been an equal focus on teacher perceptions and their influence on teacher behaviors. Educational researchers have been interested in teacher beliefs about their own work, their students, and themselves for a long time (Soto & Goetz, 1998). These researchers have suggested a strong link between teachers’ educational philosophies and their planning, decision-making, and classroom practices (e.g., Aldridge & Clayton, 1987; Eisenhart, Shrum, Harding, & Cuthbert, 1988; Johnson, 1992; Jones, 1984; Melograno & Loovis, 1991). Research on teachers’ perceived sense of efficacy has contributed significantly to our understanding of the relationship between teachers’ beliefs and practices (Soto & Goetz, 1998). According to Bandura (1977), an individual’s beliefs about his/her self-efficacy (i.e., judgments about one’s ability to complete a certain task) are the strongest indicators of human motivation and subsequent practices.

According to Sleeter (2001), a significant proportion of White preservice teacher candidates anticipate working with students who are of a diverse cultural and linguistic background than their own. However, these pre-professionals bring with them modest cross-cultural backgrounds, knowledge bases, and experiences (Barry & Lechner, 1995; Gilbert, 1995; Larke, 1990; Law & Lane, 1987; McIntyre, 1997; Schultz, Neyhart & Reck, 1996; Smith, Moallem, & Sherrill, 1997; Su, 1996, 1997; Valli, 1995). Schultz et al. (1996) found that preservice teacher candidates lack knowledge of and possess stereotypic beliefs about urban and high poverty children. Further, most of these pre-professionals demonstrate little awareness or understanding of discrimination, particularly racism (Sleeter, 2001; Su, 1996, 1997). Many perceive programs to reduce
discriminatory practices, like Affirmative Action, as biased against Whites (Su, 1996, 1997). Apparently, this dilemma is not isolated at the level of the teacher education program. It carries over into their teaching practices. Goodwin (1994) states that preservice teachers hold limited thoughts of culturally responsive teaching practices as a methodological issue. Rather, they view a culturally responsive curriculum primarily as an additive to the status quo curriculum (Vavrus, 1994).

As a whole, predominantly White teacher preparation institutions have not responded very well to the rapidly growing cultural gap between teachers and their students (Sleeter, 2001). A survey of 19 Midwest Holmes Group teacher preparation programs revealed that 94% of their faculty and students were White (Fuller, 1992 as cited in Sleeter, 2001). Only 56% of these institutions include the completion of a multicultural education course as a requirement for their elementary education preservice teacher candidates (Fuller, 1992 as cited in Sleeter, 2001).

The percentages shared earlier regarding graduate preparation programs in speech-language pathology clearly document that these programs have responded in like manner as teacher preparation programs. They too have not taken the necessary steps to address the cultural gap between speech-language pathologists and their rapidly increasing culturally and linguistically diverse clientele. Missing from this research are studies that include and/or focus on the recruitment and retention of speech-language pathologists prepared to provide culturally responsive best practices to the diverse students and families they serve.

Demonstrating the ability to communicate one’s ideas, needs, and desires is necessary in human communication. Specifically, communicating to parents, teachers,
and other significant people is critical to a young child’s development and a prerequisite to academic growth and development (Brice, 2001). Many children have trouble communicating because of communication disorders. They may exhibit many symptoms, ranging from speech to language disorders. Symptoms of communication difficulty may include difficulty following directives, engaging in conversational dialogue, pronouncing words/unintelligible speech, stuttering, understanding information given, expressing one’s self in a clear and coherent manner, recalling information, poor vocabulary, reading difficulty, and voice problems. As a result, they qualify for speech and language therapy.

Students’ proficiency in language and communication depends on their ability to match their communications to the learning-teaching style of the classroom (Brice, 2001). Students with communication disorders have the potential for high academic success. However, this success is dependent on them learning the classroom’s social, language, and learning patterns (Brice, 2001). In addition to teachers, speech-language pathologists must center their attention on classroom interactions that include the language and communications utilized. This will assist students with successfully communicating in the school environment (Brice, 2001).

Despite the educational implications and incidence of communication disorders, researchers have placed primary emphasis on teacher preparation programs. As previously stated, research studies only focus on the perceptions, expectations, efficacy, and practices of classroom teachers concerning issues related to diverse student learners. Related professions, such as speech-language pathology, have been left out of the dialogue. Consequently, there is limited research on the relationship between speech-language pathologists’ perceptions toward cultural and linguistic diversity and their
professional practices. Speech-language pathologists play a major role in the identification, assessment, and intervention of students with communicative disabilities. Like educators, they bring with them their values, beliefs, and assumptions to every screening, assessment, and intervention situation. They must determine whether a student is exhibiting a disability or merely a cultural difference. With this power comes a threat of misidentification and misdiagnosis, especially if the speech-language pathologist is not familiar with a student’s cultural background.

Jeffries (2000) addresses the following vital points that demonstrate the need to examine preservice teachers’ cultural understanding of self and others. The same points apply to speech-language pathologists, professionals also responsible for the academic growth and development of children.

1. Fewer individuals from culturally and linguistically diverse backgrounds are entering the teaching field; fewer individuals from culturally and linguistically diverse backgrounds are entering the speech-language profession.
2. Human development and socialization occur in cultural contexts that dictate an individual’s attitudes, perceptions, beliefs, values, and actions;
3. An individual’s cultural values and knowledge influence how she/he establishes or sets expectations for others; and
4. Very little empirically based research on culturally responsive pedagogy has been conducted to date.

Of particular significance, this study examined (a) speech-language pathologists’ beliefs about the language assessment of bilingual/bicultural/bidialectal students, (b) speech-language pathologists’ professional efficacy beliefs (both personal and general) as
they relate to assessing the language skills of bilingual/bicultural/bidialectal students, and (c) reported supports and barriers to assessing the language skills of bilingual/bicultural/bidialectal students. A form of sequential mixed-methods design was used to accomplish the goals of this study. Survey and interview research methods were employed. The following research questions were used to address the above inquiry. Questions 1, 3, and 4 are qualitative in nature. Question 2 is quantitative in nature.

Research Questions

This study addressed the following research questions:

1. What are the professional efficacy beliefs of speech-language pathologists about assessing the language skills of bilingual/bicultural/bidialectal students?

2. Do speech-language pathologists’ professional efficacy beliefs about assessing the language skills of bilingual/bicultural/bidialectal students vary as a function of demographic variables (i.e. race/ethnicity, years of experience, levels of professional efficacy, frequency of times with bilingual/bicultural/bidialectal children, proficiency in a language other than English, and proficiency in a dialect)?

3. What do speech-language pathologists perceive as the supports needed to assess competently the language skills of bilingual/bicultural students?

4. What do speech-language pathologists perceive as barriers to assessing the language skills of bilingual/bicultural/bidialectal students?

Hypothesis.

The researcher hypothesized that speech-language pathologists’ professional efficacy beliefs about assessing the language skills of bilingual/bicultural/bidialectal students would vary as a function of:
1. Speech-language pathologists’ race/ethnicity;
2. Years of experience as a speech-language pathologist;
3. Years provided services to children and youth;
4. Percentage of students from homes where a language other than English is spoken;
5. Percentage of students from homes where a dialect is spoken;
6. Frequency of time spent with bilingual/bicultural/bidialectal students;
7. Years of experience with bilingual/bicultural/bidialectal students;
8. Proficiency in a language other than English; and
9. Proficiency in a dialect

Significance of the Study

This study is occurring at a critical time in the history of the American educational system. The rapidly changing demographics of the American society, contrasting demographics of speech-language pathologists, widening achievement gap, and continued disproportionality of students of color in special education programs make it imperative that graduate communication sciences and disorders programs prepare culturally competent speech-language pathologists to be responsive to the needs of all students. A Master’s degree is a minimum American Speech Language and Hearing Association (ASHA) requirement for practicing speech-language pathologists. Graduate programs in communication sciences and disorders are responsible for preparing competent speech-language pathologists to work with all children, including those from culturally and linguistically diverse backgrounds; backgrounds different from the dominant mainstream culture (White, middle-class, Protestant, and heterosexual). Thus, the results of this study will be shared with institutions of higher learning and school
districts.

Participants and Procedures

Speech-language pathologists within the state of Florida were selected to participate in this study. Of particular interest to the researcher were speech-language pathologists who provide preschool and school-based services to young children and adolescents with special needs. Participating speech-language pathologists included those who provided services to preschool to high school children, aged 3 to 17 years.

A cover letter with details of the study and a request for participation was given to speech-language pathologists. The letter was accompanied by a survey developed for speech-language pathologists. Participants were asked to complete anonymously the Speech-Language Services to Bilingual/Bicultural Individuals (SLSBBI) survey. Candidates for participation in follow-up semi-structured interviews were selected using purposeful sampling.

Definition of Terms

The focal point of this section is on key terms used throughout this research project. Definitions for each term follow.

Bicultural. defined as individuals who are socialized to attain specific values, beliefs, behavior styles, communication styles, and traditions in more than one culture (Kritikos, 2003).

Bidialectal. Defined as someone who possesses the ability to speak two different dialects (Seymour & Nober, 1998; Taylor, 1976).

Bilingual. Defined as individuals who regularly use two (or more) languages (Grosjean, 1992, as cited in Isaac, 2002). Taylor (1976, p.26) defines a bilingual person
as an individual who uses two or more “languages, dialects, or styles of speech” that involves a variation in “sound, vocabulary, and syntax.” Definitions of bilingualism vary and tend to focus on bilingualism as a uni-dimensional concept (language proficiency only), while failing to acknowledge the non-linguistic and cultural aspects of communication competence (Hamers & Blanc, 1989 as cited in Isaac, 2002).

**Culture.** The process by which individuals are socialized to attain specific values, beliefs, behavior styles, communication styles, and traditions that are common to a particular group of people.

**Culturally Responsive Practices.** Practices that include the customs and values of culturally and linguistically diverse students in addition to those of the dominant mainstream culture.

**Culturally Diverse.** Refers to individuals or a group that is exposed to, and/or engaged in more than one set of cultural beliefs, values, and attitudes (Crowley, 2003).

**Dialect.** Refers to a variety of a language shared by a group of speakers and are rule-governed (Crowley, 2003; Seymour & Nober, 1998; Vafadar & Utt, 1993). Dialects can be characteristic of ethnic, regional, socioeconomic, or gender groups.

**Dominant Mainstream Culture.** In the U.S., refers to White middle-class individuals.

**General Efficacy.** One’s beliefs about the field’s ability to change individuals’ learning and behavior (Allinder, 1994).

**Linguistically Diverse.** Refers to individuals or a group that is exposed to, and/or engaged in more than one language or dialect (Crowley, 2003).

**Mixed Method Research.** Involves the systematic use of a quantitative and
qualitative phase in the research study as a whole (Onwuegbuzie & Johnson, 2004).

Mixed Research. Involves the combined use of quantitative and qualitative techniques in a single research study (Onwuegbuzie & Johnson, 2004).

Personal Efficacy. Involves beliefs about one’s own ability to change individual’s learning and behavior (Dembo & Gibson, 1985).

Pidgin. Defined as a language that is composed of two or more languages created to facilitate communication between people who do not speak a common language. Pidgin is not an individual’s primary language.

Speech Community. Refers to a group of people who have at least one speech variety in common (Seymour & Nober, 1998).

Therapeutic intervention. As used in this study, refers to the delivery of clinical services to individuals experiencing speech and/or language difficulty.

The following section will focus on factors that pose potential threats to the reliability and validity of the results.

Delimitations

One delimitation is the restriction of participants to speech-language pathologists employed by two central Florida public school districts. Inferences from this study are restricted to these two school districts. A second delimitation is the focus on spoken languages to the exclusion of sign language. Language can be communicated via oral expression (speech), written expression (reading and writing), and manual expression (sign language) (Seymour & Nober, 1998). Manual communication systems such as American Sign Language, Seeing Essential English (SEE1), and Signing Exact English (SEE2) are considered valid and rule-governed languages (Seymour & Nober, 1998).
Limitations

Limitations of this study are categorized into two groups: threats to internal validity and threats to external validity. Regarding the quantitative portion of the study, the survey instrument is a single item measuring a complex construct. This is a threat to internal validity and poses a limitation to the study. A second threat to internal validity included the following: Information received was based on self-report through surveys and interviews. Participants may have provided responses they regarded as socially acceptable. This threat is known as instrumentation (Campbell & Stanley, 1963; Onwuegbuzie, 2003). A third threat to internal validity involved passive and active researcher bias (Onwuegbuzie, 2003). The researcher’s ethnicity, statements made, and background as a speech-language pathologist may have provided an indication of the researcher’s preferences. This may have influenced participant responses as well.

While surveys alone can yield significant information, in-depth interviews added a deeper understanding to the data collected. Utilizing both quantitative and qualitative research methods “is a more complete way to learn about phenomena we are interested in.” (Onwuegbuzie & Johnson, 2004, p.409)

Threats to external validity included population and ecological validity (McMillan, 2000; Onwuegbuzie, 2003). The sample may not parallel other geographic regions across the country. Inferences from this study are restricted to select districts within the state of Florida. Further, the percentage of female participants substantially outnumbered their male counterparts. As a result, the multiple regression analysis did not compare responses by gender. Only female speech-language pathologists were selected to participate in the follow-up interviews. Thus, information gathered from this study may
be only applicable to female speech-language pathologists in these two central Florida school districts.
CHAPTER II

Literature Review

The chapter begins with a focus on the demographics regarding speech-language pathologists, and their preparation to work with culturally and linguistically diverse students. Cultural and linguistic diversity and professional efficacy are used as the theoretical background of this inquiry; thus, they will shape the focus of subsequent sections of the literature review. Terminology such as race, ethnicity, culture, class, beliefs, and perceptions are vital recurrent themes used throughout this chapter. An overview of trends and issues related to the marginalization and disenfranchisement of culturally and linguistically diverse students is followed by the origin and history of multicultural education. Due to the limited presence of research on speech-language pathologists’ beliefs and practices, subsequent sections address teacher perception and expectation research, self-efficacy, personal and general efficacy, and culturally responsive pedagogy as it relates to teachers. The chapter concludes with implications for professionals who work with children.

Demographics of Speech-Language Pathologists

On an annual or biannual basis, the American Speech, Language, and Hearing Association (ASHA) conducts the Omnibus Survey via mail to gain information related to issues of concern and interests of its members and associates. In the spring of 2003, ASHA mailed a survey to constituents with questions about their caseloads (ASHA,
Using a probability (non-replacement) sampling, employing a stratified systematic technique, ASHA selected 7,500 constituents in the United States (ASHA, 2003). The response rate was 58% \((n = 4,387)\). More than 70% of speech-language pathologists in the schools reported that they served students with autism/pervasive development disorder (77%), learning disabilities (72%), and mental retardation/developmental disability (71%). Approximately 90% of speech-language pathologists reported that they served individuals with articulation or phonological disorders (ASHA, 2003).

Approximately 99.6% of school-based speech-language pathologists reported serving students with language disorders (U.S. Department of Education, 2001).

Nearly all speech-language pathologists (99.2%) rate their overall job performance as good, very good, or exceptional (U.S. Department of Education, 2001). Furthermore, speech-language pathologists rated themselves most skillful in the areas of interpreting results of standardized tests, planning effective services, using appropriate clinical skills, and monitoring student progress and adjusting instruction accordingly (U.S. Department of Education, 2001).

ASHA’s Legislative Council used the information obtained from the surveys to identify issues of concern. ASHA’s Executive Board subsequently identified related Focus Initiatives and associated outcomes (ASHA, 2003). One identified issue of concern is accommodating culturally and linguistically diverse students’ learning needs (ASHA, 2003). This issue of concern is critical in that it directly influences all of the above areas in which speech-language pathologists report feeling skillful in.

Approximately 98% of ASHA members report that they do not speak a language other than English (Whitmire & Eger, 2003). As cited previously, nearly one-fifth of
school age children in the United States speak a language other than English at home (U.S. Bureau of the Census, 2000). Specifically, 10.5% of the U.S. population speaks Spanish in the home. Despite this fact, only 0.6% of ASHA members report speaking Spanish (Deal-Williams, 2002). Similar to the plight of teacher preparation programs, the lack of diversity in the student body and teaching body in communication sciences and disorders graduate programs raises critical issues about the adequate preparation of all students to work with culturally and linguistically diverse populations (Whitmire & Eger, 2003).

These data confirm a continuation of the current critical shortage of speech-language pathologists prepared to provide services to students from diverse racial, ethnic, linguistic, and religious backgrounds. Further, the critical shortage of culturally and linguistically diverse speech-language pathologists, graduate students, and faculty members has implications for curricula, clinical training and professional development, research initiatives, and the knowledge and skills of practitioners (Whitmire & Eger, 2003). The field of speech-language pathology is lacking in the areas of: (a) exposure to culturally and linguistically diverse populations, (b) curricula and clinical training regarding diversity, and (c) research on culturally and linguistically diverse populations (Whitmire & Eger, 2003). Because a significant number of students with disabilities require speech-language services, ensuring a qualified pool of speech-language pathologists is crucial to the successful outcomes of these students served under the Individuals with Disabilities Education Act [IDEA] (U.S. Department of Education, 2001).
Racial/Ethnic Disproportionality in Special Education

African American students, particularly African American males, are overrepresented in special education programs (Osher et al., 2002; Skiba et al., 2002; Townsend, 2000). Reducing overrepresentation of culturally and linguistically diverse students (CLD) students in special education is hardly a new concern. Since the beginning of public schooling in the United States, African American children have been labeled, misclassified, and tracked relative to educational standing (Townsend, 2000). This is largely due to a combined result of inequitable resource allocations, the application of inadequately developed and normed intelligence and achievement tests, disproportionately inappropriate placements in special education classrooms and settings, and insufficient attention to the learning styles evidenced by many of the children (Epps, 1992; Hale-Benson, 1986, 1987; Hilliard, 1976; Myrdal, 1944; Townsend, 2002b).

African American and Hispanic children and adolescents have historically been overrepresented in classes for children with emotional and behavioral disorders and more so in classes for children with educable mental retardation (Townsend, 2000).

Each decade has witnessed overrepresentation of culturally and linguistically diverse and lower socioeconomic status children in these classes (Townsend, 2002a). African American students continue to be grossly overrepresented in these programs (Oswald, Coutinho, Best, & Singh, 1999; U.S. Department of Education, Office for Civil Rights (OCR), 1983, 1990), with one study indicating their representation in classes for the severely emotionally disturbed at least doubling their actual representation in the student population (Grossman, 1999). In the OCR’s 1992 survey of elementary and secondary schools, results revealed that African American males accounted for 8.23% of
the total school enrollment nationally, but accounted for more than twice that percentage in the categories of educable mentally retarded (EMR), trainable mentally retarded (TMR), and severely emotionally disturbed (SED). According to data from the 2000-2001 school year, African Americans comprise approximately 15% of the public school population, yet are approximately 20% of those identified as having a disability (U.S. Department of Education, Office of Special Education Programs (OSEP, 2001). Specifically, African Americans comprise nearly 34% of those identified with mental retardation and 27% of those identified with an emotional disturbance (U.S. Department of Education, OSEP, 2001). Researchers and practitioners have debated this issue for quite some time with varying results.

The issue of overrepresentation or disproportionality of students of color in special education first received national attention in the 1960s. In 1968, Dunn documented disproportionate numbers of African American, American Indian, Mexican American, and Puerto Rican students in classes for the mildly retarded in California. Assessments used inaccurately identified a disproportionate number of minority students as students in need of special education or unnecessarily segregated minority students in special education classes (Harry and Anderson, 1994). Several landmark court cases of the 1970s such as Diana vs. the California State Board of Education (1970), Johnson vs. the San Francisco Unified School District (1971), and the Larry P. vs. Riles case (1979) found many of the public schools’ assessment practices to be discriminatory (Daugherty, 2001).

Assessing students from culturally and linguistically diverse backgrounds has become one of the major issues in special education (Burnette, 2000). Similarly,
assessing these students also is a critical issue in speech and language pathology. The assessment process, which includes referrals to practitioners such as speech-language pathologists, has been under intense scrutiny. Flores, Lopez, and DeLeon (2000) note the shortage of personnel qualified to assess culturally and linguistically diverse students. They assert that the tools used to assess these students are insufficient.

In addition to the issue of disproportionality in special education, a second issue involves the 1997 amendments to IDEA’s requirement to involve parents and/or someone familiar with the student’s cultural and linguistic background as part of the assessment team (Burnette, 2000). Parents are vital members of the assessment team. They provide valuable information about the student that includes her or his cultural background and her or his funds of knowledge - how she or he functions in the home environment and community (Burnette, 2000). Involving parents and cultural brokers in the assessment process will ensure diagnoses that are more accurate and decrease the occurrence of misidentification.

A third issue centers on assessing students who are limited English proficient (LEP). Title VI of the Civil Rights Act of 1964 necessitates a language assessment of any student who may be limited English proficient. This includes assessing the student’s proficiency in both the English language and his/her native language. Doing so will assist the assessor with determining which language the child is most proficient in and whether a disability exists. Further, utilizing an interpreter in this process requires making sure that the interpreter understands the context and idea of the dialogues in order to translate the meaning of what was said in a correct manner (Burnette, 2000).

A fourth issue relates to the selection and use of tests and other assessment
IDEA ’97 mandates that tests and other assessment materials (a) are not selected based on a racial or cultural basis, making it discriminatory; and (b) are administered in the child’s native language or other means of communication, unless doing this is clearly not feasible. Burnette (2000) states that assessors should be careful to examine all formal tests used in the assessment process for cultural bias by a person from the cultural group. Moreover, only a person who is knowledgeable of a child’s cultural and linguistic background and who speaks that child’s language or dialect should administer the test (McLean, 2000). Testing situations that require modifications should be used only for descriptive information (rather than scores) because making modifications may invalidate the scoring of the test (Burnette, 2000). Incorporating informal tests, such as curriculum–based assessments, observations, interviews, and play-based assessments will yield vital information. The nature and cultural specificity of standardized tests prevent them from being the sole source of providing information. Thus, they should be used only as part of the assessment process (Burnette, 2000).

The misidentification of children of color as having a disability, such as a language disorder, is not the only dilemma that educators and related professionals face. In contrast to placing children without a disability into special education programs, many children with disabilities go unserved because of the difficulty of differentiating a disability from a cultural and linguistic difference (Burnette, 2000). Underidentification can occur when an evaluator makes the assumption that a child who belongs to a specific racial/ethnic group speaks the dialect connected with that group (Ortiz, 1997; Wilson, Wilson, & Coleman, 2000). Thus, differences revealed in the assessment may be attributed to dialect rather than errors (Laing & Kamhi, 2003).
In the context of the rapidly growing culturally and linguistically diverse student populations, Congress has called for greater efforts to ensure that these students are accurately classified and appropriately placed. IDEA was reauthorized, in part, to address race-based disproportionality in special education programs. The IDEA ’97 amendments include specific provisions that require states to provide for the collection and examination of data to determine if significant disproportionality based on race is occurring in the state with respect to the identification of children as children with disabilities and the placement in particular educational settings of these children.

Although federal law mandates data collection and examination to determine race-based disproportionality, no specific remedies are suggested to correct disparities (Paolino, 2002). In the 25 years since the passage of Public Law 94-142, largely, the problem of disproportionality remains (Daugherty, 2001). In fact, African American students are two to four times more likely than their White counterparts to be identified for special education services (U.S. Department of Education, Office for Civil Rights, 1998).

The current multicultural education movement, led primarily by people of color, surfaced primarily in the 1960s and was a response to cultural deprivation theory (Ogbu, 1992). Bullock (1970) and Ogbu (1978) further state that prior to the emergence of this movement, African Americans objected to a differential and inferior curriculum; they desired a curriculum similar to what was available to Whites. Currently, multicultural education is associated with cultural diversity (Yee, 1991 as cited in Ogbu, 1992). Both terms are frequently used interchangeably. The demand for multicultural education is not only for ethnic minorities who are experiencing school failure, but also for those who are experiencing success (Ogbu, 1992). Although various models of multicultural education
exist (Ogbu, 1992), multicultural education as a whole cultivates pride in ethnic minority cultures, helps culturally and linguistically diverse student learners to develop new insights into their cultures, diminishes prejudice and typecasting, and encourages intercultural understandings (Rubalcava, 1991). Thus, multicultural education is beneficial for the majority culture as well.

The vital question, is, does multicultural education make a positive impact on the academic performance of culturally and linguistically diverse student learners (Ogbu, 1992)? According to Ogbu (1992), rarely do current models of multicultural education address this important question. However, Gibson (1976 as cited in Ogbu, 1992) suggests two exceptions, bicultural education and culturally responsive instruction. The objective of bicultural education is to generate student learners who have the knowledge and skills necessary to operate successfully in two different cultures (Gibson, 1976). According to Gibson (1976, p. 7), the goal of “education of the culturally different or benevolent multiculturalism” is to ensure equal educational opportunities for students who are culturally different.

Some researchers believe that many culturally and linguistically diverse students may be unsuccessful in school because the differences that they bring—cultural, social, and/or linguistic—are unrecognized, devalued, or misunderstood (Kea & Utley, 1998). Wilson-Oyelaran (1996) states that the way cultural differences are handled is discouraging and the determining factors for those differences result from the way power is distributed in this country. Gender, socioeconomic status, race, and language used in the home affect how we perceive differences. These factors classify differences into two categories, those that are valued, and those that are not.
The prevailing philosophy of schooling uses traditional methodology and support in adopting White middle-class ways (Hollins & Spencer, 1990; Irvine, 2003). Traditionally, the standard language, standard American history, and the voices and lives of White men are solely visible in the curriculum. This hegemonic approach further disenfranchises culturally and linguistically diverse students who have historically been disenfranchised through life experiences prior to entering school (Banks, 1989, 1994).

Culturally and linguistically diverse student learners demonstrate a variety of levels of functioning within the context of the school culture; many are acculturating to the U.S. public school system while simultaneously learning the English language (Brice, 2001). Often, differentiating between a disability or difficulty because of acculturation and language learning is complex for teachers (Brice, 2001). Similarly, school-based speech-language pathologists have the challenging responsibility of providing services to English language learners; particularly when they are monolingual and only speak English (Brice, 2001). The act of code switching (i.e., mixing two languages in the same sentence or paragraph; Brice, 2001) is a natural second language phenomenon and does not constitute a language disorder (Brice, 2001).

Traditionally, the term “language minority” has often been used to refer to individuals who speak languages other than English. However, there is justification to apply this designation to populations who speak vernacular varieties of English as well, including African American Vernacular English (AAVE) (Adger, Wolfram, Detwyler, & Harry, 1993). Similar to other language minority students, speakers of AAVE often find their indigenous language systems in conflict with the schools’ language ideals. According to Adger et al. (1993), there is a fundamental education and sociopolitical
parallel in the conflicts that can take place between the indigenous language of the
community and the mainstream language used as the standard of instruction in schools.
An assumption of language disorder rather than language difference results in the
propelling of these students in disproportionate numbers toward special education and
related services (Adger et al., 1993; Christian, 1997).

Delpit (1995) contends that culturally and linguistically diverse student learners in
the American educational system endure a “second-culture” that often appears foreign
and dominating to them. These bicultural and bilingual students must leave their dialects
and native languages outside of the classroom or therapeutic environment. Teachers often
teach “second-culture” skills and knowledge in the classroom from a moral standpoint
rather than as pragmatic skills for survival and success within the dominant mainstream
society (Banks, 1989). Culturally conventional ways of acting, speaking, and writing
represent a language of “culture and power” that students of color should achieve to
ensure success within the mainstream society (Delpit, 1995, p. 24). Children who are
socialized in ways that differ from school expectations and patterns have the difficult task
of making daily adjustments to the school culture and her/his teachers (Meyers, Torres, &
Walker, 2000). More specifically, Hale-Benson (1986) calls attention to the additional
burden these adjustments place on Black student learners: Black children must possess
the ability to imitate the acceptable behaviors of the culture in which they live and at the
same time acquire those behaviors that are deemed necessary to be upwardly mobile.

Teachers as well as speech-language pathologists must place an emphasis on
classroom interactions, inclusive of the language and communications used, to ensure
that students will learn to communicate effectively within the school environment (Brice,
Schools can teach students of color their culture of language and power through the process of code switching. Students can learn the pragmatically appropriate way to act in certain situations such as job interviews, public speaking, formal writing activities, and college entrance interviews while still receiving affirmation of their own cultural mores and language use with family and peers.

Teacher/practitioner perceptions and expectations.

Research has demonstrated a direct link between the way that teachers view their students in the classroom, the way students view themselves, and the way they perform (Rosenthal & Jacobson, 1968, 1992). Rosenthal and Jacobson (1968) conducted this well-known experiment that took place at an elementary school. Certain students were selected and placed at random into either the control group or the experimental group. Teachers were led to believe that the students in the experimental group had the potential of showing signs of a spurt in intellectual growth and development as opposed to the students in the control group. Results revealed that the first-grade students in the control group demonstrated a gain of 12 IQ points, whereas their peers in the experimental group showed a gain of 27.4 IQ points. By and large, students in the experimental group (representing grades first through sixth) demonstrated a 12.22 point gain, whereas the control group exhibited an 8.42 gain. It is apparent that the group expected to perform better did so. Thus, what teachers (and related professionals) believe, perceive, say, and do can positively or negatively affect a student.

Research centered on self-fulfilling prophecies is not new to education. The phrase “self-fulfilling prophecy” was first introduced by sociologist Robert K. Merton (1948). When developing this term, Merton (1948) borrowed from the theorem “If men
define situations as real, they are real in their consequences” (Thomas, 1928, p. 257).

Tauber (1998) provides a brief explanation of self-fulfilling prophecy:

- The teacher develops expectations.
- The teacher behaves in a certain manner based upon these expectations.
- The teacher’s behavior towards each student tells each student the teacher’s expectations/achievement for that student.
- The consistent patterns of the teacher’s behavior will mold the student’s behavior, achievement, and expectations for his or herself.
- As time passes, the student’s behavior and achievement will align more closely with the teacher’s expectations of him or her.

Rosenthal conducted his first studies in the late 1950s. In the book, *The Pygmalion Effect*, Rosenthal and Jacobson (1968) illustrate many convincing studies that propose our expectations directly influence those around us. Also known as the self-fulfilling prophecy, the Pygmalion effect is the idea that a person’s expectations about an individual can ultimately lead that individual to act and achieve in a manner that confirms those expectations (Brehm & Kassin, 1996). These expectations may range from the members on our bowling team to the students in our classrooms (Rhem, 1999) (or on our caseloads). Studies of this type are not limited to the field of education. Studies conducted outside of education document the Pygmalion effect in laboratory animals as well. Researchers with the preconceived notion that one group of white rats is more capable than another group end up with results that match these beliefs “to a degree that defies random chance” (Rhem, 1999, p. 4). As noted by Rhem (1999, p. 4), “Indeed, it would appear that we communicate something vital and undisguisable about our attitudes
toward students and teaching in ways that transcend ordinary language.” Rosenthal and Jacobson’s (1968) book did receive criticism from educational psychologists when it first appeared. This may be the result of people’s unwillingness to face disturbing facts that reveal a problem but does little in providing a solution (Rhem, 1999). Rosenthal candidly admits to not knowing how to handle the research findings. However, one point is for certain, the moral implication in his data is clear: If a teacher is absolutely certain about a student’s inability to learn, then that teacher should leave the classroom. According to Rhem (1999, p. 4), “Superb teachers can teach the unteachable.”

Research further suggests that teacher perceptions and expectations differ with the race and socioeconomic status of students. Winfield (1986) conducted a study that included a sample of five inner-city elementary schools in a major metropolitan school district. All of the schools within this district served predominantly children of color and low-SES children from the nearby neighborhoods. Forty elementary teachers, eight per school, were selected to be interviewed utilizing a semi-structured interview guide. Initially, teachers were selected to signify potentially different perspectives within the school organization (i.e., “effective and non-effective” teachers). Teachers were referred by their respective principals, reading specialists, or union representatives, new to the school, and veteran teachers who had been in the school setting. All teachers interviewed taught in classrooms where African American students represented the majority (98% - 100%).

The participating elementary schools were examined over the period of one year utilizing case study methodology. Case study narratives on each school were developed from data collected. Narratives reported on the school’s historical and community
context, the orientation of the principal, reading teachers, and teachers in general, and a study of the schoolwide instructional organization for reading. Case study narratives also included data based on teacher beliefs. Data collected from teachers’ verbal responses were obtained in interviews and analyzed using a cross-classification analysis (Patton, 1980). Teachers interviewed varied according to race, average length of service, and grade level taught; however, these characteristics were not salient in the analysis.

The cross-classification analysis uncovered four diverse types of teachers: (a) tutors, (b) general contractors, (c) custodians, and (d) referral agents. “Tutors” and “custodians” were found to assume the responsibility for improving instruction while “general contractors” and “referral agents” tended to shift the responsibility to others. Teachers labeled “tutors” specified the responsibility was theirs to provide instruction to the bottom reading group in order to improve reading achievement (e.g., “I work with the low group approximately 20 minutes daily to reinforce skills”). Teachers labeled “general contractors” believed that remedial instruction was essential, but not necessarily their responsibility (e.g., “I send my bottom group to the Title (Chapter I) aide” or “We have a district-funded supplementary remedial program for low achievers”). Teachers labeled “custodians” indicated there was not much, if anything, that could be undertaken to improve the academic proficiency of “at-risk” students (e.g., “A few will be on grade level, but the other students will just get passed on”). Their primary focus was the maintenance of low-performing students. The difference between the “custodian” teachers and those labeled “referral agents” is that “custodians” assume responsibility while referral agents believe the responsibility of maintenance belongs to someone else. Further, unlike “general contractors” who also shift responsibility, “referral agents”
believe “at-risk” students were unable to learn in the general classroom and frequently referred students for psychological testing or special education.

Overall, Winfield (1986) found that teachers’ expectations are conveyed using specific classroom behaviors and practices that vary significantly for high versus low-expectation students. Further, teachers’ expectations are formed by their personal belief systems, which are influenced by prior experience with and exposure to diverse students, teachers’ role definition, awareness of appropriate techniques, and available support services. They often see African American students from working class or lower socioeconomic families as unable to perform high quality academic work (Winfield, 1986). Teachers typically expect more from their White students than from their African American students. They expect more from middle-class students than they do from students whose families represent working class or lower socioeconomic status (Farkas, 1996; Roscigno & Ainsworth-Darnell, 1999; Winfield, 1986). Additionally, teachers have a tendency to react more positively to higher-achieving students, to females, to attractive children, to conforming children, to higher SES children, to those who sit closest to him/her in proximity, and to those who are not members of ethnic minority groups (Good, 1981; Proctor, 1984). The most salient characteristics that tend to create negative expectations are those connected to race and social class.

Consequently, these negative expectations apparently may result in preferential treatment against poor and ethnic minority student learners (Solomon, Battistich, & Hom, 1996; Casteel, 1998; Rist, 1970; Leacock, 1969). Casteel (1998) examined the treatment of African American and White students in middle schools by White female teachers during 32 hours of instruction in integrated classrooms. Results revealed that African
American students as a whole were not treated as favorably by their White female
teachers as were their White peers. According to almost all 16 dependent variables of an
adapted form of the Brophy—Good Dyadic Coding system, teachers interacted more
positively with the White students than they did with the African American students.

Solomon et al., (1996) used questionnaires to assess the attitudes, beliefs,
perceptions, and classroom practices of 24 teachers employed in urban and suburban
elementary schools throughout the U.S. The study was conducted over an entire school
year. Results revealed that teachers in urban schools working with children from lower-
SES families place more emphasis on teacher authority and control and less emphasis on
student autonomy and constructivist than undertaken in other schools. Further, these
same teachers of students from lower-SES families were less trusting of students and
more doubtful of their skills. Teachers’ beliefs consistently aligned with their practices,
although school poverty and students’ mean achievement levels were statistically
controlled. Such negative perceptions toward culturally and linguistically diverse students
lower expectations for achievement, which subsequently lower achievement (King &
Ladson-Billings, 1990). King and Ladson-Billings (1990) relate the following story:

Our student teachers complete two assignments in schools serving different
populations. One of our students (whom we’ll call Cindy) encountered a sad
example of a resident teacher’s lack of multicultural competence last year in an
‘exemplary’ elementary school in a predominantly White, affluent community.
(The US Secretary of Education identified this school as one of the finest in the
nation and the resident teacher was recommended as an ‘excellent’ teacher.) The
resident teacher, Ms. Barker, (not her real name) told Cindy there were two kinds
of Black students in the class: ‘black-Blacks’ and the ‘white-Blacks’. She explained that the ‘black-Blacks’ were ‘behavior problems’ and were less ‘capable intellectually’ than the ‘white-Blacks’ because they don’t have White values’. The students Ms. Barker called ‘white-Blacks came from middle-income professional homes and their appearance and demeanor closely resembled that of middle-class White students. (p. 17)

According to Diamond, Randolph, and Spillane (2004), teacher expectation research seldom examines teachers’ assessments of students in organizational contexts. The literature is replete with evidence that indicates the impact of school contexts on school and classroom reproductive practices (Anyon, 1981a, 1981b, 1981c; Bankston & Caldas, 1996; Bowles & Gintis, 1976; Roscigno, 2000, 1998; Roscigno & Ainsworth-Darnell, 1999). However, the literature on teacher expectations usually stresses the interactions between a teacher and his or her students (Diamond, et al., 2004). Studying teachers’ expectations also can be accomplished by exploring teachers’ sense of responsibility for student scholarship (Lee & Smith, 2001).

Diamond et al., (2004) conducted a study focused on teachers’ expectations and sense of responsibility for student learning. These researchers conducted ethnographic research in five urban elementary schools. The research included participant observation and semi-structured interviews. Utilizing the Non-numerical, Unstructured Data Indexing, Searching and Theorising (NU*DIST) (Fielding & Lee, 1993) computer program for qualitative data analysis and theorizing, the researchers documented instances when teachers and administrators expressed beliefs about students. They coded these beliefs as assets, deficits, or neutral statements. Responses that emphasized
students’ strengths were coded as asset oriented. The researchers borrowed from the earlier work of Farkas, Grobe, Sheehan, and Shaun (1990) by emphasizing cognitive and noncognitive assessments of students. Asset-oriented cognitive assessments highlighted behavioral characteristics such as maturity, responsibility, high work ethic, and the ability to work well with other students (Diamond et al., 2004). Asset-oriented noncognitive assessments emphasized students’ reading and computation ability at high levels, higher-order thinking skills, master coursework, and perform well on standardized tests. Responses that were coded as deficit-oriented usually suggested that these students did not exhibit the above characteristics and skills (Diamond, et al., 2004).

Diamond et al., (2004) subsequently looked at patterns at each school. They were particularly interested in the demographic makeup of the student population. Once themes for each school were identified, categories were established based on the nature of responses for each teacher/administrator. Data were aggregated and compared across individuals and the schools.

Data revealed that the race and class composition of the schools that were studied is related to the general beliefs that teachers and administrators have of their students (Diamond et al, 2004). Asset-oriented beliefs were stressed over deficits in White majority and Chinese majority schools. Deficit-oriented beliefs were emphasized in schools where the student population was majority African American and from low-SES families. Data further established that teachers’ sense of responsibility for student learning was higher with the students they perceived to have a surplus of learning capital. When teachers demonstrated a lower sense of responsibility, they believed that students’ lack of motivation, family background, and limited skills hindered their teaching abilities.
Remarkably, there is a limited number of studies on the beliefs and decision-making of speech-language pathologists (Kritikos, 2003). Like teachers, speech-language pathologists make numerous and quick decisions during the service delivery process (Kritikos, 2003). Two studies confirm that speech-language pathologists consider beliefs to be a significant factor related to clinical expertise. Kamhi (1994) asked speech-language pathologists to describe factors they believed to be important to conducting effective therapy. Respondents described four aspects: knowledge, technical skills, interpersonal skills, and “clinical philosophies” (i.e., beliefs). In a similar study, Kamhi (1995) found that speech-language pathologists rated interpersonal/attitudinal factors (e.g., rapport, confidence, and interest) as more vital than technical factors (e.g., diagnosis, treatment).

The socialization process helps to shape professionals’ beliefs, values, and behaviors (Rios, 1996). Professionals’ personal and professional experiences and membership in microcultural groups (e.g., class characteristics, religious beliefs) influence their customs, decision-making, and knowledge and beliefs regarding assessment and therapeutic intervention (Kritikos, 2003). These beliefs influence service practices, which in turn, influence client behavior and client outcomes (Kritikos, 2003; Porter & Brophy, 1998).

Culturally Responsive Practice

The power that educators possess can disable or empower culturally and linguistically diverse students with and without disabilities (Kea & Utley, 1998). Culturally responsive instruction draws on students’ cultures as essential sources of their education (Kea & Utley, 1998). If African American and other culturally and
linguistically diverse students are to experience academic achievement at a rate that is comparable to their White counterparts, the schooling process must be reorganized in ways that promote and support cultural inclusion (Hollins & Spencer, 1990). A culturally responsive teaching force may decrease the incidence of mislabeling that can lead to the overrepresentation of culturally and linguistically diverse students in special education programs (Ewing, 1995) and their underrepresentation in programs for the gifted and talented (Ford, 1996). Similarly, culturally responsive speech-language pathologists may decrease the incidence of misidentification as a result of therapist-centered practices.

The identification process may vary across school districts. However, general similarities exist. Once a referral is made, speech-language pathologists informally screen the student in question. If the screen results in recommendations for a formal evaluation, parental permission is obtained. The speech-language pathologist then proceeds with a full battery of tests to assess the student’s articulation, language, reading, and overall communication skills. Often, speech-language pathologists have the responsibility of screening all incoming kindergarteners without any referrals. Historically, tests used have not been representative of the student population.

While considerable strides have been made in recent years to develop a number of alternative assessment procedures that reduce some of the biases inherent in norm-referenced standardized tests, problems persist (Laing & Kamhi, 2003). These problems have been well documented (Brice, 2002; Washington & Craig, 1992; Wilson, Wilson, & Coleman, 2000). The three most familiar problems are content bias, linguistic bias, and disproportionate representation in normative samples.

Content bias takes place when test stimuli, methods, or procedures used result in
the assumption that all children have been exposed to identical concepts and vocabulary or have had comparable life experiences (Laing & Kamhi, 2003). Children from culturally and linguistically diverse backgrounds may not do as well on standardized measures in comparison to their mainstream peers because of differences in life experiences, socialization practices, and early literacy experiences (Stockman, 2000).

Linguistic bias refers to one or all of the following: (a) the discrepancy between the language or dialect used by the examiner, (b) the discrepancy between the language or dialect used by the child, and (c) the language or dialect that is anticipated in the child’s responses (Laing & Kamhi, 2003). For example, if an examiner who uses Standard American English (SAE) assesses a child who uses African American Vernacular English (AAVE), the examiner may arrive at inaccurate results because of a mismatch between the child’s dialect and the dialect of the testing instrument (Laing & Kamhi, 2003). Overidentification of culturally and linguistically diverse children has been the most prevailing problem, ascribing errors to dialect differences. Underidentification also can occur when a test examiner makes the assumption that a child who belongs to a specific racial/ethnic group will speak the dialect associated with that group (Wilson et al., 2000).

Traditionally, norm-referenced standardized tests have not included culturally and linguistically diverse populations in their normative samples. More recently, test developers have included proportions that are more representative of diverse populations in the normative sample (Laing & Kamhi, 2003). However, including these children in the normative sample does not automatically solve the issue of over- or underidentification of culturally and linguistically diverse children with language
disorders (Laing & Kamhi, 2003). Simply making adjustments to the normative sample to represent culturally and linguistically diverse children correctly may do nothing more than reduce the mean distribution of the normative sample. These children will still demonstrate language skills below the mean, but within normal age limits (Laing & Kamhi, 2003). Laing and Kamhi (2003) suggest the only way to ensure that bias does not occur may be to design an instrument specifically for culturally and linguistically diverse populations.

Furthermore, speech-language pathologists’ beliefs about the assessment process may differ based on different personal and professional experiences. The degree of experiences with and knowledge of other language and culture also is a major factor in assessment beliefs (Kritikos, 2003). For example, these experiences may influence a speech-language pathologist’s beliefs about how to interpret and gather assessment data (Kritikos, 2003). More specifically, speech-language pathologists may vary in their beliefs about (a) the clinical significance they place on a child who has bilingual input (on language acquisition) at home and (b) the value they place on using interpreters (Kritikos, 2003). These beliefs may in turn lead to the overidentification and underidentification of language disorders. For example, bilingual children with normal language ability, but limited English proficiency (LEP) are sometimes referred for speech-language intervention, whereas those whose language skills are interpreted to be resultant of a limited English proficiency are sometimes overlooked for justifiable speech-language intervention (Kritikos, 2003). Errors in the identification and assessment process may do severe injustice to bilingual children (Bogatz, Hisama, Manni, & Wurtz, 1986).
In a study conducted by Roseberry-McKibbin and Eicholtz (1994), 82% of speech-language respondents stated that they used an interpreter with children and families who spoke a language other than English as their primary language. Results revealed that 39% of the respondents experienced difficulty with the availability of an interpreter. Furthermore, 29% of the respondents disclosed that they used the services of bilingual speech-language pathologists for languages the respondents did not speak. Respondents also acknowledged that the difficulties they faced consequently affected therapeutic intervention.

In 2001, Roseberry-McKibbin, Brice, and O’Hanlon (in press), sent out a similar survey to K-12 public school speech-language pathologists. Recognizing that the previous survey is now outdated, they modified it by adding a few new questions; it has mostly identical questions. Subsequently, these researchers analyzed a total of 1,736 returned surveys and compared the results to the 1990 survey.

In 2001, more speech-language pathologists reported having English language learner (ELL) students on their caseloads. In 1990, 49% of ELL students received services by survey respondents for language disorders. Remarkably, 91% of ELL students received services by survey respondents for language disorders in 2001. The ELL population demonstrates a growth of 105%, whereas the general population demonstrates a growth of only 12% since the 1990-91 school year. The results of both surveys revealed that the most commonly represented racial/ethnic group on respondent’s caseloads was “Hispanic,” followed by “Asian.”

Respondents in both surveys were asked if they spoke a language other than English with adequate proficiency to provide clinical services to students who spoke that
language. In 1990, only 10% of respondents reported being proficient in speaking a
language other than English. In 2001, this number rose to 12%. Despite national efforts
by the American Speech, Language, and Hearing Association (ASHA) for more bilingual
speech-language pathologists, not much had changed in 11 years (Roseberry-McKibbin
et al., in press).

Respondents in both surveys were asked to indicate what specific challenges they
encountered the most in assessing and treating ELL students with communication
disorders. In 1990 and 2001, respondents reported that the foremost challenge was not
being able to “speak the language of the student.” The second challenge reported on both
surveys was “lack of less biased assessment instruments,” and the third challenge was
“lack of other professionals who speak students’ languages.” Remarkably, the challenges
reported by respondents in both 1990 and 2001 were nearly identical in order of
occurrence, indicating that not much had changed in 11 years in these specific areas
(Roseberry-McKibbin et al., in press).

One encouraging finding was the increase in respondents who indicated that they
received coursework addressing service delivery to ELL students. In 1990, 76% had not
received any coursework in this area. However, only 27% of respondents in 2001 had not
received any coursework addressing service delivery to ELL students. This finding
indicates that more universities are addressing part or all of a course to issues in service
delivery to ELL students (Roseberry-McKibbin et al., in press).

Respondents in both surveys were asked to rate a list of continuing education
training/inservice topics that addressed services to ELL students with communication
disorders in the order of importance. One newly added topic (not asked in the 1990
survey) was less biased methods and materials for differentiating between a language
difference and a language disorder. This was the area of greatest (77%) interest for the
2001 respondents, reporting that they were “quite” or “extremely” interested in this topic
(Roseberry-McKibbin et al., in press). In both 1990 and 2001, respondents (81% and
77%, respectively) rated “general assessment procedures and materials” as very
important. In 1990, 77% of respondents reported a great deal of interest in “treatment
procedures and materials.” Responses in the 2001 survey were similar (72%) regarding
interest in this area (Roseberry-McKibbin et al., in press). In both surveys, “effects of
bilingualism on language learning” was the next area of interest reported by respondents.
This was followed by “second language acquisition” and “first/primary language
developmental norms” (Roseberry-McKibbin et al., in press).

Respondents in both surveys were asked to rank order the importance of supports
needed to prepare speech-language pathologists to serve ELL students with
communication disorders. Respondents (85% for both) in the 1990 and 2001 surveys
reported that the most preferred service delivery format was “more seminars and
workshops offered by school districts.” This was followed by “more coursework at the
university level”, 82% and 76%, respectively (Roseberry-McKibbin et al., in press). In
1990, 63% of respondents reported that more continuing education opportunities should
be provided at the state level and national convention; in 2001, 64% of respondents
ranked presentations at the national convention as important (Roseberry-McKibbin et al.,
in press). Finally, 1990 (52%) and 2001(50%) respondents indicated that “more journal
articles in this area” were important (Roseberry-McKibbin et al., in press).

Vafadar and Utt (1993) surveyed 50 speech-language pathologists’ beliefs about,
self-perceived understanding of, and expertise in dealing with social dialects as they relate to language differences and language disorders. Utilizing a telephone survey, respondents were selected at random from a membership directory of a southern state’s speech-language-hearing association. Respondents’ attitudes about providing therapeutic intervention to speakers of social dialects were in the low to average range. Further, they rated themselves as being average in the understanding of and expertise in dealing with issues related to social dialects. The respondents’ self-rating of their own understanding and expertise as average implies that a need for improvement exists in the area of social dialects, including culturally responsive assessment of and intervention for these individuals (Vafadar & Utt, 1993).

It is imperative that classroom teachers and related professionals affirm, embrace, and value the cultural backgrounds that each student brings to the classroom. There is a critical need for these professionals to be responsive to the needs of all students. Speech-language pathologists must recognize the need to expose students to treatment and intervention strategies based on multicultural/diverse perspectives. Such instruction is not limited to a European-American perspective (Duff & Tongchinsub, 1990). Banks (1990) defines multicultural perspective instruction as comprising three different dimensions.

These important dimensions are related to content integration, knowledge construction, and an equity pedagogy. Content Integration involves accurate, non-biased curricular content that represents various cultures and groups. Stated differently, the culturally responsive practitioner integrates examples and content from various racial, ethnic, and cultural groups to demonstrate curricular concepts, principals, and theories (Banks, 1994).
Ladson-Billings (1994) illustrates this in the following two class scenarios. In a primary classroom, the teacher reads Cinderella, an American classic story, to the class. However, he/she reads several versions of the story. One is the familiar European tale as told by the Brothers Grimm, but the other versions are Chinese, Egyptian, and Zimbabwean. Speech-language pathologists often utilize the following higher-order thinking strategy of convergent and divergent classification. Like the classroom teacher, they would assist the students with comparing and contrasting the similarities and differences among the different versions. Similarities comprise the story construction, plot development, moral and ethical dilemmas, and the use of magic. Dissimilarities include varying standards of beauty, settings, use of language, and particular characters. In this way, the students take in the importance of understanding cultural differences and similarities (Ladson-Billings, 1994).

In an intermediate social studies class, students learn about the African slave trade. However, this lesson is not primarily from the perspective of European traders. The students also are engaged in reading a range of primary documents such as the slave narrative called *The Interesting Life of Olaudah*. This particular piece compares slavery in Africa with slavery in the Americas. Additionally, the teacher introduces information about the European feudal system. Further, the students compare the lives of enslaved people in Africa, the Americas, and medieval Europe. Finally, students create critical thinking and higher-order questions, such as, What is the relationship between slavery and racism? How could a nation firm on achieving equality and justice permit slavery? Why did some people in Africa participate in the slave trade? In addition, how does the textbook’s treatment of slavery compare to primary source material?
Knowledge Construction entails assisting students to view concepts, issues, and problems from diverse cultural perspectives as they construct knowledge about the content. Stated differently, the culturally responsive practitioner assists students with constructing knowledge and understanding the exchanges and contributions of diverse populations to U.S. culture and civilization (Banks, 1994). Unlike traditional trends, the mainstream-centric perspective is only one of several perspectives from which concepts, issues, or problems are viewed. The above case scenarios also are examples for this category.

An Equity Pedagogy includes teacher-modified instruction to ensure equity for all students. Here, educators modify their teaching in ways that will facilitate the successful academic achievement of students from diverse racial, ethnic, cultural, gender, and social-class groups. The culturally responsive teacher (practitioner) guarantees equity in pedagogy by utilizing instructional approaches that match with students’ cultures, behaviors, and cognitive styles, and empowering school cultures to ensure educational equity and advance social justice and equality (Banks, 1994). Ladson-Billings (1994, p. 24) states that for some teachers, “ensuring an equity pedagogy may be as simple as using more cooperative learning strategies in class” because it was initially developed as a way to create more equitable classroom environments (Cohen & Benton, 1988; Slavin 1987). Other teachers may have to use the language and understandings their students bring with them to school in order to bridge the gap between school and home, what they know versus what they need to learn (Au & Jordan, 1981; Erickson & Mohatt, 1982; Jordan, 1985).

Teachers may benefit from learning a student’s language and providing
instruction in both English and that first language. Likewise, speech-language pathologists may benefit from providing therapeutic instruction in English and their students’ native languages. This can make the classroom/resource room a welcoming and psychologically safe environment for speakers of other languages (Hornberger, 1988).

The use of multicultural/diverse perspective instruction broadens students’ views, builds self-esteem, and improves academic performance (Banks, 1989). When students are presented with various views of the world, they gain insight into their own behaviors (Banks, 1989). Curricular content that prepares students to live in a pluralistic society enhances the self-esteem of diverse students by assisting them with retaining and valuing their cultural identities (Grant, 1974). When multicultural/diverse perspective instruction is incorporated into classrooms, students develop problem-solving, reasoning, and higher-order thinking skills.

Culturally responsive practitioners perceive culture and its influence from multiple dimensions. They avoid the use of stereotypes and view all persons as individuals (McIntyre, 1996b). In these classrooms, students learn there is more than one appropriate answer or correct way to perceive an event, more than one valid point of view, and more than one set of cultural mores. This classroom experience facilitates their evaluation and analytical skills.

Self-Efficacy

According to Bandura (1977), an individual’s confidence in her/his own ability to perform a specific task successfully will determine the degree or likelihood of her/him actually performing the task. In this seminal work, Bandura (1977) presents an integrative theoretical framework to clarify and determine psychological changes achieved by
varying forms of treatment. According to this theory, psychological procedures modify the strength and degree of self-efficacy. In this proposed paradigm, expectations of personal efficacy are drawn from four chief sources of information: performance accomplishments, vicarious experience, verbal persuasion, and physiological states. Perseverance in activities that an individual views as intimidating generates, through experiences of mastery, a greater enhancement of self-efficacy. Findings are reported from microanalyses of enactive, vivid, and affecting methods of treatment that sustains the hypothesized correlation between perceived self-efficacy and changes in behavior.

Teaching Efficacy

Teacher efficacy research initially grew out of two items that was developed by RAND researchers (Armor et al., 1976) when teacher efficacy research was still in its infancy stage (Henson, 2002). Supported by a locus of control theory, these RAND Items (Armor et al., 1976) stated the following:

- Item 1: A teacher is unable to do a great deal because the majority of a student’s motivation and achievement is dependent on that student’s home environment.

- Item 2: If I try hard enough, I can motivate even the most challenging or problematic student.

The purpose of these items was to determine whether a teacher thought that he or she controlled student learning and motivation, which are inferred teacher reinforcers (Henson, 2002). During the late 1970s and early 1990s, these items were the guiding force of most teacher efficacy research (Henson, 2002).

Gibson and Dembo (1984) responded to concerns about construct definition and
score reliability of measurement with only two items (Henson, 2002). They developed an instrument to gauge teacher efficacy, provide construct-related validation support for the variable, and explore the relationship between teacher efficacy and observable teacher behaviors (Gibson & Dembo). They reasoned that the RAND Items each reflected dimensions of Bandura’s (1977) social cognitive theory (Henson, 2002). Specifically, RAND Item 1 was perceived to measure an outcome expectancy regarding a teacher’s belief about whether teaching in general has an effect on student learning regardless of external influences. RAND Item 2 was perceived to measure self-efficacy (Henson, 2002). According to Henson (2002), outcome expectancy and self-efficacy are two theoretically independent constructs. These constructs were subsequently named general teaching efficacy (GTE) and personal teaching efficacy (PTE), respectively (Henson, 2002).

In their study, Gibson and Dembo (1984), elementary school teachers responded to a 30-item Teacher Efficacy Scale (TES). Factor analysis of these responses produced two significant factors that were consistent with Bandura’s two-factor theoretical model of self-efficacy. Utilizing a multitrait-multimethod analysis that supported both convergent and discriminant validity, data were analyzed from teachers on three traits: teacher efficacy, verbal ability, and flexibility across two methods of measurement. Results identified differences between high and low efficacy teachers in time spent in whole class versus small group instruction, teacher use of criticism, and teacher lack of persistence in failure circumstances based on classroom observation data related to academic focus and teacher feedback behaviors.
Individuals’ beliefs about their abilities and the result of their efforts strongly influence their behaviors (Guskey, 1988; Soto & Goetz, 1998). Guskey (1988) designed an exploratory study to examine the relationship between selected teacher perceptions that past research has shown to be shared by highly effective teachers and teacher attitudes toward the implementation of novel instructional practices. In this study, data were gathered utilizing a questionnaire administered to 120 elementary and secondary school teachers. Participants received the survey directly following a one-day staff development program on mastery learning instructional strategies. Results revealed that measures of teacher efficacy, teaching affect, and teaching self-concept were notably related to teachers’ attitudes regarding the congruence, complexity, and significance of the recommended practices.

Furthermore, these beliefs influence decisions and the way individuals proceed with these decisions. Individuals will perform those tasks they feel competent in doing and will avoid all others. Individuals’ efficacy beliefs also will influence how much effort they place on a particular task and their persistence when confronted with adversity (Guskey, 1988; Pajares, 1996). High self-efficacy beliefs result in greater effort, perseverance, resilience, planning, and organization (Allinder, 1994; Guskey, 1988; Stein & Wang, 1988).

Stein and Wang (1988) investigated the relationship between teacher success in implementing innovative programs, teacher perceptions of self-efficacy, and teacher-perceived value of the programs. They used behavioral observations, interviews, and questionnaires to measure teachers’ performance, self-perceptions, and attitudes.
Teachers’ performance, self-perceptions, and attitudes were measured at numerous time points during the first year that an innovative adaptive mainstreaming program was put into place. Considerable increases were observed in both teachers’ levels of success and self-perceptions of self-efficacy.

Teachers who possess a stronger sense of self-efficacy are inclined to be more open to novel ideas (Guskey, 1988; Stein & Wang, 1988). They are more motivated to try out new methods to meet their students’ needs (Guskey, 1988; Stein & Wang, 1988). Furthermore, they are more likely to persevere in their attempts to work with students who are struggling (Gibson & Dembo, 1984). They are less likely to refer a challenging student to special education services (Meijer & Foster, 1988).

Meijer and Foster (1988) investigated relationships between teacher characteristics and their ratings of problem behavior and likelihood of referring students to special education services. The researchers conducted two pilot studies prior to the main study to establish usability of prereferral case materials and instruments. Pilot Study 1 involved 16 Dutch primary school teachers and focused on selecting appropriate cases with respect to both background information and case characteristics. Pilot Study 2 involved 25 Dutch second-grade primary school teachers and focused on testing and revising case materials and a questionnaire on these participants. Complete data sets obtained from 230 Dutch primary teachers were analyzed in the main study. Cases comprised a half-page (approximately 160 words) typed description of a second-grade student. The authors identified each student in terms of three characteristics: problem type (behavior, learning, or both); gender; and social background (high, medium, low). Other information in the case included a brief report of experiences in preschool and first
grade and most up-to-date consultation with a remedial educator who suggested more individualized services to focus on current difficulty. The authors assessed teacher characteristics using direct questions centered on specific demographic variables such as years of teaching experience, special education experience, gender, highest degree attained, parenthood, and experience teaching mixed grade classes. Teacher self-efficacy was measured using a modified version of the Dutch Teacher Self-Efficacy scales (Span, Abbring, & Meijer, 1985).

Using the work of Gibson and Dembo (1984), 15 Likert-type items were constructed around teacher-reported ability to handle challenges in the classroom. The final scale, containing 11 items on a 4-point Likert-type scale, represented the highest item-total correlations. Reducing the items from 15 to 11 resulted in an alpha coefficient of .63 for the total scale scores. Correlations between the independent variables, teacher and student characteristics, and the dependent variables (problem and referral chance) were computed. A multiple analysis of variance (MANCOVA) confirmed teacher self-efficacy to be a statistically significant predictor of both problem ratings and referral chances. Results revealed that only student problem type (learning, behavioral, or both) was statistically significantly correlated with problem and referral chance. Regarding SES, referral chance was the only dependent variable to be statistically significant. Specifically, SES was negatively associated with referral chances. Also, higher self-efficacy scores were associated with lower problem and referral chance.

In contrast, individuals with low self-efficacy believe situations to be worse than they really are, often resulting in stress and subsequent depression (Allinder, 1994; Ashton & Webb, 1986; Guskey, 1988; Pajares, 1996). Allinder (1994) randomly selected
200 special educators from four Midwest states. The focus of this study was to explore
the relationship between efficacy and selected instructional variables for two categories
of special education teachers, direct and indirect service providers.

A direct service provider was defined as an individual who is “primarily
responsible for providing instruction or behavioral intervention or behavioral
interventions with students with special needs either by working with students
individually or in a small group for part of the students’ school day” p.88. An indirect
service provider was defined as an individual who “does not work directly with
individual students for the majority of their time” (Allinder, 1994, p. 88). Rather, this
individual works primarily in a collaborative or consultative relationship with general
education teachers (Allinder, 1994).

These special educators were asked to provide relevant demographic information
(i.e., years of general teaching experience, years of experience teaching special education,
years in current position, highest degree attained, the number of schools in which they
worked, and number of students of varying disabilities whom they served). Teachers
were additionally given the Teacher Efficacy Scale and the Teacher Characteristics Scale.
The latter scale, developed by Fuchs, Fuchs, and Bishop (1992) is an 18-item
questionnaire that asked teachers to respond to a 5-point Likert-Type scale (e.g., 1 =
*Strongly Disagree or Not at all* to 5 = *Strongly Agree or To A Very Great Extent*)
(Allinder, 1994). In previous research, internal consistency of the subset scores of this
scale ranged from .72 for teaching confidence to .92 for progressiveness and innovation
(Fuchs et al., 1992).

All teacher responses underwent factor analyses. Correlations between the two
dimensions of efficacy and the instructionally relevant variables were computed using responses from teachers who met the criteria for direct and indirect service provider. Finally, multiple regression analyses were performed using responses from this subset of respondents.

Significant positive correlations were found between personal efficacy and (a) Instructional Experimentation (motivation to try an array of materials and approaches to teaching, (b) Business-Like Approach (teacher’s degree of organization, ability to plan, and fairness), and (c) Assuredness (effective instructional components such as enthusiasm and upholding high levels of clarity during lesson presentations).

Scores were computed utilizing unweighted sums of teacher responses to the items for each type of efficacy. In order to have higher efficacy reflected by higher scores, items for teaching efficacy were inverted. Cronbach’s alpha coefficients were .76 for the personal efficacy scale scores and .56 for the teaching efficacy and scale scores. Cronbach’s alpha coefficients were .87, .73, and .77 for Instructional Experimentation, Business-Like Approach, and Assuredness scale scores, respectively. Because of these influences, beliefs of self-efficacy are strong determinants of the degree of accomplishments that individuals achieve (Ashton & Webb, 1986; Soto & Goetz, 1998).

**Personal and General Efficacy**

A greater sense of efficacy assists teachers with the ability to be less disapproving of students when they make mistakes (Ashton & Webb, 1986). Moreover, higher teacher efficacy appears to be associated with student achievement and affective growth that includes improved student motivation, increased self-esteem, and added positive attitudes toward school (Ashton & Webb, 1986; Soto & Goetz, 1998). Ashton and Webb (1986)
used Bandura’s (1977) cognitive theory of social learning to define teacher efficacy as the belief in one’s ability to make his/her students academically successful. These theorists separate teacher efficacy into two dimensions: (a) “personal teaching efficacy”—beliefs that one’s abilities can positively affect students academic achievement and (b) “general teaching efficacy”—beliefs that teaching can positively affect students’ achievement regardless of students’ environment or ability.

Further, Ashton and Webb (1986) stated the importance of personal efficacy. Specifically, they reported the significant relationship between high personal efficacy and high teacher success. In addition to personal efficacy, the literature reveals the importance of general efficacy. Guskey (1988) stated that a relationship between high general efficacy and high motivation to modify practices exists. Furthermore, Hoy and Woolfolk (1993) stated that personal efficacy and general efficacy comprise professional efficacy.

Kritikos (2003) conducted a study with the goal of comparing monolingual (M) and bilingual practicing speech-language pathologists’ beliefs about efficacy and language assessment of bilingual/bicultural individuals. Bilingual speech-language pathologists were categorized into two groups based on the contexts in which they acquired their two languages: (a) those that learned a language other than English at home, abroad, or in a native culture and (b) those that learned a language other than English through instruction in high school or college. The two groups were labeled cultural experience (CE) and academic study (AS) groups, respectively.

Participants included speech-language pathologists from states that had the highest proportion of individuals who spoke a language other than English in their
homes. The state of Florida, representing 17% of bilingual individuals at that time, was one of the six chosen states in this study. Only 101 speech-language pathologists who identified themselves as bilingual were available from the state of Florida (Kritikos, 2003).

Utilizing a questionnaire, participants were asked to respond to questions about their beliefs as they relate to three domains of assessment: personal efficacy, general efficacy, and the role of bilingual input. Only 811 surveys out of the 1,024 questionnaires returned (44%) were used in the study. The remaining surveys were not used because they were not complete. Results for the three subgroups of speech-language pathologists were compared, including their reasons for believing they had high or low efficacy.

Results revealed that many of the speech-language pathologists (85% - M, 75% - AS, and 72% - CE) in the study believed themselves to be “not competent” or “somewhat competent” in assessing the language skills of bilingual/bicultural individuals even with the assistance of an interpreter. A significant number of speech-language pathologists (93% - M, 92% - AS, and 96% - CE) believed that most speech-language pathologists are “not competent” or only “somewhat competent” in assessing the language skills of bilingual/bicultural individuals even with the assistance of an interpreter.

While many of their bilingual children spoke Spanish (n = 452), just as many spoke languages other than Spanish or English (n = 448). Furthermore, 16 of the languages spoken by their clients were not known by any of the speech-language pathologists in the sample (Kritikos, 2003). These findings indicate a critical need to include preparation in understanding bilingualism/biculturalism in preservice programs for all speech-language pathologists (Kritikos, 2003).
Recommendations stressed the need for more research in the area of beliefs about the language assessment of bilingual/bicultural individuals, differences in professional efficacy (both personal and general) based on the degree of bilingual proficiency, and examining more closely knowledge and experience with differing cultures in addition to language proficiency. Furthermore, Kritikos (2003) recommends that future studies should attempt to define more clearly the relationship among knowledge, experience, professional beliefs, assessment practices, and decisions.

Teacher Efficacy Concerns

One would be remiss in overlooking recent scrutiny of the Teacher Efficacy Scale (TES). Within the last decade, the TES has been under question (Henson, 2002). Specifically, Coladarci and Fink (1995) conducted a study of correlations among scores from the central instruments of teacher efficacy and related constructs. They found poor evidence for discriminant validity of personal teaching and general teaching efficacy scores (Coladarci & Fink, 1995).

Additionally, Guskey and Passaro (1994) stated that the personal teaching efficacy and general teaching efficacy factors do not correspond to self-efficacy and outcome expectancy dimensions. Instead, personal teaching efficacy and general teaching efficacy relate to an internal versus external orientation, respectively (Guskey & Passaro, 1994). Rather than reflecting self-efficacy, this dichotomy reflects locus of control and Attributional theory orientations (Henson, 2002).

What is important to note is that the work of Coladarci and Fink (1995) and Guskey and Passaro (1994) called attention to probable “theoretical confounds” in the TES (Henson, 2002). We must remember its process of development (Henson, 2002).
While teacher efficacy research has undergone scrutiny and suffered from weak construct-related validity, several significant advances in this area have emerged (Henson, 2002).

In summary, the literature reveals that a significant number of children and adolescents in the United States are diagnosed with speech and/or language impairments. A considerable amount of these adolescents who require speech and language services reside in correctional facilities. Additionally, data revealed that speech-language pathologists serve a large number of children from culturally and linguistically diverse backgrounds on their caseloads. Several of these children speak a language other than English in their homes. Data indicate that the American student population will continue to become increasingly diverse. However, teachers and related professionals such as speech-language pathologists remain primarily White, monolingual, and non-representative of the diverse student population.

Historically, the experiences of African American and Latino children in the American public school system have not been great. These students of color are underrepresented in gifted and talented programs. African American children, particularly, are overrepresented in classes for the behaviorally disordered. Latino students represent the greatest percent of dropout rates. With the exception of a short stint in the 1970s and 1980s, an achievement gap exists between specific students of color and White students.

The cultures, language, dialects, and funds of knowledge that culturally and linguistically diverse students bring to school have been regarded as disordered by some teachers and related professionals. Instruction and assessment practices have been
primarily representative of the White middle-class culture and values. American public schools have not taken into consideration mores, customs, and values different from the dominant culture. Stated differently, institutions of public education have not been culturally responsive to the diverse group of student learners they serve.

The multicultural movement was and is an effort to make education more relevant for students of color than it has been in the past. The goal is to create curricula that go beyond “heroes and holidays.” A pervasive pedagogy, multicultural education is good for all not, just students of color. Proponents of multicultural education stress a culturally relevant educational environment that accommodates a diverse group of student learners. This can only be accomplished with the assistance of culturally competent teachers and related professionals such as speech-language pathologists.

Much emphasis has been placed on assisting preservice and inservice teachers with providing culturally relevant practices to the exclusion of related professionals such as speech-language pathologists. This focus has resulted in research on teacher perceptions, expectations, and self-efficacy. Teacher perceptions and expectations are closely associated to race and socioeconomic status. Teachers generally tend to expect more from White students than students of color. They expect more from middle-class students than students who are from a lower SES background. Teachers with a higher sense of teaching efficacy show a greater determination to work through challenging students and situations. Research reveals that teacher perceptions, expectations, and self-efficacy directly influence their practices. While teacher efficacy research has undergone intense scrutiny, recent theoretical advances and theoretically sound instruments are promising. While research on teacher perceptions and expectations, practices, and
efficacy has provided significant information to educational researchers, research focused on speech-language pathologists’ perceptions and expectations, practices, and professional efficacy is needed greatly.
CHAPTER III

Methods

The overall purpose of this study was to investigate speech-language pathologists’ (a) beliefs about the language assessment of bilingual/bicultural/bidialectal students, (b) professional efficacy beliefs (both personal and general) as they relate to assessing the language skills of bilingual/bicultural/bidialectal students, and (c) reported supports and barriers to assessing the language skills of bilingual/bicultural/bidialectal students. Of particular interest to the researcher was to determine whether differences among speech-language pathologists’ beliefs existed based on such factors as race/ethnicity, years of experience as a speech-language pathologist, years of experience working with children and youth, percentage of students from homes where a language other than English is spoken, percentage of students from homes where a dialect is spoken, frequency of time spent with bilingual/bicultural/bidialectal students, years of experience with bilingual/bicultural/bidialectal students, bilingual proficiency, and bidialectal proficiency.

This study utilized a questionnaire developed by Kritikos (2003) with minor modifications, including a request for more demographic information and the removal of items that were not related to the focus of this study. Furthermore, Kritikos (2003) included an open-ended question that allowed for comments on specific issues or issues that respondents felt important to discuss. However, there was no follow-up to seek clarification of comments or more in-depth information. In contrast, this study included
individual semi-structured interviews with selected participants as a follow-up to survey responses.

This segment provides a description of the survey development process. A rationale for selecting this method will precede the description. Following the presentation of the survey development, this chapter will provide a detailed description of the study and research questions that will coincide with it. The chapter concludes with potential delimitations and limitations to the proposed study.

Rationale

In Chapter 2, critical issues of concern regarding students of color were highlighted. Specifically, a review of the literature revealed the (a) contrasting demographics between the student population and educational professionals, (b) resultant traditional monocultural curriculum and practices, (c) poor expectations towards students of color and students with low SES, and (d) disparate outcomes between culturally and linguistically diverse and White student learners. Historically, assessment procedures that did not take into consideration a child’s linguistic or cultural norms resulted in misidentification. After reviewing the literature, concern was placed on speech-language pathologists’ beliefs and behaviors that influence assessment and intervention procedures. The push towards cultural competence has been offered as a fundamental need in the organization of this proposed research (Delpit, 1995; Irvine, 2003; Jefferies, 2000).

Terms such as attitudes, beliefs, perceptions, and barriers to compliance are often used to define categories of constructs rather than defining the constructs themselves. In this study, the focus was not on beliefs solely, but on specific beliefs toward assessment to accommodate the needs of culturally and linguistically diverse children with special
needs and their families.

Participants

The focus of this study was on cultural and linguistic diversity as it relates to the Pre-K – 12 educational process. Thus, the caseload of speech-language pathologists (preschool, elementary school, middle school, and high school) was used as the key requirement for selection. Licensure (ASHA certification, state licensure, and Florida Department of Education certification) and educational background (masters and Ph.D.) served as other selection requirements as well.

Target Population

Nationwide, more than two-thirds (71%) of the 1,127 ASHA-certified speech-language pathologists who satisfied the requirement of being employed full-time and of providing clinical services, worked in a school setting (ASHA, 2003). Nearly all school-based speech-language pathologists (92%) serve individuals with articulation or phonological disorders. Approximately 77% of school-based speech-language pathologists provide services to students with autism/pervasive developmental disorder, 72% provide services to students with learning disabilities, and 71% provide services to students with mental retardation/developmental disability (ASHA, 2003).

Instruments

The instrument in this study, the Speech-Language Services to Bilingual/Bicultural/Bidialectal Students (SLSBBBS) survey, is a modified version of the Kritikos (2003) Speech-Language Services to Bilingual/Bicultural Individuals (SLSBBI) survey. The original version consists of 25 items. Participants were required to provide
yes/no, multiple-choice, and Likert-type responses. Participants also had the opportunity to make additional written comments about the three major components: personal efficacy, general efficacy, and beliefs about the role of bilingual input. This allowed for a rich description of participants’ beliefs (Kritikos, 2003).

The original version was piloted and revised more than 30 times based on feedback from faculty at the University of Illinois – Chicago. Additionally, the Survey Research Laboratory at the University of Illinois – Chicago provided assistance in revising several drafts of the survey. Moreover, ASHA’s Multicultural Issues Board (AQ) evaluated the instrument and provided the researcher with written feedback on the strengths and weaknesses of the questionnaire as well as the above study (Kritikos, 2003). Finally, 100 of the 596 participants in the pilot study provided written feedback. This information was incorporated into the final draft of the SLSBBI (Kritikos, 2003). A detailed description of the SLSBBI, the original version, and changes made by this researcher follows.

Within the SLSBBI are five headings that precede a set of questions: learning about the population that you serve, learning about your linguistic background, learning about your academic training on bilingual issues, learning about your opinions of how to improve the field, and learning about your general background.

Demographic data The first 13 questions addressed speech-language pathologists’ demographic and professional background and experiences, as well as the demographic background of the children and adolescents they serve. Moreover, questions requested responses regarding the respondent’s ability to speak, read, and write in a language other than English.
Questions 1-5 fell under the *Learning about the population that you serve* heading. Question 1 asked, “How often do you currently work in each setting?” Question 2 asked, “How often do you currently work with each age group?” Questions 1 and 2 were written in a 4-point Likert-type format: never, not often, often, and very often. Question 3 asked, “On average, which category best describes the income of the household of the majority of the clients that you serve?” Nine choices were presented, with income ranges from less than $5,000 to $75,000 or more. This question was removed because it may be difficult for respondents to know the income levels of their clients. Further, information gained from this question did not align with the purpose of this study. Question 4 asked, “What is your best estimate as to the percentage of your caseload of individuals who come from homes where a language other than English is spoken?” Five choices were presented: none, less than 25%, 25% to 50%, 51% to 75%, and more than 75%. In the modified version, the above question was repeated to include speakers of nonstandard dialects. It read, “What is your best estimate as to the percentage of your caseload of individuals who come from homes where a dialect is spoken?” Two questions were added here. The first question asked, “How often do you currently work with bilingual/bicultural/bidialectal individuals?” Respondents had the following options from which to choose: occasionally (consultation only), 1-2 times per week, 3-5 times per week, >5 times per week, other, and never.

The second question asked, “How many years have you worked with bilingual/bicultural/bidialectal individuals?” Respondents had four options from which to choose: <1 year, 1-5 years, 6-10 years, and >10 years. Question 5 asks, “What are the most common languages spoken among the bilingual individuals you serve?”
Respondents were allowed to circle up to five choices from a list of 14. Space was provided for respondents to write in a language not represented on the list. A question was added to identify the dialects spoken among the individuals the participants served. It asked, “What are the most common dialects spoken among the bilingual/bicultural individuals you serve?” A question was added to identify the race and ethnicity of the clients they serve. It asked respondents to, “Please identify the race/ethnicity of the clients you serve. Circle all that apply.”

Questions 6-11 fell under the Learning about your linguistic background heading. Question 6 asked, “Do you speak and/or understand a language other than English?” Respondents circle yes or no. If the answer was no, respondents were directed to skip to the next section. Question 7 asked, “Which language(s) do you understand and/or speak?” Space was provided for respondents to write-in an answer. Question 8 asked, “Was the first language that you learned? English, other than English, simultaneously acquired English and another language (requested to circle appropriate answer). Question 9 asked, “At what age did you learn a language other than English?” Five choices were provided: birth to 3 years, 4-7 years, 8-11 years, 12-18 years, and over 18 years. Subcomponents to this question were added. It asked, “How long have you spoken a language other than English?” Respondents had the opportunity to respond to four choices: <1 year, 1-5 years, 6-10 years, and >10 years. Respondents were asked to respond to the number of years they had spoken a dialect. This question asked, “How long have you spoken a dialect?” Respondents had the same four choices given in the previous question. Question 10 asked, “Where did you learn a language other than English?” Four choices were provided: school, home, abroad, and other. Space was given
for respondents to provide a written answer in the space marked other. Question 11 asked respondents to “Rate your proficiency in a language other than English for the following domains: listening, speaking, reading, and writing.” Question 11 was written using a 4-point Likert-type format: not proficient, somewhat proficient, proficient, and very proficient. All other question types in this section provided response choices to each question. Two questions were added: “Where did you learn a dialect?” and “Rate your proficiency in a dialect for the following domains.” Respondents had the same answer choices given above.

Questions 12 and 13 fell under the Learning about your academic training on bilingual issues heading. Question 12 asked, “Have you had any speech-language pathology course work that addressed the following?” Respondents were given seven options from which to choose and were allowed to circle all options that apply to them. Options represented the following topics: second language acquisition, communication patterns in cultures where a language other than English is spoken, differential assessment of bilingual versus monolingual individuals, assessment tools for bilingual individuals, language disorder versus language difference, laws involved in the assessment and treatment of bilingual clients, and how to utilize a language interpreter.

Question 13 asked, “Have you attended any inservice or workshops that addressed the following?” The same topics and directions in Question 12 also were provided. Three topics were added. They included the following: cultural factors that influence learning, communication patterns in cultures where a dialect is spoken, multicultural issues/ethnically diverse populations, and working with families.

Questions 19 – 24 also asked respondents to provide information on demographic
data. They fell under the Learning about your general background heading. Question 19 asks, “Are you currently…employed full-time (30 hours per week or more), employed part-time (less than 30 hours per week), not employed, and retired? Respondents circled the statement that most appropriately describes their work hours. Respondents also were given the option to write-in work hours not listed among the options. For the purposes of this study, this question was removed. Question 20 asked, “In what state are you currently employed?” Possible choices included: California, Florida, New Mexico, New York, Texas, and other (with space available to write-in a state not listed among the above choices). For the purposes of this study, respondents were asked to indicate which county within the state of Florida they are employed. Respondents had the opportunity to write-in the appropriate county. Question 21 asked, “How many years have you worked as a certified speech-language pathologist? Possible choices included: 5 years or fewer, 6 to 10 years, 11 to 20 years, and more than 20 years. Question 22 asked, “What is the highest degree you have earned?” Possible choices included Bachelor’s degree, Master’s degree, Ph.D. or Ed.D, and other advanced degree (with space provided for respondents to indicate any degree not listed among the choices). Question 23 asked about respondents’ gender. They indicated their gender by drawing a circle around the word female or male? Question 24 asked about race/ethnicity. Possible choices included: African American, American Indian or Alaskan Native, Asian American or Pacific Islander, Caucasian, not Latino, Latino, and other. Space was provided, allowing respondents the opportunity to indicate if they belonged to another race/ethnicity not included in the list. All questions requesting demographic information appeared first on the modified questionnaire.
Beliefs about Personal and General Efficacy: Questions 14-16 fell under the Learning about your experience assessing bilingual individuals heading. Question 14 was divided into two sections: Question 14a and Question 14b. Question 14a asked, “With the help of an interpreter, how competent do you feel in assessing an individual’s language development in a language that you do not understand or speak? Question 14b asked, “With the help of an interpreter, how competent do you feel most speech-language pathologists are in assessing an individual’s language development in a language that they do not understand or speak? These two questions were changed to read: “With the help of an interpreter, how competent do you feel in assessing an individual’s language development in a language and/or dialect that you do not understand or speak? and “With the help of an interpreter, how competent do you feel most speech-language pathologists are in assessing an individual’s language development in a language and/or dialect that they do not understand or speak? Both questions are written in a 4-point Likert-type format: not competent, somewhat competent, competent, and very competent. Question 15 asked, “Which problem(s) do you encounter in assessing bilingual individuals with language disorders? Respondents were given 7 options from which to choose: (a) lack of knowledge of clients’ culture, (b) lack of knowledge of the nature of second language acquisition, (c) difficult to distinguish a language difference from a language disorder, (d) lack of availability of interpreters who speak the individual’s language, (e) lack of availability of bilingual speech-language pathologists who speak the individual’s language, (f) lack of developmental norms and standardized assessment tools in languages other than English, (g) time allocated by your employer for assessment administration, scoring, and interpretation. Five issues were added to the modified form:
(a) lack of availability of interpreters who speak the individual’s dialect, (b) lack of availability of bidialectal speech-language pathologists who speak the individual’s dialect, (c) lack of developmental norms and standardized assessment tools in nonstandard dialects, (d) utilizing test scores of translated tests, and (e) language tests published in a language other than English with flawed normative samples. The final option gave respondents the opportunity to write a problem/difficulty not included among the other options. This option was removed from the modified version and included as a topic in the follow-up interviews.

Question 16 was a forced-choice question. It asked, “Based on your experience, circle the statement you agree with the most. Who should provide language assessment to bilingual individuals with language problems?” Five options were given: (a) bilingual education specialists, (b) English as a second language (ESL) specialists, (c) speech-language pathologists, and (d) professionals should collaborate. The fifth option for this question gave respondents the opportunity to write a possible option not included in the above list.

Questions 17 and 18 fell under the Learning about your opinions of how to improve the field heading. Question 17 asked, “How can our field better prepare speech-language pathologists to carry out appropriate assessment of bilingual individuals?” It consisted of two parts: pre-service and in-service and asked respondents to “please rate the following in terms of importance.” Under the pre-service category, respondents rated the degree of importance as it related to (a) more academic course work in this area, (b) more practicum experience with bilingual clients, and (c) more active recruitment of bilingual speech-language pathologists. The modified version included the terms
bicultural and bidialectal. Under the inservice category, respondents rated the degree of importance as it related to (a) more seminars and workshops on this topic, (b) more journal articles on this topic, and (c) easier access to a bilingual speech-language pathologist (modified version included the terms bicultural and bidialectal) pool in your region. A 5-point Likert-type format was provided: very important, unimportant, not sure, important, and very important.

Beliefs about the Role of Bilingual Input: Question 18 asked respondents to circle the statement that they agreed with the most after reading a short case scenario: A five-year old child comes from a home where English and a language other than English are spoken. His comprehensive language assessment places him in the borderline range for language problems. Compared to a monolingual child with the same language and cognitive skills, how likely would you be to recommend language therapy services for this child? A 3-point Likert-type format is provided: more likely, less likely, and equally likely. This question was excluded from the version that the participants in this study receive. Rather, this information was obtained from open-ended questions during in-depth semi-structured interviews.

Finally, Question 25 solicited respondents’ opinions regarding the following issues: their effectiveness in the language assessment of bilingual individuals, most speech-language pathologists’ effectiveness in the language assessment of bilingual individuals, the effect of bilingual input on the decision of whether or not to recommend language therapy, and concerns not covered. This question was removed. Again, open-ended questions were added to the interview protocol instead. Although 16 questions were added to the original questionnaire, these questions were all of a demographic
nature and modifications were minor. Further, members of the researcher’s dissertation committee reviewed the survey and provided some of the above modifications in order to meet the needs of this current study.

*Procedures*

This study involved a mixed method research design (Tashakkori & Teddlie, 1998, 2003). It was organized into three central components that included a quantitative phase and a qualitative phase in the overall research study (Tashakkori & Teddlie, 1998, 2003). The quantitative phase included the administration of a survey. The qualitative phase incorporated a reflective analysis of the researcher’s personal experience as a speech-language pathologist and follow-up semi-structured interviews. Specifically, the researcher utilized a *dominant-status sequential design* (Onwuegbuzie & Johnson, 2004). The qualitative phase dominated the study. Three out of four of the research questions were qualitative in nature and more qualitative data were collected (reflective analysis and in-depth interviews). Further, the quantitative phase was followed sequentially by the qualitative phase in the study (Onwuegbuzie & Johnson, 2004). Subcomponents of this chapter include target population, data collection, and data analysis.

The research study employed the Speech-Language Services to Bilingual/Bicultural/Bidialectal Students (SLSBBBS) survey to explore and describe pediatric speech-language pathologists’ beliefs about (a) the assessment of bilingual/bicultural individuals, (b) their professional efficacy (personal and general), and (c) supports and barriers to professional efficacy. The rationale for using a mixed method design was *complementarity* (Greene, Caracelli, & Graham, 1997). That is, the researcher sought elaboration and clarification of the results from the quantitative phase with the
results from the qualitative phase. The associations among beliefs about efficacy and the language assessment of bilingual/bicultural/bidialectal students and differences in professional efficacy based on the degree of bilingual and bidialectal proficiency were identified.

Administration and Data Collection

Survey. Sample size is the most robust means of attaining accurate and consistent estimates for policy decisions or scientific inquiry (Gall, Gall, & Borg, 2003). The general rule for determining sample size in quantitative studies is for the researcher to employ the largest sample size possible (Gall et al., 2003). What the researcher wants to achieve in data analysis should guide the decision when determining sample size (Gall et al., 2003). Further, Jefferies (2000) offers some guiding questions to facilitate the process:

- What are the relationships among variables to be explored?
- What statistical techniques will be used to analyze the data?

Discussed in greater detail in the section labeled quantitative analysis, this study used a multiple regression analysis to address one of the research questions. Multiple regression is a procedure that requires a large sample (Hatcher & Stepanski, 1997; Pedhazur, 1997). Further, a sample with less than 100 participants may result in inaccurate findings. The larger the amount of predictor variables incorporated in the multiple regression equation, the larger the required amount of participants to ensure reliable results. Many experts recommend at least 15-30 participants for every predictor variable (Hatcher & Stepanski, 1997).

Researchers have the opportunity to choose various methods of data collection
when conducting mixed research designs. Data can be collected on the same sample or on
different samples (Onwuegbuzie & Johnson, 2004). Further, researchers may choose a
combination of random sampling and nonrandom sampling in mixed research
(Onwuegbuzie & Johnson, 2004).

The researcher used random sampling in the quantitative phase of this study. Data
were collected by administering the survey to a sample of 390 speech language
pathologists who provide services to children and adolescents, aged 3-22 years, in two
school districts in central Florida. School District I employs 190 speech-language
pathologists and School District II employs 200 speech-language pathologists. School
Districts I and II were selected based on their similarity in demographics and student
enrollment. Both are large school districts within the state of Florida and have generally
similar percentages of White, Black, Hispanic, and Asian students. They both have a
large representation of students of color and share like percentages of this population.
Additionally, the districts share like percentages of exceptional student populations
(Florida Department of Education, Florida School Indicators Report, 2003-2004; Florida

The supervisor of speech and language services for School District I invited the
researcher to participate in their end-of-the-school-year check-in process. Speech-
language pathologists were given the surveys to complete over four days of check-in. The
end-of-the-year check-in process was different for School District II. Thus, the researcher
was unable to administer the surveys directly. Rather, the supervisor of speech and
language services for School District II allowed the researcher to mail the 200 surveys via
school mail to their speech-language pathologists at their assigned school sites.
Information about the Speech-Language Services to Bilingual/Bicultural/Bidialectal Students (SLSBBBS) survey and a description of the research study with the researcher’s contact information for clarification was presented in the form of a cover letter. Both supervisors placed the survey, cover letter, and contact information sheet on their speech-language websites. School District I granted permission to the researcher to conduct research under the condition that data “be aggregated such that the district cannot be identified…” Thus, limited information about School Districts I and II is provided.

Speech-language pathologists in School District I primarily completed the surveys on the same day it was given to them and in a space designated for survey completion. Others took the survey with them and mailed it to the speech-language supervisor. Speech-language pathologists in School District II were given two weeks to return completed surveys back to their supervisor. All surveys were completed anonymously.

The contact information sheet was provided on a voluntary basis. In addition to requesting name, email address, and telephone number, this sheet asked speech-language pathologists if they were interested in participating in follow-up in-depth interviews in the form of a yes/no question. Contact information sheets that were returned to the researcher in person were placed in a separate pile from the completed surveys and not in any particular order. Contact information sheets that were returned via school mail were received in separate envelopes from the completed survey. Thus, there was no association between the completed survey and the person who completed it. This procedure ensured complete anonymity. Respondents also had the opportunity to indicate their willingness to participate in a follow-up via email or telephone if this was their preference. Some
respondents utilized the email option.

Speech-language pathologists who returned the contact information sheet were automatically entered into a drawing to win one of three prizes, each equivalent to a credit of $50 worth of speech-language materials from a well-known supplier. The researcher provided an extra incentive of a gift certificate for each the selected interview participants and one guest to attend a movie theater of their choice.

*Semi-structured interviews.* The researcher employed a phenomenological design (Moustakas, 1994) in the qualitative phase of this study. The long interview is generally the method used to collect data in the phenomenological investigation (Moustakas, 1994). This interview process is both informal and interactive. Information from phenomenological research comes from first-person reports of life experiences (Moustakas, 1994). Further, it utilizes open-ended comments and questions (Moustakas, 1994). The primary researcher may have developed an interview protocol in advance to evoke a comprehensive set of responses based on an individual’s experience of the phenomenon. However, these pre-developed questions are modified or not used when the participant conveys a complete story of his or her experience of the phenomenon (Moustakas, 1994).

In this study, the researcher developed a set of open-ended questions to guide the semi-structured interview with speech-language pathologists. These questions were developed from a review of the research literature (Shealey, 2003) and as a follow-up to questions on the survey conducted in the quantitative phase of this study. Following a social conversation intended to create a relaxed and trusting atmosphere (Moustakas, 1994), each participant was asked to take a few minutes to reflect on the experience of
providing services to bilingual, bicultural, and bidialectal children, moments of particular awareness and impact, and then to provide a full description of that experience (Moustakas, 1994). This process allowed the researcher the opportunity to gain a better understanding of each interview participant’s experience (Moustakas, 1994). While each interview participant was asked identical questions, variability existed in the posing of additional questions to seek clarification of a point or statement made by respondents. The interview process lasted from 45 to 60 minutes per interview and was audio taped.

Some researchers will make a case for an emerging research design in which a set number of participants in a study are not decided in advance (Seidman, 1998). Rather, new participants are subsequently added as new dimensions of the issues develop from previous interviews (Lincoln & Guba, 1985; Rubin & Rubin, 1995). Other researchers make a claim for a “snowballing” method, when the selection of one participant leads to another (Bertaux, 1981). Dukes (1984) suggest studying 3 to 10 participants in a phenomenological study. Deciding how many participants are “enough” to interview is an “interactive reflection of every step of the interview process and different for each study and each researcher” (Seidman, 1998, p.48). A stratified purposeful sampling technique was used to gain maximum variation (Seidman, 1998). Ten speech-language pathologists who have worked consistently with bilingual/bicultural/bidialectal students and represent various races/ethnicities (African American/Black, Asian/Pacific Islander, Latino, and White) were identified. Copies of the cover letter, questionnaire, contact information sheet, and interview questions are located in Appendix A, Appendix B, Appendix C, and Appendix D, respectively. Table 1 depicts a summary of research questions and their alignment to the survey and interview questions.
<table>
<thead>
<tr>
<th>Research Question</th>
<th>Survey Question</th>
<th>Interview Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What are the professional efficacy beliefs of speech-language pathologists about assessing the language skills of bilingual/bicultural/bidialectal students?</td>
<td>35, 36</td>
<td>4, 5, 6, 7, 8, 9, 11, 14, 20, 21, 22, 25, 26, 27, 28, 30, 33</td>
</tr>
<tr>
<td>2. Do speech-language pathologists’ professional efficacy beliefs about assessing the language skills of bilingual/bicultural/bidialectal students vary as a function of demographic variables (i.e. race/ethnicity, years of experience, levels of professional efficacy, frequency of times with bilingual/bicultural/bidialectal children, proficiency in a language other than English, and proficiency in a dialect)?</td>
<td>3, 4, 5, 6, 9, 10, 13, 14, 15, 16, 17, 18, 19, 20, 22, 23, 24, 25, 25, 27, 28, 29, 30, 31, 32, 33, 34</td>
<td>N/A</td>
</tr>
<tr>
<td>3. What do speech-language pathologists perceive as the supports needed to assess competently the language skills of bilingual/bicultural/bidialectal students?</td>
<td>38, 39</td>
<td>9, 12, 13, 14, 15, 16, 18, 19, 23, 28, 29, 31, 32, 34, 35, 37, 38</td>
</tr>
<tr>
<td>4. What do speech-language pathologists perceive as barriers to competently assessing the language skills of bilingual/bicultural/bidialectal students?</td>
<td>37</td>
<td>9, 10, 12, 13, 14, 15, 17, 18, 19, 24, 28, 29, 31, 32, 33, 34, 36, 37, 39</td>
</tr>
</tbody>
</table>
Data Analyses

Quantitative and qualitative data analyses assessed respondents’ beliefs about professional efficacy (personal and general), as measured by each subscale as they relate to the following variables: race/ethnicity, fluency in languages other than English, fluency in dialectal variations, professional development training, years of experience, and exposure to culturally and linguistically diverse student learners and their families. The analyses also assessed respondents’ beliefs about supports and barriers to assessing the language skills of bilingual/bicultural/bidialectal students. The following data analysis procedures were conducted to answer the research questions: quantitative and qualitative analyses. Each procedure is explained in detail below.

Quantitative Analyses

Utilizing the SAS System (Hatcher & Stepanski, 1997) for univariate and multivariate statistics, quantitative analyses included calculating the frequency and percentage of responses and statistical analyses of group differences in responses using a multiple regression analysis (Hatcher & Stepanski, 1997). This flexible method permits researchers to answer a variety of research questions with several different types of data (Hatcher & Stepanski, 1997). According to Gall et al., (2003), the researcher’s first step in conducting a multiple regression analysis is to calculate the Pearson Product-Moment Correlation coefficient, $r$. This statistical technique is suitable for determining the extent to which a relationship exists between variables. Further, the correlation coefficient is a summation of the linear relationship that exists between two variables that is not influenced by the variables scales (Gall et al., 2003). Educational researchers commonly use this statistical technique because it contains a small standard error on continuous
scores (Gall et al., 2003).

The most familiar multiple regression analysis procedure entails a “single continuous criterion variable measured on an interval or ratio scale, and multiple continuous predictor variables also assessed on an interval or ratio scale” (Hatcher & Stepanski, 1997, p. 381). Multiple regression techniques were used to examine the role of the independent variables in predicting a linear relationship with the dependent variable (Pedhazur, 1997; Jefferies, 2000). According to Hatcher and Stepanski (1997, p. 381), the multiple regression analysis also allows the researcher to establish the following:

- Whether a notable relationship exists between the criterion variable and the several predictor variables when taken as a group
- Whether the multiple regression coefficient for a particular predictor variable is statistically significant
- Whether a certain predictor variable provides a rationale for a significant amount of variance in the criterion, apart from the variance accounted for by the other predictor variables.

In this study, the criterion variable was professional efficacy (personal efficacy and general efficacy) for speech-language pathologists. The predictor variables were race/ethnicity (African American/Black, Hispanic/Latino, and other race), years of experience as a speech-language pathologist, years of experience working with children and youth, percentage of students from homes where a language other than English is spoken, percentage of students from homes where a dialect is spoken, frequency of time (exposure) spent with bilingual/bicultural/bidialectal students, years of experience working with bilingual/bicultural/bidialectal students, proficiency levels in a language
other than English, and proficiency levels in a dialect. The criterion variable and predictor variables were all continuous and were all measured on an interval or ratio scale. Consequently, multiple regression analysis was the suitable procedure for this study. The following assumptions (Hatcher & Stepanski, 1997, p. 446; Pedhazur, 1997) underlying multiple regression were considered:

- **Level of measurement** – The criterion variable and predictor variables should be assessed on an interval or ratio level of measurement.

- **Random sampling** – Each participant in the sample will contribute one score on each predictor variable, and one score on the criterion variable. These sets of scores should represent a random sample of speech-language pathologists drawn from two school districts in central Florida.

- **Normal distribution of the criterion variable** – For any combination of values of the predictor variables, the criterion variable should be normally distributed.

- **Homogeneity of variance** - For any combination of values of the predictor variables, the criterion variable should be normally distributed.

- **Independent observations** – A given observation should not be affected by (or related to) any other observation in the sample. Violation of this assumption occurs if the various observations represented repeated measurements taken from a single case or if some cases contributed more than one set of scores on the criterion variable and predictor variables.

- **Linearity** – The relationship between the criterion variable and predictor variables should be linear; the mean criterion scores at each value of a given predictor should fall on a straight line.
• Errors of prediction – The errors of prediction should be normally distributed and the distribution of errors should be centered at zero; the error of prediction associated with a given observation should not be correlated with the errors associated with the other observations; the errors of prediction should demonstrate a constant variance; the errors of prediction should not be correlated with the predictor variables.

• Absence of measurement error – The predictor variables should be measured without error. Violation of this assumption may lead to underestimation of the regression coefficient for the corresponding predictor.

• Absence of specification errors – The model represented by the regression equation should be theoretically tenable. In multiple regression, specification errors most frequently result from omitting relevant predictor variables from the equation, or including irrelevant predictor variables in the equation. Specification errors also result when researchers posit a linear relationship between variables that are actually involved in a curvilinear relationship.

In addition to taking the above assumptions into consideration, the researcher inspected data sets for potential complications concerning outliers (an atypical observation that does not suitably fit the regression model) or multicollinearity [when two or more predictor variables exhibit a high degree of correlation with each other] (Freund & Littell, 1991). Multicollinearity can hinder regression coefficient estimates from exhibiting statistical significance, cause them to be biased, or display the wrong sign (Freund & Littell, 1991).

Question 2 was answered utilizing the above statistical techniques. While the
major analysis for Questions 1, 3, and 4 is qualitative and thematic in nature, it was informative to use statistical analyses as well. In particular, descriptive statistics were utilized to count the prevalence of the themes that emerged.

Qualitative Analysis

Interviews. The establishment of validity and verification procedures is vital in qualitative research (Sanger et al., 2003). The qualitative research literature is replete with the significance of establishing trust and collecting rich, thick, descriptions (Creswell, 1998; Creswell & Miller, 2000; Maxwell, 1996; Zwiers & Morrissette, 1999). The researcher used the following verification procedures to ensure reliability and validity of results: member checks, interrater reliability, description of researcher bias, and rich, thick description (Creswell, 1998; Creswell & Miller, 2000). The researcher conducted individual interviews. From those interviews, the researcher subsequently collected transcripts of respondents’ comments utilizing the above method of analysis. The respondents’ comments were transcribed verbatim by a trained transcriptionist and coded by the researcher. In order to ensure accuracy of responses, member checking took place. Interview participants were given a copy of their individual transcripts and asked to provide clarification and/or modification of responses if appropriate. Participants were also given the opportunity to make modifications and/or provide supplemental information. The above procedures took place prior to the analysis of respondent’s comments.

The researcher used the Atlas.ti qualitative software program to facilitate the process. Atlas.ti contains various tools that allow the researcher to select, code, sort, and annotate data without difficulty (McHatton, 2004). However, this software program does
not produce themes independently. The researcher must interpret the data. Themes in respondent’s spontaneous comments were identified and subsequently collapsed into smaller themes utilizing a modified method of the Stevick-Colaizzi-Keen Method of Analysis of Phenomenological data (Moustakas, 1994) and establishing interrater reliability to organize and analyze the verbatim transcripts of the participant’s experiences. Utilizing the modified method of the Stevick-Colaizzi-Keen Method of Analysis of Phenomenological data, the following steps were taken:

- Reviewed each statement for significance as they described the experience of assessing the language skills of bilingual/bicultural/bidialectal children.
- Recorded all statements relevant to the phenomenon; included all statements that were relevant to Research Questions 1, 3, and 4.
- Listed each non-repetitive, non-overlapping statement; redundant and vague responses were omitted. These statements are the invariant horizons or meaning units of the experience of assessing bilingual/bicultural/bidialectal children.
- Associated and clustered the invariant meaning units into themes.
- Provided frequency data on the descriptive statements/ideas according to the percentage of speech-language pathologists who commented about each theme that emerged.
- Synthesized the invariant meaning units and themes into a description of the textures of the experience. Verbatim examples were included.
- Reflected on textural description and constructed a description of the structures of the experience through imaginative variation.
- Constructed a textural-structural description of the meanings and essences of the
experience; descriptions represented the participant’s views about their professional efficacy beliefs and perceived supports and barriers to assessing the language skills of bilingual/bicultural/bidialectal students.

To establish interrater reliability, the following steps were taken:

- Identified themes in respondent’s spontaneous comments given to independent raters (doctoral students) trained in coding qualitative data
- Forty percent ($n = 4$) of transcripts randomly selected from the 10 interviews and given to independent raters
- Independent raters given instructions to read the transcripts and code any comments that signified identified themes
- Reviewers and researcher subsequently met together and compared notes, giving reasons for each developed category
- Themes that emerged were established through a consensus approach (Sanger, Moore-Brown, Montgomery, Rezac, & Keller, 2003).

The above analysis contributed to answering Questions 1, 3, and 4.

**Self-Reflection**

Recognizing that no researcher enters a research situation separate from her/his own biases, the researcher completed a narrative of her cultural and linguistic background as well as professional experiences as a speech-language pathologist. Using a phenomenological approach, she provides a complete description of her own experience of the phenomenon (Moustakas, 1994). Details of her own professional efficacy and perceived supports and barriers to assessing the language skills of bilingual/bicultural/bidialectal students are discussed. Once again, the researcher utilized
a modified method of the Stevick-Colaizzi-Keen Method of Analysis of Phenomenological data (Moustakas, 1994) to organize and analyze the verbatim transcript of the researcher’s experience. The following steps were taken:

- Reviewed each statement for significance as they described the experience of assessing the language skills of bilingual/bicultural/bidialectal children.
- Recorded all statements relevant to the phenomenon; included all statements that were relevant to Research Questions 1, 3, and 4.
- Listed each non-repetitive, non-overlapping statement; redundant and vague responses were omitted. These statements are the invariant horizons or meaning units of the experience of assessing bilingual/bicultural/bidialectal children.
- Associated and clustered the invariant meaning units into themes.
- Synthesized the invariant meaning units and themes into a description of the textures of the experience. Verbatim examples were included.
- Reflected on textural description and construct a description of the structures of the experience through imaginative variation.
- Constructed a textural-structural description of the meanings and essences of the experience; descriptions represented the researcher’s views about her professional efficacy beliefs and perceived supports and barriers to assessing the language skills of bilingual/bicultural/bidialectal students.
Figure 1 – Establishing Reliability

Inter-rater Reliability Established by Two Doctoral Students

10 Interviews

Individual Themes
Theme (1)
Theme (2)
Theme (3)
Theme (4)
Theme (5)
Theme (6)
Theme (7)
Theme (x)

Composite Themes
Theme (1)
Theme (2)
Theme (3)
Theme (x)
Figure 2 – Composite Analysis

Surveys
- Efficacy Beliefs
- Cultural Factors
- Demographic Information
- Assessment Experiences
- Professional Training
- Caseload Characteristics

Composite Analysis of Speech-Language Pathologists’ Professional Efficacy Beliefs

Interviews
- Efficacy Beliefs
- Facilitators & Barriers
- Demographic Information
- Assessment Experiences
- Professional Training
- Field Experiences
Research Questions

This study addressed the following research questions:

1. What are the professional efficacy beliefs of speech-language pathologists about assessing the language skills of bilingual/bicultural/bidialectal students?

2. Do speech-language pathologists’ professional efficacy beliefs about assessing the language skills of bilingual/bicultural/bidialectal students vary as a function of demographic variables (i.e. race/ethnicity, years of experience, levels of professional efficacy, frequency of times with bilingual/bicultural/bidialectal children, proficiency in a language other than English, and proficiency in a dialect)?

3. What do speech-language pathologists perceive as the supports needed to assess competently the language skills of bilingual/bicultural students?

4. What do speech-language pathologists perceive as barriers to assessing the language skills of bilingual/bicultural/bidialectal students?

Delimitations

A delimitation is the restriction of participants to speech-language pathologists employed by two central Florida public school districts. Inferences from this study were restricted to these two school districts. Another delimitation was the restriction of interview participants to female speech-language pathologists. The vast majority of speech-language pathologists within these two local school districts mirror the national demographics, namely, female. The limited number of male survey respondents resulted in the exclusion of gender comparisons in the multiple regression analysis. Without this information, the researcher was unable to make comparisons between quantitative and qualitative data regarding gender. For that reason, the researcher decided to interview
female speech-language pathologists. Once again, inferences from this study were restricted to female speech-language pathologists within two school districts in central Florida.

**Limitations**

Limitations of this study are categorized into two groups: threats to internal validity and threats to external validity. The survey instrument is a single item measuring a complex construct. This is a threat to internal validity and poses a limitation to the study. A second threat to internal validity included the following: Information received was based on self-report through surveys and interviews. While surveys alone can yield significant information, in-depth interviews added a deeper understanding to the data collected. This legitimizes the need to incorporate a qualitative portion to this study. However, participants may have provided responses they regarded as socially acceptable. Actual observations or focus groups would have added triangulation to data collected. A third threat to internal validity involved passive and active researcher bias (Onwuegbuzie, 2003). The researcher’s ethnicity and statements made may have provided an indication of the researcher’s preferences during the interview process.

Threats to external validity included population validity and ecological validity (McMillan, 2000; Onwuegbuzie, 2003). The sample may not have represented adequately other geographic regions across the country. Further, inferences from this study were restricted to select districts within the state of Florida.

The final stages of this study include results and implications for graduate communication sciences and disorders departments, educational researchers, and speech-language pathologists. The researcher will present interpretations of the findings and
recommendations for future research. This information will be shared in Chapters IV and V, respectively.
<table>
<thead>
<tr>
<th>Research Question</th>
<th>Procedure</th>
<th>Variables</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What are the professional efficacy beliefs of speech-language pathologists about assessing the language skills of bilingual/bicultural/bidialectal students?</td>
<td>Semi-structured interviews Qualitative analysis of respondents’ comments Descriptive statistics</td>
<td>DV = professional efficacy beliefs: (a) personal efficacy beliefs (b) general efficacy beliefs IV/Perceived Antecedents = assessing language skills of bilingual/bicultural/bidialectal students</td>
</tr>
<tr>
<td>2. Do speech-language pathologists’ professional efficacy beliefs about assessing the language skills of bilingual/bicultural/bidialectal students vary as a function of demographic variables (i.e. race/ethnicity, years of experience, frequency of times with bilingual/bicultural/bidialectal children, proficiency in a language other than English, and proficiency in a dialect)?</td>
<td>Multiple Regression Analysis Calculation of frequencies/percentage of responses Alpha level = .05</td>
<td>Criterion Variable = professional efficacy beliefs: (a) personal efficacy beliefs (b) general efficacy beliefs Predictor Variables = demographic variables</td>
</tr>
<tr>
<td>3. What do speech-language pathologists perceive as the supports needed to assess competently the language skills of bilingual/bicultural/bidialectal students?</td>
<td>Semi-structured interviews Qualitative analysis of respondents’ comments Descriptive statistics</td>
<td>DV = language skills of bilingual/bicultural/bidialectal students IV/Perceived Antecedents = supports</td>
</tr>
<tr>
<td>4. What do speech-language pathologists perceive as barriers to competently assess the language skills of bilingual/bicultural/bidialectal students?</td>
<td>Semi-structured interviews Qualitative analysis of respondents’ comments Descriptive statistics</td>
<td>DV = language skills of bilingual/bicultural/bidialectal students IV/Perceived Antecedents = barriers</td>
</tr>
</tbody>
</table>
CHAPTER IV

Results

The overall purpose of this study was to investigate speech-language pathologists’ (a) beliefs about the language assessment of bilingual/bicultural/bidialectal students, (b) professional efficacy beliefs (both personal and general) as they relate to assessing the language skills of bilingual/bicultural/bidialectal students, and (c) reported supports and barriers to assessing the language skills of bilingual/bicultural/bidialectal students. Of particular interest to the researcher was to determine whether differences among speech-language pathologists’ beliefs existed based on such factors as race/ethnicity, years of experience as a speech-language pathologist, years of experience working with children and youth, years of experience working with bilingual/bicultural/bidialectal students, exposure to bilingual/bicultural/bidialectal students, and the degree of bilingual and bidialectal proficiency.

In this chapter, a linkage between the data collected and the research questions asked is provided. Both quantitative and qualitative methods were used in the study. This chapter is organized into three sections. The first section gives a summary of frequency counts. The second section presents results of survey responses regarding professional efficacy beliefs, a multiple regression analysis of survey data, and an analysis summary of interview participants’ experiences of assessing the skills of bilingual/bicultural/bidialectal students. With the exception of Research Question 2, quantitative results will precede qualitative results for each research question. Section 3
provides a reflective analysis by the principal investigator.

Research Questions

Four research questions directed data collection and analysis of speech-language pathologists’ professional efficacy beliefs about assessing the language skills of bilingual/bicultural/bidialectal students.

1. What are the professional efficacy beliefs of speech-language pathologists about assessing the language skills of bilingual/bicultural/bidialectal students?

2. Do speech-language pathologists’ professional efficacy beliefs about assessing the language skills of bilingual/bicultural/bidialectal students vary as a function of demographic variables (i.e. race/ethnicity, years of experience, levels of professional efficacy, frequency of times with bilingual/bicultural/bidialectal children, proficiency in a language other than English, and proficiency in a dialect)?

3. What do speech-language pathologists perceive as the supports needed to assess competently the language skills of bilingual/bicultural students?

4. What do speech-language pathologists perceive as barriers to assessing the language skills of bilingual/bicultural/bidialectal students?

Section 1

Frequency counts and descriptive statistics. The researcher gained access to 390 speech-language pathologists in two central Florida school districts. Of these, 230 (59.0%) participants volunteered to participate in the study. Four of these participants were actually speech-language assistants and did not meet the participant requirement of the study (i.e., practicing preschool and school-based speech-language pathologists). This further reduced the speech-language pathologist population by four to 226. Of the 226
surveys returned (58%), five failed to meet the researcher’s criteria of not having any missing responses. These five surveys were omitted, leaving a remaining total of 221. The eventual response of 221 completed surveys thus represents a 56% response rate, representing a greater response rate than Kritikos’ (2003) rate of 35%. Findings included participants’ report of speech-language pathology (SLP) characteristics, estimates of client characteristics, and SLP belief characteristics about the two criterion/dependent variables (personal and general efficacy). The speech-language pathology characteristics included the general background and linguistic background of participants.

Participant Demographics

The sample consisted of 214 females (97%) and 7 males (3%). Fifty-three respondents (24%) had worked as speech-language pathologists for 20 years or more. Novice speech-language pathologists (0-3 years) and those with 4-7 years of experience both represented the next largest group with 23%, respectively. Speech-language pathologists provide services to children and youth as well as adults. As a result, the researcher was particularly interested in knowing how many years of experience, specifically, they had with children and youth. In terms of years of experience providing services to children and youth, 59 respondents (26%) represented the category of 4-7 years, followed by 53 (23.4%) with more than 20 years, and 50 (22%) with 3 years or fewer.

Regarding the distribution of participating speech-language pathologists by educational level, 80% \((n = 177)\) held master’s degrees and 19% \((n = 43)\) held bachelor’s degrees. Speech-language pathologists are required to possess a masters’ degree. Those with a bachelor’s degree only were “grandfathered” and not required to obtain a master’s
degree when this became a requirement. In terms of professional credentials, the majority of respondents held state certification by the Florida Department of Education ($n = 184, 83\%$), the ASHA certificate of clinical competence ($n = 149, 67\%$), and Florida state licensure in speech-language pathology ($n = 122, 55\%$). In terms of gender, most ($n = 214, 97\%$) indicated that they were female. Further, 184 (83\%) indicated that they were White (not of Hispanic/Latino origin), representing the largest group of respondents. Thirty-seven respondents (17\%) indicated that they represented a racial “minority” group. The distribution of participants of color was as follows: Hispanic/Latino ($n = 17$), African American/Black – not of Hispanic/Latino origin ($n = 15$), and Asian American or Pacific Islander ($n = 5$). None of the respondents indicated that they were of American Indian or Alaskan origin. Of the 221 respondents, 220 (99\%) indicated that they very often worked in a school setting.
Table 3 – Summary of Years of Experience, Educational Level, Certification and Licensure Status, Gender, Race/Ethnicity, and Setting Responses of Speech-Language Pathologists

<table>
<thead>
<tr>
<th>Years</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-3</td>
<td>51</td>
<td>23</td>
</tr>
<tr>
<td>4-7</td>
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<td>23</td>
</tr>
<tr>
<td>8-11</td>
<td>28</td>
<td>13</td>
</tr>
<tr>
<td>12-20</td>
<td>38</td>
<td>17</td>
</tr>
<tr>
<td>Over 20</td>
<td>53</td>
<td>24</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Years w/ Children and Youth</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-3</td>
<td>50</td>
<td>22</td>
</tr>
<tr>
<td>4-7</td>
<td>59</td>
<td>26</td>
</tr>
<tr>
<td>8-11</td>
<td>24</td>
<td>11</td>
</tr>
<tr>
<td>12-20</td>
<td>35</td>
<td>16</td>
</tr>
<tr>
<td>Over 20</td>
<td>53</td>
<td>24</td>
</tr>
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<table>
<thead>
<tr>
<th>Educational Level</th>
<th>Frequency</th>
<th>%</th>
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<tr>
<td>Bachelors</td>
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<td>19</td>
</tr>
<tr>
<td>Masters</td>
<td>177</td>
<td>80</td>
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<tr>
<td>Ph.D. or Ed.D.</td>
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<td>1</td>
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<table>
<thead>
<tr>
<th>Certification/Licensure</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Certification</td>
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<td>83</td>
</tr>
<tr>
<td>ASHA</td>
<td>149</td>
<td>67</td>
</tr>
<tr>
<td>State License</td>
<td>122</td>
<td>55</td>
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<table>
<thead>
<tr>
<th>Gender</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>214</td>
<td>97</td>
</tr>
<tr>
<td>Male</td>
<td>7</td>
<td>3</td>
</tr>
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<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American/black</td>
<td>15</td>
<td>7</td>
</tr>
<tr>
<td>American Indian/Alaskan Native</td>
<td>----</td>
<td>----</td>
</tr>
<tr>
<td>Asian American/Pacific Islander</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Caucasian/white</td>
<td>184</td>
<td>83</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>17</td>
<td>8</td>
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<table>
<thead>
<tr>
<th>Setting</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>School</td>
<td>220</td>
<td>99</td>
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Note: n = 221
Table 4 is a summary of the following: client characteristics, such as the age of the students the participants serve; the race(s) of the students that the participants primarily served; percentage of students who came from homes where a language other than English was spoken; percentage of students who came from homes where a dialect (i.e., African American Vernacular English) was spoken; frequency of time spent with bilingual/bicultural/bidialectal students; and years of experience with bilingual/bicultural/bidialectal students. Regarding the frequency of time spent with particular age groups, the majority of respondents very often worked with children aged 3-5 years \((n = 115, 52\%)\) and 6-11 years \((n = 180, 81\%)\). The majority of respondents reported that they primarily provided speech-language services to White children \((n = 191, 86\%)\), Hispanic/Latino \((n = 170, 77\%)\), and African American/Black children \((n = 165, 75\%)\). Only 25 (11%) participants indicated that they provided services to Asian American or Pacific Islander children and 5 (2%) to American Indian or Alaskan Native children.

Of the 221 respondents, 100 (45%) reported having less than 25% of students from homes where a language other than English is spoken. The next largest group \((n = 92, 42\%)\) reported having 25%-50% of students from homes where a language other than English is spoken. Concerning dialect speakers, most respondents \((n = 119, 54\%)\) indicated having less than 25% of students from homes where a dialect is spoken followed by 69 (31%) respondents who indicated having 25%-50% of students from homes where a dialect is spoken. Further, the largest group of respondents \((n = 166, 75\%)\) reported working with bilingual/bicultural/bidialectal students 3-5 times per week, followed by 51 (23%) who reported working with these students 1-2 times per week.
Regarding years of experience working with bilingual/bicultural/bidialectal students, 89 (40%) respondents indicated having 1-5 years. This represented the largest group. This was followed by 72 (33%) of respondents who indicated having greater than 10 years of experience.
Table 4 – *Summary of Estimates of Speech-Language Pathologists: Age of Students, Percentage, Frequency of Times, and Years of Experience with Bilingual/Bicultural/Bidialectal Students*

<table>
<thead>
<tr>
<th>Age of Clients Served</th>
<th>Frequency</th>
<th>%</th>
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<tbody>
<tr>
<td>0-2</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>3-5</td>
<td>115</td>
<td>52</td>
</tr>
<tr>
<td>6-11</td>
<td>180</td>
<td>81</td>
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<tr>
<td>12-18</td>
<td>56</td>
<td>25</td>
</tr>
<tr>
<td>19-22</td>
<td>13</td>
<td>6</td>
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<table>
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<tr>
<th>Race/Ethnicity of Clients Served</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American/black</td>
<td>165</td>
<td>75</td>
</tr>
<tr>
<td>American Indian/Alaskan Native</td>
<td>5</td>
<td>2</td>
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<tr>
<td>Asian/Pacific Islander</td>
<td>25</td>
<td>11</td>
</tr>
<tr>
<td>Caucasian</td>
<td>191</td>
<td>86</td>
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<tr>
<td>Hispanic</td>
<td>170</td>
<td>77</td>
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<table>
<thead>
<tr>
<th>Bilingual/Bicultural</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 25%</td>
<td>100</td>
<td>45</td>
</tr>
<tr>
<td>25-50%</td>
<td>92</td>
<td>42</td>
</tr>
<tr>
<td>51-75%</td>
<td>22</td>
<td>10</td>
</tr>
<tr>
<td>Greater than 75%</td>
<td>7</td>
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<table>
<thead>
<tr>
<th>Bicultural/Bidialectal</th>
<th>Frequency</th>
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<tr>
<td>Less than 25%</td>
<td>119</td>
<td>54</td>
</tr>
<tr>
<td>25-50%</td>
<td>69</td>
<td>31</td>
</tr>
<tr>
<td>51-75%</td>
<td>22</td>
<td>10</td>
</tr>
<tr>
<td>Greater than 75%</td>
<td>11</td>
<td>5</td>
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<table>
<thead>
<tr>
<th>Time Spent</th>
<th>Frequency</th>
<th>%</th>
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<tbody>
<tr>
<td>1-2 times per week</td>
<td>51</td>
<td>23</td>
</tr>
<tr>
<td>3-5 times per week</td>
<td>166</td>
<td>75</td>
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<tr>
<td>Consultation Only</td>
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<thead>
<tr>
<th>Years Spent</th>
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<tr>
<td>Less than 1 year</td>
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<td>6</td>
</tr>
<tr>
<td>1-5 years</td>
<td>89</td>
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<tr>
<td>6-10 years</td>
<td>47</td>
<td>21</td>
</tr>
<tr>
<td>Greater than 10 years</td>
<td>72</td>
<td>33</td>
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Table 5 provides a summary of the most common languages, other than English, spoken in the homes of the respondents’ students. Of the 221 respondents, 216 (97%) reported Spanish as a language spoken in their students’ homes. This represented the largest group of respondents in this category. The second largest group of respondents, 62 (28%) reported Creole as a language spoken in their students’ homes. This was followed by 17 (8%) respondents who indicated having students from homes where Arabic was spoken and 14 (6%) who indicated having students from homes where Tagalog was spoken.

Table 6 presents a summary of the most common dialects spoken in the homes of the respondents’ students. Respondents reported African American Vernacular English \((n = 184, 83\%)\), Hispanic English Vernacular \((n = 183, 82\%)\), Southern Dialect \((n = 50, 23\%)\), and Caribbean Dialect \((n = 42, 19\%)\) as the dialects most often spoken in their students’ homes.

### Table 5 – Languages Other Than English Spoken by Speech-Language Pathologists’ Students

<table>
<thead>
<tr>
<th>Languages</th>
<th>Frequency</th>
<th>%</th>
</tr>
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<tbody>
<tr>
<td>Arabic</td>
<td>17</td>
<td>8</td>
</tr>
<tr>
<td>Creole</td>
<td>62</td>
<td>28</td>
</tr>
<tr>
<td>Spanish</td>
<td>216</td>
<td>97</td>
</tr>
<tr>
<td>Tagalog</td>
<td>14</td>
<td>6</td>
</tr>
</tbody>
</table>

### Table 6 – Dialects Spoken by Speech-Language Pathologists’ Students

<table>
<thead>
<tr>
<th>Dialects</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American Vernacular English</td>
<td>184</td>
<td>83</td>
</tr>
<tr>
<td>Caribbean</td>
<td>42</td>
<td>19</td>
</tr>
<tr>
<td>Hispanic English Vernacular</td>
<td>183</td>
<td>82</td>
</tr>
<tr>
<td>Southern</td>
<td>50</td>
<td>23</td>
</tr>
</tbody>
</table>


*Linguistic Background of Participants*

Tables 7 and 8 depict the respondents’ linguistic backgrounds. Specifically, Table 7 provides summary results on whether respondents spoke or understood a language other than English, spoke or understood a nonstandard dialect, which language they learned first, age at which they learned a language other than English and/or nonstandard dialect, how long they had spoken a language other than English and/or nonstandard dialect, and where they learned a language other than English and/or a nonstandard dialect. Table 8 provides information on which language(s) and/or dialects the respondents most commonly spoke and proficiency in a language other than English and/or nonstandard dialect (Items 20-32 on the survey).

Twenty-five percent of the respondents indicated that they understood and/or spoke a language other than English. The most common language spoken among these participants was Spanish \((n = 40, 18\%)\). The second largest group of respondents \((n = 10, 5\%)\) indicated that they spoke French. Italian and Creole represented the third largest group of respondents, \((n = 5, 2\%)\), respectively. It is interesting to note here that while a large percentage of respondents indicated that they provided services to children from homes where Spanish and Creole was spoken, a mismatch existed between these students and the number of speech-language pathologists who reported understanding and/or speaking these languages.

Ninety-three percent of the respondents reported that English was the first language they learned while only 5% reported that they first learned a language other than English. The remaining group (2%) indicated that they simultaneously acquired English and another language. Of the respondents who indicated that they understood
and/or spoke a language other than English, 20 (9%) learned this language at between 12 and 18 years of age. This represented the largest group in this category. The majority \((n = 37, 17\%)\) of these respondents indicated that they had spoken a language other than English for greater than 10 years. Further, 24 (11\%) and 23 (10\%) reported learning a language other than English at school and home, respectively. Notably, 176 (80\%) of respondents indicated that they were not proficient in listening, 183 (83\%) in speaking, 189 (86\%) in reading, and 196 (89\%) in writing a language other than English.

Twenty-six percent of the respondents indicated understanding and/or speaking a dialect. The largest group of respondents \((n = 41, 19\%)\) in this category reported that they understood/spoke African American Vernacular English. This was followed by 17 (8\%) of respondents who reported that they understood and/or spoke Southern Dialect, 12 (5\%) who reported understanding and/or speaking Hispanic English Vernacular, and 8 (4\%) who reported understanding and/or speaking a Caribbean dialect. Once again, a stark contrast existed between the linguistic variations of students and the clinicians responsible for providing speech and language services to them.

Of the respondents who indicated that they understood/spoke a dialect, 26 (12\%) reported that they learned a dialect between birth to 3 years of age. This represented the largest group. The next largest group \((n = 14, 6\%)\) indicated that they learned a dialect when they were more than 18 years of age. Regarding the length of time that they had spoken a dialect, the vast majority of respondents \((n = 40, 18\%)\) indicated greater than 10 years. Further, 30 (14\%) indicated that they learned a dialect at home and 16 (7\%) indicated that they learned a dialect at school. This represented the two largest groups of respondents in this subcategory. Of these respondents, 166 (75\%) reported that they were
not proficient in listening, 179 (81%) in speaking and reading, respectively, and 192 (87%) in writing a nonstandard dialect.
Table 7 – *Summary of Linguistic Background of Speech-Language Pathologists*

<table>
<thead>
<tr>
<th>Speak/Understand</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Language Other Than English</td>
<td>56</td>
<td>25</td>
</tr>
<tr>
<td>Dialect</td>
<td>57</td>
<td>26</td>
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First Language Learned

<table>
<thead>
<tr>
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<th>Frequency</th>
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<td>206</td>
<td>93</td>
</tr>
<tr>
<td>Language Other Than English</td>
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</tr>
<tr>
<td>Simultaneously Learned</td>
<td>10</td>
<td>5</td>
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</table>

Age Learned Language Other Than English

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<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-3 Years</td>
<td>15</td>
<td>7</td>
</tr>
<tr>
<td>4-7 Years</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>8-11 Years</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>12-18 Years</td>
<td>20</td>
<td>9</td>
</tr>
<tr>
<td>Over 18 Years</td>
<td>14</td>
<td>6</td>
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</table>

Years Spoken Language Other Than English

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>%</th>
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</thead>
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<td>2</td>
</tr>
<tr>
<td>1-5 Years</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>6-10 Years</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Greater Than 10 Years</td>
<td>40</td>
<td>18</td>
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Location Learned

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>%</th>
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<tbody>
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<td>11</td>
</tr>
<tr>
<td>Home</td>
<td>23</td>
<td>10</td>
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<tr>
<td>Abroad</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
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<td>1</td>
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Age Learned Dialect

<table>
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<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-3 Years</td>
<td>26</td>
<td>12</td>
</tr>
<tr>
<td>4-7 Years</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>8-11 Years</td>
<td>4</td>
<td>2</td>
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<tr>
<td>12-18 Years</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Over 18 Years</td>
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<td>6</td>
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Years Spoken

<table>
<thead>
<tr>
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<th>Frequency</th>
<th>%</th>
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<td>&lt;1</td>
</tr>
<tr>
<td>1-5 Years</td>
<td>7</td>
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<td>6-10 Years</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Greater Than 10 Years</td>
<td>40</td>
<td>18</td>
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Table 7 Continued - *Summary of Linguistic Background of Speech-Language Pathologists*

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<thead>
<tr>
<th>Speak/Understand</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Location Learned</strong></td>
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</tr>
<tr>
<td>School</td>
<td>16</td>
<td>7</td>
</tr>
<tr>
<td>Home</td>
<td>30</td>
<td>14</td>
</tr>
<tr>
<td>Abroad</td>
<td>1</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Other</td>
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<td>4</td>
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Table 8 - Languages Other Than English and Dialects Most Commonly Spoken and/or Understood by Speech-Language Pathologists’ Proficiency Responses

<table>
<thead>
<tr>
<th>Languages</th>
<th>Frequency</th>
<th>%</th>
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<tbody>
<tr>
<td>Creole</td>
<td>5</td>
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<tr>
<td>French</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>Italian</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Spanish</td>
<td>40</td>
<td>18</td>
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</table>

<table>
<thead>
<tr>
<th>Dialects</th>
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<th></th>
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</thead>
<tbody>
<tr>
<td>African American Vernacular English</td>
<td>41</td>
<td>19</td>
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<tr>
<td>Caribbean Dialect</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Hispanic English Vernacular</td>
<td>12</td>
<td>5</td>
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<tr>
<td>Southern</td>
<td>7</td>
<td>8</td>
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<table>
<thead>
<tr>
<th>Listening Proficiency (Language)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Proficient</td>
<td>176</td>
<td>80</td>
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<tr>
<td>Somewhat Proficient</td>
<td>21</td>
<td>10</td>
</tr>
<tr>
<td>Proficient</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>Very Proficient</td>
<td>12</td>
<td>5</td>
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<table>
<thead>
<tr>
<th>Speaking Proficiency (Language)</th>
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<th></th>
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</thead>
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<tr>
<td>Not Proficient</td>
<td>183</td>
<td>83</td>
</tr>
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<td>Somewhat Proficient</td>
<td>22</td>
<td>10</td>
</tr>
<tr>
<td>Proficient</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Very Proficient</td>
<td>10</td>
<td>5</td>
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<table>
<thead>
<tr>
<th>Reading Proficiency</th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Proficient</td>
<td>189</td>
<td>86</td>
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<tr>
<td>Somewhat Proficient</td>
<td>11</td>
<td>5</td>
</tr>
<tr>
<td>Proficient</td>
<td>11</td>
<td>5</td>
</tr>
<tr>
<td>Very Proficient</td>
<td>10</td>
<td>5</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Writing Proficiency</th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Not Proficient</td>
<td>196</td>
<td>89</td>
</tr>
<tr>
<td>Somewhat Proficient</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>Proficient</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Very Proficient</td>
<td>7</td>
<td>3</td>
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<table>
<thead>
<tr>
<th>Listening Proficiency (Dialect)</th>
<th></th>
<th></th>
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<tr>
<td>Not Proficient</td>
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<td>75</td>
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<td>3</td>
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<tr>
<td>Proficient</td>
<td>23</td>
<td>10</td>
</tr>
<tr>
<td>Very Proficient</td>
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### Table 8 Continued - Languages Other Than English and Dialects Most Commonly Spoken and/or Understood by Speech-Language Pathologists’ Proficiency Responses

<table>
<thead>
<tr>
<th>Speaking Proficiency</th>
<th>Frequency</th>
<th>%</th>
</tr>
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<tbody>
<tr>
<td>Not Proficient</td>
<td>179</td>
<td>81</td>
</tr>
<tr>
<td>Somewhat Proficient</td>
<td>17</td>
<td>8</td>
</tr>
<tr>
<td>Proficient</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Very Proficient</td>
<td>17</td>
<td>8</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reading Proficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Proficient</td>
</tr>
<tr>
<td>Somewhat Proficient</td>
</tr>
<tr>
<td>Proficient</td>
</tr>
<tr>
<td>Very Proficient</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Writing Proficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Proficient</td>
</tr>
<tr>
<td>Somewhat Proficient</td>
</tr>
<tr>
<td>Proficient</td>
</tr>
<tr>
<td>Very Proficient</td>
</tr>
</tbody>
</table>

---

**Preservice and Inservice Training**

Table 9 is a summary of the data for preservice and inservice training. In Items 33 and 34 on the survey, participants reported whether they had taken courses and/or workshops in the following areas: (a) second language acquisition (48%, for both), (b) communication patterns in cultures where a language other than English is spoken (49% and 45%, respectively), (c) communication patterns in cultures where a dialect is spoken (43% and 32%, respectively), (d) differential assessment of bilingual versus monolingual individuals (35% and 30%, respectively), (e) cultural factors that influence learning (54% and 47%, respectively), (f) multicultural issues/ethnically diverse populations (58% and 53%, respectively), (g) assessment tools for bilingual/bidialectal students (30% and 26%, respectively), (h) language disorder versus language difference (67% and 52%,
respectively), (i) laws involved in the assessment and treatment of bilingual/bidialectal students (27% and 24%, respectively), (j) working with families (33% and 26%, respectively), and (k) how to utilize a language interpreter (24% and 18%, respectively). Remarkably, respondents reported they had the least amount of preservice and in-service training in the areas of interpreters (24% and 18% of the respondents, for preservice and in-service training, respectively), laws (27% and 24%, respectively), assessment tools (30% and 26%, respectively), working with families (33% and 26%, respectively), and differential assessment (35% and 30%, respectively).

Table 9 – *Summary of Speech-Language Pathologists’ Preservice and Inservice Training*

<table>
<thead>
<tr>
<th>Preservice Training (Course Work)</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Second Language Acquisition</td>
<td>107</td>
<td>48</td>
</tr>
<tr>
<td>Communication Patterns (Language)</td>
<td>108</td>
<td>49</td>
</tr>
<tr>
<td>Communication Patterns (Dialect)</td>
<td>96</td>
<td>43</td>
</tr>
<tr>
<td>Differential Assessment</td>
<td>78</td>
<td>35</td>
</tr>
<tr>
<td>Cultural Factors</td>
<td>119</td>
<td>54</td>
</tr>
<tr>
<td>Multicultural Issues</td>
<td>129</td>
<td>58</td>
</tr>
<tr>
<td>Assessment Tools</td>
<td>66</td>
<td>30</td>
</tr>
<tr>
<td>Disorder vs. Difference</td>
<td>149</td>
<td>67</td>
</tr>
<tr>
<td>Laws</td>
<td>59</td>
<td>27</td>
</tr>
<tr>
<td>Working with Families</td>
<td>72</td>
<td>33</td>
</tr>
<tr>
<td>Utilizing an Interpreter</td>
<td>53</td>
<td>24</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Inservice Training (Workshops)</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Second Language Acquisition</td>
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<td>48</td>
</tr>
<tr>
<td>Communication Patterns (Language)</td>
<td>100</td>
<td>45</td>
</tr>
<tr>
<td>Communication Patterns (Dialect)</td>
<td>70</td>
<td>32</td>
</tr>
<tr>
<td>Differential Assessment</td>
<td>66</td>
<td>30</td>
</tr>
<tr>
<td>Cultural Factors</td>
<td>104</td>
<td>47</td>
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<tr>
<td>Multicultural Issues</td>
<td>118</td>
<td>53</td>
</tr>
<tr>
<td>Assessment Tools</td>
<td>58</td>
<td>26</td>
</tr>
<tr>
<td>Disorder vs. Difference</td>
<td>114</td>
<td>52</td>
</tr>
<tr>
<td>Laws</td>
<td>52</td>
<td>24</td>
</tr>
<tr>
<td>Working with Families</td>
<td>58</td>
<td>26</td>
</tr>
<tr>
<td>Utilizing an Interpreter</td>
<td>40</td>
<td>18</td>
</tr>
</tbody>
</table>
Section Two

Research Question 1: What are the professional efficacy beliefs of speech-language pathologists about assessing the language skills of bilingual/bicultural/bidialectal students?

Quantitative results. In Item 35 on the survey, each participant indicated her or his degree of personal efficacy (competence in assessing a student’s language development in a language and/or dialect they do not understand or speak). Item 36 on the survey requested each participant to indicate his or her degree of general efficacy (most speech-language pathologists’ competence in assessing a student’s language development in a language and/or dialect they do not understand or speak). These two items addressed Research Question 1.

Regarding personal efficacy, the largest group of respondents \( n = 109, 49\% \) reported they felt somewhat competent in assessing a student’s language development in a language and/or dialect they did not understand or speak. This was followed by 53 respondents (24%) who reported they felt competent. Regarding general efficacy, the largest group of respondents \( n = 140, 63\% \) reported that most speech-language pathologists were somewhat competent in assessing a student’s language development in a language and/or dialect they did not understand or speak. The next largest group of respondents \( n = 46, 21\% \) in this subcategory reported that most speech-language pathologists were not competent. Table 10 lists a summary of results.
Table 10 – *Summary of Speech-Language Pathologists’ Personal and General Efficacy Responses*

<table>
<thead>
<tr>
<th>Personal Efficacy</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Competent</td>
<td>48</td>
<td>22</td>
</tr>
<tr>
<td>Somewhat Competent</td>
<td>109</td>
<td>49</td>
</tr>
<tr>
<td>Competent</td>
<td>53</td>
<td>24</td>
</tr>
<tr>
<td>Very Competent</td>
<td>11</td>
<td>5</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>General Efficacy</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Competent</td>
<td>46</td>
<td>21</td>
</tr>
<tr>
<td>Somewhat Competent</td>
<td>140</td>
<td>63</td>
</tr>
<tr>
<td>Competent</td>
<td>34</td>
<td>15</td>
</tr>
<tr>
<td>Very Competent</td>
<td>1</td>
<td>&lt;1</td>
</tr>
</tbody>
</table>

*Qualitative results.* Many mixed method researchers advocate for “quantitizing” or converting qualitative data into numerical codes, such as a frequency distribution of participants’ responses or the conceptualization of effect sizes (Becker, 1970; Becker, Geer, Hughes, & Strauss, 1977; Lazarfeld & Barton, 1955; Onwuegbuzie, 2001; Onwuegbuzie & Johnson, 2004). In fact, Lazarfeld and Barton, (1955) coined the term “quasi-statistics.” Becker (1970) asserted that failing to arrive at conclusions utilizing quasi-statistics in qualitative data was a major fault and demonstrated a lack of rigor. Thus, qualitative findings in this study also are accompanied by frequency distributions.

Responses to professional efficacy beliefs about assessing the language skills of bilingual/bicultural/bidialectal students were similar among interview participants of color. Those from culturally and/or linguistically diverse backgrounds demonstrated greater personal efficacy beliefs than their White counterparts. This was particularly true of the bilingual speech-language pathologists who spoke languages such as Creole, Spanish, and Tagalog. Specifically, speech-language pathologists of color (75%) primarily believed themselves to be “very competent” or “competent.” The following
statements are a description of the personal efficacy beliefs of the interview participants of color:

I think I’m very competent. (Latina speech-language pathologist)

I feel very competent. I feel that I do the best job that I can and if I don’t know the answers then I need to go out and find the answers or at least attempt to find the answers. (Latina speech-language pathologist)

I feel like I’m competent but I still have room to learn, I mean we should all keep learning, but I think that I am competent, I’m sufficient for now. (Asian speech-language pathologist)

I feel reasonably comfortable knowing what to do or what to say and when to hold and when to fold and when to walk away. I know really when to say I can’t do it, I need an interpreter, I need another speech pathologist involved. Outside of having a second language myself, I feel reasonably comfortable because that was my goal in figuring that out 12 credits ago. (African American speech-language pathologist)

I’m not one to sit back and go ‘I really don’t have any idea.’ And if I don’t have an idea, I’m gonna try and seek out the information in order to help the parents and the child in the best way that I know how. (Asian speech-language pathologist)

In contrast, the White speech-language pathologists believed that they were only “somewhat competent” (50%) or “not competent” (50%) at all. The following statements are a description of the personal efficacy beliefs of the White interview participants:

I wouldn’t say I am 100% competent but I would say that if I were put in a situation where I had no interpreter and the parents barely spoke English, then I would figure out what I needed to do to effectively serve that client because you can’t leave a client with not having the proper treatment and properly assessing them. So definitely, I would do what I needed to do as a professional and ethically to serve that client. (Haitian American speech-language pathologist)

I would say I’m not, I would give myself incompetent. I think I do my best based on the resources that I have and with the caseloads that I am faced with. I don’t feel like I was always the most qualified person to be providing these children services. (White speech-language pathologist)
Well I feel fairly adequate. Again, you know there’s the problem with me not being absolutely 100% sure that the test is being interpreted correctly. (White speech-language pathologist)

One speech-language pathologist believed that her personal efficacy depended on the student being assessed, that is, whether she was familiar with a particular student’s language and culture.

It all depends upon the student. If I am aware of the intricacies of the culture and of the language, I feel highly competent. However, if I am not, for instance, the German student I have, I feel highly incompetent. I don’t think I can adequately meet that child’s needs because I am not aware of the German culture and the little intricacies that they have. (Haitian American speech-language pathologist)

Many of the speech-language pathologists of color related personal experiences similar to those of their bilingual/bicultural/bidialectal students, as exemplified by the following:

I have always been able to relate to them more, especially since I didn’t learn English until I was older and I was labeled as dumb because my old language wasn’t as proficient as peers my age because of my second language so I have always been able to relate to culturally diverse students and have always had that knack of making them understand what they need to understand but not in a traditional way. When I went to school there was no such thing as testing in native languages. They wanted to retain both my brother and myself. And my father, being a college graduate, he refused. So if my father didn’t refuse and wasn’t an advocate for us, we would both be behind, we would have been retained in class but also we would have been put in a special class. We would have been labeled some form of ESE. However, even though my father was an advocate for us, he did listen to a lot of the teachers and a lot of the “professionals” who, at that time, told my parents to stop speaking the other languages to us. They were told that they needed to speak only English to us cuz we were speaking two different languages at home, French and Creole. We weren’t even speaking English at home. Because of that, our native languages regressed as our English progressed and as of now my brother is not fluent in any language. I have tried very hard to maintain my fluency, but it is not as appropriate and as correct as it should be. (Haitian-American speech-language pathologist)

I identify. I have a lot of empathy for them and not only empathy. I just understand. For some reason, there’s a connection. I grew up in a bilingual home. (Latina speech-language pathologist)
I don’t have a problem with it, particularly with AAVE (African American Vernacular English), because that’s my dialect. I was raised in Midwest Ohio but moved from Ohio to Maryland at a very young age and went from a primarily Caucasian environment to predominantly African American and was picked on, made fun off, Black girl talking White, etc., etc. So did what I had to do to learn to code switch. My parents knew enough to understand that in society we would be judged based upon how we spoke. It didn’t matter how much money we had, didn’t matter what kind of clothes we wore, what kind of house we lived in, when we went out in the real world to interview for that job, we just had to learn Standard English. They knew the challenges we would be up against if we didn’t learn it. The hardest thing I’ve found is trying to get the classroom teachers to understand that, look, this isn’t wrong. It’s just different. What he’s (student) saying is the same thing you’re saying in standard English. So I try to impress upon them (teachers) not to make the child feel that the way you’re teaching them is the right way. It’s just a different way. You’re saying the same things, but this is a different way to say it, you know. (African American speech-language pathologists)

Interview participants reported mixed beliefs of general efficacy for assessing students who were bilingual, bicultural, and/or bidialectal. The largest group of interview respondents (40%) believed that the field of speech-language pathology was not competent. The next largest group of respondents (30%) believed that the field was competent. This was followed by the third group (20%) who believed that the field was somewhat competent. Once again, one interview participant believed that the field’s general efficacy relied on individual therapists and school districts. Most believed that the field of speech-language pathology was making strides to meet the needs of culturally and linguistically diverse student learners. All interview participants believed that much more work is needed in this area. Table 11 presents a summary of interview participants’ personal and general efficacy beliefs. The following statements exemplify participants’ beliefs:

I know we are trying but whether it’s effective or not, I can’t say. Unless it directly affects you, most people won’t go out there and find out the information. …I know that ASHA has done, they’ve done numerous things to try to include the
assessment and treatment of culturally diverse populations. So for one to think that the information is not out there it would be inaccurate because it is out there. It’s just a matter of one researching it and finding the information. (Haitian American speech-language pathologist)

I think we are striving toward ideals for the children, but we still have a ways to go. (Asian speech-language pathologist)

I don’t think we are meeting the needs at all. I mean not at all. There is just so much, at least here, it’s difficult to say because we don’t have as many bilingual therapists as we should. (Asian speech-language pathologist)

Table 11 – Summary of Interview Participants’ Personal and General Efficacy Beliefs

<table>
<thead>
<tr>
<th>Personal Efficacy</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Competent</td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td>Somewhat Competent</td>
<td>1</td>
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</tr>
<tr>
<td>Competent</td>
<td>3</td>
<td>30</td>
</tr>
<tr>
<td>Very Competent</td>
<td>3</td>
<td>30</td>
</tr>
<tr>
<td>Depends</td>
<td>1</td>
<td>10</td>
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<table>
<thead>
<tr>
<th>General Efficacy</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
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<td>4</td>
<td>40</td>
</tr>
<tr>
<td>Somewhat Competent</td>
<td>2</td>
<td>20</td>
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<tr>
<td>Competent</td>
<td>3</td>
<td>30</td>
</tr>
<tr>
<td>Very Competent</td>
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<td>---</td>
</tr>
<tr>
<td>Depends</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Research Question 2: Do speech-language pathologists’ professional efficacy beliefs about assessing the language skills of bilingual/bicultural/bidialectal students vary as a function of demographic variables (i.e., race/ethnicity, years of experience, levels of professional efficacy, frequency of times with bilingual/bicultural/bidialectal children, proficiency in a language other than English, and proficiency in a dialect)?

This question examined the possible relationship between the criterion variables (speech-language pathologists’ professional efficacy - personal and general efficacy) and the predictor variables (i.e., speech-language pathologists’ race/ethnicity, years of...
experience, frequency of times with bilingual/bicultural/bidialectal children, proficiency in a language other than English, and proficiency in a dialect).

To gain a better understanding of the nature of the relationship between the criterion variable and the predictor variables, the data were analyzed using two Statistical Application Software (SAS, version 9.1.3) System procedures. The SAS System is a modular, integrated, and hardware-independent computer software system (Hatcher & Stepanski, 1997). It allows the researcher to carry out the most sophisticated multivariate analyses while simultaneously conducting simple analyses (Hatcher & Stepanski, 1997). The researcher can analyze data by submitting a short SAS program and retrieving a prewritten procedure from a library of prewritten statistical algorithms (Hatcher & Stepanski, 1997).

Results were analyzed using both bivariate correlation and multiple regression. First, the researcher used PROC CORR to compute Pearson correlations among the variables. This procedure is useful for understanding the simple bivariate relations among the variables (Hatcher & Stepanski, 1997). Means, standard deviations, Pearson correlations, and coefficient alpha reliability estimates for personal and general efficacy appear in Tables 12 and 13, respectively.

The correlations in the personal efficacy column of Table 12 provide the reader with information about the pattern of simple bivariate correlations between personal efficacy and the 11 predictor variables. The bivariate correlations revealed that none of the predictor variables were statistically significant; none were significantly related to personal efficacy. The $p$ value associates with each predictor all were above the traditional significance level of .05. Based on the above results, the researcher could not
reject the null hypotheses that personal efficacy and the 11 predictor variables are uncorrelated in the population.

The correlations in the general efficacy column of Table 13 provide the reader with information about the pattern of simple bivariate correlations between general efficacy and the 11 predictor variables. The bivariate correlations revealed one predictor variable that was statistically significantly related to general efficacy: Hispanic/Latino ($r = -.18$). This correlation was significant at $p < .05$. Based on these results, the researcher could reject the null hypotheses that general efficacy and Hispanic/Latino are uncorrelated in the population.

The correlation between general efficacy and the remaining predictor variables, in contrast, were not significant. The $p$ value associates with each remaining predictor all were above the traditional significant level of .05. Based on these results, the researcher could not reject the null hypotheses that general efficacy and these predictors variable are uncorrelated in the population. The bivariate correlations also revealed that the two criterion variables were significantly related to each other: personal efficacy and general efficacy ($r = .56$). The correlation between personal efficacy and general efficacy was significant at $p < .001$.

The researcher then used PROC REG to perform a multiple regression analysis in which professional efficacy was “simultaneously regressed on the predictor variables” (Hatcher & Stepanski, 1997, p. 417). This analysis determined whether a statistically significant relationship exists between professional efficacy and the linear grouping of predictors (Hatcher & Stepanski, 1997). Stated differently, the researcher learns whether a statistically significant relationship exists between professional efficacy and the
predictor variables taken as a group (Hatcher & Stepanski, 1997). Additionally, the researcher reviewed the multiple regression coefficients for each of the predictors to determine which were statistically significant and which standardized coefficients were relatively large (Hatcher & Stepanski, 1997, p. 417).

The observed $R^2$ value specifies the percent of variance in the criterion variable that is explained by the linear grouping of predictor variables (Hatcher & Stepanski, 1997). Regarding personal efficacy, $R^2 = .08$. This indicates that the linear combination of the 11 predictor variables accounted for 8% of the variance in personal efficacy, $F(11, 195) = 1.48, p = .14$, adjusted $R^2 = .03$. In this case, the $p$ value is greater than .05. Thus, the researcher cannot reject the null hypothesis and conclude that the obtained value of $R^2$ is statistically significant. Stated differently, the researcher cannot conclude that $R^2$ is statistically greater than zero in the population.

Concerning general efficacy, $R^2 = .09$. This indicates that the linear combination of the 11 predictor variables accounted for 9% of the variance in general efficacy, $F(11, 202) = 1.83, p = .051$, adjusted $R^2 = .04$. In this case, the $p$ value is at the traditional significance level of .05. Thus, the researcher can reject the null hypothesis and conclude that the obtained value of $R^2$ is statistically significant.

The researcher reviewed beta weights (standardized multiple regression coefficients) to assess the relative significance of the 11 variables in the prediction of personal efficacy and general efficacy. The beta weights are presented in Tables 14 and 15 for personal efficacy and general efficacy, respectively. Table 14 demonstrates that two of the 11 predictors displayed statistically significant beta weights: other race and years worked with bilingual/bicultural/bidialectal students. Both predictors demonstrated
small beta weights. Other race demonstrated a beta weight at -.16 ($p < .05$), while the beta weight for years worked with bilingual/bicultural/bidialectal students was .22 ($p < .05$).

Table 15 demonstrates that two of the 11 predictors displayed statistically significant beta weights: Hispanic and years worked with bilingual/bicultural/bidialectal students. Once again, both predictors displayed small beta weights. Hispanic demonstrated a beta weight at -.20 ($p < .05$), while the beta weight for years worked with bilingual/bicultural/bidialectal students was .27 ($p < .05$).
Table 12 - Means, Standard Deviations, and Intercorrelations Involving Demographic and Personal Efficacy Variables

<table>
<thead>
<tr>
<th>Variable</th>
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<tr>
<td>3. Hispanic/Latino</td>
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<td>-.05</td>
<td>-.05</td>
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<tr>
<td>5. Years worked in field</td>
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<td>-.05</td>
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<tr>
<td>6. Years provided services to children and youth</td>
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<td>-.16</td>
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<td>7. Percentage of students from homes where</td>
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<tr>
<td>language other English is spoken</td>
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<tr>
<td>8. Percentage of students from homes where a dialect is spoken</td>
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<td>.01</td>
<td>.01</td>
<td>.22</td>
<td>.07</td>
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<tr>
<td>bilingual/bicultural/bidialectal students</td>
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<td>.03</td>
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<td>.05</td>
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</table>

Note. n = 207.

No p values less than .05
Table 13 - Means, Standard Deviations, and Intercorrelations Involving Demographic and General Efficacy Variables

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<tr>
<th>Variable</th>
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<td>-.18*</td>
<td>-.08</td>
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<tr>
<td>7. Percentage of students from homes where language other English is spoken</td>
<td>2.73</td>
<td>.80</td>
<td>-.01</td>
<td>.04</td>
<td>.12</td>
<td>.16</td>
<td>-.14</td>
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<tr>
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<td>.88</td>
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<td>.40</td>
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<tr>
<td>9. Frequency of time spent with bilingual/bicultural/bidialectal students</td>
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<td>.48</td>
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<td>.00</td>
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<td>-.04</td>
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<td>-.02</td>
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<td>-.13</td>
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<td>12. Proficiency in a dialect</td>
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<td>.03</td>
<td>.04</td>
<td>.36</td>
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*Note. n = 214.*

*p < .05
Table 14 - *Beta Weights Obtained in Multiple Regression Analyses Predicting Personal Efficacy*

<table>
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<th>Predictor</th>
<th>Beta Weights</th>
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<tr>
<td>African American/Black</td>
<td>-.01</td>
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<tr>
<td>Hispanic/Latino</td>
<td>-.09</td>
</tr>
<tr>
<td>Other race</td>
<td>-.16*</td>
</tr>
<tr>
<td>Years worked in the field of speech-language pathology</td>
<td>-.27</td>
</tr>
<tr>
<td>Years provided speech-language services to children and youth</td>
<td>.07</td>
</tr>
<tr>
<td>Percentage of students from homes where language other English is spoken</td>
<td>.06</td>
</tr>
<tr>
<td>Percentage of students from homes where a dialect is spoken</td>
<td>.05</td>
</tr>
<tr>
<td>Frequency of time spent with bilingual/bicultural/bidialectal students</td>
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</tr>
<tr>
<td>Years worked with bilingual/bicultural/bidialectal students</td>
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<tr>
<td>Proficiency in a language other than English</td>
<td>.14</td>
</tr>
<tr>
<td>Proficiency in a dialect</td>
<td>.06</td>
</tr>
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</table>

*Note.  n = 207*

Beta weights are standardized multiple regression coefficients obtained when personal efficacy was regressed on all 11 predictors.

*p <.05
Table 15 - *Beta Weights Obtained in Multiple Regression Analyses Predicting General Efficacy*

<table>
<thead>
<tr>
<th>Predictor</th>
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<td>African American/Black</td>
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</tr>
<tr>
<td>Frequency of time spent with bilingual/bicultural/bidialectal students</td>
<td>-.07</td>
</tr>
<tr>
<td>Years worked with bilingual/bicultural/bidialectal students</td>
<td>.27*</td>
</tr>
<tr>
<td>Proficiency in a language other than English</td>
<td>.04</td>
</tr>
<tr>
<td>Proficiency in a dialect</td>
<td>-.10</td>
</tr>
</tbody>
</table>

*Note. n = 214*  

Beta weights are standardized multiple regression coefficients obtained when personal efficacy was regressed on all 11 predictors.

*p < .05*
Research Question 3: What do speech-language pathologists perceive as the supports needed to assess competently the language skills of bilingual/bicultural students?

Quantitative Results

Item 39 on the survey asked respondents to rate items in terms of importance on a 5-point Likert scale (i.e., very unimportant, unimportant, not sure, important, and very important). The researcher divided these items into preservice and inservice solutions (i.e., more academic course work in this area, more practicum experience with bilingual/bicultural/bidialectal students, more active recruitment of bilingual/bicultural/bidialectal speech-language pathologists, more seminars and workshops on this topic, more seminars and workshops on this topic, more journal articles on this topic, and easier access to a bilingual/bicultural/bidialectal speech-language pathologist pool in their county). This item addressed Research Question 3.

Regarding solutions at the preservice level, 56% of respondents rated the provision of more academic course work in this area as important, 51% thought it was important to offer more practicum experience with bilingual/bicultural/bidialectal students, and 44% rated more active recruitment of bilingual/bicultural/bidialectal speech-language pathologists as very important. Regarding solutions at the inservice level, 57% rated the provision of more seminars and workshops on this topic as important, 49% rated the offering of more journal articles on this topic as important, 53% rated easier access to a bilingual/bicultural/bidialectal speech-language pathologist as very important, 56% rated more experience with bilingual/bicultural/bidialectal students as important, and 45% rated more active recruitment of bilingual/bicultural/bidialectal speech-language pathologists as very important. The above percentages represented the
most frequently chosen levels of importance for each solution. Table 16 is a summary of respondents’ opinions of how to improve the field.

Table 16 – Solutions for Improving the Field (Rated as 5, very important or 4, important)

<table>
<thead>
<tr>
<th>Solutions (Preservice)</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>More Course Work</td>
<td>179</td>
<td>81</td>
</tr>
<tr>
<td>More Practicum Experience</td>
<td>168</td>
<td>76</td>
</tr>
<tr>
<td>Active Recruitment</td>
<td>184</td>
<td>83</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Solutions (Inservice)</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>More Seminars</td>
<td>190</td>
<td>86</td>
</tr>
<tr>
<td>More Journal Articles</td>
<td>141</td>
<td>64</td>
</tr>
<tr>
<td>Access to Bilingual/Bidialectal SLPs</td>
<td>201</td>
<td>91</td>
</tr>
<tr>
<td>More Practicum Experience</td>
<td>155</td>
<td>70</td>
</tr>
<tr>
<td>Active Recruitment</td>
<td>185</td>
<td>84</td>
</tr>
</tbody>
</table>

Qualitative Results

An essential step in the analysis of qualitative data involves the development of categories (Constas, 1992). According to Goetz and LeCompte (1984, as cited in Constas, 1992), the goal of qualitative research is to reconstruct the particular categories that research participants employed to conceptualize their own worldviews. The researcher utilized a modified method of the Stevick-Colaizzi-Keen Method of Analysis of Phenomenological data (Moustakas, 1994) to organize and analyze the verbatim transcript of the participants’ beliefs about assessing the language skills of bilingual/bicultural/bidialectal students. The following steps were taken:

- Reviewed each statement for significance as they described the experience of assessing the language skills of bilingual/bicultural/bidialectal children.
- Recorded all statements relevant to the phenomenon; included all statements that were relevant to Research Questions 1, 3, and 4.
• Listed each non-repetitive, non-overlapping statement; redundant and vague responses were omitted. These statements are the invariant horizons or meaning units of the experience of assessing bilingual/bicultural/bidialectal children.

• Associated and clustered the invariant meaning units into themes.

• Provided frequency data on the descriptive statements/ideas according to the percentage of speech-language pathologists who commented about each theme that emerged.

• Synthesized the invariant meaning units and themes into a description of the textures of the experience. Verbatim examples were included.

• Reflected on textural description and constructed a description of the structures of the experience through imaginative variation.

• Constructed a textural-structural description of the meanings and essences of the experience; descriptions represented the participants’ views about their professional efficacy beliefs and perceived supports and barriers to assessing the language skills of bilingual/bicultural/bidialectal students.

Perceived supports were evident throughout the interview transcripts. When asked what supports were needed, the following six themes emerged:

• Need for standardized tests in multiple languages and multicultural contexts

• Need more Bilingual speech-language pathologists

• Need more exposure to diverse students during clinical practicum experience

• Need more resources

• Need more research focus on multicultural speech-language issues

• Need ASHA requirement for certification in another language; Need required
continuing education units/credits specifically in multicultural issues

Each of these themes is described in what follows. Table 17 contains the raw intensity effect sizes for the six categories (themes) associated with perceived supports. Raw intensity effect sizes are based on numbers of participants selecting numerous themes (Onwuegbuzie & Teddie, 2003; Witcher, Onwuegbuzie, & Minor, 2001).

Need for standardized tests in multiple languages and in multicultural contexts. Fifty percent of the interview participants (n = 10) reported a need for standardized tests in multiple languages and multicultural contexts. Interview participants believed that having tests in multiple languages is of critical importance to the bilingual/bicultural/bidialectal students they assessed and the field of speech-language pathology as a whole.

An ideal test would put into account the cultural differences and the language differences between cultures or among cultures, but we don’t live in an ideal world. (Asian speech-language pathologist)

Having the proper test, like if you know ahead of time that you are going to be assessing a child who’s bilingual, having the proper test, even if it’s just a simple, you know, vocabulary test…That would be helpful just to have a vocabulary base to see how their vocabulary is. (Haitian American speech-language pathologist)

Further, participants acknowledged that certain language tests existed in the Spanish language. While language tests exist in the Spanish language, most of the speech-language pathologists interviewed stated that tests in other languages were primarily nonexistent and desperately needed. This is evident in the following statement:

To be honest with you, I think it’s unfair cuz there are no standardized assessments for bilingual students, especially when they speak a language other than Spanish. They finally have instruments that are in Spanish dialects, not just standardized Spanish, but Spanish dialects where lets say Spanish from Venezuela is not the same as Spanish from Puerto Rico. But they don’t have any standardized testing for students who speak a language other than Spanish and considering I don’t speak Spanish, I don’t assess those students. I assess the other students and it’s hard. Like for instance, the language sample. There is one part of
the language sample where they [students] have to give directions and the example they give is how to make a peanut butter and jelly sandwich. That is an American thing. I mean, growing up, I never had peanut butter and jelly sandwiches. I didn’t have peanut butter and jelly sandwiches until I was in college cuz that’s not something that as Haitians we do. We always do the traditional rice and beans stuck together with chicken or traditional Haitian dishes. We don’t have dishes like that. The closest we have is like bread and butter and it’s not even the same way Americans do it. We do ours completely different. So a lot of the examples we have, if you are not really from this country, the child is at a disadvantage and being charged and graded incorrectly. (Haitian American speech-language pathologist)

However, some of the interviewees stated that while tests exist in the Spanish language, they are limited. They do not take into consideration the various within-group differences in the Spanish language and culture. Differences in vocabulary, for example, exist where one word in San Salvador may mean something very different in Puerto Rico.

Some of the tests are offered in Spanish… but we are also in a sense kind of limited as to what we can and can’t use as well as availability of some measures and screeners and things like that.

… some tests, the biases in the test, for instance, the CELF (Clinical Evaluation of Language Functions) -Spanish. Depending on where the child is from depends on how I score it. For instance, I know for a fact that children from north Puerto Rico, they’ll say nena instead of nina so that test will count that wrong. I would have to count that as wrong.

Some participants acknowledged that more tests are now taking into consideration dialectal variations of the English language when testing an area such as syntax.

I know that like the new PLS [Preschool Language Scale] and like right now the CELF-3, they have things that you know, characteristics of the different languages, mostly Spanish, and dialectical variations so that way you are not scoring the child incorrectly.

However, one participant spoke of a conflict between the allowances of such tests and the automatic assumption that all students of a race/ethnicity, particularly a student of color, use the same speech patterns. This is reflected in the following statements:
One thing I have a huge problem with and I don’t know if this is relevant … with African Americans a lot of the tests allow like if they make a mistake, and say hisself, it’s okay. I have a problem with that because especially if I know the class (SES) that person is from … because one thing I like to do is try to get to know the parents, try to get to know the background of the child … and if the child’s socioeconomic status is a little bit higher and the family is not speaking the Ebonics, then I’m going to count it wrong … but it has not been like that. Because he’s African American it’s okay for him. (Latina speech-language pathologist)

I assessed a White child who was coming from a low income (background). I knew the area he lived in and I heard his mother speak. I gave him the CELF-3 and I believe it’s one of the syntax portions, where the hisself, herself, that portion, I can’t remember what it is offhand. Well, he said hisself and many people were telling me to mark it wrong but I said I heard his mom say it. How can I mark it wrong? He’s getting that at home, his community. Because, once I brought that up, then they didn’t know what to do. Either I was going to mark it right or wrong. I marked it right because it’s almost to me discriminatory in another way. Because he’s White you have to mark it wrong? (Latina speech-language pathologist)

Need more bilingual speech-language pathologists. A second theme that emerged was the need for more bilingual speech-language pathologists. Ninety percent of the interview participants believed that it was more appropriate for a bilingual speech-language pathologist to assess bilingual children. Many of the interviewees stated that a backlog of bilingual students, waiting to be assessed, was common because of the lack of accessible bilingual speech-language pathologists in their counties. Of the bilingual speech-language pathologists employed by the school districts, most of them were English/Spanish speakers only. This caused a dilemma for students who spoke a foreign language other than Spanish.

I honestly just think, in summary, that I would prefer to use a speech pathologist. I mean, of course I know that this is in a perfect world, but I’m not really comfortable using interpreters. If you need an interpreter, it’s the next best thing probably to a speech pathologist in the field. I think there are only four bilingual speech pathologists in ______________ County, speaking Spanish, from what I’ve been told. (African American speech-language pathologist)
Since I am one of the few bilingual SLPs that speaks Creole, usually that list is long and it’s timely so it’s not done in the most efficient manner. Unfortunately, I have to make an additional referral to one of the Spanish speaking SLPs in the county and test the student. I could be waiting about a month for a kid to be assessed. (Haitian American speech-language pathologist)

If the child is completely bilingual speaking… I really think that translators are great but a speech therapist that has been, I don’t know how I should say this, but is qualified to test in both the English and Spanish, a bilingual speech pathologist, should be the one to assess the child because they can maybe pull things out in Spanish versus English as well as knowing the test. (Latina speech-language pathologist)

…Sometimes we need to look beyond standard scores and use our clinical judgment. Just because a psychological test says that the dominant language is English does not necessarily mean that you could only test them in English. I feel that even if you test them in English they should be referred to a bilingual therapist to be tested in Spanish also and compare results for me to be more accurate. (Latina speech-language pathologist)

Well I think that the ideal situation would be that a speech-language pathologist assess these children in their language. (White speech-language pathologist)

*Need more exposure to diverse students during clinical practicum experience.*

When asked about their graduate school experiences, 60% of the speech-language pathologists reported that they wanted their practica to include more experiences with a wide variety of students, particularly those from culturally and linguistically diverse backgrounds. They believed this experience would have better prepared them to provide speech and language services with this population, as characterized by the following:

Just is not anywhere representative of what’s in the general population, not at all, not enough diversity, at least not when I was in school. It may have changed now and maybe a better effort is being made towards that because maybe somebody is doing just what you’re doing, talking about it rather than saying okay this is what you might see. No, put me in an environment where I can see this and I can see that and I can see because it’s out there. I am sure there are people who would be happy to allow the university to do a collaborative type of thing with the school district even to say you know what, all right, we are going to go to this particular area and look at this population or a school that is fully diverse just to get this exposure. It would be important because it really would prepare you then for what
you’re going to face when you get out of school. I mean, not everybody’s just a phonetically impaired child that needs a little articulation therapy. (African American speech-language pathologist)

One thing that I regretted about my master’s training was that I didn’t have the opportunity to work with a lot of culturally diverse populations. (Haitian American speech-language pathologist)

I think there should be, like for instance, you’ve got an internship usually in different settings. I say even with the settings, they should also have a certain amount of hours with multicultural people. We really need to be exposed and in a lot of places they don’t do that. I mean you don’t get a chance to anyway, you take what you can get, as far as hours. But I think also socioeconomic not just cultural but socioeconomic. (Latina speech-language pathologist)

Need more resources. Another theme that emerged was the need for more resources such as an easily accessible staffed clearinghouse. Sixty percent of the interview participants reported the need for more resources. Specifically, the interview participants stated that a center, website with more than articles, or a cross-county network of resources and available culturally and/or linguistically diverse speech-language pathologists would be beneficial. The following statements provide a description:

Well, I think they should appoint in every school district, I’d take the top ten urban school districts, there should be an appointment of a person who deals with multicultural issues. For example, there should be a go to person in each urban school district, urban being a school district that had a majority of, 40% or more ethnic minority students at least. Then maybe there should be a region, like, you know if a school district like, for example, in our case, __________ is more of an urban school setting; perhaps there should be someone you could go to, a clinician. She could probably speak to the issues of multicultural issues in education and perhaps multicultural issues in speech pathology. (African American speech-language pathologists)

I think there needs to be a way to go and observe and talk to other therapists in the field that have more experience in this area. I think there needs to be maybe even a website that people can go and ask questions and get responses to, you know. I’m having this case scenario and what are some things to do or options to go forth with. I know ASHA has a website that you can go to and ask questions but I think it also needs to, in some cases, it need to be a quicker response time than
plugging in your questions and waiting for a response. (Latina speech-language pathologist)

…At least to have a website where we can go to and just type in a region and type in an area and get an example of the dialectical differences. (Haitian American speech-language pathologist)

Sometimes you don’t have access to somebody that’s bilingual in your school that can translate. How do you go about finding assistance or programs out there? Are there resources…where do you go to look for this information?…because surfing the web is great but sometimes its very frustrating too when you can’t find exactly what you are looking for in the first couple of attempts for somebody that has limited patience? (Latina speech-language pathologist)

I think we need to network for one another. If we’re in the county, having an area where we have questions. I think there should be a criteria set up. I think the county in itself should have support, contacts. We may not have someone who speaks Creole but, hey, there may be a speech therapist outside that can help give us ideas. (Latina speech-language pathologist)

*Need more research focus on multicultural speech-language issues.* Of the 10 interview participants, three (30%) felt that more research is needed in the areas of assessment and treatment of bilingual/bicultural/bidialectal students. Further, these speech-language pathologists reported the need to develop more materials and research-based practices in multicultural speech-language issues, as exemplified by the following:

It’s just based on what your knowledge is, so…more people wanting to go get their doctorates to give therapists like me the materials they need [to provide effective speech-language services]. (Latina speech-language pathologist)

In our field there’s not enough research being done on it and maybe if ASHA probably made that a priority for them to receive those type of, develop those type of materials, it could be…Even though it’s becoming more and more important and more prevalent, I just don’t see it as something that’s…I think we are now just beginning to address Spanish. We kind of have dealt somewhat with African American English. (African American speech-language pathologist)

*Need ASHA requirement for certification in a language other than English; Need continuing education units/credits specifically in multicultural issues.* Forty percent of
the interview participants believed that they were at a disadvantage because of their inability to speak another language. Further, 60% of these professionals felt that requiring certification in a language other than English and a specific number of continuing education units in multicultural speech-language issues would increase the knowledge base of speech-language pathologists. Culturally responsive practices would increase while the misidentification of culturally and linguistically diverse students as language disordered would decrease. The following statements provide a description of participants’ beliefs regarding this theme:

I say require having the continuing education. I would expect myself to go into more continuing education courses for bilingual students. I don’t have that much of a caseload when it comes to dialectal students, but I think I should have the requirement, for ASHA to have a requirement that we should have some kind of class of that sort or continuing education courses. (Latina speech-language pathologist)

I think, specifically, for speech pathologists to become nationally certified, ASHA does not require you to have a language component or that addresses cultural groups, not that I know of. I honestly think they should have a requirement in their program. (African American speech-language pathologist)

I think speech pathologists should be given the chance and also be aided by the county to receive certifications in other languages. Just as an example, I have never learned academically the way to write Creole. I took French in high school and college and I can read and write in French. I can read somewhat in Creole but I have never been able to write in it and I would have loved to have that opportunity to have someone instruct me. (Haitian American speech-language pathologist)

I think, requiring us, just as if you have to have a medical record errors 2 hours, or HIV update. So, maybe we need that requirement so that we are forced to unite and to move forward with this and make sure that we are fair to the people we are serving. (White speech-language pathologist)
Table 17 – Summary of Raw Intensity Effect Sizes for Themes Associated with Perceived Supports

<table>
<thead>
<tr>
<th>Generic Category</th>
<th>Raw Intensity Effect Sizes ($n = 10$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standardized tests in multiple languages</td>
<td>.5</td>
</tr>
<tr>
<td>Bilingual speech-language pathologists</td>
<td>.9</td>
</tr>
<tr>
<td>Exposure to diverse students</td>
<td>.6</td>
</tr>
<tr>
<td>More resources</td>
<td>.6</td>
</tr>
<tr>
<td>Research focus on multicultural speech-language issues</td>
<td>.3</td>
</tr>
<tr>
<td>ASHA requirement</td>
<td>.6</td>
</tr>
</tbody>
</table>

Research Question 4: What do speech-language pathologists perceive as barriers to assessing the language skills of bilingual/bicultural/bidialectal students?

Quantitative Results

In Item 37 on the survey, respondents indicated what problems they encountered in assessing bilingual/bicultural/bidialectal students with language disorders. This item addressed Research Question 4. Table 18 contains a summary of the data for the following problems: (a) lack of knowledge of client’s culture (b) lack of knowledge of the nature of second language acquisition (c) difficult to distinguish a language difference from a language disorder), (d) lack of availability of interpreters who speak the individual’s language, (e) lack of availability of interpreters who speak the individual’s dialect, (f) lack of availability of bilingual speech-language pathologists who speak the individual’s language, (g) lack of availability of bidialectal speech-language pathologists who speak the individual’s dialect, (h) lack of developmental norms and standardized assessment tools in languages other than English, (i) lack of developmental norms and standardized assessment tools in speakers of nonstandard dialects, (j) time allocated by your employer for assessment administration, scoring, and interpretation, (k) utilizing test
scores of translated tests, and (l) language tests published in a language other than English with flawed normative samples. In terms of problems, lack of availability of bilingual speech-language pathologists, lack of developmental norms and standardized assessment tools in languages other than English, and lack of availability of interpreters were the problems most frequently reported by respondents.

Table 19 is a summary of responsibilities. In terms of responsibility for assessment (Item 36 on the survey), participants were asked who should provide language assessment to bilingual/bidialectal students with language problems. Respondents were to choose the statement they agreed with the most out of five possibilities: bilingual education specialists, English as a second language specialists (ESL), speech-language pathologists, professionals should collaborate, and other. In the space provided for “other”, respondents primarily specified “bilingual speech-language pathologists” as the professionals who should be responsible for assessment. Altogether, respondents most frequently chose “collaboration” (58%).

Table 18 – Problems Encountered by Speech-Language Pathologists

<table>
<thead>
<tr>
<th>Problem</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cultural Knowledge</td>
<td>74</td>
<td>33</td>
</tr>
<tr>
<td>Second Language Acquisition</td>
<td>64</td>
<td>29</td>
</tr>
<tr>
<td>Distinguishing Disorder vs. Difference</td>
<td>89</td>
<td>40</td>
</tr>
<tr>
<td>Available Interpreters (Language)</td>
<td>123</td>
<td>56</td>
</tr>
<tr>
<td>Available Interpreters (Dialect)</td>
<td>75</td>
<td>34</td>
</tr>
<tr>
<td>Available Bilingual SLPs</td>
<td>147</td>
<td>67</td>
</tr>
<tr>
<td>Available Bidialectal SLPs</td>
<td>82</td>
<td>37</td>
</tr>
<tr>
<td>Standardized Assessment – Language</td>
<td>133</td>
<td>60</td>
</tr>
<tr>
<td>Standardized Assessment – Dialect</td>
<td>94</td>
<td>43</td>
</tr>
<tr>
<td>Allotted Assessment Time</td>
<td>67</td>
<td>30</td>
</tr>
<tr>
<td>Translated Test Scores</td>
<td>74</td>
<td>33</td>
</tr>
<tr>
<td>Flawed Normative Samples</td>
<td>58</td>
<td>26</td>
</tr>
<tr>
<td>(In tests published in other language)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 19 – Summary of Responsibility Responses

<table>
<thead>
<tr>
<th>Responsible Professional</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bilingual Education Specialists</td>
<td>17</td>
<td>8</td>
</tr>
<tr>
<td>ESL Specialists</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Speech-Language Pathologists</td>
<td>36</td>
<td>16</td>
</tr>
<tr>
<td>Professional Should Collaborate</td>
<td>128</td>
<td>58</td>
</tr>
<tr>
<td>Other</td>
<td>34</td>
<td>15</td>
</tr>
</tbody>
</table>

**Qualitative Results**

The researcher utilized a modified method of the Stevick-Colaizzi-Keen Method of Analysis of Phenomenological data (Moustakas, 1994), previously stated, to organize and analyze the verbatim transcript of the participants’ beliefs regarding barriers to assessing the language skills of bilingual/bicultural/bidialectal students. Like supports, perceived barriers were evident throughout the interview transcripts. In addition to the above bulleted perceived supports, the following five themes regarding barriers emerged:

- Limited coursework on multicultural speech-language issues at graduate level
- Existing coursework / professional development training must provide information that is more specific
- No protocol / systematic method in place
- Interpreters facilitate process in absence of a bilingual speech-language pathologist, but are not trained in test protocol
- Difficulty distinguishing a language difference from a language disorder

Table 20 is a summary of intensity effect sizes for the five categories (themes) associated with interview participants’ perceived barriers.
Limited coursework on multicultural speech-language issues at graduate level;

Existing coursework / professional development training must provide information that is more specific. Most (80%) interview participants reported that they received a minute number of graduate-level coursework in the area of multicultural speech-language issues.

I think we need more than one course and I think we need it introduced earlier on than right at the end of your graduate studies. (White speech-language pathologist)

You know, I don’t recall any specific coursework. Every class will touch on, oh you have to worry about cultural diversity or environmental aspects about a specific culture and things like that, but there was never any type of definitive course that focused on all of these issues that can and do arise when working with (these children). (Latina speech-language pathologist)

They primarily believed that the coursework and inservice training taken only “glossed” over topics. These speech-language pathologists would have preferred information specific to various dialects, languages, and cultures.

I’ve taken several courses and they might have talked more about the general but, you’re not really walking away with anything and some of the people who have taught me have known less than me. (African American speech-language pathologist)

I think we should have at least a resource. We should have our own books on the culture in terms of not only the language spoken but the culture, about how to approach different cultures, like the little girl I was talking to you about. They’re from more of a Muslim background and you don’t really speak to the woman as much. The man is the decision maker. (African American speech-language pathologist)

When asked if there was a content area that they would have liked either to receive training in or additional information about, one speech-language pathologist responded:

…having a class on learning language development and maybe the top five other languages that are spoken, like Asian, Spanish, Arabic, you know, other languages that are predominantly spoken in the United States, really looking through the language development of other languages and the linguistics of that too, a linguistic program. (Latina speech-language pathologist)
No protocol / systematic method in place. Added to the above theme was participants’ belief that a specific protocol or systematic method on assessing bilingual/bicultural/bidialectal students be developed and implemented. Specifically, half (50%) of these speech-language pathologists felt a step-by-step “how to” approach would be most beneficial and assist them with meeting the needs of the diverse student learners they serve.

…having even a rubric of some of the major diverse languages in the country and what to look for and what not to look for and what in these particular languages will let you know if it’s a disorder or not…Definitely something that I could reference if I needed to. (Haitian American speech-language pathologist)

Maybe creating something to be aware of, like a checklist or list of things for us to be aware of but also having consideration that maybe not everything is on that list. (Latina speech-language pathologist)

More pertinent guidelines, from our employers…from our county, to say if you have a bilingual child this is what you need to do because there is not a real clear road for us. A lot of it is left up to us to make that judgment call. (White speech-language pathologist)

Interpreters facilitate process in absence of a bilingual speech-language pathologist, but are not trained in test protocol. All of the interview participants reported that while bilingual speech-pathologists were the ideal professionals for assessing bilingual/bicultural/bidialectal students, interpreters were often used because of the limited availability of bilingual speech-language pathologists. Further, the use of interpreters in the absence of a bilingual speech-language pathologist facilitated the assessment process, which included communicating with students’ parents. However, these speech-language pathologists acknowledged that they were limited to interpreters who were not trained in test protocol. Moreover, not being proficient in a student’s particular language left them unsure as to whether the untrained interpreter asked test
questions without providing contextual clues.

I usually ask one of the bilingual aides to interpret for me and a lot of times they have difficulty coming up with the interpretation, you know the words, and especially the sentence structure. But we do have some formal tests with the Spanish protocol and that makes it easier. But I feel a lot of times like I’m not sure if they are asking the questions correctly because I don’t know what they are saying and I sometimes feel like they give too much support or too much information and again I wonder about the validity of the test at that point. (White speech-language pathologist)

**Difficulty distinguishing a language difference from a language disorder.** The final theme that emerged was participants’ difficulty with distinguishing a language difference from a language disorder in the bilingual/bicultural/bidialectal students referred to them. Four out of 10 of these speech-language pathologists reported that this was a challenge for them.

The major challenge is really making sure that your diagnosis is correct because you wouldn’t want to say that it’s a language difference when it really was a disorder. (Haitian American speech-language pathologists)

I think a challenge is, again, I make sure that I am looking at the dialect so that I am not labeling a child as having a delay or disorder when it actually may just be a difference. (White speech-language pathologist)

Table 20 - *Summary of Raw Intensity Effect Sizes for Themes Associated with Perceived Barriers*

<table>
<thead>
<tr>
<th>Generic Category</th>
<th>Raw Intensity Effect Sizes (n = 10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited coursework/ Non-specific Existing courses</td>
<td>.7</td>
</tr>
<tr>
<td>No protocol / systematic method</td>
<td>.5</td>
</tr>
<tr>
<td>Untrained Interpreters</td>
<td>1.0</td>
</tr>
<tr>
<td>Language difference vs. disorder</td>
<td>.4</td>
</tr>
</tbody>
</table>
Section Three

Reflective analysis. I would be remiss in carrying out this research study without acknowledging the personal biases that I bring as one with insider knowledge. As an insider, I share in experiencing the phenomenon of assessing the language skills of bilingual/bicultural/bidialectal students. I subsequently learned that I was not alone in considering myself an insider. My participants regarded me as an insider also. This was confirmed by such statements as “I’ll help you…you’re one of us” and “You don’t need to provide an incentive, I’ll do it just because of who you are” (a speech-language pathologist). Those who agreed to participate were ecstatic that someone was actually conducting research on this very important topic. They believed that the findings of this study would provide assistance with this challenging situation.

Added to my personal experiences of this phenomenon are the cultural and linguistic experiences I bring as a bicultural and bidialectal individual. Together, they influence my perceptions and practices as a researcher as well as a speech-language pathologist. Thus, this component focuses on my reflections of these experiences as well as the implications and possible effect on the results of the study.

The purpose of this reflective analysis allows readers to delve into my experiences of assessing the language skills of bilingual/bicultural/bidialectal students. Further, it provides clarification of how these experiences intersect with my experiences as a bicultural/bidialectal individual. It also gives an account of what sparked my interest in this topic and what guided my inquiry. According to a fellow colleague, an experience led me into this inquiry, but who I am keeps me here.

I was born on the island of Saint Thomas, United States Virgin Islands. However,
I spent my first few years of life in Brooklyn, New York. I subsequently moved back to Saint Thomas with my family the summer after I completed the fourth grade. Up until that point, I knew nothing about Saint Thomas other than the fact that it is an island in the Caribbean and my birthplace.

Growing up in New York, I naturally demonstrated a regional dialect and accent. I primarily spoke Standard American English (SAE). While I was aware that my parents and some friends of the family spoke with a different accent than I did, I never thought about it beyond that. I was a New Yorker from Brooklyn.

When we returned to the Caribbean, I became aware of a new culture and a new way of living. Life in the fast lane now became life in the slow lane! City streets and skyscrapers were replaced with two lane roads and primarily single story buildings. They even drove on the left side of the road. Stories of Cinderella and Snow White were replaced with stories of Anansi and Cowfoot Woman. Codfish became saltfish. Sweet potato became yam. In addition to hot dogs, hamburgers, and pizza, I grew to love calaloo, johnnycake and cheese, and conch. In addition to playing double-dutch, I played Chinese jump rope. Childhood fears of ghosts hiding under the bed became jumbies. While I learned about Shakespeare’s Macbeth and Romeo and Juliet in English literature, math story problems and grammar exercises were also written in a Caribbean context. Additionally, I learned about Caribbean history in addition to United States history.

I became increasingly aware of the differences between my speech patterns and that of my peers. I learned about the African slaves’ use of a pidgin language or “tongue” as a means of communication among themselves (many spoke different African languages) and their masters on plantations in the West Indies. Slavery ended earlier in
the West Indies as a result of slave revolts and the tropical climate. Unable to cope with
the climate and accompanying mosquitoes, many plantation owners abandoned their
estates. The emancipated slaves maintained the language as well as some African
traditions and passed it down to future generations in the islands. Today, “patois” is a
natural Caribbean dialect spoken by most locals. I should note that within group
variations of patwa exist across the Caribbean.

My classmates also were very aware that I spoke differently from them. Despite
learning about my Caribbean heritage, they frequently called me a “yankee.” Just about
everyone who exhibited speech patterns from the “mainland” (a term used by U.S. Virgin
Islanders to refer to the States) were called “yankees” whether they were from New York
or Alabama. I became the subject of teasing. Desperate to fit in, I embraced this new way
of speaking. I must have mastered it well because my father took notice. He was not
pleased at all with the dialect that I now used to communicate with and made it his
business to let me know. I could not understand what the issue was. After all, I was now
speaking like him. Why was he showing disdain for his own dialect?

As I look back at that time and conversations that have since followed, I
recognize that my father did not make those statements because he had disdain for his
heritage. He did not correct me because he regarded Standard American English as a
superior dialect of English. Rather, he was aware that social forces beyond his control
would judge me based on my speech patterns. Speaking what was then (and continues to
be) referred to as broken English would categorize me as ignorant and unlearned. My
father knew that I would eventually return to the mainland one day. He was preparing me
to be successful in a mainstream American society that regarded anything different as
deviant.

I returned to the “mainland” to attend college. I met fellow classmates from New York and realized that I had not forgotten the speech patterns I previously learned. It felt natural returning to the same dialect as these classmates. We spoke a form of African American Vernacular English (AAVE) in addition to SAE. I spoke SAE by day in my classes and a form of AAVE by night among my friends. I also maintained my ability to speak my Caribbean dialect with family members and individuals from other islands in the Caribbean. I learned to operate in duality. To this day, this is who I am. If there were such a word, one could say I operate in “triality.” I currently maneuver around the dominant mainstream culture as well as the African American and Caribbean subcultures.

I took classes in public speaking and voice and diction at the undergraduate level. These classes naturally required students to give speeches and presentations on various topics. One assignment sticks out in my mind. Students were asked to choose a particular piece of literature and read aloud to the entire class. For this assignment, I chose to read a frequently cited passage from the New International Version of the Bible. I chose not to read this passage from the King James Version because I wanted to ensure that my classmates understood what I was reading. My professor commented that it would have read better had I chosen to read from the King James Version instead. In my opinion, the beauty was in what was being conveyed. In contrast, she felt that “it just wasn’t the same.” I remember receiving instruction on what I was told was the correct way to pronounce certain words. I remember receiving instruction on the one right way to deliver a presentation and feelings of inferiority. None of the above took into account the influences that culture has on diction and presentation style. I am a story teller. I present
information in a round about way, much like my African and Caribbean ancestors.
However, the use of circumlocution: expressing thoughts with “unnecessary” words (The New Merriam-Webster Dictionary, 1989) was frowned upon. I needed to get to the point.

In my opinion, the connection between language and culture is undeniable. It is impossible to separate the two. They are intertwined and dependent upon each other. Why should I or any bilingual/bicultural/bidialectal individual be asked to leave who we are outside of the classroom? I am a proud African Caribbean American (without the hyphen, please). All three are significant to my existence. All three personify who I am.

While working on my master’s degree, I completed my school internship at an elementary school located in a middle-class neighborhood. A teacher made a referral of a White male student for articulation errors. I will call him “Charles” to protect his privacy. According to his teacher, Charles did not pronounce the /th/ sound in words. Instead, he substituted the /t/ sound for /th/. During the screening process, I developed a rapport with him. Rather than focus solely on a screener, I engaged Charles in conversation about his hobbies and family. I noticed that he demonstrated a similar speech pattern to my own when I communicated with a Caribbean dialect. I subsequently learned that Charles’ father was previously employed by a company in Saint Thomas. Charles lived with his dad in Saint Thomas during this time. He adapted to the culture of the islands, which included the use of a Caribbean dialect or “patois.” Charles’ speech patterns were not characteristic of a disorder. Rather, they were characteristic of a difference.

My internship supervisor was relieved that I was present during this referral. I was relieved as well. However, Charles’ teacher had to be reassured that substituting /t/ for /th/ was a normal feature of speaking patwa and that it was okay to speak this dialect.
This incident stayed in my mind throughout the years. What would have happened to Charles had I not been there? Worse, how many more children were misidentified as having a speech and/or language disorder when in fact they were exhibiting a speech and/or language difference? How many more bilingual/bicultural/bidialectal students were propelled into special education programs in the absence of a bilingual/bicultural/bidialectal speech-language pathologist and/or culturally responsive practitioner?

At the master’s level I enrolled in a class that focused on counseling individuals and families of individuals with communication disorders. Like the other classes, one of the assignments required me to prepare a presentation on a given topic. The written comment that I received on my evaluation asked me to refrain from saying “ax” rather than “ask.” Although this correction was undertaken in a private manner, I was so embarrassed. From that day on, I made a conscious effort to pronounce that word with the /sk/ blend and not the x.

I was one of four African American graduate students out of approximately 30 students in my program. Not one professor, instructor, or clinical supervisor looked like me. At that time, differences versus disorders were not discussed in a culturally responsive manner. There was a one-size fits all mentality in my program. Standard American English was the yardstick against which all other dialects were measured against. Standardized articulation and language assessments did not make accommodations for cultural and linguistic differences. Classes with a focus on cultural diversity did not exist. My clinical practicum and internships provided me with limited experiences with culturally and linguistically diverse clients. These clients were primarily
White, from middle-class backgrounds, and able to pay out-of-pocket therapy expenses at the clinic. How was this supposed to help me once I entered the real world of large caseloads primarily made up of African American and Latino children? Unfortunately, these experiences were not isolated to my graduate program. I subsequently learned of similar experiences shared by other speech-language pathologists.

It is interesting to learn that scholars such as Delores Battle, Harry Seymour, and Orlando Taylor published articles on multicultural speech-language issues before I entered my graduate program in 1991. Why was this information not covered in any of my classes? Was this the result of willful disregard for cultural differences, hegemony, or resistance to a differing point of view? My presence and the presence of other students of color should have been enough to justify the need for developing a culturally responsive curriculum.

Not surprisingly, this hegemonic thinking spilled over into other disciplines as well. Early on in my career as a speech-language pathologist, I remember ever so often pronouncing a couple of words characteristic of patois. One of my colleagues, who happened to be a physical therapist and a White male, commented that my use of a dialect was not appropriate for a speech-language pathologist. A conflict existed in me. I became increasingly self-conscious. I was a speech-language pathologist who happened to speak patois and a form of AAVE in addition to SAE. Did I have to give up speaking patois in order to be a speech-language pathologist? Did this come with the territory?

The New Merriam-Webster Dictionary (1998, p. 382) defines patois as “a dialect other than the standard dialect; uneducated or provincial speech; jargon.” It is no wonder to me that mainstream America views any deviation…departure or variation from
Standard American English as ignorant or wrong. This sort of thinking has been instilled in the minds of many Americans, including me. The first word that came to my mind was deviation.

My final reflection involves providing services to bilingual/bicultural/bidialectal students as a speech-language pathologist. In addition to speaking patois and a form of AAVE, I studied the Spanish language up to my sophomore year in college. My birthplace, Saint Thomas, is geographically located near the island of Puerto Rico. I have had the opportunity to participate in the Latino Caribbean culture. Further, I lived in Miami for eight years. At that time, I was very fluent in reading, writing, and understanding Spanish but not as fluent in speaking it.

During my 12 years of experience as a speech-language pathologist, I have had the opportunity to work with many students from culturally and linguistically diverse backgrounds, both in and out of the classroom setting. One of my students was a young Latino boy from Peru. He was a student in a self-contained language impaired class. I will call him Javier to protect his privacy. When I first met Javier, he was still learning the English language. His younger brother received instruction in a full-time ESOL (English for Speakers of Other Languages) classroom and was not diagnosed with a language disorder. His mother did not speak English with the exception of a few words.

I felt comfortable providing therapeutic intervention based on the recommendations of his initial evaluation. I spoke to Javier in Spanish (using basic vocabulary) and English in the classroom setting to the dismay of the classroom teacher with whom I partnered. She believed that Standard American English only should be spoken in the classroom. As a matter of fact, this teacher would often tell our African
American English and Hispanic English Vernacular speakers not to speak “dumbonics” in the classroom. She never acknowledged the beauty of their cultural speech patterns. I would provide damage control and explain to the students that there was nothing wrong with their dialects, but they needed to learn how to “code switch” or use both in the appropriate settings; unfortunately, others were not as accepting of their dialects.

I was relieved that Javier was originally evaluated by another speech-language pathologist. I am not sure if the evaluator was a bilingual Spanish/English speaker. This was most certainly a luxury. Bilingual speech-language pathologists were few and far between. Consequently, English language learners (ELLs) are often placed on an evaluation waiting list and can remain on this list well into the school year.

Despite my comfortableness with the Spanish language, I certainly did not feel competent to speak with his mother during parent conferences, not without the assistance of an interpreter. I was aware of within-group differences that exist in the Spanish language. As a result, a bilingual aide assisted me as my translator when communicating with his mother. While the bilingual aide is not from Peru, she speaks Spanish fluently and is of Latino descent. I remember times when she expressed difficulty translating certain words and phrases from Spanish to English and vice-versa. She also commented, at times, that certain words she used in Spanish to express a certain feeling were different than the words Javier’s mom used. While I could keep up with the conversational exchange between the bilingual aide and Javier’s mom, I was never 100% certain that the aide relayed the information accurately. Further, she was not trained in test protocol. I certainly did not feel confident in performing a reevaluation even with the use of an interpreter and hoped that it would never come to that.
Although I suspected it, I later learned that Javier was subsequently diagnosed with ADHD (attention deficit hyperactive disorder) and a behavior disorder. He was removed from the self-contained classroom and placed into another setting. I have always considered the self-contained language impaired classroom to be a dumping ground, but that is an entirely different issue. Returning to the issue at hand, I wonder how much of the ADHD contributed to his learning difficulties rather than a so-called language disorder.

While the availability of bilingual Spanish/English speech-language pathologists has increased considerably, there remains a limited number (or absence) of professionals who speak any other languages. For example, I have had to work with a student who only spoke Portuguese. The availability of bilingual speech-language pathologists or aides, who were proficient in the Portuguese language, was nonexistent at that time.

The director of a local Islamic school referred a student to me for communication difficulty. He had contacted the local school district and was desperate for an evaluation by a speech-language pathologist. However, “Ali” (name changed to protect his privacy) was about to turn 22 years four months later. During this time, students with disabilities did not receive services in the public schools after the age of 21.

“Ali” spoke Arabic and some English. Once again, a bilingual speech-language pathologist who also spoke Arabic was not available. I requested an interpreter who spoke Arabic in addition to English. The director of this school provided me with this assistance. Prior to initiating the evaluation, I was able to obtain a case history report written by a professor of neurology and psychiatry as well as a faculty of medicine at a university in Cairo Egypt. It was written in English. Ali’s mother has a history of difficult
labor. Ali developed severe jaundice immediately following labor and has a history of delayed developmental milestones.

I used the Kaufman Brief Intelligence Test (K-BIT), Frenchay Dysarthria (slurred speech) Assessment, Oral and Written Language Scales (OWLS), and informal assessments to measure receptive and expressive language skills. It was the most frustrating of my experiences with assessing the language skills of bilingual/bicultural/bidialectal students. There were no language tests available to assess accurately this individual. The tests that were used were not available in the Arabic language. Further, some of the words on the K-BIT did not exist in Ali’s language. While I did notice a motor speech disorder with noticeable facial asymmetry and difficulty following directives, I did not feel comfortable diagnosing a language disorder. This was largely due to the language barrier and use of an interpreter who was not trained in test protocol. I was not sure if the interpreter restated what I said verbatim, modified my words to his preference, or provided Ali with clues. I felt thoroughly incompetent. Perhaps, this was truly competence in that I knew enough to seek assistance in a culturally responsive manner. While I did provide my findings to the Islamic school’s director, I made recommendations for a psychological evaluation to be conducted prior to a speech-language diagnosis. I did not continue with this case.

I have come to realize that these experiences are not solely my experiences. Many other speech-language pathologists of color have experienced the struggle of navigating between two cultures. In addition, the challenge of assessing the language skills of students who speak a language or dialect that we do not understand or speak transcends all racial groups. It is an important issue that has serious implications for the American
Speech, Language, and Hearing Association (ASHA), graduate schools that prepare speech-language pathologists, and local school districts. These implications are presented in detail in Chapter 5.
CHAPTER V

Discussion

This study examined (a) speech-language pathologists’ beliefs about the language assessment of bilingual/bicultural/bidialectal students, (b) speech-language pathologists’ professional efficacy beliefs (both personal and general) as related to assessing the language skills of bilingual/bicultural/bidialectal students, and (c) reported supports and barriers to assessing the language skills of bilingual/bicultural/bidialectal students. The researcher utilized a dominant-status sequential mixed-method design to obtain responses from 221 survey participants and 10 interview participants. This chapter includes a summary of the findings, recommendations for district-level speech-language programs, the American Speech, Language, and Hearing Association (ASHA) focused initiatives, and university preparation programs. Additionally, implications for future research and limitations of the study are provided.

Quantitative Analyses

Quantitative analyses of speech-language pathologists’ professional efficacy beliefs revealed that most speech-language pathologists believed they personally were “somewhat competent” to assess the language skills of students who spoke languages and dialects they did not understand and/or speak. Further, speech-language pathologists primarily believed that most speech-language pathologists are “somewhat competent” in assessing the language skills of bilingual/bicultural/bidialectal students. These findings
corroborated the results of Kritikos (2003). The majority of speech-language pathologists in that study reported low levels of professional efficacy. Specifically, these speech-language pathologists reported that they and the field in general were “not competent” or “somewhat competent” to assess the language skills of multicultural/multilingual individuals.

In this study, it was hypothesized that speech-language pathologists’ professional efficacy beliefs about assessing the language skills of bilingual/bicultural/bidialectal students would vary as a function of (a) speech-language pathologists’ race/ethnicity, (b) years of experience as a speech-language pathologist, (c) years of experience with children and youth, (d) percentage of students from homes where a language other than English is spoken, (e) percentage of students from homes where a dialect is spoken, (f) frequency of time spent with bilingual/bicultural/bidialectal students and their families, (g) years worked with bilingual/bicultural/bidialectal students, (h) proficiency in a language other than English, and (i) proficiency in a dialect. While none of the predictor variables were significantly related to personal efficacy, one of the predictor variables (Hispanic/Latino) was significantly related to general efficacy.

Qualitative Analysis

The qualitative analysis yielded slightly different results. Reported personal efficacy beliefs did not vary as a result of years of experience, exposure to bilingual/bicultural/bidialectal students and their families, level of bilingual proficiency, or level of bidialectal proficiency. However, speech-language pathologists’ personal efficacy beliefs did vary as a function of race/ethnicity. Higher beliefs of personal efficacy existed among speech-language pathologists of color. These professionals
primarily reported that they were “very competent” or “competent.”

While meeting with the independent raters, the researcher questioned the professional efficacy beliefs of the speech-language pathologists of color. How could they feel “very competent” or “competent” when assessing the language skills of students who spoke languages that these professionals did not understand or speak? However, the independent raters both believed that the speech-language pathologists felt more competent because of their own diverse backgrounds. One of the raters noted that while these professionals of color may not have been familiar with a particular language, they knew their limitations and “knowing your limitations and seeking out assistance is a type of competence.”

Although this idea was not the initial thought of the researcher, she easily identified with the reasoning behind it. These speech-language pathologists of color were more in tune and articulate about seeking family input and cultural brokers from students’ ethnic backgrounds unfamiliar to them. All agreed that the speech-language pathologists of color appeared better able to relate because of their own diverse backgrounds. They possessed what the researcher termed insider knowledge.

The reported higher beliefs of personal efficacy among the speech-language pathologists of color, even for languages and/or dialects they do not understand or speak, might be an indication of their ability to relate to their bilingual/bicultural/bidialectal students. In accordance with findings from previous literature, this ability to relate with individuals from culturally and linguistically diverse backgrounds results from personal experiences and a feeling of having something in common with the students.

The socialization process assists in determining professionals’ perceptions, values,
and actions (Rios, 1996). Further, their personal and professional experiences as well as membership in a microcultural group (e.g., religious beliefs, ethnicity) affect the decisions they make, their knowledge, and their beliefs about assessment and therapy intervention (Kritikos, 2003; Porter & Brophy, 1988). Many of these speech-language pathologists of color experienced similar events in their childhood, incidences of being referred for language delays or recommendation for retention because of language differences and a lack of available bilingual educational professionals knowledgeable in multicultural issues. Many saw themselves as advocates for bilingual/bicultural/bidialectal students. These experiences shaped their thinking, particularly in the area of assessment, and subsequent practices. Further, their reported practices identified with culturally responsive actions that ranged from collaborating with families in order to prevent assumptions and stereotyping to teaching their students how to maneuver between two cultures (i.e., code switching).

General efficacy beliefs, in contrast, did not vary as a function of the above demographic variables. Unlike the survey results, the majority of speech-language pathologists who were interviewed believed that the field was “not competent” with regard to assessing the language skills of bilingual/bicultural/bidialectal students. This may be related to the fact that the majority (80%) of interviewees were speech-language pathologists of color, in contrast to the majority (83%) of survey respondents who were not speech-language pathologists of color. All interview participants believed that the field needed improvement in this area.

Perceived supports and barriers as well as the demographics of survey respondents, which highlight low numbers of speech-language pathologists from
bilingual/bicultural/bidialectal backgrounds, confirmed the needs of the field to address assessment and intervention practices of bilingual/bicultural/bidialectal students. Regarding perceived supports, respondents held the highest regard for the provision of more academic course work in this area, more practicum experience with bilingual/bicultural/bidialectal students, and active recruitment of bilingual/bicultural/bidialectal speech-language pathologists. Regarding perceived barriers, respondents overwhelmingly reported the following: lack of availability of bilingual speech-language pathologists who speak the individual’s language, lack of developmental norms and standardized assessment tools in languages other than English, difficulty distinguishing a language difference from a language disorder, and lack of availability of interpreters who speak the individual’s language.

Reported supports and barriers to assessing the language skills of bilingual/bicultural/bidialectal students also coincided with survey responses. Themes that emerged emulated the survey responses as well as the results of Roseberry-McKibbin and Eicholtz (1994) and Roseberry-McKibbin et al., (in press). Although 11 years passed between survey administrations, they both yielded comparable results. The results from both studies indicated the need for more bilingual speech-language pathologists. Further, they acknowledged their inability to speak a language other than English as a barrier to working with students whose native language was not English. Other reported challenges were the limited availability of “nonbiased” instruments and the accessibility of bilingual professionals. Respondents also reported a great interest in receiving continuing education in general assessment and intervention procedures that were “less biased” and provided clarity in distinguishing language differences from language disorders. Other
topics of interest included second language acquisition and developmental norms for first and second languages.

Similarly, speech-language pathologists in the present study overwhelmingly expressed the need for more speech-language pathologists of color, particularly those who were bilingual. Most of these professionals believed that bilingual speech-language pathologists, rather than interpreters, should have the responsibility of assessing bilingual children. Further, they expressed most interpreters were not trained in test protocol, interfering with the reliability and validity of the test results. A critical shortage of bilingual/bicultural/bidialectal speech-language pathologists exists. The few who exist, particularly bilingual speech-language pathologists, are inundated with heavy caseloads (Banotai, 2004).

In several of the interviews, speech-language pathologists spoke of the limited coursework that existed at the graduate school level. Most would have preferred coursework that focused on specific issues of language assessment and treatment intervention relative to particular languages and dialects. Further, these speech-language pathologists expressed the need for more research-based, systematic approaches to the assessment and treatment of bilingual/bidialectal/bicultural students.

Many suggested that graduate preparation programs become more apt at bridging theory to practice. They articulated the necessity for clinical practicum experiences to model a caseload that would be found in the “real world” as much as possible. Specifically, these speech-language pathologists reported that it was essential for clinical practicum speech-language pathology students to work with a culturally and linguistically diverse clientele before completing their graduate programs.

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Upon graduating, speech-language pathologists expressed the importance of maintaining professional development in the area of multicultural speech-language issues. Specifically, many reported the need for a required amount of continuing education units/hours/credits particularly in this area. Further, they suggested a requirement for all speech-language pathologists to be certified/proficient in another language other than English.

Speech-language pathologists also expressed the importance of the field in general and school districts in particular, providing more resources in the form of multicultural speech-language specialists, websites with quicker response rates and live personnel, and cross-county networks of bilingual/bicultural/bidialectal speech-language pathologists. These responses have serious implications for graduate preparation programs in communication sciences and disorders, school districts, and the American Speech, Language, and Hearing Association.

Limitations

There are several limitations to this study. Self-reported data present limitations. Further, the researcher’s race/ethnicity as an African Caribbean American and background as a speech-language pathologist presents limitations as well. Participants may have provided responses they perceived to be the “correct answer” or “socially acceptable.” This threat is known as reactive arrangements (Onwuegbuzie, 2003).

Another limitation in this study was the threat to population validity and ecological validity (McMillan, 2000; Onwuegbuzie, 2003). Research participants were limited to speech-language pathologists employed by two central Florida school districts. It is possible that speech-language pathologists who reside in other areas of the state or
elsewhere in the nation would report different levels of professional efficacy beliefs as well as supports and barriers to assessing the language skills of bilingual/bicultural/bidialectal students. Further, the percentage of female participants substantially outnumbered their male counterparts. As a result, the multiple regression analysis did not compare responses by gender. Further, only female speech-language pathologists were selected to participate in the follow-up interviews. Thus, information gathered from this study may be only applicable to female speech-language pathologists in these two central Florida school districts.

Missing from the data is the opportunity to observe participants’ practices in assessing bilingual/bicultural/bidialectal students. Actual observations of participant’s practices would have allowed the researcher either to corroborate or to refute the presence of the reported beliefs. Finally, the researcher utilized an independent transcriptionist. Although instructed to record verbatim, some responses may have been lost in translation. This posed a threat to descriptive validity and interpretive validity (Maxwell, 1992, 1996).

**Implications for Graduate Preparatory Programs**

Based on the findings of this study, a major goal for communication sciences departments should be to ensure that prospective speech-language pathologists represent the diversity of the American population. These programs should focus on the following:

- **Actively recruit individuals who represent a rich variety of culturally and linguistically diverse backgrounds.** Having a culturally and linguistically diverse representation of speech-language pathologists will increase the number of these professionals who are prepared to assess the language skills of a diverse group of
students;

- *Prepare individuals to be proficient in at least one language other than English and dialectal variations by including a variety of languages and dialects as part of the course work requirements.* Individuals will choose to learn or improve proficiency in at least one language and dialect, thereby increasing the number of bilingual and bidialectal professionals in the field;

- *Prepare individuals to embrace and value the cultural differences represented in our diverse society.* It is not enough simply to tolerate or be aware of cultural and linguistic differences. Individuals, with the assistance of graduate preparatory programs, must come to the realization that more than one way of knowing exists. Specifically, in order for graduate preparation programs to prepare future practitioners to be culturally responsive, they must also be prepared to embrace and appreciate multiple perspectives and the cultural diversity that exist among the American population;

- *Provide students with more substantive information about individual cultures, languages, and dialects with ample practical experiences.* Curriculum should be relevant, providing detailed information, and not glossed-over, politically correct terminology. Student speech-language pathologists should be given many opportunities to work with culturally and linguistically diverse students and their families while completing their clinical practicum and internship experiences. Graduate preparatory programs should form partnerships with local school districts and other educational agencies, particularly in areas representative of a large number of culturally and linguistically diverse student learners; and
• Focus active recruitment efforts on increasing the numbers of doctoral students and faculty researchers of color, and those who are interested in expanding the knowledge base in this area. Preparing future speech-language pathologists to provide culturally responsive services to bilingual/bicultural/bidialectal students only can be accomplished through faculty who are knowledgeable in the areas of linguistic diversity, second language acquisition, and cultural variations in language development. Increasing the number of diverse scholars of color and those interested in multicultural speech-language issues will expand the knowledge base and assist graduate preparatory schools with this challenge. They must possess knowledge and skills in the above areas, derived from active research agendas.

Currently, language tests written in languages other than Spanish are lacking. Most standardized tests have not included bilingual populations in their normative sampling (Banotai, 2004). One test was recently developed with African American Vernacular English speakers in mind. However, many others have only made accommodations for these dialectal variations. Lisa Bedore, assistant professor at the University of Texas at Austin, cautioned that it is possible for a person to be linguistically competent without being culturally competent and vice versa (Banotai, 2004).

Having the ability to speak and/or understand a language is not enough. It must be accompanied by cultural competence training. One must be knowledgeable of culture and its interconnection with language. Cultural knowledge is defined as an individual’s familiarity with specific cultural and behavior characteristics, history, values, and belief systems of members of another ethnic group (Adams, 1995). This knowledge must be
accompanied with cultural awareness, which is, cultivating sensitivity and understanding of another ethnic group (Adams, 1995). An individual who demonstrates cultural awareness is flexible and open to cultural differences (Adams, 1995). An individual who demonstrates cultural sensitivity knows that cultural differences as well as similarities exist but does not judge (i.e., negatively or positively) those cultural differences (National Maternal and Child Health Resource Center on Cultural Competency, 1997). However, this knowledge does not solely make an individual culturally competent.

Achieving cultural competence goes beyond knowledge, awareness, and sensitivity of cultural morays and characteristics of a select ethnic group. It is a set of corresponding behaviors, attitudes, and policies that come together in a system, organization, or among professionals and enables that system, organization, or those professionals to operate efficiently in cross-cultural situations (Cross, Bazron, Dennis, & Isaacs, 1989). Operationally defined, cultural competence is demonstrated when knowledge about individuals and groups of people are integrated and transformed into specific standards, policies, practices and attitudes, and used in appropriate cultural settings to increase the quality of services; thereby producing better outcomes (Davis, 1997).

Implications for ASHA

ASHA has shown a definite desire to expand the knowledge base through its Focused Initiatives. Currently, ASHA is in the process of updating its guidelines as they relate to the assessment and therapeutic intervention of individuals who are culturally and/or linguistically diverse. Recommendations to ASHA include:

- *A stricter regulation of continuing education units/hours.* ASHA should lead state
certification and licensing boards in requiring speech-language pathologists to dedicate a set number of hours toward assessment and treatment of bilingual/bicultural/bidialectal individuals. As interview participants commented, speech-language pathologists have been required to enroll in continuing education courses/trainings for annual HIV/AIDS updates, biannual CPR renewal, and annual medical errors updates, regardless of their work setting (i.e. hospital or school). Many suggested that the multicultural speech and language issues requirement would be more relevant;

- *A requirement for speech-language pathologists to become proficient in a language other than English.* ASHA should collaborate with graduate preparation programs to outline standards for establishing proficiency. Many pre-major undergraduate programs already have this requirement as part of the general liberal arts curriculum. This requirement for speech-language pathologists would involve greater detail than the mere conjugation of vocabulary words and would become a regular part of the graduate curriculum. In addition to becoming proficient in a language, speech-language pathologists should be immersed in a culture representative of the language they are learning through field experiences and practicum assignments. In addition to Spanish, speech-language pathologists should be given the opportunity and encouraged to learn other languages not traditionally taught, but often spoken by the students of color on their caseloads (e.g., Creole, Tagalog);

- *Expand speech-language pathologists’ knowledge in the area of dialectal variations.* Expanding speech-language pathologists’ knowledge in the area of
dialectal variations must go beyond solely relying on a test that may include an addendum to a few grammatical structures of a particular dialect. These professionals must be cautioned not to assume that every African American, for example, speaks African American Vernacular English. Cultural competence training will equip these professionals with knowledge necessary to provide appropriate services to children and youth who speak various dialects.

The researcher is not suggesting that speech-language pathologists, who are regular speakers of standard American English (SAE), speak a dialect as their mode of communication. However, culturally competent speech-language pathologists embrace their students’ dialects as respected and viable means of communication. Further, information will be gained from a culturally responsive assessment process, one in which the clinician involves the family.

Finally, some speech-language pathologists characterized ASHA’s resource website as “pinch hitting” and providing “no definitive answer”, whereas others expressed the need for more easily accessible experts to be on-hand. This difficulty is enhanced when the ASHA representative is not knowledgeable of state mandates. Further, they expressed that typically there is only one designated expert in a particular area to provide assistance. Consequently, this expert often is unavailable, resulting in voicemails, multiple referrals to other individuals, and poor response rates (i.e., unreturned phone calls). Findings from this study support the need for ASHA to provide more experts, specialized in the area of multicultural/multilingual speech-language issues. Further, these experts must be more accessible and knowledgeable of state mandates related to speech-language pathology.
Implications for School District Level Speech-Language Supervisors

As stated previously, the demographics of the American population are changing at a rapid rate (Martin & Midgley, 1999; Riche, 2000). America is becoming increasingly diverse and the public schools are experiencing this change as well (Blair, 2003). However, the number of bilingual/bicultural/bidialectal speech-language pathologists far outweighs the number of speech-language pathologists prepared to serve them (U.S. Bureau of the Census, 2000; U.S. Department of Education, 2001; U.S. Department of Education, 2001, Office of Special Education Programs; Whitmire & Eger, 2003).

In order to meet the needs of this diverse clientele, school districts must ensure that their speech-language pathologists are receiving the necessary resources to perform adequate services. Such resources must include:

- Actively recruiting (internationally and nationally) of bilingual/bicultural/bidialectal speech-language pathologists to fill vacancy positions;
- Assisting immigrant speech-language pathologists with work visas;
- Providing more professional development workshops in this area that focus on specific issues of cultural diversity with real-life examples;
- Utilizing local and national consultants who are experts in multicultural speech-language issues;
- Providing current employees with extensive training to serve as lead clinicians in this area specifically; and
- Collaborating with nearby school districts to pool resources in this area (“borrow” bilingual/bicultural/bidialectal speech-language pathologists, share the cost of
Implications for Future Research

As stated previously, educational researchers have placed a larger focus on teacher perceptions, self-efficacy beliefs, and subsequent practices when working with students of color. Related professionals, such as speech-language pathologists, have been left out of the dialogue. Consequently, limited studies with a focus on speech-language pathologists’ beliefs in providing services to culturally and linguistically diverse students exist. In fact, this study is one of two studies with a specific focus on speech-language pathologists’ professional efficacy beliefs. To some extent, the present data revealed findings that were consistent with the previous study (Kritikos, 2003). Future research might continue in the mixed method tradition or focus solely on either the quantitative or qualitative research traditions. The following recommendations for future research stem from the following findings:

- **Develop cases of real-life examples.** Case studies with specific scenarios related to assessment and treatment of culturally and linguistically diverse students could be developed. Speech-language pathologists could provide responses to a series of cases that simulate the world in which these professionals work. This would serve to enhance data collection in the form of triangulation. The researcher could determine whether differences truly exist across groups of speech-language pathologists (i.e., race/ethnicity, years of experience);

- **Modify survey.** The survey used in this study primarily grouped bilingual/bicultural bidialectal students as a whole. Perhaps, a modified questionnaire would separate the above into separate distinctions. This would
provide the researcher with any differences in professional efficacy beliefs that speech-language pathologists may have regarding bilingual and bidialectal students;

- Engage in participant observation or case studies. Participant observation and case studies of speech-language pathologists would provide greater in-depth information concerning their professional efficacy beliefs. The researcher could ask questions that are more specific about beliefs as it relates to race/ethnicity, culture, linguistic diversity, and role of the parents. Although time consuming, the researcher would gain a voluminous amount of information obtained over time; and

- Replicate the study. Replicating the study would confirm findings and add to a currently limited knowledge base in this area of research. This study focused on participants employed by two large school districts. The researcher could include participants from other Florida counties according to their district size (i.e., small, medium, large) to determine comparisons, across the state of Florida, or at a national level.

While there is a wealth of information and studies on teacher beliefs and practices, this is not the case for related professionals such as speech-language pathologists. Like educators, school-based speech-language pathologists provide services to culturally and linguistically diverse students and their families. Further, they share the responsibility with educators of ensuring an adequate education for students with disabilities and those placed at risk in the least restrictive environment. Despite the educational implications, limited research in the area of speech-language pathologists’ beliefs and practices exist.
The limited presence of research focused on speech-language pathologists in this area justifies the need for this present study.

The purpose of this study was to examine speech-language pathologists’ (a) beliefs about the language assessment of bilingual/bicultural/bidialectal students, (b) professional efficacy beliefs (both personal and general) as they relate to assessing the language skills of bilingual/bicultural/bidialectal students, and (c) reported supports and barriers to assessing the language skills of bilingual/bicultural/bidialectal students. The researcher was particularly interested in determining whether differences among speech-language pathologists’ beliefs existed based on the following factors:

- Race/ethnicity;
- Years of experience as a speech-language pathologist;
- Years of experience working with children and youth;
- Percentage of students from homes where a language other than English is spoken;
- Percentage of students from homes where a dialect is spoken;
- Frequency of time spent with bilingual/bicultural/bidialectal students;
- Years worked with bilingual/bicultural/bidialectal students;
- Proficiency in a language other than English; and
- Proficiency in a dialect

The findings from this study provide a rationale for the active recruitment of culturally and linguistically diverse speech-language pathologists and researchers focused on multicultural speech-language issues, clearer guidelines and protocol for providing services to bilingual/bicultural/bidialectal student learners, more practicum and internship
experiences with bilingual/bicultural/bidialectal students, and preservice and inservice
cultural competence training. Further, these findings support the need for further research
in this area. Information gathered from subsequent studies will expand the current
dialogue, adding to the knowledge base of speech-language pathologists’ professional
efficacy beliefs as well as supports and barriers to assessing the language skills of
bilingual/bicultural/bidialectal students.
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Appendices
Appendix A: Cover Letter

Dear Colleague:

Please allow me to introduce myself. I am Karen Harris, a fellow speech-language pathologist and doctoral candidate at the University of South Florida’s Department of Special Education.

As part of my dissertation research, I am interested in your opinion about assessing the language skills of bilingual, bicultural, and bidialectal students with special needs, particularly when Standard American English is not the first or native language. As a speech-language pathologist, you are well aware of the various issues involved in assessing and providing therapeutic intervention services to bilingual, bicultural, and bidialectal students. Enclosed is a short questionnaire that was designed to elicit responses about speech-language services provided to bilingual, bicultural, bidialectal individuals by monolingual and multilingual speech-language pathologists.

Your responses can provide me with a greater understanding of the supports, barriers, and confidence associated with assessing the language skills of bilingual/bicultural students with special needs. Your decision to participate in this research study is completely voluntary. You are free to participate in this research study or to withdraw at any time. Participation in this study is completely anonymous and will in no way affect your job status. There are no known risks associated with participation in this study.

Speech-language pathologists who return the completed questionnaire within the time allotted will be automatically placed in a drawing to win one of three prizes. Each prize is a gift certificate/store credit at Super Duper Publications equivalent to $50 in speech-language therapeutic materials. All questions must be answered or labeled “not applicable”. Answering this questionnaire should take approximately 20-25 minutes of your time.

To ensure complete anonymity, your contact information (i.e. name, number, email address) will be used to contact you if you are a recipient of one of the prize drawings or if you indicate interest in participating in subsequent follow-up interviews. If you are interested in participating in follow-up interviews, please indicate this on your contact information sheet or contact me directly at (813) 335-6100 or kpharris@tempest.coedu.usf.edu.

While the survey will provide me with valuable information, knowledge gained from individual interviews with you will be more in-depth. I am interested in your perceptions as it relates to your experiences with assessing the language skills of bilingual/bicultural students. I will meet with you on a mutually agreeable day and at a mutually agreeable place and time. Individuals selected to participate in follow-up interviews will receive a gift certificate equivalent to 2 movie theatre tickets at the end of
the complete interview session. Interview sessions will be approximately 1-2 hours in length. In an effort to correctly record your responses, you may be contacted later for clarification of any responses made to interview questions. Thus, you will have the opportunity to make modifications to any statements you make. While interviews will be audio taped, no information will be included in the final write-up to identify you.

If you are completing this survey via a speech-language website in your school district, Please follow the instructions at the website for submitting the completed survey. If you are completing this survey in person, please return the completed survey and contact information sheet to me or my designated representative. The documents will remain separate to ensure anonymity. If you are completing this survey via school mail, please return the completed questionnaire (and contact information sheet) in separate envelopes to your supervisor of speech-language services by Wednesday May 26, 2004.

If you have any questions about this research study, contact Karen Harris at the above number or email address.

If you have questions about your rights as a person who is taking part in a research study, you may contact the Division of Research Compliance of the University of South Florida at (813) 974-5638.

Thank you for your support in furthering the professional growth and development of our field. Your assistance is greatly appreciated.

Sincerely,

Karen P. Harris, M.S. CCC-SLP
Appendix B: Speech-Language Survey

**SPEECH-LANGUAGE SERVICES TO BILINGUAL, BICULTURAL, AND BIDIALECTAL STUDENTS**

This survey is designed to identify speech-language pathologists’ self-perceived knowledge and competence to assess the language skills of bilingual, bicultural, and bidialectal children with special needs and their families. Your responses will inform and guide decisions related to recruitment, retention, and professional development needs.

**FORM DIRECTIONS:** Do not write your name. This survey is anonymous. Please use a pencil and mark only one bubble for each question, answer, or statement. Make solid marks that fill the circle completely. Erase cleanly any marks you wish to change. Remember to complete both sides. Via the web: Place an x in

<table>
<thead>
<tr>
<th>Part One – Demographic Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning About Your General Background</td>
</tr>
</tbody>
</table>

1. How many years (total) have you been working in the field of speech-language pathology?
   - [ ] 3 years or fewer
   - [ ] 4-7 years
   - [ ] 8-11 years
   - [ ] 12-20 years
   - [ ] More than 20 years

2. How many years (total) have you provided speech-language services to children and youth?
   - [ ] 3 years or fewer
   - [ ] 4-7 years
   - [ ] 8-11 years
   - [ ] 12-20 years
   - [ ] More than 20 years
   - [ ] Not applicable

3. What is the highest degree you hold?
   - [ ] Bachelors
   - [ ] Masters
   - [ ] Specialist
   - [ ] Ph.D. or Ed.D.
   - [ ] Other ___________(specify)

4. Do you hold state certification by the Department of Education in speech-language pathology?
   - [ ] Yes
   - [ ] No

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5. Do you hold the ASHA certificate of clinical competence?
   ○ Yes  ○ No

6. Do you hold a state license in speech-language pathology?
   ○ Yes  ○ No

7. In which Florida county do you primarily provide services?

8. What type of services do you primarily provide? (Darken all that apply.)
   ○ Consultative
   ○ Direct Services
   ○ Individual Services
   ○ Group Services
   ○ Other ___________________ (specify)

9. What is your gender?
   ○ Female  ○ Male

10. What is your race/ethnicity?
    ○ African American/black (not of Hispanic/Latino origin)
    ○ American Indian or Alaskan Native
    ○ Asian American or Pacific Islander
    ○ Caucasian/White (not of Hispanic/Latino origin)
    ○ Hispanic/Latino
    ○ Other _________________ (specify)

**Note** via the web: Place an x next to the appropriate number.

11. How often do you currently work in each setting?
    a. School          Never  Not Often  Often  Very Often
                       1      2        3      4
    b. Hospital        1      2        3      4
    c. Clinic          1      2        3      4
    d. Home Health     1      2        3      4
    e. Other ___________ 1      2        3      4
12. How often do you currently work with each age group?

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Never</th>
<th>Not Often</th>
<th>Often</th>
<th>Very Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Ages 0-2</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>b. Ages 3-5</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>c. Ages 6-11</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>d. Ages 12-18</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>e. Ages 19-22</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

13. To whom do you primarily provide services? (Darken all that apply.)

- African American/black
- Asian/Pacific Islander
- Caucasian
- Hispanic
- Native American
- Other

14. What is your best estimate as to the percentage of your caseload of individuals who come from homes where a language other than English is spoken?

- None
- Less than 25%
- 25% to 50%
- 51% to 75%
- More than 75%

15. What is your best estimate as to the percentage of your caseload of individuals who come from homes where a dialect (i.e. African American Vernacular English, Caribbean dialect) is spoken?

- None
- Less than 25%
- 25% to 50%
- 51% to 75%
- More than 75%

16. How often do you currently work with bilingual/bicultural/bidialectal students?

- Occasionally (consultation only)
- 1 to 2 times per week
- 3 to 5 times per week
- Other ________________ (specify)
- Never

17. How many years have you worked with bilingual/bicultural/bidialectal students?

- Less than 1 year
- 1 to 5 years
- 6 to 10 years
- Greater than 10 years
18. What are the most common languages spoken among the bilingual individuals you serve? (Darken up to five choices.)

- Arabic
- Chinese
- Creole
- French
- Gujarati
- Hebrew
- Hindi
- Italian
- Japanese
- Korean
- Polish
- Russian
- Spanish
- Tagalog
- Urdu
- Yiddish
- Other ___________________

19. What are the most common dialects spoken among the bilingual individuals you serve? (Darken up to five choices.)

- African American Vernacular English
- Appalachian Dialect
- Caribbean
- Gullah
- Hispanic English Vernacular
- Mandarin Chinese Vernacular
- Southern Dialect
- Other ____________________
24. How long have you spoken a language other than English?

- Less than 1 year
- 1 – 5 years
- 6 – 10 years
- Greater than 10 years

25. Where did you learn a language other than English?

- School
- Home
- Abroad
- Other ________________________ (specify)

26. Rate your proficiency in a language other than English for the following domains:
   Specify language you are referring to if you indicated more than one language above.
   Not Proficient Somewhat Proficient Proficient Very Proficient

   Language(s)
   a. Listening ___________ 1 2 3 4
      ___________ 1 2 3 4
   b. Speaking ___________ 1 2 3 4
      ___________ 1 2 3 4
   c. Reading ____________ 1 2 3 4
      ____________ 1 2 3 4
   d. Writing ____________ 1 2 3 4
      ____________ 1 2 3 4

27. Do you speak and/or understand a dialect?

- Yes
- No (Skip to question 33)

28. Which dialect(s) do you understand and/or speak? ____________________,
    ____________________, ____________________, ____________________

29. At what age did you learn a dialect?

- Birth to 3 years
- 4 – 7 years
- 8 – 11 years
- 12 – 18 years
- Over 18 years
30. How long have you spoken a dialect?

- Less than 1 year
- 1 – 5 years
- 6 – 10 years
- Greater than 10 years

31. Where did you learn a dialect?

- School
- Home
- Abroad
- Other ________________________ (specify)

32. Rate your proficiency in a dialect for the following domains: Specify dialect you are referring to if you indicated more than one dialect above.

<table>
<thead>
<tr>
<th>Dialect(s)</th>
<th>Not Proficient</th>
<th>Somewhat Proficient</th>
<th>Proficient</th>
<th>Very Proficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Listening</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Speaking</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Reading</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Writing</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

33. Have you had any speech-language pathology course work that addressed the following? (Darken all that apply.)

- Second language acquisition
- Communication patterns in cultures where a language other than English is spoken
- Communication patterns in cultures where a dialect is spoken
- Differential assessment of bilingual vs. monolingual individuals
- Cultural factors that influence learning
- Multicultural issues/ethnically diverse populations
- Assessment tools for bilingual/bidialectal individuals
- Language disorder vs. language difference
- Laws involved in the assessment and treatment of bilingual individuals
- Working with families
- How to utilize a language interpreter
- Other ________________________ (specify)
34. Have you attended any inservices or workshops that addressed the following?
(Darken all that apply.)

○ Second language acquisition
○ Communication patterns in cultures where a language other than English is spoken
○ Communication patterns in cultures where a dialect is spoken
○ Differential assessment of bilingual vs. monolingual individuals
○ Cultural factors that influence learning
○ Multicultural issues/ethnically diverse populations
○ Assessment tools for bilingual/bidialectal individuals
○ Language disorder vs. language difference
○ Laws involved in the assessment and treatment of bilingual individuals
○ Working with families
○ How to utilize a language interpreter
○ Other ____________________ (specify)

Learning About Your Experience Assessing Bilingual/Bicultural/Bidialectal Individuals

35. With the help of an interpreter, how competent do you feel in assessing a student’s language development in a language and/or dialect you do not understand or speak?

○ Not competent
○ Somewhat competent
○ Competent
○ Very competent

36. With the help of an interpreter, how competent do you feel most speech-language pathologists are in assessing an individual’s language development in a language and/or dialect that they do not understand or speak?

○ Not competent
○ Somewhat competent
○ Competent
○ Very competent
37. Which problem(s) do you encounter in assessing bilingual/bicultural/bidialectal students with language disorders? (Darken all that apply.)

○ Lack of knowledge of client’s culture
○ Lack of knowledge of the nature of second language acquisition
○ Difficult to distinguish a language difference from a language disorder
○ Lack of availability of interpreters who speak the individual’s language
○ Lack of availability of interpreters who speak the individual’s dialect
○ Lack of availability of bilingual speech-language pathologists who speak the individual’s language
○ Lack of availability of bidialectal speech-language pathologists who speak the individual’s dialect
○ Lack of developmental norms and standardized assessment tools in languages other than English
○ Lack of developmental norms and standardized assessment tools in speakers of nonstandard dialects
○ Time allocated by your employer for assessment administration, scoring, and interpretation
○ Utilizing test scores of translated tests
○ Language tests published in a language other than English with flawed normative samples

38. Based on your experience, circle the statement you agree with the most. Who should provide language assessment to bilingual/bidialectal students with language problems?

○ Bilingual Education Specialists
○ English as a Second Language (ESL) Specialists
○ Speech-Language Pathologists
○ Professionals should collaborate
○ Other _______________________________ (specify)

Learning About Your Opinions of How to Improve the Field

39. How can our field better prepare speech-language pathologists to carry out appropriate assessment of bilingual/bidialectal individuals? Please rate the following in terms of importance.

<table>
<thead>
<tr>
<th>Pre-service</th>
<th>Very unimportant</th>
<th>Unimportant</th>
<th>Not sure</th>
<th>Important</th>
<th>Very Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. More academic course work in this area</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>b. More practicum experience with bilingual/bicultural/bidialectal clients</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
c. More active recruitment of bilingual/bicultural/bidialectal speech-language pathologists

<table>
<thead>
<tr>
<th></th>
<th>Very unimportant</th>
<th>Unimportant</th>
<th>Not sure</th>
<th>Important</th>
<th>Very Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inservice</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. More seminars and workshops on this topic</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>b. More journal articles on this topic</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>c. Easier access to a bilingual/bidialectal speech-language pathologist pool in your county</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>d. More experience with bilingual/bicultural/bidialectal clients</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>e. More active recruitment of bilingual/bicultural/bidialectal/speech-language pathologists</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

THANK YOU FOR YOUR ASSISTANCE!

**Instructions for completion via speech-language website:**
Once completed, follow the instructions provided to submit the surveys. You may also print the survey and send it to your speech-language supervisor via school mail.

Email and/or call the researcher with your name, address (school or home), and phone number with area code. Your name will be automatically entered in a raffle to win one of three $50 gift certificates redeemable at Super Duper Publications or Linguisystems.

**Instructions for completion in person:**
Give completed survey and data information sheet to the researcher. These documents will be kept separately in order to ensure complete anonymity. Your name will be automatically entered in a raffle to win one of three $50 gift certificates redeemable at Super Duper Publications or Linguisystems.
**Instructions for completion via school mail:**
Submit the completed survey and contact information sheet with your name, number (including area code) to your supervisor in **separate** envelopes via school mail. You may also provide your contact information via email. This will ensure complete anonymity. Your name will be automatically entered in a raffle to win one of three $50 gift certificates to Super Duper Publications or Linguisystems.
Appendix C: Demographic Data Sheet

Name: __________________________________________________

Phone Number: (    ) __________________________

Email Address: _________________________________________

I am interested in participating in follow-up interviews. Please contact me.

Please check one.

Yes ________

No ________

Please complete below for my general information:

Years of experience __________________________

Certification area (if applicable) __________________________

Licensure (if applicable) ___________________________

Languages spoken __________________________

Gender _____________________________

Race/Ethnicity ___________________________
Appendix D: Interview Questions

1. How do you think society in general perceives disability?

2. Are you aware of any beliefs about disability that are associated with the __________ culture?

3. How do you feel about those beliefs?

4. What are your thoughts about working with culturally and linguistically diverse students and their families?

5. In your opinion, what is the relationship between culture and language?

**Focus on Bilingual/Bicultural Students**

6. Have you ever assessed a bilingual student?

7. How often have you assessed bilingual students?

8. What are your thoughts about assessing bilingual students?

9. Tell me about your experiences with assessing bilingual students.

10. What are some challenges regarding assessing students who are English language learners?

11. What things do you consider or keep in mind when assessing a bilingual student?

12. What prerequisites do you see as vital to assessing bilingual students?

13. What ethical issues should be considered when assessing bilingual students?

14. What do you think contributes to the misidentification and overrepresentation of English language learners in special education programs?

15. Tell me about your experiences with using an interpreter.

16. What are the advantages to using an interpreter?
17. What are the disadvantages to using an interpreter?

18. Tell me about coursework or inservice training you’ve received regarding working with culturally and linguistically diverse students and their families.

19. Is there a content area that you would have liked to receive training in or additional information about?

20. How well do you believe the field of speech-language pathology is doing in effectively meeting the needs of culturally and linguistically diverse students?

21. How competent do you feel you are in effectively meeting the needs of culturally and linguistically diverse students and their families?

22. How competent do you feel you are in assessing the language skills of bilingual students?

23. What supports do you see as necessary in assessing the language skills of bilingual students?

24. What barriers do you see in assessing the language skills of bilingual students?

**Focus on Speakers of Dialectal Variations**

25. Have you ever assessed a student who speaks a dialect (i.e. African American Vernacular English, Gullah, Hispanic English Vernacular, Appalachian English)?

26. How often have you assessed students who speak a dialect?

27. What are your thoughts about assessing students who speak a dialect?

28. Tell me about your experiences with assessing students who speak a dialect.

29. What are some challenges regarding assessing students who speak a dialect?
30. What things do you consider or keep in mind when assessing a student who speaks a dialect?

31. What prerequisites do you see as vital to assessing students who speak a dialect?

32. What ethical issues should be considered when assessing students who speak a dialect?

33. What do you think contributes to the misidentification and overrepresentation of speakers of dialects in special education programs?

34. Tell me about your experiences with using an interpreter.

35. What are the advantages to using an interpreter?

36. What are the disadvantages to using an interpreter?

37. Is there a content area that you would have liked to receive training in or additional information about?

38. What supports do you see as necessary in assessing the language skills of students who speak a dialect?

39. What barriers do you see in assessing the language skills of students who speak a dialect?
About the Author

Karen Patricia Harris received a Bachelor of Science Degree in Communication from the University of Miami in 1990 and a Master of Science Degree in Speech and Language Pathology from Nova Southeastern University in 1993. She holds the Certificate of Clinical Competence by the American Speech Language and Hearing Association (ASHA) and has 12 years of experience as a speech-language pathologist. Karen entered the Ph.D. program at the University of South Florida in fall 2001. She is the recipient of the LASER Doctoral Fellowship and Cathy Lynn Richardson Endowed Doctoral Scholarship. Her research interests are in the areas of cultural competence, as it relates to the assessment and intervention of bilingual, bicultural, and bidialectal students, and the sociocultural aspects of language and literacy development in African American children.